

Culture Clash: Aligning Payers and Providers for Real Reform

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Before true healthcare reform can be enacted, the cultural differences between providers and payers need to be addressed.

At a Glance

- **Self-imposed cost containment is not part of providers' heritage.**
 - **The payer business model and its problems are complicated; simplistic reforms won't help.**
 - **Health reform needs to be refocused on policies that allow providers and payers to align their cultures so that all parties benefit from potential synergies to provide top-quality care as inexpensively as possible.**
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cul.ture: the set of shared attitudes, values, goals, and characterizes an institution or organization
Collegiate Dictionary

practices that
—Merriam-Webster's 11th

Efforts to legislate healthcare reform in the United States have been insensitive to significant cultural differences between key players whose competing interests are at stake. Meaningful improvements in cost, quality, and access will not be accomplished until reformers adopt policies that reconcile the underlying culture clashes, beginning with providers and payers.

We have all experienced culture clash, perhaps when we participated in a corporate merger or welcomed an expansion sports franchise to our city. We know intuitively that success or failure of a new venture is ultimately determined by how well leaders manage the transition for competitors who suddenly find themselves on the same team. Failure is almost guaranteed if historical differences between merged stakeholders are not openly and constructively addressed on common grounds.

Unfortunately, oversimplification of healthcare reform over the past year has been pushing the medical marketplace in a counterproductive direction. Reform's final manifestation—insurance overhaul—would force providers and payers to respond to unfunded mandates (and unintended consequences) without resolving serious structural problems that positioned reform as a top political issue in the 2008 elections. The result of reform-cum-insurance overhaul would be disastrous in the absence of proactive policy to promote necessary changes in provider-payer interactions. Aligning this relationship is an essential step toward improving health care in the United States, with or without a reform law.

The relationship between providers and payers has deteriorated in recent years for reasons directly related to historical differences in their cultures. Efforts to cast either stakeholder as a villain are correspondingly inappropriate because both have done what was expected of them in the evolution of American health care since the mid-20th century. However, historical vindication does not justify preserving the status quo. All sides in the reform battle of 2008-10 agree on one point: Economic realities of the 21st century will not support business as usual for anyone involved in health care. Carefully crafted change is imperative. This fact compels us to

understand cultural differences between two pillars of the industry.

Provider Culture

The culture of modern hospitals, health systems, and their medical staffs is deeply rooted in tradition. Indeed, today's provider enterprises still reflect their origins as hospices nursing to the poor in the Middle Ages. Colonists and religious organizations brought this European model to the United States, where the hospital evolved to become the "doctors' workshop." Due to the Flexner Report (1910), hospitals also became the center for medical education because they provided concentrations of "teaching material" in a predominantly rural country. Subsequent urbanization and development of outpatient care have changed the functions of a hospital, but it is still perceived to be the physician-focused center of the provider universe.

The Flexner Report's legitimization of scientific medicine and hospital-based medical education is still a foundation of provider culture. A health system's self-image is largely defined by its ability to provide physicians with all the technology they need to practice medicine at the state-of-the-art—that is, to do everything that needs to be done for every patient without regard to financial circumstances. Provider culture fiercely resists economic considerations because the Hippocratic Oath (as traditionally interpreted) says that money is not supposed to influence a physician's decisions.

Providers' cultural antipathy to economic considerations is also embedded in Medicare, beginning with President Johnson's begrudging acceptance of provider-controlled fiscal intermediaries as the political compromise that enabled its enactment in 1965. Medicare's administrative agency (initially the Health Care Financing Administration, now the Centers for Medicare & Medicaid Services) and other financial third parties have subsequently controlled their costs by negotiating price discounts, not by controlling physicians' decisions. (A payer's refusal to pay for care ordered by a physician does not legally bar the physician from making the order.) Public opposition to perceived government intervention in the patient-physician-hospital relationship on financial grounds even played a major role in preventing health reform in 2009.

In addition to taking below-cost reimbursement for benefits covered by Medicare and Medicaid, providers have paid a price for their ongoing freedom to make clinical decisions by accepting obligations to redistribute income, such as EMTALA and charity care criteria for exemption from taxation. Providers have survived by charging above-cost prices to private payers (cost-shifting) and competing for market share. The resulting economic outcome is a failure from the perspectives of efficiency, effectiveness, and equity. However, recent experience in other major American industries (e.g., automotive, banking, and finance) shows that stakeholder culture does not necessarily change in response to obvious market failure. In health care, culture still drives providers to supply state-of-the-art services on their own terms and to expect adequate overall reimbursement from others.

The economy has obliged by allowing health care's consumption of gross domestic product to rise from 4 to 17 percent over the past 50 years—growth unparalleled in any other private sector of the economy. The Great Recession of 2009 and related shifts in economic circumstances will not continue to support this expansion, suddenly threatening the survival of many providers and their business partners. Something's got to give ... and will. How well depends on developing and implementing reform policies that are sensitive to providers' culture. Self-imposed cost containment is not part of providers' heritage.

Payer Culture

The everyday characteristics of third-party financial intermediaries flow from a very different history. Payer culture is uniquely American and not even a century old. Unlike almost every other country in the western world, the United States formally rejected government-run finance mechanisms for health care in the decades surrounding World War Two. Private payers were even given a major role in reimbursement when Medicare was created. The third-party payer is as American as apple pie, purposefully created as a private enterprise to channel funds from purchasers to providers in an era when the general populace formally rejected anything that smacked of socialism.

Given their publicly ordained origin as private enterprises, payers can survive only by generating revenues in excess of expenses. A reform law that increases any private payers' expenses correspondingly forces the payers to raise revenues and/or to develop "work-arounds" that make the medical marketplace even more inefficient. Nevertheless, a no-fault explanation for market failures does not rationalize the status quo. Our payment system needs to be reformed as much as our provider system, but reforms must fix the underlying problems. The final reform proposals being considered in Washington fail to address the underlying problems and would only make

things worse.

Although the political case for reform-cum-insurance overhaul highlights real problems in the individual and small-business markets, payer culture places high value on hard work to keep corporate customers satisfied. Third-party payers could not stay in business without the large purchasers (and their brokers) that buy health insurance on behalf of employees—and the business is extremely competitive in most markets. Employers commonly put their benefits business out to bid every year or two, and they have finally reached the limits of what they are willing and able to pay for employee health insurance.

The result is continual product innovation, as currently evidenced by payer-purchaser partnerships that are transforming health benefits from a contentious entitlement to a synergistic engagement between employers and employees. Some payers are arguably among the most progressive and creative leaders of the four principal parties (patient, provider, payer, and purchaser) in the medical marketplace. Unlike providers, payers also bear risks inherent in true insurance products, and their finances are highly regulated. The payer business model and its problems are complicated. Improvements are needed, but simplistic reforms won't help.

Culture Clash Must Be Resolved

The tense relationship between providers and payers is the predictable result of incompatible cultures. Providers see their mission as supplying physicians with state-of-the-art tools to practice medicine and expect that purchasers and patients will ultimately foot the bill. Payers are cast in the role of third-party intermediary, bearing risk in the process of assuming fiduciary responsibility for purchasers and patients with limited budgets. This arrangement is fundamentally dysfunctional.

No other nation has structured its medical marketplace like ours. We should not be surprised that the United States ranks near the bottom on lists of cost, quality, and access for health care in developed countries. In addition, the current political climate works against consensus on comprehensive approaches to reform, a problem exacerbated by polarizing leadership and intense conflict between and within the political parties. If reform in 2010 is built on a lowest common denominator of insurance overhaul, its foundation will be very unstable.

Frantic efforts to force a political solution have diverted attention from solving the structural problems of health care. Getting a reconciled bill to the president's desk is not a move forward—and may well be a move backward—if the resulting law fails to resolve destabilizing cultural conflicts between providers and payers. Reform needs to align providers and payers to produce care of acceptable quality as inexpensively as possible. (Social equity is a different issue that should be addressed on its own terms, ideally in the context of giving all Americans access to an efficient and effective healthcare system. The United States does not currently have the resources to build a good health system and make it available to everyone.)

Creating Common Ground for Reform

Payers and providers are not going to play well together as long as they are stuck in a win-lose game. Here are three examples of new policies that could get reform moving in a positive-sum direction by creating common ground in the interests of providers and payers while most important, aligning them to reduce costs and improve quality for purchasers and patients.

Sharing clinical data to identify lowest-cost care. All parties agree that data and information technology are keys to reducing waste (i.e., cutting costs) in health care. The economic recovery act's Health Information Technology for Economic and Clinical Health (HITECH) title affirms bipartisan commitment to digital transformation as a precondition for meaningful healthcare reform. (On the other hand, the law's cumbersome implementation demonstrates the serious problems of hurried legislation.) Many payers have already developed intelligent data systems to identify the least-cost clinical interventions to produce a desired outcome—information that providers should be using to reduce expenses in their operations. Unfortunately, a payer's gain is a provider's loss (and vice versa) in today's marketplace. Well-reasoned healthcare reform would include policies to promote, not prevent, data sharing that reduces costs for all parties.

Constructing common infrastructure to coordinate effective care. Numerous studies also show that quality suffers because patient care is not coordinated. In response to this challenge, payers and providers have separately developed mechanisms to prevent duplication of services and delivery of counterproductive care. Benefits management programs (payer) and medical homes (provider) serve the same purposes, but they are not appropriately integrated because payers and providers are operating on different balance sheets. To solve this

problem, health policy experts make a compelling case for bundled payments to accountable care organizations. Today's successful health maintenance organizations provide a good business model for payer-provider integration, but their generally atypical origins do not provide an organizational development model for overcoming cultural barriers that prevent care coordination and global payment in most marketplaces. Reform must address this problem.

Streamlining reimbursement processes. The shift from fee-for-service to bundled payment and value-based purchasing will also require the development of a new interface between providers' and payers' financial systems. This process will go well only if the two parties find common ground in reconciling today's complicated procedures for deciding who owes what to whom and how it will be paid. Providers and payers will need to work together to make future financial obligations understandable to all parties, especially patients as they become responsible for a much greater portion of their total bill. Standardizing transactions and automating processes will require collaboration that has been hindered by the clash of cultures.

Given such challenges, payers and providers surely realize that their futures are interdependent. They should also understand that their attitudes, values, goals, and practices must change constructively—but these organizational attributes will not change unless the payers' and providers' survival is guaranteed in the process. Health reform needs to be refocused on policies that allow providers and payers to align their cultures so that all parties benefit from potential synergies to provide top-quality care as inexpensively as possible.

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