The Three Myths

When it comes to healthcare, there are three incorrect assumptions that continue to mislead HR executives.

By Scott Wallace and Elizabeth Teisberg

According to the *2014 Kaiser Family Foundation/Health Research and Education Trust* survey, employer spending on healthcare continues to rise, with average expenditures of more than $12,000 per employee in 2014. A 2012 Deloitte survey of U.S. employers, *Opinions about the U.S. Health Care System and Plans for Employee Health Benefits*, shows more than 60 percent of employers give the healthcare system a grade of "C" or below. Few employers think they are getting their money's worth in terms of better employee health.

Meanwhile, the growing burden of chronic disease presents some of the starkest evidence of the failure of the healthcare system to improve health outcomes. According to the Centers for Disease Control and Prevention, more than half of all American adults have a chronic condition and more than 20 percent have at least two.

In a pattern that can only be described as "medical nihilism," healthcare providers generally assume that the health of patients with a chronic condition inevitably declines, although clear evidence exists that Type 2 diabetes can be reversed. Although dissension among academicians persists, there are well-documented examples of patients whose lifestyle changes eliminated their diabetes symptoms.

Part of the reason that healthcare continues to fail so many patients is that failure remains acceptable to the companies and government agencies that foot the bill. In the business realm, many HR executives implicitly accept three myths about healthcare. By recognizing the myths and starting to address them, HR executives can begin to get better employee health for the money.

Myth No. 1:

Healthcare is a Commodity

Most organizations assume employee healthcare is a commodity and contract for services with that implicit assumption. Commodities such as road salt or coal are uniform and undifferentiated. Purchasers' primary worries relate to whether there will be enough of the material when it's needed. Similarly, employers tend to think about whether they are providing sufficient amounts of healthcare for employees' needs.

But healthcare isn't a commodity. There are differences between types of services, such as heart surgery compared to well-baby care. In addition, there are vast differences in the health outcomes of patients who see different providers. Some of those outcomes are dramatically better than others. Prostate-cancer care offers a stark example.

The Martini Klinik in Hamburg, Germany, provides comprehensive prostate-cancer care. While the five-year life expectancy of patients at the Martini Klinik is almost indistinguishable from the average life expectancy across all prostate-cancer centers in Germany, far fewer patients of Martini Klinik suffer adverse consequences after cancer surgery. Specifically, Martini Klinik patients have about one-fifth the rates of incontinence and impotence after their surgeries.

How do they do this? The "secret sauce" isn't secret, but it has many ingredients. One is measurement. Martini Klinik has a

comprehensive measurement process that's used in semi-annual reviews comparing its dozen surgeons to each other on a range of metrics, including the number of days until patients are continent, how well patients did compared to expected results and patients' self-reported health statuses at intervals following surgery.

A second ingredient is a learning culture that uses seminars, group reading assignments and presentations by residents to keep the entire team current on innovations in the science of prostate cancer. The third is expertise enabled by focus. The Martini Klinik surgeons each perform more than 200 prostate surgeries each year, and none do any other type of surgery.

Back pain provides another vivid example of differences in health outcomes. Half a million Americans per year undergo back surgery, enduring acute pain, post-surgical rehabilitation, significant expense as well as time away from work and normal activities. But only about 5 percent of people with back problems actually benefit from surgery. It isn't that these few patients are lucky, nor is it that only a small percentage of spine surgeons are good. Back care is not a commodity service.

A knowledgeable team can identify the small set of patients likely to benefit from surgery and can use other approaches -- including physical therapy, yoga and ergonomic lifestyle changes -- to help others who won't benefit. In turn, providers with the appropriate specialized expertise help those patients who are good candidates for surgery while saving others tremendous amounts of money, pain and time.

Healthcare is steeped in mystique, and many caregivers are described as miracle workers. That halo often carries over to the hospital, where the most eminent clinical teams work. However, results within a hospital or health system also often vary tremendously across services. A hospital with world-class breast-cancer results might only get average results in kidney transplants, and it might be significantly below average in hip replacements.

Unlike road salt, one hospital or healthcare system is not interchangeable with another. Recognizing variation in the quality among types of services and among outcomes of healthcare services by different providers has significant implications for healthcare purchasers.

Myth No. 2:

The Biggest Problem is Cost

Assuming healthcare services are commodities makes it logical for price to be the key purchasing consideration. If services are interchangeable, it makes sense to insist on narrow networks and use the resulting bargaining power to achieve lower prices. The commodity purchasing mind-set also leads to the view that employees can fix the problem just by shopping for low prices.

For some aspects of healthcare, the commodity mind-set is close to valid. Flu vaccines from one manufacturer are equivalent to those of another. Consequently, paying more for a higher-priced flu shot makes no sense. But if one needs cancer treatment, or treatment for back pain, or care for a malfunctioning heart valve, there are multiple dimensions to a good choice of provider.

Instead of focusing only on cost, HR leaders need to pay attention to value -- the outcomes achieved for the money spent. Value is the usual decision criterion in purchasing, both in business and in day-to-day life, and it is far more common than buying solely based on cost. Employers don't always hire the least-expensive employees or buy the cheapest phone service. Rather, in these decisions, one normally considers which choice best fits one's needs and provides the most value.

Similarly, when it comes to healthcare, employers should want services that are demonstrated to get employees back to work sooner, or services with experts who can figure out when back surgery is likely to be effective, or ones that use telemedical communications to improve outcomes. Employers may, for instance, want primary care for employees that is available outside of work hours and team-based diabetes care that dramatically reduces the work time missed for essential medical appointments.

Yet a failure to focus on value is a core problem in healthcare. Despite year-over-year record spending, the health of too many Americans is getting worse, not better. Employers and employees alike aren't getting enough health for the money being spent. That's in part because many big purchasers focus only on price, seeking discounts rather than insisting on high-value healthcare.

One way to begin addressing this is to ask providers about the outcomes of their care. How quickly do employees return to work after having a knee replaced? How many employees who get diabetes care from that doctor are succeeding in critical lifestyle changes? Cost matters, but while looking at costs, employers should also be looking at value -- at what they are getting for their money.

Myth No. 3:

Healthcare Quality is Hard to Define

HR leaders often point out that the definition of value in healthcare is multifaceted and that measuring quality is difficult. While quality is indeed multifaceted, the starting point is to recognize that quality in healthcare leads to better health outcomes for patients.

Think for a moment about why someone seeks care: It is to fix something that's wrong or to prevent a threatened harm. People seek care to heal broken bones or to treat infections or diseases that are affecting their quality of life -- or maybe threatening to end it. At a general level, a good outcome is when the problem is fixed or when a person is able to return to work or to normal activities. The fix will differ by medical problems -- is the tooth pain gone? Can the patient drive, work, read, swallow or run? In most situations, the definition of a good outcome is not mysterious.

Despite the clear objective of patients to get better or to remove a critical risk, remarkably few care providers measure whether their patients got better. Every hospital tracks process and inputs: what it does to and for patients. Most providers track inputs down to individual tablets of Tylenol dispensed. Employers have traditionally accepted these measures of inputs and processes as representative of quality rather than insisting on also seeing data on outcomes. As a result, employers pay for a lot of care without ever knowing whether those expenditures purchased better health for employees. That's a missed opportunity to improve value.

The federal government's efforts in patient-experience tracking haven't fixed the problem. The surveys measuring hospitals have added to the process metrics a range of questions for patients about how they were treated -- whether the hospital staff was respectful and the amenities comfortable.

The underlying assumption persists that outcomes are somehow too difficult to identify and report, and so they aren't included in government-mandated surveys. Even the popular net-promoter score, reflecting whether the patient would recommend the hospital, seems to make the unstated assumption that outcomes are really a matter of the patient's luck rather than the clinical team's expertise. It is time to dispel the myth and ask for data on patients' answers to that most fundamental question: Did you get better?

Beyond the Myths

To recap, healthcare services are not interchangeable commodities. Healthcare outcomes vary due to factors other than luck. Some clinical teams achieve consistently better outcomes than others for prostate cancer, back pain or healthy maternity.

Sophisticated healthcare purchasing considers the results achieved for the money spent, not just the cost of health benefits. Two options with the same price may not be equal, and lowering prices may not be the only way to reduce overall spending. Highly effective care may reduce the quantity of services needed.

Meaningful health outcomes are not mysterious. Employees know if they can go to work today, if their pain is reduced or if their vision is impaired. Anyone who has gone through it will know how many months the cancer treatment took before his or her real energy returned.

Patients can answer simple questions about whether their healthcare fixed their problem. Those answers give critical information about a company's healthcare investments and whether these critical investments are paying off.

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