PARTNERSHIPS PAVE THE WAY TO SUCCESSFUL HEALTH CARE REFORM

BY JEFFREY C. BAUER, Ph.D.

Politicians made sure health reform was a dominant issue in the 2008 elections, and conventional wisdom said major overhaul of the medical care delivery system was inevitable in 2009. Yet, when all was said and done, a whole lot more was said than done. Pundits and scholars will analyze the outcome for years to come, but one conclusion is already clear: the unforeseen (but not unforeseeable) economic collapse was a "game-changer." For this reason, the hypothetical outcome of political attempts to overhaul health care in the future is a red herring. The troubled state of the economy right now must shape the business of health care in 2010.

This article analyzes the interplay between health reform and economic stagnation and concludes that voluntary, outcomes-based partnerships between multiple stakeholders in local markets offer the best hope for generating cost and quality improvements. Conflict between special interests and political gridlock compel the pursuit of a non-legislative solution, such as voluntary partnerships, to solve the economic problems of health care sooner rather than later.

THE LESSONS OF 2009

Last year's effort to overhaul health care reflected deep political divisions and highlighted conflicts between the national organizations representing key stakeholders (e.g., American Hospital Association, American Medical Association, America's Health Insurance Plans, Pharmaceutical Manufacturers Association). When politicians and industry groups ultimately were forced to address specific details, initial commitments to a general principle of shared sacrifice disintegrated. However, inability to forge a compromise in Washington did not negate the premise that brought everyone together in the first place: Our health system and economy are heading toward disaster if mounting problems in medical care delivery and payment are not soon resolved.

Our health system and economy are heading toward disaster if mounting problems in medical care delivery and payment are not solved in the near future.

The 2009 debate over health reform also showed that the United States cannot afford to consider universal access until medical care becomes efficient and effective. Economic circumstances have precluded giving everyone access to expensive medical care that is often inconsistent and/or unproductive. Even in the unlikely event that the political players could agree on the foundations of a right to health care, many years would be needed to implement the resulting legislation.

Likewise, the recession makes it highly unlikely that providers will be able to increase revenues any time soon. Turnarounds in the stock and housing markets may give an impression that the worst is behind us, but the 2010 outlook for employment and credit — the economic factors that give people money to pay their medical bills — is still pretty grim. Most econo-

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What Congress leaves out, local stakeholders can do.

EXAMPLES OF MULTI-STAKEHOLDER PARTNERSHIPS IN LOCAL MARKETS

Developing long-term contracts that would give providers, payers and purchasers an opportunity to realize returns on investments in health promotion and disease management.

Establishing contractual relationships that overcome the perverse incentives of fee-for-service reimbursement.

Updating reimbursement policies to favor telemedicine and home-based care when these new technologies provide equal or better care at a lower cost.

Working as a group (including health systems, practitioners and technology developers and vendors) with state legislatures and trial lawyers to align liability laws and clinical practice standards with the progressive use of health information technology.

mists believe that unemployment and consumer spending will not start to improve until late in the year. Government budgets will be hammered by declining tax revenues, with more cuts in public spending on health care a likely result. Business income is also likely to stagnate, resulting in fewer employees with health benefits and reduced coverage for those who remain insured.

ECONOMIC IMPLICATIONS FOR PATIENTS AND PROVIDERS

The recession has significantly increased patients' out-of-pocket responsibility for medical bills at the very time when households have less money to spend. The result is more bad debt on the balance sheets, putting immediate pressure on providers to become efficient and effective. However, performance improvement alone is not a sufficient condition for providers' survival, given other economic circumstances that are putting the brakes on historical growth of health care spending. Providers could do everything right in response to the recession and still fail in a marketplace marred by other imperfections.

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Indeed, the 2009 debate over health reform highlighted several serious market failures that are beyond providers' control, such as the perverse economic incentives of fee-for-service reimbursement, the significant costs of defensive medicine and patients' poor health behaviors. These forces significantly increase demand for health care, but last year's reform proposals effectively left providers and their business partners to deal with the problems on their own. Because providers do not control demand-side economic forces and cannot count on reforms from Washington, they need to find another path to survival and growth. Today's political and economic circumstances suggest a workable alternative: creating voluntary, multi-stakeholder partnerships in local markets.

A GENERAL CONCEPT OF PARTNERSHIPS FOR REFORM

The composition and activity of reform-focused partnerships will be as diverse as the marketplaces they serve. Even where leaders recognize the need for an alternative approach to improving cost, quality and access as quickly as possible, no single partnership model can or should be pursued. Indeed, the 2009 debate over health reform clearly exposed serious problems inherent in one-size-fits-all solutions. The best approach will be one that encourages creativity for the specific purpose of producing many models that can be shared across our remarkably diverse country.

In other words, the American medical industry needs to introduce competing products and services that reflect new technologies and economic circumstances. This is "creative destruction," the process of progressive economic renewal that occurs when entrepreneurs develop innovative products that replace mature (i.e., stagnant) products. [1] A single, federally defined model of partnerships would not produce knowledge about what works and does not work in highly differentiated local markets with unique problems, resources and opportunities. If a national policy were to emerge, it should promote partnerships as a general mechanism to advance the goals of health reform while allowing the specific characteristics of the partnerships to vary by marketplace. However, a national policy is not likely to emerge any time soon. Progressive local leaders need to move forward on their own.

To produce essential improvements in efficiency and effectiveness, local partnerships must involve multiple stakeholders. A good health care marketplace cannot be created by one economic entity acting alone because cost, quality and access are ultimately defined by multiple interactions of providers, purchasers, payers and consumers. Economic theory also states that one of the worst market failures, monopoly, exists when one stakeholder controls economic outcomes in a marketplace. Consequently, antitrust law compels competition among several stakeholders whenever possible. Leaders who create partnerships to meet the goals of health reform must be sure that the associations do not result in price fixing, market sharing, technology suppression or other economic harms that define monopoly power.

All other things being equal, providers will want to create vertical partnerships that could include their suppliers, one or more third-party payers (public and/or private) and employers who purchase employee health coverage from the payer(s). Consumer representation, through participation of organized groups (e.g., local chapters of cancer, heart and diabetes associations) and targeted marketing activities, also should be included in the partnerships when possible.

These new, reform-focused partnerships should *not* be horizontal arrangements involving only providers, such as regional hospital networks. The goal should be to create associations involving each of the economic entities that interact to define cost, quality and access in a marketplace. Provider-only groups will not serve this essential purpose. Ideally, to harness the potential benefits of creative destruction while minimizing risk of antitrust problems, several competing partnerships will exist in markets with multiple provider organizations, payers and purchasers.

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The partnerships must operate transparently (i.e., with public accountability) in the pursuit of objectively measurable goals to reduce costs, improve quality and/or expand access. They must also operate non-confrontationally, focusing on collaboration to solve health care's problems rather than casting blame on the other stakeholders. Indeed, potential partners are likely to be the "they" referenced in the common self-defense statement, "It's their fault."

Specific examples of multi-stakeholder partnerships in local markets could include:

- *Developing long-term contracts that would give providers, payers and purchasers an opportunity to realize returns on investments in health promotion and disease management.* Under current practice, provider panels and employee health plans are opened to competitive bids every one to three years, allowing purchasers to save money by selecting new vendors when short-term contracts expire. Neither the provider nor the payer has an incentive to invest in health promotion and disease prevention. Progressive three-way partnerships could develop performance-based contracts for five to nine years — long enough for all parties to realize returns on investments in beneficiaries' health.
- *Establishing contractual relationships that overcome the perverse incentives of fee-for-service reimbursement.* The 2009 debate over health reform highlighted this serious flaw in our traditional payment mechanism, but it did nothing to solve the problem. Multi-stakeholder partnerships in local markets would provide an excellent opportunity to develop global reimbursement systems (e.g., bundled payments for disease episodes instead of itemized billing for individual services) and other mechanisms (medical homes, collaborative practices, etc.) that reward providers for coordinating care rather than maximizing volume.
- *Updating reimbursement policies to favor telemedicine and home-based care when these new technologies provide equal or better care at a lower cost.* Many studies demonstrate the cost-effectiveness of specific remote care technologies, but rigid Medicare policies have hindered changes in private third-party payment for them. Local partnerships could develop appropriate reimbursement for telemedicine and related services provided in non-traditional settings (such as homes, workplaces, retail centers).
- *Working as a group (including health systems, practitioners, and technology developers and vendors) with state legislatures and trial lawyers to align liability laws and clinical practice standards with the progressive use of health information technology.* A high priority should be placed on eliminating unnecessary expenses of defensive medical practice and avoidable medical errors. Information technology is a common denominator for solving these costly problems. Consequently, key stakeholders need to coordinate

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technology applications and laws at the state level. Health information technology funding under the American Recovery and Reinvestment Act of 2009 will presumably accelerate its adoption but does not address such technology's important relationship with professional liability.

Of course, multi-stakeholder partnerships will find other opportunities to address problems that cannot be solved politically or unilaterally, including appropriate clinical collaboration to improve the use of technology by eliminating excess capacity. (This article does not address changes that each stakeholder must make on its own; there are many.) Regardless of the scope of the partnerships, the keys to success are a clear statement of the problems to be solved, a pragmatic commitment to finding solutions that improve outcomes for all parties and a willingness to be held publicly accountable for performance. Providers are the logical stakeholders to initiate partnerships in most marketplaces.

CALL TO ACTION

A timeless observation by Winston Churchill provides a solid rationale for local partnerships as a necessary next step on the road to health reform: "Americans can be counted on to do the right thing, after they have exhausted the other possibilities." Several decades of exhaustive efforts to reform health care under government leadership have failed to reduce costs, improve quality or increase access — strongly suggesting that another possibility must now be pursued. Partnerships of providers, payers, purchasers and patients are the only viable alternative on the American horizon. (Other possibilities, like nationalization of health care, exist in theory but are not going to be put into practice in the United States any time soon, if ever.)

Margaret Mead offered another sound reason for turning to local partnerships to solve our perennial problems with health care: "Never doubt that a *small* group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has." Last year's unfocused debate over health reform clearly demonstrated the inability of a *large* group of thoughtful, committed citizens to improve something as complex as health care. Now is the time for local stakeholders to get the job done. If the collective wisdom of Churchill and Mead isn't reason enough to try this new approach in 2010, the economy is.

NOTE

1. Joseph A. Schumpeter introduced this concept in his 1942 classic work, *Capitalism, Socialism, and Democracy* (New York: Harper Perennial Modern Classics, 2008).

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