

## A Progress (?) Report on Consumer-Directed Health Care

By Jeffrey C. Bauer, Ph.D.

The latest government-directed approach to reform, consumer-driven health care (CDHC), was formalized in the Medicare Modernization Act of 2003. The law generated several new programs to promote consumer involvement in the purchase of medical services. It was based on the untested assumption that providers would reduce costs and improve quality to compete for the business of informed consumers who were spending more of their own money for health care.

Many commentators suggest that consumerism is only a short-lived fad because relatively few Americans have opted for the insurance product that defines CDHC, a health savings account (HSA). However, my recent discussions with financial officers from hospitals across the country suggest that the HSA is a red-herring. The high deductibles that define HSAs are becoming the norm for traditional reimbursement products, too.

The real issue for providers is high-deductible health plans (HDHP), not consumer-directed health plans. Providers cannot breathe a sigh of relief just because HSA growth is unimpressive. Out-of-pocket obligations are rising fast for all patients, well beyond the level where they can be "written off." Consequently, senior executives in hospitals cannot ignore the new programs that were designed to promote and facilitate CDHP because these reform mechanisms are just as relevant to the bigger reality of HDHP.

### Update on Reform Mechanisms

Rightly or wrongly (the subject for another forum), policy-makers and legislators have promoted three distinct approaches to reform.

- Transparency in pricing – Some impressive programs have been launched to give consumers enough information to base their care decisions on price. For example, Alegen Health (Omaha, NE) and Medseek (Birmingham, AL) have created a portal that allows patients to get advance estimate of prices for care. Even if HSAs don't grow, pricing services like this one surely will.
- Provider accountability for quality – Numerous public and private groups are now publishing data that can be used to compare outcomes of care on a hospital-by-hospital basis. Analysts rightly raise questions about the reliability of the data and the validity of the comparisons, but their concerns are being met through ongoing refinements in methodology. The grading systems will never be perfect, but they will be good enough to influence provider selection.
- Individual responsibility for health – Consumers already have abundant resources to help them control demand. They can turn to dozens of professional Web sites to understand and manage their health problems. For example, some of the nation's leading health plans provide their beneficiaries with excellent information that can help them make intelligent medical decisions. Many free Web-based services also make good information available to consumers who do not belong to a progressive health plan. Consumers can no longer complain (as they could in the 20th century) that providers control access to medical information.

(Continued...)

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## A Progress (?) Report on Consumer-Directed Health Care (Continued...)

In other words, the market mechanisms for supporting consumerism in health care are alive and well – even if the formal mechanisms of consumer-directed health care (i.e., HSAs) are so far falling short of expectations. The number of informed consumers can be expected to grow at a rapid pace, along with high deductibles and hospital receivables.

### The Missing Ingredient: Affordability

Policy-makers behind the Medicare Modernization Act and related reforms in the private sector failed to address the most important consideration: affordability. Neither providers nor consumers are going to be better off if consumers have good information about care they cannot afford. All providers have got to get serious about cutting the waste out of their enterprises, producing good-quality services and helping patients find the resources to pay for desired care.

As health care becomes more competitive, providers must think and act like businesses that sell cars, homes, vacations and other commodities that are not bought with current income. Price and quality are very important, but consumers ultimately base their "big ticket" purchases on monthly payments. The hospitals that succeed in the new marketplace will know how to produce a good service at a low price *and* how to make it affordable.

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## Physicians' Group Publishes Pricing Online

*Editor's note: The California HealthCare Foundation supplies our Executive Women in Healthcare Web site with "Current Healthcare News." The Foundation is the source for the following article. (Left clicking the underlined phrases will take you to the links.)*

**H**ealthCare Partners, a physician group in Southern California, last month became one of the first and largest health care organizations in the country to post procedure prices online, the *AP/Wall Street Journal* reports.

The group, which treats more than 500,000 patients, was driven in part by the increasing number of retail clinics that offer simple medical services at publicized prices.

Physicians once thought that publicizing prices was unnecessary, but prices have become more important as health care costs increasingly are shifted to employees, according to the *AP/Journal* (*AP/Wall Street Journal*, 5/28).

The listed prices in most cases are more than what the group receives from government programs and less than or equal to negotiated insurer rates, according to Robert Margolis, a founding physician and CEO of the medical group.

Some say that publicizing prices is of limited value to consumers because without knowing the necessary steps to diagnose and treat a condition, patients will be unable to get an accurate cost estimate, the *Los Angeles Times* reports. In

response, HealthCare Partners is limiting its online price list to common and routine tests and preventive care services. The physician group offers a toll-free support number for patients who want more detailed cost information (*Girion, Los Angeles Times*, 5/28).

HealthCare Partners hopes potential patients will appreciate the price transparency and choose to visit a physician group over a walk-in clinic (*AP/Wall Street Journal*, 5/28). Some experts said that given the competitiveness of Southern California's health care market, HealthCare Partners' effort could spur other physician groups to post the cost of procedures online (*Los Angeles Times*, 5/28).

Procedure prices can be found on a "fees for basic services" page on the [group's Web site](#) (*AP/Wall Street Journal*, 5/28).

### Broadcast Coverage

American Public Media's "[Marketplace](#)" recently reported on HealthCare Partners Medical Group. The segment includes comments from:

- Karen DeSalvo, an associate professor at Tulane University School of Medicine; and
- Stefan Kertesz, an assistant professor at the University of Alabama School of Medicine (Roth, "Marketplace," American Public Media, 5/28).

A [transcript and audio](#) of the segment are available online.

## Is the Pen Mightier Than the Scalpel?

Conference speakers have been dramatizing the cost of healthcare for years by holding up a pen. They go on to say that the pen in the hand of a doctor accounts for the vast number of dollars spent in healthcare. The idea is that doctors write hospital orders and prescriptions.

Now the pens in the hands of doctors are taking on a new meaning. Doctors are becoming authors of books that are becoming best sellers. Two of the most successful physician-authors currently are Doctors Jerome Groopman and Atul Gawande. Both practice at Harvard, write for *The New Yorker* and have produced books now on the best sellers' lists. They are not alone.

In the last six months at least six books of memoir and opinion by doctors at every stage of professional life have been published. They range from a new physician, Shani Stein-Ratzker who has written *M.D.: A Four-Year Journey Through Medical School*, to a retired physician, Gerald Weissmann who has written *Galileo's Gout: Science in an Age of Endarkenment*.

Doctors John E. Castaldo and Lawrence P. Levitt want to educate and inspire readers with their book, *The Man With the Iron Tattoo and Other True Tales of Uncommon Wisdom: What Our Patients Have Taught Us About Love, Faith and Healing*. Due out shortly is a book of social criticism, *The Corrosion of Medicine: Can the Profession Reclaim Its Moral Legacy*, by Doctor John Geyman.

There is a trend in the making. Doctors are writing newspaper columns. They are blogging, submitting work to literary journals and signing up for courses designed to help them become published writers.

What's behind the trend?

Kathryn Montgomery, a professor of literature who directs the medical humanities and bioethics program at Northwestern University's Feinberg School of Medicine in Chicago, answered the question partially in *The New York Times*. "Doctors are storytellers," she said. "They spend all day long listening to stories and telling stories. It's not surprising they write." In the past, doctors like Anton Chekhov, William Somerset Maugham and William Carlos Williams wrote fiction and poetry. Today's doctors are writing mostly memoirs.

Perhaps another contributing factor to today's surge of physician-writers is television. The number of programs featuring actors wearing scrubs and saving lives has grown. Publishers believe they sense a public appetite for words of real doctors who are writing about real medicine.

*The Times* reports that Dr. Groopman made his *New Yorker* debut 10 years ago with the story of a patient dying of cancer, who came to him asking for "magic." The patient had heard that Dr. Groopman was a "medical genius, a wizard." The patient called him "St. Jerome."

Dr. Groopman struggled to get the patient a few months of remission, only to find the man more miserable in health than he ever was in his fight against the disease.

Dr. Groopman has made it clear, in his writings since then, that medicine has no magic, wizards or geniuses and very few saints. In his latest book, *How Doctors Think*, Dr. Groopman looks at medicine when it goes wrong. He asks why should an emergency room doctor misdiagnose a heart attack, or a pediatrician fail to recognize a malnourished infant or a highly trained surgeon mistake the problem crippling Dr. Groopman's right wrist? The flawed thinking is broken down, step by step, like the diagrams in a manual showing how to do card tricks.

Dr. Gawande is also in the fix-it business. He too began his writing career (as a second-year surgical resident 10 years ago) debunking the idea of magic in medicine. In his new book, *Better: A Surgeon's Notes on Performance*, he celebrates some of the most routine parts of medicine – the washing of hands, the inoculation of children.

Doctors Groopman and Gawande write with a mission: to find and to fix.

Almost all medical schools now ask students to read the writings of doctors, and some now require students to write about their own experiences. Practicing physicians can turn to short courses like "Writing the Medical Experience" offered at Sarah Lawrence College's summer school, or the short workshops in narrative medicine offered by the faculty of the Columbia University College of Physicians and Surgeon in New York.

A trend is definitely on its way.

## Computer Kiosks Used in the ER

A computer is the first thing patients communicate with after walking into this emergency room. What makes this so surprising is that this hospital has one of the busiest ERs in the country, it is a public hospital and it serves a large indigent population. Many of its patients don't use computers.

This ER is in Parkland Memorial Hospital in Dallas, Texas. The emergency services department sees more than 300 patients a day – 115,000 to 120,000 a year.

Instead of standing in line – sometimes for hours – just to explain their symptoms, patients now type their problems into a computer at one of three automated check-in kiosks. The idea is to keep sick folks from having to stand while waiting, and to more quickly reach patients who might not look sick but whose illness demands immediate attention.

While similar machines are appearing nationally to check in patients at medical clinics, Parkland officials said they believe they are among the first to have a system in a hospital emergency room. A donation through University of Texas Southwestern Medical School paid for the \$50,000 project.

The kiosks went up just three weeks ago, and bugs are still being worked out. Because of the large number of people who are not comfortable with computers, the technology can present challenges. The machines look and operate like automated check-in kiosks at the airport.

"A lot of these folks don't use a computer at all," Jamie Ensminger, a nurse in charge of the project, told *The Dallas Morning News*. "They get really aggravated." But Parkland personnel stand by to give directions and type in information for people who need help, and the hospital continues to adjust to make the system more user-friendly, he said.

Before the system went in, patients could stand for hours, "like a ride at Six Flags," Mr. Ensminger said. Nurses constantly monitored the condition of people waiting and pulled from the line people who were in obvious need of immediate help. But some potentially life-threatening problems – like chest pain or stroke symptoms – aren't always easy to see, and some patients are too shy to complain.

At the kiosks, patients type in their name, birth date and gender before being led to myriad ailments from which they choose their chief complaint. Patients can choose English or Spanish.

A reporter for the Dallas newspaper described the process. If the first laundry list of problems doesn't fit – allergic reaction, homicidal thoughts, shortness of breath and so on – patients can point on the screen to a specific body part that hurts. Certain ailments, combined with information like the person's age, are immediately flagged. Monitors in the nurses' station keep a tally of who is waiting, and blinking dots cue them to people who should be seen right away – like an older person with chest pains, for example.

The system has its shortfalls. Patients who are illiterate or not computer savvy need a lot of help. And patients with less serious illnesses still must wait for care during busy times. But the long lines have been eliminated, Mr. Ensminger told a reporter. And patients can sit down sooner.

Parkland is already using the new data to analyze how long people have to wait for care. A patient's record previously didn't start until he or she made it through the first line. Now, that record starts almost immediately.

If the kiosks are a success, look for other hospitals to adopt them.

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