

In Focus - June 22, 2015

A Question of Balance

They Said It

"It is undeniable from a macro point of view — the Cleveland area will have higher costs per patient. That's just math," [Michael Heil](#), CEO of HealthWorks, a hospital consulting firm based in Kensington, Calif.

One of the basics of our free enterprise economic system is that businesses succeed when they deliver to their customers the product or service they want at a price they are willing to pay. When this nexus occurs, we achieve a balance of supply and demand. Economists call this happy place *equilibrium*.

Sometimes, equilibrium is not so much a happy place as it is an odd place. Consider air travel. We grouse about the nit-picking price for every element of it, the kneecap challenging space between seat rows and the seemingly random actual departure and arrival times. And yet, more of us are flying than ever before. Why? Because we like the low air fares such cattle herding allows. The airlines have figured out that we are willing to give up comforts to save money and still get to our far flung destinations more quickly than the alternatives. Yes, it's equilibrium but not the friendly skies anymore.

Beyond equilibrium, another Business 101 axiom is that every business has four stakeholders: its owners, customers, employees and the public. The corollary to this axiom is that these stakeholders do not have the same interests and sometimes, the interests of two or more of the stakeholders are in conflict. It is a responsibility of management to identify its stakeholders' interests, figure out how to sufficiently satisfy those interests, minimize the conflicts and make a suitable profit. When a business operates this way, it is *satisficing*, that is, it is making decisions that may not be optimal from any one point of view but are decisions sufficiently acceptable to all stakeholders.

Health systems are businesses, whether they function under the guise of non-profit or even have the words "university" or "charity" as part of their names. So it is with doctors who are not (yet) employees of hospital systems also. They are as much owner/operators of businesses as they are practitioners of the healing arts. As such, every aspect of the healthcare system is intended to make a profit; even if it is called something else like a "surplus."

As a set of thousands of businesses, our healthcare system operates within this context of equilibrium and satisficing. As to equilibrium, and just like the airlines, the providers have what we want. In this case, it's the ability to excise our tumors, deliver our babies and prescribe drugs that make us feel better. Employer-sponsored health insurance is the main currency. With this currency, plan members can achieve equilibrium with the providers' prices.

With air travel, we can avoid some of the *a la carte* pricing, say, by bringing our own snacks on board. With healthcare, once we're in the system, we've pretty much lost control of the costs. Due to asymmetry of information, the ethos we grant providers, and our own insecurities about the fate of our unwell bodies, the providers make the vast majority of the testing and treatment decisions and, hence, make the cost decisions too.

In response to the ever-rising costs, employers are increasing their use of high deductible health plans and the defined contribution approach to finance employee healthcare. These cost-shifting techniques raise the question: will employers continue to provide enough healthcare currency for their employees to maintain equilibrium with the additional services and higher provider prices?

As to satisficing, healthcare systems are increasingly offering services that appear to be in the interests of plan members, plan sponsors and even the larger community, but may, in fact, be primarily demand-inducing techniques. Consider the explosion of outpatient facilities, telemedicine, family health and wellness centers and advertising of same-day appointments. Each of these is promoted as good for patients. However, all create new opportunities to drive more patients into the system for testing, treatment and billing for more services. Is easing entry into the system an example of satisficing, a balancing of the interests of stakeholders, or is it Say's Law - supply creating its own demand?

A local example of a health system seemingly acting in the interests of patients *and* the community is University Hospitals' (UH) recent announcement that it will create its own multi-million dollar Level 1 trauma center. The ostensible rationale is to provide better access to the highest level of care for severe injuries to Cleveland's East Siders more quickly than when these patients are sent to. UH has not cited any data to support the medical need for an additional trauma center. We've heard nothing about the number of patients who died or whose conditions became worse because of having to travel to MetroHealth's centrally located Level 1 trauma center. Does Cleveland need to bear the cost of another Level 1 trauma center? [The Plain Dealer](#) tells us: "The frustrating answer for Clevelanders, national trauma experts say, is that only an unbiased outside evaluation of the city's existing trauma network and resident needs could tell. And UH didn't ask for one."

UH's trauma center gambit needs to be seen as part of its strategy *to grow*, just like other health systems and any other business. "Where there are opportunities for growth and improvement and where there are opportunities for us to provide world-class care . . . we will do that," said UH CEO Tom Zenty [in a recent interview](#) with *Crain's*. Substitute world-class cars for world-class care, and Mr. Zenty sounds just like the CEO of General Motors.

Similarly, we have the Cleveland Clinic's move to exit its rent-a-hospital arrangement in Lakewood and shift patient volume to its owned hospitals: Fairview, Lutheran and, eventually, its emerging Avon hospital. This is no different than your COO deciding that production should be shifted from a plant where you share the revenue to one where you keep it all. We must remember that in the case of healthcare, the units of production are our plan members. And that's the point; healthcare is a growth-seeking, profit-seeking contest among fewer and larger provider systems. Our plan members are the growth and profit chips on the table. In general, providers are *conflating*, not satisfying the interests of our plan members with their growth and profit priorities. Benefits managers must act on their behalf.

This supply side will continue to grow, and it is admittedly hard for benefit managers to mitigate the demand and extra cost it creates. Simply shifting the cost to employees will not maintain the equilibrium.

We are losing the battle for their minds to the marketing departments of the health systems and pharmaceutical companies. As such, we need to tactfully, but clearly educate our plan members about healthcare providers being businesses operating on the same capitalistic principles as any other business. People will act differently if they think of providers of care as sellers of care as well.

More health care often does not result in better health or quality of life. More testing of asymptomatic individuals leads to more treatment, not better results. More treatment of the natural aging process leads to a medicalized path to the later years of life. "Is grey hair a disease?" as Dr. Nortin Hadler once wrote, or just an opportunity for testing and treatment? Doing all these things can help restore some balance and make our plan members as empowered as the savvy airline traveler.

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