Proprietary Hospitals in Cost Containment

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Any effort to control the rise in health care costs must start with analyzing the causes, which are really quite simple. Most cost control efforts fail because they do not address the causes. The causes are large subsidies in several forms that send a false message that health care is free and should be used abundantly, and expansive reimbursement programs that reward inefficient providers with higher payments. This combination of demand stimulation and cost-plus reimbursement produced the world's most expensive health care delivery system and strident calls for reform.

A long overdue change in public policy took effect October 1, 1983, when Medicare payments moved from cost-plus reimbursement to fixed, prospectively determined prices. Because it addressed one of the causes of medical inflation, this change has been effective in slowing the rise in Medicare expenditures. Sponsorship of a hospital is not a determinant of its cost-effectiveness. There are examples of efficient and inefficient hospitals in both the voluntary and the investor-owned or taxpaying hospitals. The determining factor is the will of management to keep costs under control. (Am J Cardiol 1985;56:40C–42C)

Rising health care costs in recent years have caused the government, insurance companies, employers and other payers of medical bills to search for ways to limit cost increases.

Most of the efforts have been ineffective because they fail to address the causes of health care cost increases. These causes are quite simple:

(1) Large subsidies in several forms gave the false impression that health care is free and should be used abundantly.
(2) Expansive reimbursement programs rewarded inefficient providers with higher payments than efficient providers.
(3) Inclusion of the non-needy elderly in Medicare diverted substantial resources from the truly needy.

This combination of demand stimulation and cost-plus reimbursement with its incentives for inefficiency worked synergistically to create the world's most expensive health care delivery system. Strident calls for reform came from some of the same places responsible for stimulating demand and for rewarding the inefficient. Their rhetoric and their action went in opposite directions until recently.

Demand-stimulating subsidies have included employer-paid health insurance as a tax-free benefit (food, shelter, clothing and transportation are paid by the employee with after-tax dollars). Other demand stimulation came from the tax-supported Medicare and Medicaid programs for the elderly and the poor. These well-intentioned programs sent a message—loud, clear but false—to consumers that their care, seemingly, was free.

A long overdue change in public policy took effect October 1, 1983, when Medicare payments moved from cost-plus reimbursement to fixed, prospectively determined prices based on diagnosis related groups (DRGs). At last, one of the causes of medical inflation—cost-plus reimbursement—was addressed. Predictably, the runaway rise in hospital costs has begun to be brought under control. All hospitals now have clear incentives to become efficient and to bring productivity to their use of labor, except those hospitals in the excessively high-cost states of Massachusetts, New York, New Jersey and Maryland. (It is noteworthy that all other DRG payments have been reduced by about 2% as a result of excess payments to these 4 states.)

With all hospitals in the same region now being paid the same price, those who keep their costs below the payment will produce a profit or surplus. Those who do not are in real jeopardy.

Now I am going to offer a contrarian's view on DRGs. Knowing that the incremental cost of an additional test or an extra hospital day is very small, Humana has encouraged its medical staff members to fight all out for their patients, to use their best medical judgment rather than worry about costs. Our productivity enables us to maintain a calm environment in today's volatile and threatening climate.

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While DRG incentives are creating the expected productivity improvements in hospitals, demand-stimulating government subsidies continue and are in direct conflict with shrill government rhetoric in favor of cost containment.

Outside the federal sector, changes requiring consumers to pay a portion of their previously "free" care have reduced demand. Employers have imposed co-payments and higher deductibles for their employees to pay, bringing reduced use. The smaller number of patients has spurred competition among providers.

Hospitals that emphasize quality, productivity and responsiveness to customers should do well in this cost-conscious, competitive environment. These attributes can exist whether a hospital is a taxpaying investor-owned hospital, a voluntary tax-exempt facility or a public hospital. Quality, productivity and responsiveness to customers are vital. We identified those when Humana's statement of purpose was formulated more than a decade ago. It reads: "The mission of Humana is to achieve an unequaled level of *measurable* quality and productivity in the delivery of health services that are responsive to the needs and values of patients, physicians, employers and employees."

Everyone in our company has a clear understanding of this statement. By following it, we have established the high quality of our hospitals while achieving cost-effectiveness. Our hospitals have a cost advantage of 18% compared with other hospitals in the same markets. Our analysis of last year's Medicare cost reports in Louisville showed that 3 Humana hospitals provided 26% of the area's medical care while receiving only 24% of the revenues.

Our fourth hospital in Louisville is the University of Louisville's teaching hospital. This public hospital was losing $10,000 a day in 1982 and was forced to cut programs and turn away some indigent patients. We began operating the hospital in 1983 and have an 8-year contract to provide an unlimited amount of care to the county's indigent population for a fixed maximum payment, which increases annually by the lesser of tax revenue or consumer price level increases. Louisville thus is one of the few, if not the only, major American city whose indigent care problems have been solved.

Humana's emphasis on quality and responsiveness has enabled this hospital to increase significantly its number of private patients, and *all* patients receive a single, high-quality level of care.

Humana Hospital–University opened on May 1, 1983, having been built and equipped by the University of Louisville and the Commonwealth of Kentucky at an approximate cost of $73 million. Humana provided an additional $5.7 million of equipment during the 16 months of operation that ended August 31, 1984, thereby making available many new or expanded services, including:

- The region's first electrophysiology laboratory to test and evaluate patients with irregular or unusual heart activity,
- A cardiac catheterization unit, eliminating the necessity of sending patients to other hospitals for this service,
- An adult burn care unit was added when Louisville's largest and most profitable voluntary hospital, citing a $400,000 loss on burn center operations, suddenly and unilaterally stopped admitting adults to its burn center,
- An acute dialysis unit, providing acute peritoneal dialysis and acute hemodialysis,
- A neurology/neurosurgical intensive care unit for patients requiring special neurological care,
- A diabetes unit, a transitional care unit, 1-day surgery, a sleep laboratory, neonatal echocardiology, digital angiography, an endoscopy laboratory, a pulmonary diagnostic laboratory, a cochlear ear implant program, a laser surgery program and a microsurgery program.

In 1984 Humana Hospital–University was the only hospital in the city to reduce its average revenue per case and average cost per case. Despite reduced revenue per case, the hospital went from loss to a profit of $2.5 million in 1984 (20% of which was shared with the University of Louisville School of Medicine).

The improved financial results came from a combination of factors. In the months before Humana began operating the hospital, the university, through financial necessity, reduced personnel to 5.5 full-time equivalent employees per occupied bed. Then, after Humana opened the new hospital, higher volumes of patients enabled us to reduce the ratio to 4.1 employees per occupied bed while increasing the total number of employees. Other reductions in cost came from Humana's operating systems, including centralized accounting, national purchasing contracts, inventory control, productivity management and a computerized information system.

Humana's growing experience with the University of Louisville School of Medicine encouraged us to agree to build a new teaching hospital for the Chicago Medical School, a large voluntary nonprofit medical school. Humana will begin construction immediately upon receipt of a certificate of need from appropriate regulatory authorities.

The concept that has worked so well in providing indigent people with affordable access to high-quality hospital care in Louisville is being extended to the private sector through a family of innovative prepaid health plans known as Humana Care Plus. By January 20, 1985, this plan was being sold in 16 cities and had more than 115,000 members. Under Humana Care Plus, the patient retains the freedom to choose a family physician, who may in turn refer the patient to any Humana hospital staff member. Because Humana hospitals have open staffs, specialists may maintain patient relationships by joining a network hospital staff. We are able to share hospital cost savings with purchasers by providing members significant incentives to use Humana hospitals. We guarantee that premium costs will rise no faster than the cost of living index for up to 4 years.

Efforts by the government, insurance companies and other payers of health care costs have affected physicians as well as hospitals. Constraints are affecting medical practice at various levels.

The first level of constraint is the peer review organization that is judging medical decisions without seeing the patients. Similarly, requirements for second opinions before hospitalization impact practice patterns.

A second level of constraint impeding free choice is the DRG method of payment. A physician's choice of pacemakers, for example, is limited by the DRG price for the procedure.

A third level of constraint is the emergence of health maintenance organizations (HMOs) and preferred provider organizations (PPOs) in which patients are funneled to certain physicians. The HMO and PPO environment may cut costs for society, but it often interferes with free choice of physician and the traditional referral patterns built over the years. It also may have an impact on fee structure if physicians choose to compete on prices.

In this changing environment of medical practice, new alliances are going to be made. I suggest that physicians consider allying themselves with those organizations that are well positioned to offer high-quality services at affordable prices. Consider being part of an organization that has a reputation for excellence and attracts patients because of it. A concept that we find useful in Humana hospitals is the Center of Excellence, in which a particular specialty is of such high quality that it attracts referrals from a wide area. Our Centers of Excellence provide support for physicians in clinical research and medical education, 2 areas where physicians in private practice often have frustrations because they are away from a university environment. If one can establish a solid reputation for excellence, any HMO or PPO will be a lesser contender without you.

Productivity is another area that should be analyzed. Peter Drucker,[1] the renowned management consultant, author and university professor, says that productivity is the first test of management's competence. I believe that those physicians who concentrate on providing responsive, high-quality services at the affordable prices made possible by high productivity will maintain reasonable incomes. One key to productivity and lower costs in cardiology is high volumes to absorb the fixed costs of equipment and overhead.

Our cardiac catheterization laboratory at Humana Hospital–Audubon, the home of the Humana Heart Institute International in Louisville, performs invasive studies for 1,500 patients a year. These include diagnostic cardiac catheterization for congenital, valvular, myocardial and coronary artery diseases, primarily in adult patients. We also perform endomyocardial biopsy studies and have just added the latest in electrophysiologic studies for arrhythmia diagnosis and treatment—both medical and surgical.

In addition, we do coronary angioplasty in more than 100 patients per year, including elective and, more recently, acute angioplasty in acute myocardial infarction. We also do streptokinase treatment for acute myocardial infarction—both intracoronary and intravenous.

Because of high volume and laboratory efficiency, we have been able to maintain charges, according to Blue Cross/Blue Shield, at a level 25% below our competition, while functioning as a teaching laboratory for cardiology and internal medicine residents. These lower charges, in turn, attract still more referrals.

Humana Hospital–Audubon is but one of several Humana hospitals with a high volume of cardiac diagnostic procedures and surgery, requiring the cooperative skills of well-trained cardiovascular surgeons and cardiologists.

Dr. Robert Goodin, director of cardiology for Humana Hospital–Audubon and The Humana Heart Institute International, notes that the laboratory regularly has a low rate of "normal" studies, indicating careful clinical selection of patients to undergo these risky and expensive studies. Through careful use of noninvasive studies, cardiologists avoid cardiac catheterization studies in approximately 150 patients a year. Their noninvasive studies include electrocardiography, Holter monitoring, echocardiography (including M-mode, 2-dimensional and Doppler), exercise cardiography and such nuclear medicine studies as myocardial perfusion studies using thallium and gated wall motion studies.

The Humana Heart Institute has a large cardiac rehabilitation center for postoperative and postmyocardial infarction patients. More than 95% of the center's entrants complete the full program and a high percentage resume comfortable, enjoyable living, many at their previous occupations. A telephone monitoring system provides telemetry for exercise at home so that out-of-town patients can participate. This is important because 40% of the patients live beyond a reasonable driving distance to the rehabilitation center.

The large volumes of high-quality services performed at the Humana Heart Institute make it possible to do research and experimental work, such as implantation of the total artificial heart, at low, affordable cost. This is why Humana could afford to donate the full costs of up to 100 artificial heart implants. With this contribution from Humana, principal investigator Dr. William DeVries and his team can pursue their search for the useful limits of this technology free from financial restraints.

Research at the Humana Heart Institute is undertaken with the added safety that comes from having the backup of an outstanding cardiovascular service, with all its depth. The Institute's cardiovascular surgeons have participated in a combined total of over 12,000 procedures. The Institute has the only neuroradiologist in the city. A full range of cardiology services is available and cardiologists play a major role in screening candidates for an artificial heart.

We are in a transitional period in which government funding for research faces limitations because of other priorities. It is encouraging that private initiative has provided nontraditional but necessary financial support for the artificial heart project in a hospital setting rendered all the more appropriate because of its demonstrable long-term commitment to excellence and affordability in cardiology.

Reference

1. **Drucker PF.** Management Tasks, Responsibilities, Practices. New York: Harper & Row, 1974:111.