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Stop waiting for healthcare's 'twilight zone' to end

By Stephen Klasko, M.D. | July 28, 2017

Healthcare might be complicated, but the Democrat-Republican divide on the subject is actually easy to explain. Because no one wants to deal with the difficult, complex moves we would need to create a system that is more consumer-oriented, fair, transparent, logical, and value-driven, those of us who pay the bills are consistently left with $1 to pay for $1.25 worth of services.

The Democrats say, "No problem … we'll just give everyone an extra 25 cents to pay for that healthcare dollar until the cost goes down."

Meanwhile, Republicans, who don't like to give away money, say, "We just won't completely cover 20 percent of people, so the net result will get us down to $1."

Both sides are missing the tyranny of math. If you increase access to healthcare, you will by definition either increase cost or decrease quality (or both). If you want to increase quality, you will inevitably increase cost or decrease access.

That means the true solution to our national healthcare dilemma is disruption, which to this point none of us has had the incentive or gumption to deliver.

Here's what needs to be disrupted:

1. The runaway pricing of drugs, especially given the fact that the largest payer in the universe (Centers for Medicare and Medicaid Services, which is the U.S. government, which really means the taxpayer) cannot negotiate pricing

2. The problem of OPM, or "other people's money:" Healthcare is the only service we use that is largely disconnected from our wallets.

3. The lack of data coordination and/or aligned incentives between payers and providers

4. The way we handle end of life issues. No, we don't need death panels, but we do need a logical, ethical, just, realistic allocation of finite resources.

5. The ridiculous contingency and malpractice rules that really don't benefit anyone other than plaintiff lawyers (and maybe the Gulfstream Aerospace Corp., which sells those lawyers their private jets).

6. A payment structure for providers in which we ask primary care doctors to act like NFL quarterbacks, but we pay them like NFL kickers.

7. The lack of an "open-source coding" opportunity for EHRs that would significantly decrease costs for legacy systems and allow companies to compete on differentiation.

Managing the change

I know what you're thinking: Aren't we in the age of alternative payment models, like MACRA? Why aren't all of us scared to death that we won't be ready for all these alternative payment models? Simply put, many doctors and hospitals believe they can just wait out the current "twilight zone" of healthcare.

We all talk about transitioning from volume to value, but the pace is painfully slow and depending on your age, you can probably outlast the change. Why? Again, both government and providers are satisfied with incremental change — no pressure, no pain — when an "extreme makeover" is what we need.

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As the CEO of Thomas Jefferson University and Jefferson Health, a large academic health system, I do not absolve myself from this grand overspending. Because of OPM, hospitals send ridiculously unreadable bills, because we know someone else is paying them. (Your brain would explode if you actually had to interpret them.) We have too many beds in many communities, yet we oversee organizations that are adding beds, and we have no way of ferreting out underperforming hospitals.

But we understand the need for change, so we have decided to make the leap from a hospital company to a consumer health entity. This means that while we have tripled in size since 2014, we have not increased beds. Instead, we've invested in telehealth, digital solutions, and strategic partnerships.

It means that in the last year we have merged our health science university with a university known for design, the built environment, and Nexus Learning. It means that we are working with technology partners to learn how to provide efficient, integrated, value-driven services — something academic medical centers are not necessarily known for.

And it means, most importantly, that we are taking a cue from the retail industry. That the future is getting care out to where people are. Malls are not dead, but I would rather do my holiday shopping in my pajamas watching "Game of Thrones" than deal with the cars and people at a mall an hour away.

Similarly, hospitals will still be needed, but our goal is to get care out to people wherever they are — in what we call a "hub and hub" model (as opposed to the traditional academic "hub and spoke" system).

At Jefferson, we are moving in this direction with our community hospital mergers and our investment in telehealth. But we know the change can't come all at once if we want to keep our doors open. So we are leveraging our strength as a top-tier academic medical center to attract patients in need of our fee-for-service procedures like surgeries. We are deliberately phasing in telehealth as a replacement for ER visits.

And, importantly, we're establishing appropriate incentives for physicians and other providers. To paraphrase Upton Sinclair, it's hard to get people someone to do something when their salary depends on them not doing it. So we tied our chairs' salary incentives to telehealth adoption. And we connected our payer partnerships to the savings elicited by getting care closer to home. It takes a lot of work and communication and some time, but you can start to align your physicians' incentives with where the organization is going.

So, politicians, providers, pharma, insurers, lawyers, software folks, doctors, nurses, and everyone else in the healthcare ecosystem: Let's get away from Congress's current game, as Democrats and Republicans yell at each other about who has the best solution for an impossible task.

Instead, let's think about 'D & R' not as Democrat and Republican, but Disruption and Re-imagination. Then we can stop blaming each other and enjoy the fruits of a logical, forward thinking, and equitable healthcare system.

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Image Credit: The Twilight Zone | Getty Images