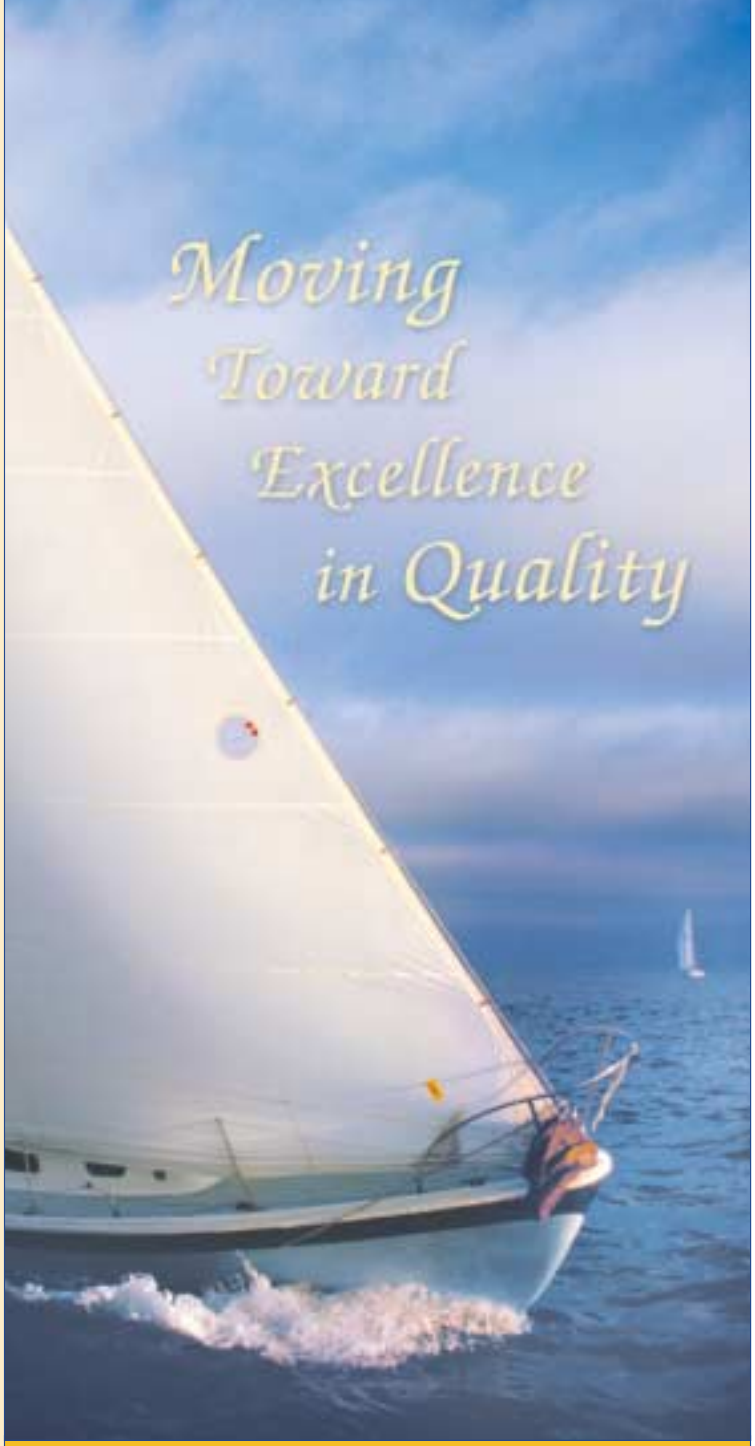

Insights from the 2001 Annual Chairman & CEO Report

THE GOVERNANCE INSTITUTE

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Moving Toward
Excellence in Quality

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Preface

In today's fast-changing and unforgiving healthcare environment, hospitals increasingly face demands for improved quality of care. Be it pressure from payers who see better quality as an opportunity to curb double-digit increases in healthcare premiums or demands from Internet-savvy consumers who are increasingly taking responsibility for making healthcare decisions (and paying a larger part of the bill), hospital chief executive officers (CEOs) and board members face a clear mandate to improve the quality of services they offer to their customers. Studies from independent organizations, such as the Institute of Medicine (IOM), make it clear that there is plenty of room for potential improvement, particularly when it comes to reducing preventable errors and deaths. This 2001 conference of board chairmen, chairwomen, and CEOs of the members of The Governance Institute was organized to help respond to the challenge of meaningfully improving quality.

The annual Chairman & CEO Conference provides an opportunity for The Governance Institute to help its members exchange practical ideas with experienced faculty. This year marks the 11th anniversary of the event. Its theme, "Moving Toward Excellence in Quality," addresses perhaps the most important priority facing boards of leading U.S. hospitals and health systems. An excellent faculty joined in Palm Beach, Florida, with over 170 health sector leaders from 33 states. This paper summarizes the observations and conclusions reached during the session.

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Faculty

The Governance Institute thanks the speakers at the 2001 Annual Chairman & CEO Conference for being so generous with their time and expertise:

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The ServiceMaster Company

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Chapter I

The Role of Leadership in Pursuing Excellence in Quality

Without question, the most important determinant of an organization's ability to provide high-quality care is the quality of its leadership. Great leaders are able to motivate their employees to pursue excellence and provide the financial resources and other tools necessary for them to succeed. To shed light on this issue, the Chairman & CEO Conference included three speakers who touched on the critical aspects of being a successful leader, including spiritual and financial leadership.

"If you live in the past, you're a loser."
Bill Clement

The Best Leaders Strive to Be the Best

Bill Clement, a former star in the National Hockey League, entrepreneur, actor, and television broadcaster, opened the conference with a simple yet powerful message for the leadership of hospitals and health systems—strive to be the best in whatever you do. Mr. Clement knows a lot about being the best; not only did he win two Stanley Cup championships during his playing days, he also became a top actor and broadcaster after retiring. To become the best (and make the most of it), it is helpful to understand what it is like to be at the bottom and in the middle as well. Mr. Clement has had this experience as well, as a failed restaurant venture left him bankrupt after his retirement from hockey.

Dream big and dare to fail . . . we are best as climbers striving to reach the summit, not as individuals already perched on the summit."
Bill Clement

Without question, there are challenges when an individual or organization attempts to be the best. Hospital CEOs and board members, for example, face financial and economic issues that could threaten their organization's very survival. With the nation's economy struggling, hospitals face the prospect of caring for more patients without insurance. Complying with HIPAA (Health Insurance Portability and Accountability Act) mandates will add to costs, while finding and retaining an adequate number of qualified nurses and other allied health professionals remains difficult.

Overcoming these challenges requires leadership. But what is strong leadership? In Mr. Clement's view, leadership is about motivating people. Anyone can be a leader. The trick is to figure out how to influence others.

Two Pillars of Leadership

Mr. Clement highlighted two "pillars" of leadership.

Pillar #1: Be a Source of Energy

The best leaders are a source of energy for those around them. Being a source of energy requires a positive attitude, even when the ability to remain positive may be tested by physicians and others. As the "flagbearers" of their institutions, hospital CEOs and board members have a

special obligation to portray a positive attitude. Such an attitude can be a powerful force for influencing others' behavior, as it can be a clearinghouse for positive energy. For example, the leaders of Fedex Corporation have been incredibly successful in instilling a positive attitude in employees; one employee in a small town in Wisconsin displayed such enthusiasm for (and knowledge about) the company's quality improvement program that a judge for the Malcolm Baldrige Award* lobbied heavily for FedEx to win the award (which it did). Attitudes are also important because they are one of the few things over which one has complete control. And while a positive attitude can rub off on others, so can a negative attitude. Leaders who constantly have a negative attitude become "energy vampires" who "suck the life" out of an organization.

Some See the Glass Half Empty, Others Half Full

To demonstrate how different individuals can have different attitudes with respect to the same situation, Mr. Clement shared the story of two shoe salesman who went to the Australian outback in search of a new market. Noticing that the natives did not wear shoes, one reported that there was no opportunity to crack the market (assuming that natives would not change their ways), while the other saw a tremendous untapped opportunity.

Pillar #2: Act as "Glue" for the Organization by Pulling Others, Not Pushing

Leaders must pull people rather than push. When a leader pulls others, people will follow that leader wherever he or she goes. Leaders who push are acting as dictators who will ultimately lose their position of leadership, as pushed individuals rebel or leave. Pulling people, in turn, requires making them feel vitally important to an organization and its culture. To demonstrate how powerful this approach can be, Mr. Clement shared a story of his playing days in the National Hockey League. A severe knee injury suffered during the Stanley Cup finals made it difficult for him to walk, let alone skate. A respected teammate (now a general manager in the league) urged him to try to play by emphasizing how vital his contributions were to the team. That motivation inspired Mr. Clement to try, and he went on to play effectively in the next three games, helping his team win the Stanley Cup. Leaders should not assume, moreover, that workers know that their contributions are vital. On the contrary, one must take the small amount of time that is necessary to make them feel important and appreciated. Lip service will not get the job done.

Conclusion

Mr. Clement wrapped up his remarks by exhorting leaders to continue their efforts to influence and motivate others, even when they feel tired of giving. The best leaders are relentless in their efforts. They continue to strive to be better even when they may have reached the top of their profession.

Spiritual Leadership as a Way to Motivate Employees

As Mr. Clement noted in his remarks, a key aspect of leadership is motivating employees. William Pollard, chairman of the board of The ServiceMaster Company, built on Mr. Clement's remarks by offering his views on the role of spiritual leadership in motivating and getting the most out of employees. He began by noting the importance of a strong relationship among key leaders; in particular, the relationship between a board chair and CEO can set the tone for an entire organization and help with the challenges that an organization faces.

*The Malcolm Baldrige healthcare criteria include leadership (120 of 1,000 possible points), strategic planning (85), focus on patients/other customers/markets (85), information and analysis (90), staff focus (85), process management (85), and organizational performance results (450).

The Role of Healthcare in Society

Healthcare is as essential today to the communities it serves and to society at large as it has ever been. In the wake of the terrorist attacks, the healthcare industry stands ready to serve and respond with unparalleled resources to care and cure, resources that no other industry can offer.

Yet the industry has gone through great change in the past 25 years, primarily as a result of cost control and compliance programs pushed by the payer industry that have led to more efficient (if not more effective) healthcare. These programs have been bureaucratic in nature, and have generally not responded to the needs of patients. Regulators have also found hospitals to be an easy target for cost-cutting.

"Hospitals are islands of hope, security, and stability in today's world."
William Pollard

The Key to Quality and Success: People

Reflecting on the nature of quality in a services environment, Mr. Pollard believes that excellence in quality has nothing to do with bureaucratic compliance programs. Rather, quality is driven by what is in the hearts and minds of those people who deliver healthcare services. Like everyone, healthcare workers are looking for purpose and meaning in their lives and their work. And the key to success in the healthcare field is to motivate these employees to serve patients as real, live people rather than as individuals with illnesses or a particular classification of reimbursement.

The Key to Motivation: Developing the Whole Person

Senior management must serve as the guiding force in motivating employees. This effort requires the development of people both in terms of human character and moral behavior. Mr. Pollard believes that the spiritual side of humans affects their character, judgment, and desire to serve others. It also provides stability in these uncertain times. The key challenge for leaders, therefore, is to help employees to find compassion, commitment, a willingness to serve, a desire to learn, and respect and love for others. While to some extent these values are instilled in individuals long before they join an organization, organizational leaders have an important role to play in teaching them and in making sure that they are embodied in the organization's mission statement. Leaders must also embrace and embody these values in their everyday routines by investing in quality and training programs that emphasize development of the whole person; these programs fail if they focus only on the work aspect of an individual with no attention to his or her heart and soul.

What Is Your Business?

Mr. Pollard related a story of when Peter Drucker asked the board of directors of ServiceMaster to define their key business. While many focused on the services the company offered (e.g., cleaning services), the real business of ServiceMaster is in training and motivating employees to serve clients. The business, like most others, begins with people, who are "packaged" in a variety of ways to service consumers.

The Role of Spirituality at ServiceMaster

From a service perspective, 80–85% of what ServiceMaster does today was not a part of the company 12 years ago. In fact, the only business that remains from 12 years ago is now being sold, meaning that the company's core services have completely turned over during this time period.

What has remained constant, however, is the need for motivated employees who are committed to serving others. The leadership of ServiceMaster offers training and development programs to its 50,000 employees plus another 150,000 individuals. In many ways this training and development is the

Lack of Spiritual Assets the Biggest Problem Facing Society

A study by a respected University of Chicago economist found that the biggest issue facing society today is not a lack of opportunity or resources, but rather the lack of distribution of spiritual resources and spiritual assets. In other words, a void exists in the development of character and spirituality of people, as character development is simply not a priority.

"Never give a job or a title to someone who cannot live without it."
William Pollard

organization's core activity. To ensure that this pipeline remains strong, ServiceMaster seeks to function as a community that can shape human development. This commitment begins with the company's four core objectives—to honor God in all we do, to pursue excellence, to develop people, and to grow profitably. This essentially means to seek to do what is right (and avoid what is wrong). The company's leadership firmly believes that everyone has dignity and worth, and that everyone has a "fingerprint of potential" that can be reached through service to others.

Leading by Example

To unlock this potential, leaders must do more than offer words; conduct remains far more important than anything a leader might say. Leaders must be perceived as no better than those they lead; no work task should be "beneath them." For this reason, everyone at ServiceMaster, including Mr. Pollard, spends time in the field doing service work, such as cleaning the floors of a hospital. Every new hire—even a senior vice president—spends time during their first two months in the field. Every year the company also hosts a "we-serve day" where all employees spend a day in the field delivering direct services to customers or customers of our customers.

Timeless Values in Turbulent Times

Mr. Pollard closed his presentation by reviewing a set of "timeless values" for leaders in these turbulent times:

- Learn to trust the people and be surprised by their potential.
- Promote diversity; potential cannot be judged by appearance.
- Make yourself available; it is too easy to be tied up in meetings all the time.

  Mr. Pollard tries to spend 75% of his time out of his office, mostly with customers and employees.

"Have you thought about what really matters to you? To me? To the people we serve?"
William Pollard

Spirituality without Being Perceived as Inappropriate

Leaders might not always be comfortable touching the moral side of people, as their actions may draw criticism regarding the appropriateness of such activities. Mr. Pollard offered some advice on how to introduce spirituality into a company without drawing criticism. He cautioned leaders to be very careful not to be perceived as giving orders. For example, at his company, he refuses to lead bible study groups, even though employees ask him to. His fear is that other employees might believe that he is implicitly expecting them to take part in these groups, or that failure to take part might somehow be perceived negatively. The key is to let individuals express their own spirituality, whatever that might be, without instilling one's own beliefs on others.

- Demonstrate a commitment to employees, who will be motivated by covenants and conduct, not contracts.
- Show love and care for people; treat them as the subject of work, not the object of it.

  This makes all the difference in motivating others. Individuals who are treated as the subject of work understand the importance of their work to the overall picture; those treated as the object of work view the activity as something to keep them busy all day.

- Remember that leadership is both art and science.

  The ability to transform a company will depend on its existing culture. The key is for leadership to identify and work with key individuals who have influence over others. Within 12 to 18 months, most employees typically are won over.

> *"People must be won over; they cannot be ordered or directed."*
> William Pollard

Healthcare, like all businesses, is its people. Leaders must take the time to ask workers what matters to them and the customers they serve. By investing in the whole person, hospital leaders can create a winning formula for quality of service and care for patients.

Financial Leadership as a Catalyst for Quality

Successful organizations have strong financial leadership that moves the organization toward the goal of excellence in quality. Quality improvement requires a significant investment of an organization's resources. Effective financial management ensures that sufficient funds are available for investment in initiatives designed to enhance care and service excellence. To shed additional light on this issue, Kenneth Kaufman, founder and managing partner of Kaufman, Hall & Associates, offered his view on the role of financial leadership in an organization's efforts to pursue excellence.

Learning from the Fortune 500

Mr. Kaufman emphasized how techniques used by Fortune 500 corporations can also help hospitals achieve their goals. Corporations, such as General Electric (GE), are pioneers in the use of finance as a leadership tool. Many not-for-profit hospitals have much to gain from learning about and applying GE's approaches. In Mr. Kaufman's view, the use of "best practices" financial leadership should be considered an organizational imperative. CEOs are responsible for ensuring that this leadership occurs.

A Governance Checklist for Best-Practices Finance

Best-practices finance involves "nuts and bolts" issues, such as billing and reimbursement, collections and receivables, accounting practices and financial statements, and budget preparation. These activities must be done properly on a daily basis. The CFO and CEO provide ongoing oversight.

Other financial best practices, for which top leaders also provide oversight, include financial planning, capital allocation, investment policy and procedures, and debt/interest rate management.

"Nuts and bolts financial activities can either energize or embarrass. They must be done right."
Kenneth Kaufman

Taken collectively, these financial activities and the financial culture of an organization help to create a leadership model. Best-practices financial leadership can not only assist with execution, but can also serve as an envisioning and engaging process within the organization. Financial planning and capital allocation, when done properly, can help create a vision for where the organization is headed and a plan for how to get there. At a minimum, capital allocation must be consistent with an organization's strategic and financial plan. The capital allocation and budget preparation processes can engage key personnel in the organization's future plans. In a traditionally sized community hospital, it would not be unreasonable to include 150 to 200 people in the capital allocation process and an even greater number in the budget preparation process. This breadth of involvement builds buy-in.

Proper performance of each of the best-practice finance activities is critical to the organization's overall success. As indicated in the chart below, the activities define the organization's vision, engage the organization's staff, and enable staff to execute the organization's strategic and financial plan in order to achieve short- and long-term goals.

"Best Practices" Finance: Guidelines for Sustained Leadership

Best Practices Checklist	Envision	Engage	Execute
Financial Planning	X		
Capital Allocation	X	X	
Budget Preparation		X	
Billing & Reimbursement			X
Collections & Receivables			X
Accounting Practices			X
Investment Policy			X
Debt & Interest Rate Management			X

A Function-by-Function Review of Best Practices

Mr. Kaufman provided a function-by-function review of the best practices within finance.

Function #1: Billing and Reimbursement

An organization cannot "win" financially without consistent revenue growth. Achieving this growth requires accurate and on-time billing procedures, prompt filing of cost reports and timely settlements. Close management of contracts, including the negotiation of favorable terms, collection of what is owed, and the willingness to walk away from unfavorable deals, are also critical. Leaders must be willing to change or end arrangements that are not in the organization's best interest.

"Poor collections is a leading indicator of poor financial management . . . without cash flow, you cannot run an organization."
Kenneth Kaufman

Function #2: Collections

Collections is not a trivial matter; the difference between an average collection time of 72 and 90 days represents a significant amount of money. Collections directly reflects the quality of an organization's overall financial management. Rating agencies, insurers, investment bankers, financial advisors, and other capital market players believe that poor collections is almost always a "leading indicator" of problems throughout the rest of financial management. Thus, effective oversight of collections by the board, CEO, and CFO is very important.

Collection of receivables is the "ditch-digging" of finance; it is a blue-collar job that requires excellent systems (e.g., software) and processes. In the end, consistent success in collections requires hard work and exceptional diligence on the part of management.

"Wall Street will not stand for a restatement which turns a $5 million profit into a loss 90 days after the quarter ends."
Kenneth Kaufman

Function #3: Accounting Practices

Organizational credibility is dependent on the accuracy of the monthly, quarterly, and annual financial statements. Major audit adjustments which alter the meaning of the financial statements make all members of senior management—and often the board—seem inattentive and unreliable. In addition, middle managers cannot be expected to make the needed day-to-day adjustments to operations if the credibility of the financial statements is at question.

Two frequently occurring problems illustrate the importance of good accounting practices. The first is the failure of many organizations to accurately estimate contractual allowances. Rating agencies and other capital market professionals have little patience for poor estimates. The second is the need to accurately recognize losses on sales or discontinued operations, such as physician practices.

"The amount of human capital and money used in budgeting is unacceptable . . . especially given the uncertain outcome of the budgeting processes."
Kenneth Kaufman

Function #4: Budgeting

The budgeting process in many hospitals is a significant waste of scarce time and resources that diverts both clinical and administrative staff. Often the budgeting process becomes an end in itself that ultimately provides uncertain value. After hundreds of people have invested time in the budgeting process over several months, the end result must be a management tool that is worth that level of effort.

Best-practices budgeting requires the following:

- A highly integrated relationship between the financial plan and the budget
- A best-practices database containing the utilization and financial information required to create the budget
- Budget leadership from the department managers
- A budget process that provides useful reports to management throughout the year
- Excellent technology and budget software

Function #5: The Financial Plan

The financial plan is the backbone of financial management. A properly executed plan provides an explicit roadmap to financial success. A financial plan that is based on sound corporate finance principles serves to quantify the financial equilibrium for a healthcare provider and balances financial capabilities with strategic objectives.

In a period of scarce resources, the ability to stay on sound financial footing is critical. The CEO and board must understand the organization's financial imperatives and what it can afford to spend.

A sophisticated financial plan organizes around the following concepts:

- High-quality financial forecasts
- Expected level of required capital investment

  This aspect is becoming more important. Hard work is required to understand what level of investment will keep the organization competitive. Guessing will not suffice; once a number is set, it is hard to change.

- A "scientific" understanding of debt capacity and cash position
- Identification of the capital shortfall
- Quantitatively determined financial goals and objectives that solve the capital shortfall

Function #6: Capital Allocation

Capital allocation is the process used to make capital investment decisions. Long-term financial success requires best-practices capital allocation. Available capital can be deployed for future growth or re-investment in the organization, or to improve balance sheet liquidity. The cost of making poor capital investment decisions is often immediate and severe.

Best-practices capital allocation must be supported by the competent use of analytical techniques, which can provide significant value. The most important project metric is free cash flow. Thus, as a first step, a project's net present value (NPV) should be calculated.

In addition, Monte Carlo simulation should be used to assess project and portfolio risk. Finally, given today's economic uncertainties, it is critical to quantify and respect the organization's capital constraint. The CEO's job is to keep an organization's spending in line.

"Whether you are General Electric, the New York Yankees, or Northwestern Memorial Hospital, great organizations are great allocators of capital."
Kenneth Kaufman

Function #7: Debt and Interest Rate Management

Debt is an essential resource for all healthcare providers. No hospital can fund its growth strategy solely from reserves, or even from a combination of reserves and operating cash flow. The critical issue is to find the combination of debt instruments that will provide an organization with its lowest cost of capital at an acceptable level of risk. For many organizations debt and interest rate management has emerged as a critical cost issue and a significant priority. During the past 15 years, hospitals have become more adept at using a variety of debt instruments to achieve the lowest cost of capital.

Mr. Kaufman recommends organizing debt management strategies around a series of questions, as outlined below:

- How much debt should your organization have?
- How much of the total debt should be fixed rate versus variable rate?

  With today's environment of falling short-term rates, hospitals can generate significant savings through use of variable-rate instruments.
- What style of variable-rate debt should be used (assuming this form of debt makes sense)?
- Should interest rate swaps or other derivatives be used? How can derivatives be used to reduce the total cost of capital at risk levels that are acceptable to the board?

"If you can only afford to spend $40 million, then spend $40 million. Do not let politics force you to spend $52 million."
Kenneth Kaufman

Function #8: Asset and Liability Matching

In today's business world, there are some clever and unexpected ways to make and lose money. One of these is the matching of long- and short-term investment instruments. The proper matching of assets to liabilities is often a counterintuitive adventure that has led many boards down a wrong path.

To illustrate the complexity and potential of this approach, Mr. Kaufman reviewed the relative merits of the potential options for minimizing overall portfolio risk in a rising interest rate market. He highlighted four potential combinations of debt and investment instruments:

1. **Fixed-rate debt and fixed-rate investments:** While many organizations opt for this approach, there are better combinations in an environment where rates are rising.
2. **Variable-rate debt and fixed-rate investments:** In a rising-rate environment, this approach is less than optimal because as rates rise, borrowing costs also rise and the value of fixed-rate investments falls.
3. **Variable-rate debt and variable-rate investments:** This approach would lead to a rise in the costs of borrowing, but returns on investment would also increase.
4. **Fixed-rate debt and variable-rate investments:** This strategy represents the best approach, as borrowing costs would remain stable while returns on investment funds rise.

"The proper matching of assets to liabilities is often a counterintuitive adventure that has led many boards down a wrong path."
Kenneth Kaufman

Perhaps the most important lesson with respect to the matching of assets and liabilities is that investment and borrowing decisions are inextricably linked. Thus, it is a big mistake to have separate committees handling these two functions. The costs of a mistake in this area can be very significant. For a hospital with hundreds of millions of dollars in investments, losing a few percentage points in interest earnings may forfeit millions of dollars a year in cash flow. This extra money will be critical at a time when most hospital leaders feel that they do not have enough capital capacity to meet their organization's financial requirements. Thus, asset and liability matching becomes a leadership issue, not just a management issue.

Conclusion: Critical Leadership Reminders

Mr. Kaufman concluded his remarks by reminding hospital CEOs and board members of Don Brennan's famous remark that "culture eats strategy." (Brennan is the retired past president and CEO of Ascension Health.) Leaders who are determined to promote a strategy that is not consistent with their organization's culture will find significant resistance from all parts of the organization. He also urged hospital leaders to think carefully about the strategies they pursue, and urged them not to continue to make the mistakes of the past, such as purchasing physician practices at unsupportable prices. Most importantly, he reiterated the importance of financial leadership as a "robust property" that works irrespective of the changes in market conditions. Thus, it can serve to assist leaders and ensure success even in the most difficult economic times.

"Leaders who are determined to promote a strategy that is not consistent with their organization's culture will find significant resistance from all parts of the organization."
Kenneth Kaufman

Chapter II

The Strategies and Tools for Excellence in Quality

Strong leadership is the first—but not the only—requirement for achieving excellence in quality. Leaders must also develop the right strategies and make use of the right tools for improvement. To help hospital CEOs and board members to better understand this issue, the conference included a series of presentations on various strategies and tools that can lead to markedly improved quality and enhanced patient safety.

First Task: Understanding the Quality and Safety Problem

The first, critical task in addressing quality and safety issues is to understand the nature of the problem. To shed light on this issue, Michael Guthrie, M.D., M.B.A., a senior vice president for Premier, Inc. (one of the nation's largest healthcare alliances), reviewed the root causes of quality and safety problems within the nation's hospitals and health systems.

Trends in Quality and Safety Improvement in Hospitals

Dr. Guthrie began by highlighting key trends and influences related to quality and safety improvement within hospitals. These include not only the recent IOM reports, but also the activities of the media, Joint Commission, National Committee for Quality Assurance, government regulators, Congress, and employer coalitions. The rise of consumerism and new technologies also play a role. Of particular note are the activities of purchasers. For example, the Leapfrog Group, a coalition of large employers, is involved in a new form of activism on behalf of consumers. The coalition is no longer looking to control costs through discounts or rationing, but rather wants consumers to choose healthcare providers differently. These purchasers are also beginning to make (and publicize) calculations of the number of lives that poor quality care claims each year; consumers and the media understand this metric.

In response to these trends, providers must shift attitudes. The issue can no longer be framed as money versus quality of care and safety. Rather, money and quality/safety must be viewed together as "co-dependent variables." This shift may be difficult for hospitals and physicians, as each side believes that the other is concerned primarily with money, to the detriment of quality and safety.

Root Causes of the Quality and Safety Problem

The quality and safety problems in the U.S. healthcare system are large. By "drilling down" the IOM figures, one can quickly calculate that the number

of deaths due to medical errors each year is equivalent to the number of deaths that would occur if one large airliner crashed every day, or if a ship the size of the Titanic sunk every 5.5 days. Large corporations, such as General Motors, have calculated that an estimated 367 of their employees die each year due to inpatient medical errors. In fact, nationwide more people die in a given year as a result of medical errors than from motor vehicle accidents, breast cancer, or AIDS. Statistics such as these quickly get the attention of the media and Congress.

"Variety is the spice of life, but variation can kill you."
Michael Guthrie, M.D.

What, then, are the root causes of these quality and safety problems? Dr. Guthrie described several of the most important.

Failure to Use Best Practices

The care delivered to a patient is still determined primarily by the habits of a physician rather than scientific evidence. Variation from best practices remains the norm; as a result, there is overuse, underuse, and misuse of tests, treatments, and procedures. Identifying variation remains a key strategy in uncovering opportunities for improvement.

Growing Complexity

The "half-life" of medicine—the amount of time it takes for 50% of information to be rendered obsolete—has dropped from five years to 2.5 years since the 1970s. The rapid growth of medical knowledge makes it impossible for any individual physician to keep up, even with increased specialization. The emergence of genetics into mainstream medicine will only add to this problem. Systems of care are becoming more complex, as diagnosis and treatment of individuals require better information flow and greater coordination among caregivers; information technologies are not yet up to the task, as the basic medical record-keeping system has not changed in three generations. Fixing this problem may cost millions of dollars.

Consumerism

Armed with more information, consumers are now challenging their traditional relationship with providers. While consumerism will emerge differently in different communities, it will generally involve giving consumers greater choice, control, service, and convenience. The net result will be more intense competition. And as consumers are asked to contribute more of their own money to pay for healthcare, their demands will only increase.

"Consumers will demand care when they want, how they want it, and for a price they are willing to pay."
Michael Guthrie, M.D.

Physician Overload

Physicians are feeling increasingly overloaded. As noted previously, it is hard to keep up with medical knowledge when the number of new drug approvals increased by 50% over 20 years (from 1980 to 2000). Adjusted rates of real income have declined while workloads have remained steady and in some cases increased. Requirements imposed by regulations, coding, and oversight have also increased. Not surprisingly, the result has been a steady, continuous decline in physician satisfaction over the past 20 years.

Given these trends, it is not clear how much time, energy, and effort physicians are willing to devote to the challenge of improving quality and safety. Hospital CEOs and board members must understand and address these limitations as they devise strategies for working with and motivating physicians to tackle quality and safety issues.

Fixing the Quality and Safety Problem

To effectively address quality and safety problems, the industry must learn to develop and deploy systems for delivering health services that will either prevent, or anticipate and compensate for, the errors that human beings inevitably make. In addition, there are other barriers to improvement, such as the following:

- Little demand for higher quality, at least in some markets
- Lack of adequate information technology to help identify sources of variation and other quality problems
- Skewed financial (and other incentives) for physicians and hospitals
- A complex responsibility matrix

Given these barriers, progress in improving quality and safety will depend not only upon the quality of the solution, but also upon the degree to which it is accepted by physicians. It is the responsibility of hospital CEOs and board members to work closely with the medical staff to make sure that ideas are accepted. To that end, Dr. Guthrie recommends that hospital boards and senior management engage in the "5Ms"—measurement, management, (working with) the medical staff, money, and marketing. More specifically, he advocates the following types of activities:

- Develop a functional information system that has clinical outputs as its principal objective.
- Routinely monitor and report on performance against agreed-to measures.

  This report should be reviewed by the board and linked to best practices.

- Recruit quality champions by creating an environment that supports their development and rewards their work.
- Ensure adequate funding for quality measurement.

  The board should expect to see a clinical return on investment, in terms of both reduced costs and saved lives.

- Hire and incentivize executives based on quality criteria.

  Dr. Guthrie urged board members to evaluate whether today's CEO is the right person to lead the organization over the next decade. Good CEOs can motivate their staff and make good decisions on critical issues such as information technology.

- Insist on medical leader participation.
- Create a shared understanding among management and the medical staff of the need for change.
- Shape the vision of performance improvement.

- Mobilize commitment.
- Make change last through use of incentives and encouragement.
- Monitor progress continually.
- Measure the clinical return on investment of potential projects, and then choose accordingly.

Physician leaders must also embark on changes, as outlined below:

- Develop and use credible data.
- Design effective use of administrative support.
- Craft shared goals for improvement.

  Management creates the infrastructure and systems for measurement, while physicians become the "stewards" of the science by monitoring outcomes, identifying/interpreting gaps in performance, and developing systems to fix care.

- Find and support participation among "rank-and-file" physicians.
- Start the effort somewhere, perhaps with a relatively simple problem that produces an easy "win."

The End Result

Dr. Guthrie concluded by reviewing the benefits of embarking on these activities. He believes that such actions can result in remarkable interventions that will make hospitals safer and quality of care better. The net result will not only be the saving of lives, but also a greater sense of purpose and pride among physicians and hospital staff. This, in turn, will assist in the recruiting of nurses and allied health professionals who will be attracted to an institution that puts quality and safety at the forefront. Institutions that successfully navigate this long road will receive public recognition and, at least in some communities, a market advantage as payers and consumers reward the highest-quality institutions with increased market share.

Evidence-Based Medicine as a Tool for Excellence in Quality

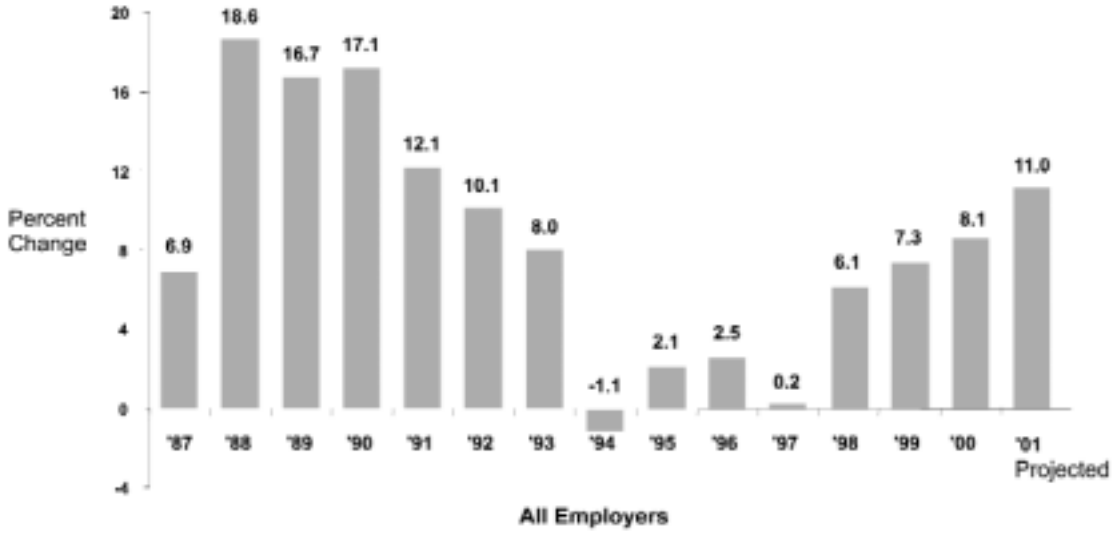
Much of the healthcare delivered in the United States is not based on scientific evidence; studies suggest that closer adherence to science-based guidelines and protocols could markedly improve quality and reduce costs. To shed light on this potential approach to quality improvement, Michael L. Millenson, a healthcare consultant based in Highland Park, Illinois, and author of *Demanding Medical Excellence: Doctors and Accountability in the Information Age* (University of Chicago Press), laid out his views on why use of evidence-based medicine is the best—and perhaps only—alternative available to the U.S. healthcare system as it seeks to control costs and improve quality.

The Coming Crisis in Healthcare

Mr. Millenson believes that a "storm is brewing" in healthcare. Even before the events of September 11, 2001, the industry faced both cost and quality pressures that are only going to be exacerbated in the face of anthrax and

other potential bioterrorism attacks. As demonstrated in the chart below, the healthcare industry faces a cost crisis, with double-digit increases expected in the years ahead. (These figures do not include responses to bioterrorism concerns, which could add another one to three percentage points to these growth figures.)

Rising Healthcare Costs, Dwindling Options



Source: *Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans.*

The Medicare program faces a $48 billion shortfall this year, with the prospects of multi-trillion dollar deficits over the next 75 years. Spending on national defense, which will increase in the face of the September 11 attacks, will crowd out the dollars that government has available to spend on healthcare. This "crowding-out effect" will be exacerbated as the reality of the economic slowdown filters its way into budget projections; current projections appear too optimistic.

Performance-Based Healthcare the Only Option

Just as the events of September 11 are leading to a sea change in the field of security, this crisis will force the healthcare industry to change as well. Mr. Millenson sees a combination of economic pressure, information technology, and a new *zeitgeist* that will transform medicine and healthcare. This transformation will be driven by the adoption of performance-based care that will be far superior to other alternatives; quality will no longer be measured by subjective standards, but rather by a combination of subjective and objective performance criteria.

Of course, healthcare has gone through crises before that have not led to the adoption of performance-based healthcare. The "era of assessment and accountability" has been talked about since 1988, when Arnold S. Relman, M.D., announced its arrival in the New England Journal of Medicine. Yet it never came, largely because dollars kept flowing to those that provide healthcare services, regardless of the quality and cost-effectiveness of the care they delivered.

The key questions, therefore, are as follows—why is this crisis different? Why can the industry no longer afford to put off the era of accountability and performance measurement? In Mr. Millenson's view, the answer is relatively simple—other options that have been tried in the past simply will not work anymore.

There are three primary ways to control healthcare costs—paying less for care, doing less, and doing things better. The industry has already gotten as much as it can out of the first two approaches. In its early days, managed care was quite successful in extracting price discounts from providers eager to attract business in an era of excess supply. But the days of excess capacity are over, and providers are now in a position of negotiating strength with managed care organizations. Managed care has also attempted to cut costs by doing less. But this strategy is perceived as un-American, and as a result managed care companies have faced a tremendous backlash from consumers.

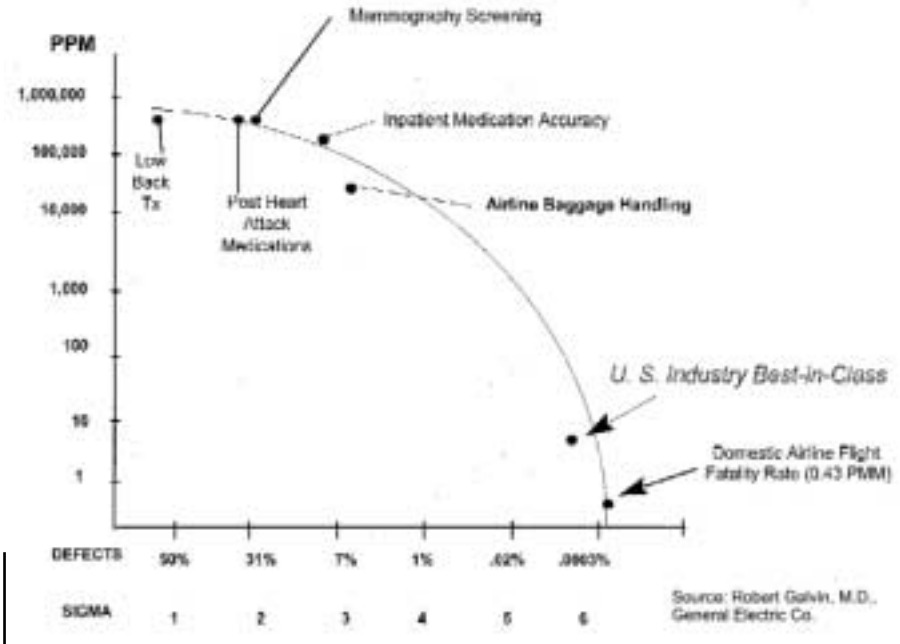
"If we need money for defense and education, we can't afford to spend it on healthcare that harms people."
Michael Millenson

Thus, with costs again raging out of control, the only alternative is to do things better; this approaches offers the potential of providing the same or better quality care for less money.

The Preferred Path: Evidence-Based Care and Physician–Patient Partnership

The problem in healthcare today is not bad or incompetent people or institutions. Addressing the problem is not simply a matter of people trying harder. Rather, the system itself is broken, and a new mental paradigm is needed to fix it. In Mr. Millenson's view, there are two key components to that new paradigm: evidence-based care and physician–patient partnership.

"Worse than Airline Baggage"



Evidence-Based Care

The evidence supporting the value of evidence-based medicine is strong. A recent report by IOM documents the large gap between today's care and ideal care (see box on next page). As demonstrated in the chart at left, some aspects of medical care have a poorer quality record than does the airline baggage handling industry.

More importantly, perhaps, the message that healthcare quality is poor is reaching mainstream audiences, including Congress and the general public. Large payers also understand it, as evidenced by the fact that they now employ clinicians.

In short, the healthcare "guild" no longer controls information on quality. And now that the public and politicians understand the quality problems in the industry, they might take action. In Mr. Millenson's view, this is reason enough for the industry to take matters into its own hands.

The Patient–Physician Partnership

Mr. Millenson envisions a new era where patients and physicians are partners in care. Patients will not tell physicians what to do (as some fear), but at the same time physicians will no longer force patients down a particular path based solely on the physician's personal preferences. Rather, decisions will be made collaboratively based on the medical evidence, the physician's experience, and the patient's preferences. This movement is consistent with broader trends toward consumerism in society at large.

Specific Challenges and Responses

Mr. Millenson laid out a series of specific challenges that the industry faces with respect to quality, along with details of how the industry is responding in an era of evidence-based medicine and physician–patient partnership.

Challenge #1: Improving Patient Safety

The first IOM report estimated that between 44,000 and 98,000 individuals die in hospitals each year due to preventable errors. Mr. Millenson believes these estimates are conservative. He cited other studies that suggest even higher figures, such as the Centers for Disease Control and Prevention estimate that each year two million people develop hospital-acquired infections, leading to 90,000 deaths, 25 to 75% of which are preventable. According to *Archives of Surgery*, each surgical infection costs $12,500. In addition, according to the *Journal of the American Medical Association*, there are 2.2 million adverse drug events each year, leading to 106,000 deaths; the annual cost of preventable drug errors is $2 billion.

In response to these problems, purchasers such as the Leapfrog Group (a coalition of large employers representing millions of covered lives) are encouraging employers to provide comparative information on the quality of providers to employees. They are also promoting use of three measures that are known to be effective in improving patient safety—computerized physician order entry (CPOE) systems, intensivists in the intensive care units, and limiting of referrals to high-volume institutions for certain procedures where volume is correlated with quality. Mr. Millenson sees this approach as nothing less than a revolution in healthcare. He would like to see providers similarly step up to the plate by taking accountability for errors; he wonders why no healthcare provider has offered to make care "free" in the event of a medical error.

Challenge #2: Improving Treatment of Chronic Disease

Three-quarters of spending on healthcare in the U.S. is for people with chronic diseases; this figure will increase as the population ages. Heart disease is the leading cause of death for men and women, while the incidence of diabetes is reaching epidemic proportions. Asthma is a growing cause of illness and death among children. Yet compliance with screening and treatment guidelines in each of these diseases is poor. For example, a

A Wide Chasm between Today's Healthcare and Ideal Care

A recent report by IOM highlights the wide gap between care offered today and ideal care. Below are a few quotations from the report:

"Health care today harms too frequently and routinely fails to deliver its potential benefits."

"Between health care we have and the care we could have lies not just a gap, but a chasm."

"Trying harder will not work. Changing systems of care will."

Source: *Crossing the Quality Chasm: A New Health System for the 21st Century*, Institute of Medicine, 2001.

study at Duke University found that if everyone in North America with heart disease got needed treatments (e.g., beta blockers, aspirin, ACE inhibitors), there would be 80,000 fewer deaths each year.

In response to this problem, providers must make themselves accountable for improving compliance with established guidelines. As explicit comparisons among hospitals and across health plans are made available in an easy-to-understand format, patients and the media are beginning to understand the wide variability in performance that exists. Mr. Millenson wonders what the legal risk will be for institutions that do not improve their performance to levels found elsewhere in a community. And he also wonders whether communities that are below national standards will find themselves at risk in an era where information flows freely across the country.

Challenge #3: Improving Acute Care

As with chronic disease, the evidence would suggest that providers do not follow treatment guidelines in their care of patients in the acute setting. Half of heart attack patients, a substantial number of cancer patients, and patients in 80% of trauma centers do not receive known-to-be-effective care (e.g., beta blockers for heart attack victims), resulting in excess deaths, disabilities, and costs. The widespread failure to administer antibiotics to pneumonia patients results in similar quality and cost problems. Addressing each of these problems is not only an economic and quality imperative, but also a moral imperative.

In response to this issue, there is a general movement to create accountability among hospitals and physicians, driven largely by the placement of comparative performance information on the Internet. Mr. Millenson shared several examples of Web sites that provide such information, including Healthgrades.com (which compares mortality rates in hospitals based on risk-adjusted Medicare claims data) and medicalconsumers.org, which highlights the volume and mix of procedures performed by hospitals and individual physicians.

The Net Result: Better Quality and Lower Costs

The payoff for high performance is dramatic. Experts believe that quality can be improved by 50 percentage points; even if they are wrong and the potential for improvement is only 20 or 30 percentage points, the benefits will be tremendous. Estimates suggest that customer service can be improved by 35 percentage points, while the cost of care can be reduced by 30 percentage points. The potential to reduce the cost of treating illness is not yet determined, but thought to be equally large.

The Danger of Failing to Act

Mr. Millenson warned of the risks to the industry if its leaders do not step up to the plate by adopting evidence-based medicine and patient–physician partnerships. He noted that because providers have largely failed to respond thus far, purchasers are beginning to treat healthcare providers like vendors. He also noted that consumers are becoming much more involved in their own healthcare, using Web sites sponsored by employers and others to search for information on their own diagnosis and treatment that will help

them to make better treatment decisions. Consumers also use these databases to make explicit comparisons among providers. The power of the Internet, moreover, is breaking down geographical barriers, so that providers are being held to best-in-nation (not best-in-community) standards. Chat rooms, patient-sponsored Web sites, and other innovations are making it impossible for providers to hide anymore.

The Future: Cede Control, or Move Toward Excellence in Quality

Mr. Millenson believes that there is no choice for providers—they must move toward excellence in quality, or they will cede control of the allocation of healthcare resources to others, such as legislators, litigators, regulators, or the media. Each of these options will result in suboptimal outcomes. Legislation will protect high-profile diseases such as breast cancer or prostate cancer, leaving everything else "up for grabs." Litigators will use the courts to determine allocation of resources, with widespread lawsuits in state and federal court on behalf of patients who do not get the care they want. Regulators will set prices in an effort to pay as little as possible for care without causing horror stories. And the media will use sensationalism and horror stories to help determine how resources are directed. In addition, Mr. Millenson predicts more "financial finagling," with well-to-do patients purchasing first-class service while those without resources get second-class care. (He calls this "Titanic-style" medicine.)

"Science and technology will revolutionize our lives, but memory, tradition, and myth frame our response."
Michael Millenson

Rather than face this two-tiered system, Mr. Millenson calls on the industry to act now by moving toward excellence. The demographic, technology, and budget pressures that are driving this crisis are not going away. There is not enough money to give middle-class America all the care that it wants. And there is no payer-based solution to the problem; movement to a single-payer system or widespread use of medical savings accounts will not solve the crisis. The only solution is the adoption of evidence-based medicine and physician–patient partnerships. This will lead to a new model of care in which the evidence is applied to individual cases, with final decisions being based on the experience and preferences of physicians and patients. Joseph Pine II, a noted healthcare expert at the Harvard Business School, calls this approach "mass customization." It allows for the delivery of affordable goods and services with enough variety and customization that nearly everyone finds exactly what they want. It was pioneered by Dell Computer, but is equally applicable to the healthcare industry.

Conclusion

The movement to performance-based medicine is in its infancy. Its impact on the future of hospitals and physicians is not entirely clear, although those providers who cannot compete with best practices are likely to find themselves at risk. Looking forward, Mr. Millenson envisions an era in which economics, ethics, and clinical science/technology are all intricately linked. Because the nation can no longer afford continued cost increases, the status quo is no longer a viable alternative. Some other means of allocating healthcare dollars will emerge. He worries that the industry's response will be to try to win by influencing the politicians and the regulators. This strategy is likely doomed to fail; a much better response is to participate and actively lead the movement to a performance-based healthcare system.

"Six-Sigma" Quality as a Tool for Improvement

Along with evidence-based medicine, use of "six sigma" can also lead to improved quality. Lowell Kruse, president and CEO of Heartland Health in St. Joseph, Missouri, discussed his organization's use of this tool. Formed in 1984 from the merger of Methodist Medical Center and St. Joseph Hospital, Heartland is a community-owned, not-for-profit health system with its own 30,000-member health plan. As the sole community provider, it is the referral center for a 21-county region with 300,000 residents. With 2,600 employees (including 50–60 employed physicians), Heartland has net annual revenues of $200 to $225 million.

Drivers of Quality at Heartland Health

The leaders of Heartland Health believe that quality begins with the board of directors. (A sign bearing this message hangs in the organization's boardroom.) The organization's focus on quality is the result of a number of factors, as outlined below:

- Heartland's leadership believes that focusing on quality is the right thing to do; providers have a moral obligation to provide the best and safest care humanly possible.
- The organization was concerned about recruiting and retaining nurses and other professionals, and understood that these individuals wanted to be part of a winning organization with a demonstrated commitment to quality.
- Several well-publicized reports (e.g., from IOM) highlighted the critical need to focus on quality and greater safety.
- Purchasers (e.g., the Leapfrog Group) and consumers began to demand higher quality and greater safety.

Heartland Health's Quality Goals

Heartland Health has four critical success factors with respect to the quality of its services; the Heartland board of directors views the attainment of these targets as being critical to the long-term success of the organization.

- Become the employer of choice in the community, with 100% of employees rating the system as an "excellent" place to work.
- Offer exceptional customer service, with customers rating Heartland as "excellent" 100% of the time.
- Offer care and services that lead to improvement in population health indicators such as health status.

  Heartland's goal is to rank in the upper quartile of like communities on this standard.

- Achieve superior financial performance, in terms of cost per capita by payer group.

  Heartland's goal is to rank in the lower quartile in terms of costs per capita by payer group. Currently, Medicare represents 60% of their revenue, Medicaid 10%, uninsured 5%, and commercial insurance 25%.

The Quality Journey

Heartland began its quest to achieve these goals shortly after the organization's formation in 1984. In fact, in 1986 Heartland implemented the C.A.R.E. program of the American Hospital Association, which was helpful but did not really address the issue of quality improvement. In 1991, Heartland ventured outside of the traditional healthcare arena by providing all employees with "Seven Habits" training, a program pioneered by Stephen Covey, author of *Seven Habits of Highly Effective People*. In 1995, Heartland's leadership conducted a cultural assessment which concluded that quality could not improve unless the culture did. By 1996, Heartland got even more serious about improving quality. Utilizing board members with previous experience on the issue, Heartland's leadership tapped into the resources of the Xerox Corporation and the Excellence in Missouri Foundation to help develop its continuous improvement methodology known as PASTE (Problem, Analysis, Solution, Transition, Evaluation), which is depicted below.

"Culture eats strategy for lunch everyday . . . if you don't have the right culture, nothing else matters, and your strategy won't work."

The PASTE Continuous Improvement Methodology

In 1997, Heartland's board and senior management used another cultural assessment along with a leadership "inventory" to gauge progress. After finding that the organization was still not where they wanted it to be, the system redoubled its efforts in 1998, focusing on PASTE and introducing a 360-degree evaluation tool. Also in that year, Heartland sent in its first application to the Excellence in Missouri Foundation for the Missouri Quality Award, receiving a "nice letter" in response. (Founded in 1992, the Excellence in Missouri Foundation bestowed its first healthcare award on St. Luke's Shawnee Mission Hospital in 1995.) In 1999, Heartland's second application earned them a site visit; that same year the hospital's orthopedics program was designated one of the top 100 in the nation. In 2000, Heartland won the *Missouri Quality Award*, while its orthopedics and cardiology program (which was only 12 years old) received top 100 designation.

Current Quality Initiatives

For 2001–2002, Heartland is once again "upping the ante" with respect to its quality-improvement agenda through the following initiatives:

- Adopting the Malcolm Baldrige healthcare criteria, which include leadership (which is worth 120 out of 1,000 possible points), strategic planning (85), focus on patients/other customers/markets (85), information and analysis (90), staff focus (85), process management (85), and organizational performance results (450)

  Founded in 1987, the Malcolm Baldrige committee created its first healthcare award in 1996. While no hospital has yet won the award, two organizations (Baptist Hospital, Inc., Pensacola, FL, and SSM Health Care, St. Louis, MO) were chosen for site visits this year. In recent years, scoring weights have shifted from process-oriented to results-oriented measures.

- Incorporating a Balanced Scorecard performance measurement system to guide the operating plan

  Developed in 1992, the Balanced Scorecard merges financial, clinical, and customer satisfaction scores into a single performance measure, making it easy for the board to gauge progress toward established quality goals. (See chart on the next page for an illustration of how Heartland's organizational architecture incorporates the Baldrige criteria and supports the use of a Balanced Scorecard.)

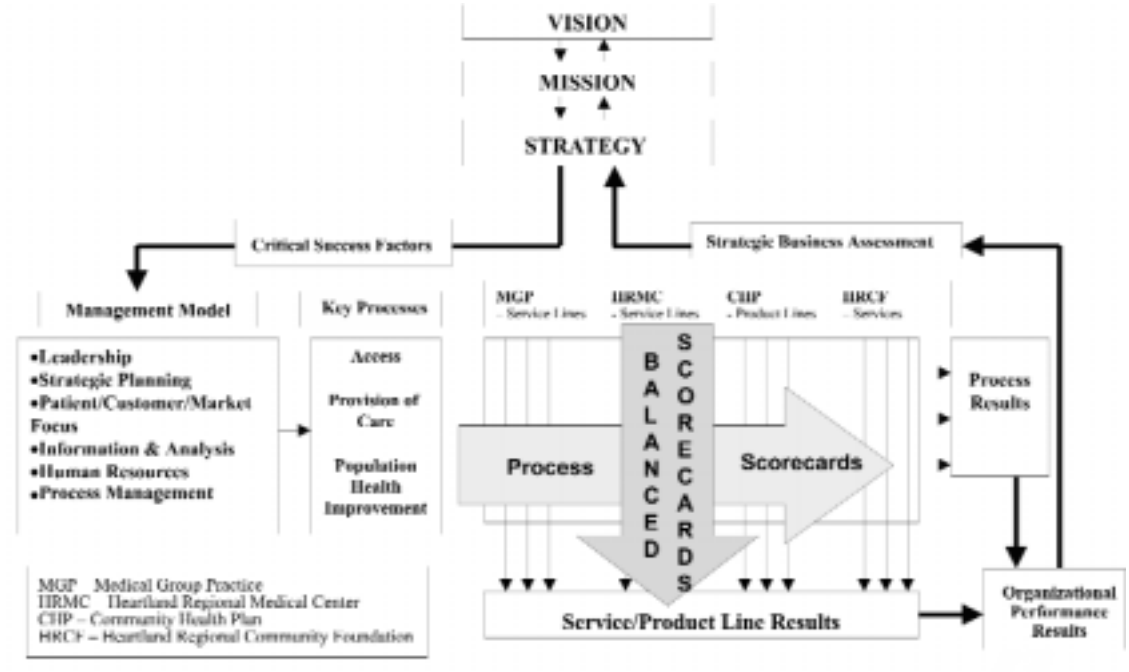
- Formalizing the physician leadership structure

  Heartland invests more than $1,000,000 annually to compensate 31 medical directors for their important role in driving quality improvement. This program is highly effective in engaging the medical staff.

- Introducing six-sigma tools, known at Heartland as "PASTE plus"

  Heartland is paying particular attention to this approach, as outlined in the next section.

Heartland Health Organizational Architecture



Six-Sigma Initiatives at Heartland Health

Heartland Health's vision is **to make Heartland and its service area the best and safest place in America to receive healthcare and live a healthy and productive life.** To achieve this vision, Heartland's leaders have turned to the six-sigma philosophy.

Ninety-Nine Percent Not Good Enough

The six-sigma philosophy holds that 99% quality performance is not acceptable. The reason is simple—even at 99% performance, an unacceptable number of errors occur. For example, 99% performance translates into the following:

- 20,000 lost articles of mail every hour
- 15 minutes a day of unsafe drinking water
- 5,000 incorrect surgical procedures each week
- Four or more accidents at major airports each day
- 200,000 wrong drug prescriptions each year
- Seven hours each month with no electricity

In fact, 99% quality translates into more than 6,000 defects per million opportunities (roughly four sigma); reaching six-sigma levels of quality allows for only 3.4 defects per million opportunities.

Heartland Has a Long Way to Go

When first introduced to the staff of Heartland Health, six-sigma goals seemed impossible to achieve. As the statistics below make clear, massive improvement was needed:

- The number of incomplete medical records at any time needed to decline from ***1,450 per month to just 18 per year***.
- The number of clerical errors found during a weekly audit of incomplete charts needed to drop from ***24 per month to 14 per year***.
- The annual number of adverse drug events had to fall from ***1,040 to just five***.
- The number of patients coming to the operating room with incomplete orders had to decline from ***45 per week to three per year***.
- The number of patients with incorrect billing statements needed to drop from ***60 per month to 24 per year***.
- The number of surgeries scheduled for 8 a.m. that did not start on time had to fall from ***12 per month to just one per year***.

Implementing Six Sigma

Heartland Health's leadership does not view six sigma as a panacea or as the only way to improve quality. Rather, it is a sophisticated and important tool that represents a way to deploy strategy across the system. More importantly, it is a "belief system" that signals that poor quality or preventable errors are not acceptable. The key is to have a culture that talks about and learns from these mistakes, so that systems can be put in place to prevent future recurrences.

At Heartland six sigma is only one of three methods for improving quality. In areas where there is a known answer to a relatively small issue (defined as having the potential to save $100,000 or less, ideally in 30 days and in no more than six months), Heartland uses a "workout" approach that consists of putting a team in charge of implementing the solution. For bigger problems (up to $250,000) where the answer is less clear, process improvement teams (PIT) tackle the issue. Six sigma is only used for issues with the potential to generate $500,000 or more in savings and at least a 10-fold improvement in quality within six months. Examples of current six-sigma projects include the following:

- Improving automatic adjudication of claims, which currently occurs 7% of the time (translating to zero-sigma quality)

  The goal is a 10-fold increase to 70%, representing two-sigma quality.

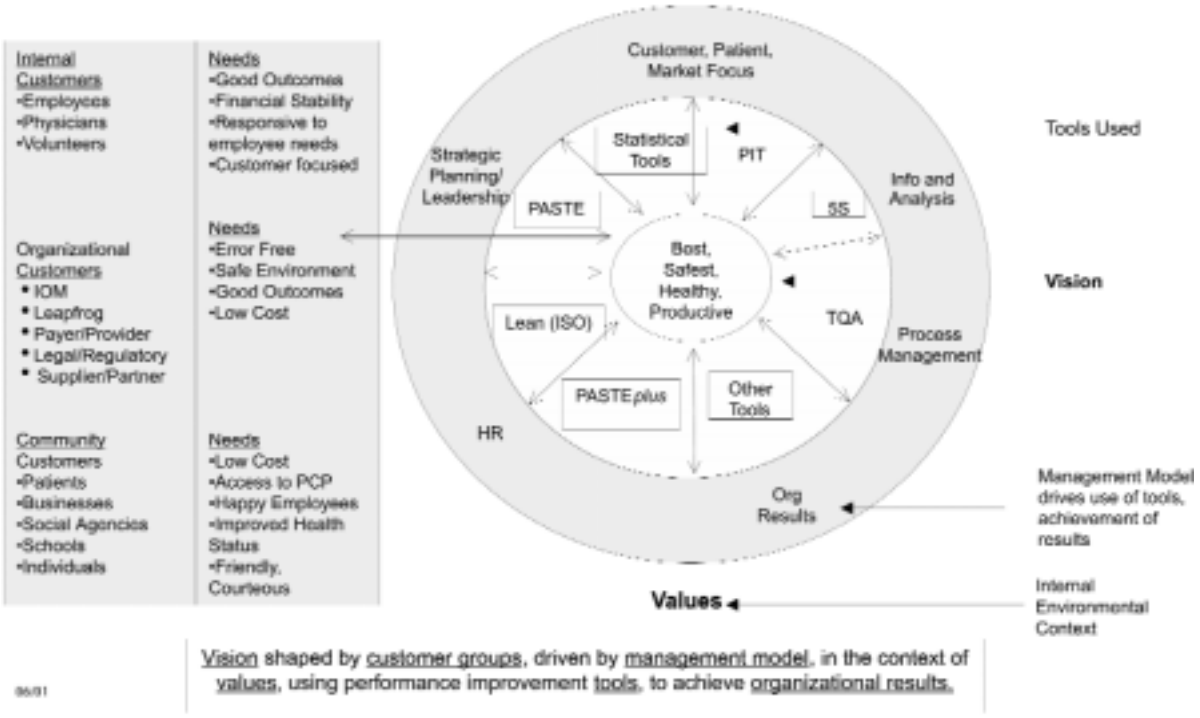
- Reducing medication errors

  Currently errors occur during the care of 7% of patients (three-sigma quality); the goal is a 10-fold reduction to 0.7%, representing four-sigma quality.

Putting It All Together

Mr. Kruse closed by emphasizing that the quality system at Heartland Health works as a whole—as depicted below, the vision is shaped by customer groups, driven by management models, and operates in the context of values, using performance-improvement tools to achieve organizational results.

Heartland Health Quality System



He also highlighted the need to develop and train coaches to help organizations improve their quality continuously. These coaches can teach six-sigma methodologies and other similar quality-enhancement tools and techniques.

Achieving Quality through Productivity

Not everyone is a believer in the six-sigma strategy for quality, at least not in today's environment. One such skeptic is Tor Dahl, an economist, consultant, associate professor at the University of Minnesota, and president and CEO of Tor Dahl & Associates. Mr. Dahl, along with Marisa Hinnenkamp, a senior associate who works with him, challenged the view that use of six sigma is the key to achieving quality. Rather, they emphasized the need to focus first on quality improvement through productivity enhancement.

"Behind every quality error is a performance glitch."
Tor Dahl

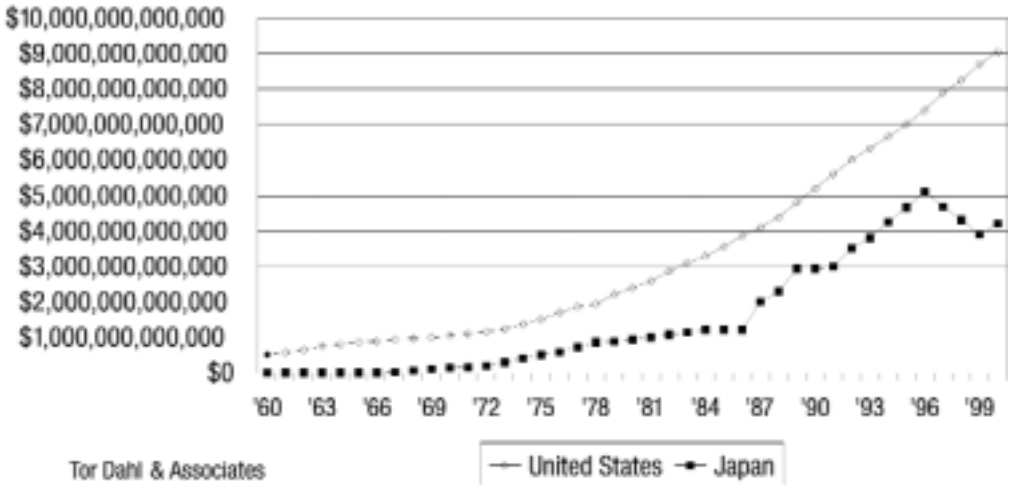
Six Sigma Not Resulting in High Returns

Six sigma focuses on achieving perfection by reducing defects; the six-sigma goal calls for only 3.4 defects for every million opportunities, well above the 25,000 defects per million that currently take place in hospitals. But the problem with a focus on perfection is that it causes a resistance to change. And change is necessary to improve performance. Equally importantly, while six sigma focuses on doing things right, it does little to address the issue of what is the right thing to do. To support his views on six sigma, Mr. Dahl shared data on several companies at the forefront of this philosophy.

- The U.S. company associated most with six sigma, Motorola, has suffered one of the steepest falls in stock price of any Fortune 500 company.
- Stock prices for major players in the airline industry, which offer eight-sigma levels of safety, have lagged the S&P 500 for years. (The poor performance began long before the tragic events of September 11.)
- Most of the rise in the stock of General Electric (a pioneer in six sigma) occurred before the company implemented the approach.

In addition, countries at the forefront of six sigma, such as Japan, have turned in poor economic performance. Growth in Japan's gross domestic product (GDP), which during the 1980s was expected to exceed that of the U.S., has consistently lagged behind.

Heartland Health Quality System



The Key: Focus on Performance and Productivity, Not Quality

In Mr. Dahl's view, the key issue that six-sigma advocates miss is that success is not just a matter of quality; it is also a matter of performance. Performance, moreover, is driven by productivity. Unfortunately, productivity in the health sector has deteriorated by an average of 2.6% per year over the past 10 years, making healthcare the only major sector of the economy with negative productivity growth. As a result, the U.S. spends more of its GDP on health (13.7%) than many other countries, yet achieves relatively mediocre results (The U.S. is ranked 19th in infant mortality, 21st in life expectancy, and 37th in systems performance).

Mr. Dahl believes that the U.S. healthcare industry suffers from a *performance problem*. To correct this problem, the industry should not focus on quality, because a singular focus on achieving perfection will only enhance performance to the point that waste is gone. Once waste is eliminated, performance improvement ceases, because the underlying process has not changed. Rather, in order to improve, one must change the way something is done, which requires a focus on performance. Since every quality problem is the result of a performance glitch, improving performance will improve quality as well.

What Is the Right Thing to Do?

If quality is defined as "doing the right thing right all of the time," the key question becomes—what is the right thing? To shed some light on this issue, Ms. Hinnenkamp reviewed the two "right" strategies for ensuring competitive survival—**achieving cost-effectiveness** and **earning a monopolistic advantage**. She and Mr. Dahl believe these are the only strategic choices an organization faces; thus they are clearly the right thing to do.

Getting to the Right Thing

Actually doing the right thing requires a process to free resources for investment in cost-effectiveness and monopolistic advantage.

Step #1: Screening

The first step in this process involves screening out those things that no one should be doing. A survey conducted by Mr. Dahl and Ms. Hinnenkamp suggests that there are three major activities that should be eliminated—unnecessary meeting time, unneeded reports and paperwork (which are generally not read), and redundant and duplicative efforts.

Step #2: Delegation

People need to be headed in the right direction and performing the right jobs. Thus, the next step is to delegate tasks to the ideal person for the job (the "ideal task performer"). For example, nurses should not be spending time cleaning floors. The ideal individual for a job may reside within the organization, or outside (at an outsourcing company). The survey suggests that the top tasks that can be delegated relate to clerical and administrative duties.

Step #3: Planning

Having screened and delegated, the next step is to plan, as planning allows an individual to do the right thing in the future as well. Studies suggest that 15 minutes of planning saves one hour of execution, yielding a net return on investment of 300%. Surveys show that the top three areas that can benefit from planning are scheduling, providing clarity and consistency to organizational direction (rather than constantly putting out fires), and budgeting.

Step #4: Efficiency

Once an organization is doing the right thing with the right people in the right jobs, the next challenge is to do them in the right way. This is also known as efficiency, which is achieved when the resources needed to do a task, service, or product are necessary and sufficient. In other words, an organization is efficient if it creates the most benefit with the least amount of resources that could possibly be used. Surveys suggest that the top three areas for potential efficiency gains include communication flow between people, teamwork and cooperation, and systems (e.g., processes and work flow) in general.

Efficient organizations reap several benefits. They tend to get the biggest "bang for the buck" (which can lead to monopoly advantage) and/or, for a "given bang, they spend the least amount of buck."

Step #5: Eliminating Waiting Time

The last challenge is to do the right thing in the right way all the time. This step requires the reduction and/or elimination of waiting time. In principle, all waiting time can be eliminated, as one can always do something else that is productive. Surveys suggest that the top opportunities to reduce waiting time include speeding up approval and decision-making processes and reducing time spent waiting for materials, supplies, and information.

"Not only is he idle who does nothing; he is also idle who could be better employed."
Socrates

The Net Result: Monopoly Advantage and/or Cost-Effectiveness

Once an organization has screened what should not be done, delegated what should be done to ideal task performers, it is left with the right things to do, which are those that allow the organization to serve its customers better than the competition. These things should always be planned and executed using the least amount of resources.

In aggregate this approach should help an organization to free up at least two-thirds of its resources. (Surveys suggest that 92% of what an individual does can be improved upon, with only 8% deemed "perfect.") These resources can be used for investment in one or both of the key strategic options available—expanding what no one else does better for clients (which creates monopoly advantage) or reducing the resources to deliver products or services (which creates cost-effectiveness).

Surveys suggest that the top three ideas for redeploying resources so as to create cost-effectiveness include the following:

- Eliminating non-productive internal communication and meetings
- Fixing inadequate internal systems and processes
- Training to ensure adequate skills and proficiency

The best redeployment of resources in order to create overall monopoly advantage includes investing in customer satisfaction and service, investing in high-quality products and services, and devoting resources to organizational survival and profitability.

Quality Improvement versus Productivity Improvement

While players in almost every industry have no choice but to strive for high quality, they do have a choice in how they get there. Mr. Dahl advocates an initial focus on achieving a quantum leap in productivity levels (which will lead to quality improvement), rather than first focusing on quality improvement. A quantum leap in productivity is essentially a disruptive event that requires a re-thinking of economic activity. It serves to "unfreeze" a company by introducing variation. Quality improvement, on the other hand, is a stabilizing event that fundamentally reduces variation in products and processes. It serves to "freeze" a company in place. Since a focus on quality improvement takes out the variations in products and processes while a focus on productivity introduces variation, productivity improvement must necessarily precede quality improvement.

The Potential of Productivity Improvement

In many industries today, quality is no longer an option. Those that do not offer it will not stay in business. But quality is not a source of competitive advantage in many industries; rather it is a given. When quality is expected, performance takes center stage. In essence, the quality revolution has ended and the performance revolution is just beginning.

Productivity improvement is the key to enhanced performance. It is also the key to superior financial returns. At a productivity level of 1%, for example, it takes 72 years for wealth to double; this was the approximate rate of growth for the 10,000 years before the Industrial Revolution. When productivity jumped to 3% during the Industrial Revolution, wealth doubled every 24 years. But if we were able to boost productivity by 10% each year (a "productivity revolution"), wealth doubles every seven years.

These types of gains can filter down to individual companies as well. For example, if 3M, a leader in six-sigma quality, instead focused on boosting productivity by 10% per year (an easily achievable goal), its earnings—and therefore its stock price—would likely rise by more than five-fold in five years.

Some individual organizations have achieved tremendous success by focusing on productivity, as outlined below:

- The Fort Rucker Army Aviation Base boosted productivity by 17% within six months, leading to three million consecutive hours of accident-free maintenance in a very hazardous work place. This performance allowed the base to win the prestigious "Army Aviation Materiel Readiness Award."
- ICI Films Americas used a focus on productivity to turn a $16 million loss into $78 million in profits, while at the same time turning a negative return on net assets (RONA) into a 39% RONA. By moving from a rigid hierarchy to empowered, self-directed work teams, the company moved from a #3 position in the industry to #1 (including best customer service) and also dramatically improved its record with respect to safety, health, and the environment.

The Danger of Focusing on Quality First

Productivity improvement can only happen if change takes place. But as noted earlier, a focus on quality "freezes" an organization's systems and processes. Mr. Dahl estimates that the quality revolution in the U.S. reduced productivity from three percent to one percent for a 22-year period (1973 to 1995). As a result, the U.S. GDP was $10 trillion less than it might have been, and per capita income in 1995 was $30,000 instead of $60,000.

- Within the field of healthcare, the Marshfield Clinic has boosted its net margins from roughly zero in 1997 to over 5% in 2000, primarily by focusing on productivity improvement, which has also led to higher satisfaction among both customers and employees.

"Productivity is not a burden. People are happy when they are productive. They don't like having to do "dumb" things."
Tor Dahl

The Key to Productivity Growth: Freedom

A revolution in productivity will not come from an edict from above or an act of Congress. Like any revolution, it will be sparked when the system becomes more important than the people it services (as may be true in healthcare today). In other words, productivity revolutions go hand in hand with freedom. Just as the freest societies enjoy the highest levels of per capita GDP, the corporations in which employees are "free" enjoy superior performance. Feelings of freedom, in turn, are driven by an individual's "affective domain"—the part of the mind responsible for feelings of pleasure/pain, freedom/confinement, and energy/lethargy. Productivity improvement requires change to take place within the affective domain.

A Word on September 11, 2001

The tragic events of September 11 took away some of the world's freedom; Americans and others around the world now may be afraid to travel, assemble, or even communicate with each other. Individuals have lost their sense of control, satisfaction, and optimism. They are stressed, and generally in a negative mood. As a result, performance has suffered, and productivity may have even turned negative.

In essence, the terrorists have had a major impact on the affective domain of individuals. And it will take strong leadership to overcome the negative effects of the terrorist acts. But Mr. Dahl is optimistic that this will occur, and he is optimistic that the terrorists will be defeated. The key to a turnaround—and a return to high performance in the economy—is a leader able to engage his followers through change, growth, achievement, recognition, caring, nurturing, liberation, positive feedback, support, communication, education, and the articulation of a clear vision and goals. President Bush, who possesses one of the most inward-oriented outlooks of any president this country has ever seen, has thus far risen to the challenge of providing that type of leadership.

The terrorists, however, manage their constituencies through negative control, including violence, intimidation, confinement, negative feedback, close supervision, lack of support, lack of vision/goals, use of orders, and the withholding of information, training, and development. Over time, this approach can never win, as the followers will abandon their leaders.

"You never light the fire from above; you light the fire from below . . . leaders must engage American ingenuity at every level of the corporation."
Tor Dahl

Conclusion

Mr. Dahl concluded by reiterating the key steps to improving both performance and quality. The first is to "unfreeze" the organization by focusing on productivity improvements, which should result in massive gains. The second step is to "freeze" the organization by focusing on quality, which will lock in these gains. Productivity, therefore, precedes quality. And the key to productivity improvements is to promote positive change within the affective domain of individuals.

Chapter III

Other Key Issues for Boards and CEOs to Monitor

In addition to its focus on excellence in quality, the conference included presentations on two other issues of critical importance to hospital CEOs and board members over the next several years. The first involves the potential for the emergence of a new, stricter standard of accountability for not-for-profit hospital boards and individual board members. The second issue relates to the health policy agenda that will likely emerge out of the federal government over the next 12 months.

Issue 1: A New Standard of Public Accountability for Boards?*

Linda Miller is president of Volunteer Trustees, a national organization of non-profit hospital governing boards, and head of the Foundation for Education and Research, which has received national recognition for its leadership role in hospital conversions. Her presentation focused on practical advice to the boards of not-for-profit hospitals as they come under greater scrutiny from states' attorneys general and the community, particularly with respect to strategic decisions.

On the Front Lines

She began by noting that hospitals are increasingly on the front lines in the nation's war on terrorism. In the days following September 11, New York City hospitals lost $367 million in revenues as they postponed elective surgeries and discharged non-critical patients in preparation for casualties from the World Trade Center attacks. At present, these hospitals are investing large sums of money to buy supplies and take other precautions (e.g., separating ventilation systems that serve the emergency room from the rest of the hospital) designed to minimize the impact of any future terrorist attack, including bioterrorism. Looking ahead, it will be a challenge for hospital management and board members to find the money necessary for hospitals to continue to play this leading role.

Increasing Challenges to Board Authority

Even as they are being thrust into the front lines of the war on terrorism, not-for-profit hospital boards are seeing an increasing challenge to their authority, particularly as it relates to the conversion of these entities to for-profit status, mergers, the closing down of facilities or services, and other strategic (or major) decisions. Acting on behalf of local communities, states' attorneys general are evaluating these decisions to ensure that the community is fairly compensated and that quality of care is preserved. In at least 10 states, the boards of hospitals, foundations, and schools have been

*Much of Ms. Miller's presentation references *Boards Under Fire*, a white paper co-sponsored by Volunteer Trustees and The Governance Institute, Fall 2001.

challenged. Ms. Miller believes that these incidents may represent a critical mass, suggesting that the boards of not-for-profit entities are being held to a new standard of public accountability.

The Historical View: Expectations of Autonomy

Historically, not-for-profit hospitals have enjoyed relative autonomy, with little public accountability or oversight. These expectations of autonomy are reflected in the activities of the Internal Revenue Service, which has issued few challenges to the tax-exempt status of these institutions. Board members have historically faced little threat of personal or legal liability for their actions, while state and federal laws and standards of community benefit have done little to restrict the autonomy of these institutions.

Not surprisingly, the structure of not-for-profit boards has historically reflected this expectation of autonomy. Most boards are self-perpetuating bodies that make decisions in private after consensual discussions that lead to unanimous votes. Education of board members tends to be informal, non-didactic, and non-standardized. Members learn on the job and often have little knowledge of legal issues or requirements that relate to board activities and membership.

This autonomy and structure stand in sharp contrast to other sectors of the economy. For example, for-profit, publicly trade companies are held to strict accountability and oversight that shapes the process and the structure of the board. Board members are elected annually by stockholders. Affirmative disclosure of any self-dealing is required, along with information on the number of meetings attended by, and compensation arrangements for, board members and senior management. Strict guidelines govern potential conflicts of interest, and outside directors are encouraged to engage their own legal counsel. Finally, the Securities and Exchange Commission is charged with overseeing the activities of these companies and their board members, who are directly accountable to shareholders. Similar levels of oversight govern the boards of private foundations and charitable trusts. Self-dealing is prohibited. All assets must be dedicated to the mission of the organization, with distribution of funds governed by charitable trust law. Board members may delegate certain activities to committees or staff, but there are restrictions and ultimate accountability rests with the board.

The Current View: Boards in Limelight, Under Scrutiny

Because of a variety of factors, including the proposed sale or conversion to for-profit status of a number of not-for-profit hospitals, boards of these institutions are increasingly in the limelight, with much of the news being negative. Ms. Miller shared several case examples that highlight the challenges.

Case #1: Palm Beach, Florida

Two local hospitals, Good Samaritan (located in the wealthier part of town) and St. Mary's (a Catholic facility located in a poorer section of town), began several years ago to function under a joint operating agreement in which the two entities are managed as a single operation. At the time the agreement

went into place, $26 million was divested into a foundation so that the two entities would be of equal size. Within four years, the system had lost $100 million, at which time the board decided to close all services at St. Mary's Hospital other than psychiatric and geriatric care in order to "save" the system. The state attorney general intervened, threatening a lawsuit designed to preserve the charitable mission of the organization. The attorney general dissolved the board, charging that they failed to understand the system's financial situation and they had ignored the community's needs. Ultimately, a mediator worked with various parties to develop a resolution, which ironically involved the sale of the system to a for-profit entity.

Case #2: New York, New York

This case involves Manhattan Eye & Ear Institute, a pre-eminent specialty hospital that has operated on the city's Upper East Side for more than a century. For a number of years, the institution's board and senior management avoided affiliating with other hospitals or getting involved in managed care contracts. Physicians repeatedly asked the board to strengthen senior management, which resisted overtures from two nearby not-for-profit systems to take over the institution. After hiring an investment banker, the board decided to close the hospital and replace it with clinics to be set up around the city. The hospital site was to be sold to an outside developer.

The state attorney general intervened, charging that the board had abandoned the purpose of the institution and ignored the community and its own doctors. After the hospital closed for a brief period of time, the court fired the board, believing that it had confused the preservation of the hospital with the preservation of the board, and had forgotten that what was good for the hospital is of paramount concern. The court re-opened the hospital, putting its management out to bid.

Case #3: Manchester, New Hampshire

In 1994, a Catholic hospital and a non-Catholic hospital merged into a single system. The system promised to bring economies of scale and cost savings to the two entities. After four years in which none of these savings had materialized, the system announced that it was consolidating all services except for psychiatric care and rehabilitation services at the non-Catholic institution. This created problems for both institutions; the secular hospital resented the Catholic influence while the Catholic hospital opposed certain non-Catholic traditions. Believing that the community's wishes were being ignored, the state attorney general intervened to stop the consolidation, which he viewed as violating the social contract and charitable mission of the organization. The system and the board were "unmerged," effectively undoing what had been done over the past six years.

Case #4: San Diego, California

The management of Sharp Healthcare, a six-hospital system, approached the management of Columbia/HCA about becoming a partner in a 50/50 joint venture in 1996. Sharp's board was informed of these discussions several weeks after they began. Based on advice from an investment bank, the

board selected Columbia/HCA as its partner, even though several neighboring systems made significantly higher takeover bids. (A few board members resigned in protest during this process.) Concerned that community interests were being ignored, the state attorney general intervened, imposing a "stand still" order. The attorney general questioned whether the sale was a fair and legal dissolution of not-for-profit assets, and whether the board had violated the trust the community placed in it. He also questioned whether the process of decision making, which included use of an investment banker with a vested interest in a deal with Columbia/HCA, was biased. Ultimately, the attorney general found that the process represented a serious breach of trust that could cost the community between $100 and $200 million. He threatened to hold Sharp's board of directors personally liable for the difference. Not surprisingly, the deal fell through. While the board refuses to discuss the issue publicly, it seems clear that Sharp's management had alienated its own board of trustees.

Case #5: Minneapolis, Minnesota

Operating as a merged organization, Allina and Medica are the largest hospital system and managed care organization in Minnesota. Concerned about how community dollars were being spent, the state's attorney general recently completed an investigation into the system's spending, with a focus on use of consultants, travel, and other areas. In October 2001, the attorney general released a six-volume report detailing his concerns, as well as a memorandum of understanding which put the system on a "short leash" with respect to oversight and spending, including use of spending caps and the requirement that certain expenditures be pre-approved.

The Role of the Attorney General

As these five case examples make clear, the states' attorneys general play a critical role in bringing challenges to the actions of not-for-profit hospital boards. In fact, they generally have the sole legal authority within a state to challenge a board's actions. While historically they have paid relatively little attention to the activities of not-for-profit hospitals, there appears to be a growing willingness to take action, particularly when representatives of a local community voice their concerns. As politicians, attorneys general also believe they will get good publicity if they take on a not-for-profit board in an effort to "defend the disenfranchised."

The "Ammunition": Trust and Non-Profit Corporation Law

Two sets of laws potentially apply to not-for-profit hospital boards—charitable trust law and non-profit corporation law. Historically, non-profit corporation law has been used. Recently, however, there would appear to be a growing willingness to hold the boards of not-for-profit hospitals to the stricter standards of accountability under charitable trust law, which include absolute restrictions on self-dealing and limits on the ability to delegate authority. (Non-profit corporation law allows the delegation of authority to committees of qualified individuals as long as proper due diligence is followed.) With its origins in common law, charitable trust law also embodies a strong sense of public purpose, and insists that 100% of assets be dedicated to that purpose.

Both sets of laws, moreover, impose three sets of fiduciary obligations on the boards of not-for-profit hospitals, as outlined below:

- **The duty of obedience to purpose**

  Every decision must further public purpose; this duty is the rationale for tax exemption. Failure to live up to it represents a breach of trust on the part of boards.

- **The duty of due care**

  Boards must exercise due diligence and reasonable inquiry in making decisions. Under non-profit corporation law (but not charitable trust law), delegation is allowed, but only to qualified individuals after proper due diligence. Ignorance, however, is never a legitimate excuse for a board member.

- **The duty of loyalty**

  Money must go back to the community, not to private individuals. As a result, there are strict limits on self-dealing and related-party transactions.

Lessons from the Front

Ms. Miller offered not-for-profit boards her advice on how to avoid scrutiny from the attorneys general. She began by noting that the real challenge is not in fact from an attorney general, but rather from a rift between the hospital and the community. She urged boards to view community oversight as a complement to, not an enemy of, strategic decision making. She cautioned against the board's distancing itself from the community, or from being perceived as arrogant. By viewing the institution and the community (or the preservation of the institution and its public purpose) as competing interests, boards leave an open invitation to be second-guessed.

Instead, she advocated learning the following "front-line" lessons:

- **The view from the boardroom may not be the same as from the community.**

  Nothing mobilizes a community faster than the sale or closure of a not-for-profit hospital, especially if the transaction involves the transfer of millions of dollars into a foundation. Boards should be prepared for a challenge, and should do everything possible to make the community a part of the process, so that they understand the reasons for the proposed transaction, and why the transaction is better than potential alternatives. Informing the community of a "done deal" after the fact is a recipe for disaster.

- **There is little to be gained by refusing to deal with an inquiring public.**

  This stance will sabotage any deal, as it portrays the image of an institution that belongs to its board rather than to the public. Communities and attorneys general should be involved in the strategic decision-making process; they may know what in fact is in the community's best interest.

- **The greater the real or perceived gulf between the board and the community, the greater the potential for confrontation.**

  Boards should continually re-think their composition and the role of the community in strategic decision making.

- **Distinguish between what needs to be secret and what does not.**

  Confidentiality creates a reason for suspicion in the community. In some cases there may be a need for confidentiality during a process, but there is seldom a need to keep the terms of a deal secret after it is completed.

- **There must be a good reason for use of multiple boards, and a better process where they do exist.**

  A multitude of boards confuses a community and attorneys general. While consolidated systems may need to have multiple boards, problems arise when certain boards are systematically shielded from the strategic decision-making process and then later asked for approval of a final decision.

Advice to Boards:
"Whatever decision you make, picture it on the front page of the newspaper."
Linda Miller

- **Board members have to understand the role of consultants, including who they work for and how they are compensated.**

  Boards have a right to rely on consultants but only if proper due diligence is performed, including a review of their impartiality and financial incentives. Too many deals are completed based on the advice of investment bankers who have a financial interest in the transaction.

- **Politics plays an important role in all of this.**

  The domain of not-for-profit hospitals is primarily a political one. Boards that show a concern for politics are more likely to succeed in accomplishing their objectives.

- **It is important to understand the nature of public accountability, including the appropriate role for, and relationship between, the board and CEO.**

  Boards must demonstrate that they are in fact independent.

A Model for Tomorrow's Governance

Ms. Miller closed by laying out her proposed model for how not-for-profit boards should govern in the future. First, she suggested that boards need to "grow" into new models as their organizations become more complex; in particular, she sees a need for both local and regional governance. She advocated the development of a close connection between the hospital and the community, with this connection in place during decision-making processes. (Ms. Miller believes establishing this connection is the single most important thing a board can do.) Finally, she stressed the need to focus on process; there is no "one-size-fits-all" prescription for hospitals. The process of who is informed when will play as important a role in final outcomes as the decisions themselves.

Issue 2: Health Policy in the New Administration

Another important issue facing CEOs and board members over the next year relates to new health-related policies that could come out of Congress and the Bush administration. James Scott, a senior vice president with Premier, Inc., and its Premier Advocacy unit in Washington, DC, offered his views on what the industry can expect from the federal government. He began with a review of the hierarchy of factors that will influence health policy outcomes in the administration, and then offered his views on what will happen over the course of the next year.

"Politics comes from the word 'Poli,' which is a Greek prefix meaning 'many' and the word 'tics,' which are 'blood-sucking animals."
Jim Carville

Factors Influencing Health Policy Outcomes

President Bush brought a new style to Washington, DC, in January, 2001. And although the events of September 11 have changed that style somewhat, Mr. Scott still believes that this administration will have a distinctly different style than its predecessor.

Before the terrorist attacks, policy decisions in Washington were determined by four key factors:

1. **Personality**

   If there is a dispute between individuals, legislation gets bogged down. In some instances, personality can also work in a positive way to promote the passage of legislation.

2. **Politics**

   Every issue is a political one, particularly in an evenly divided Congress.

3. **Process**

   The branches of government are very process-oriented in their work.

4. **Policy**

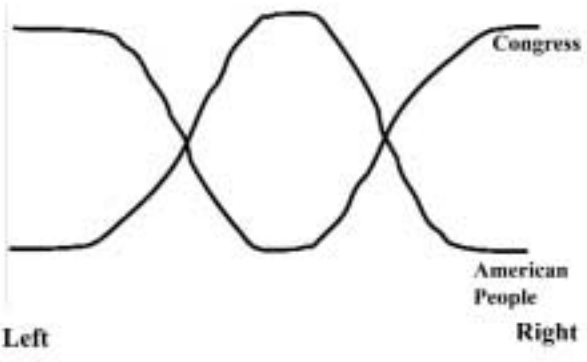
   Policy only becomes relevant once issues of personality, politics, and process have been resolved. In some instances, lobbyists for the hospital industry make the mistake of jumping straight to policy.

After the events of September 11, a fifth factor has emerged that influences policy—patriotism. As a result, issues related to terrorism and national defense will now be a higher priority than other issues, including healthcare. In addition, the rising level of patriotism since the terrorist attacks has served to change some personalities in Congress. Mr. Scott noted that the Republican and Democratic leaders in Congress (including Representatives Gephardt and Hastert and Senators Daschle and Lott) now meet with President Bush once a week for breakfast; these leaders are forging personal relationships where none had existed before.

The Role of Political Philosophy

Mr. Scott noted that the philosophical make-up of Congress actually is quite different from that of the American people. As depicted in the chart below, most Americans describe themselves as being centrists, while representatives in Congress tend to be more extreme in their political philosophy, with the majority describing themselves as being to the far left or right of the philosophical spectrum. Only one in six members of Congress describe themselves as being moderates.

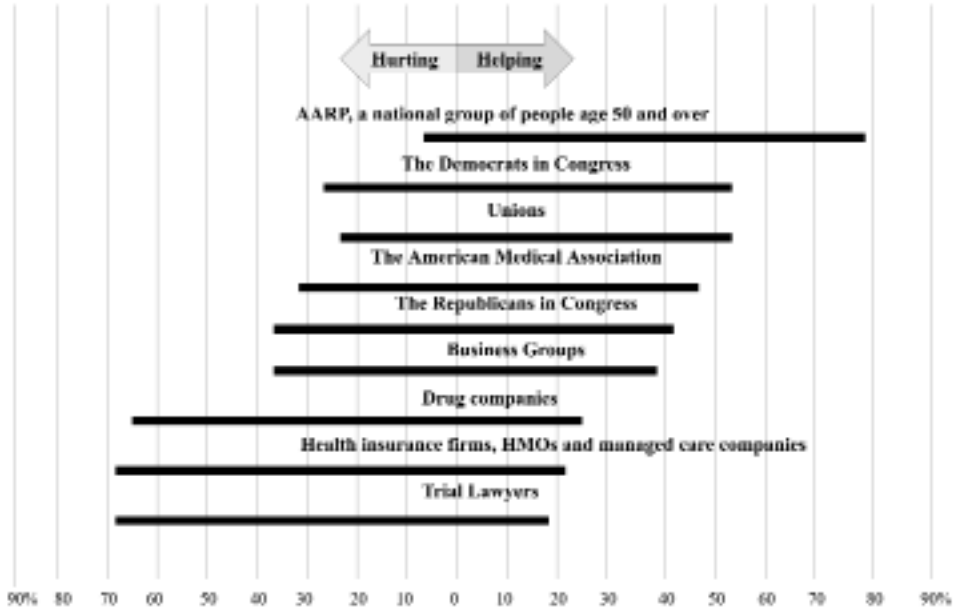
Political Bell Curve



The 2001 Healthcare Agenda

To understand the healthcare agenda in 2001 one must first examine the views of the people with respect to the various players. As depicted in the chart below, most Americans view the American Association of Retired Persons (AARP), the Democrats in Congress, and unions as positive influences on healthcare. The American Medical Association, Republicans in Congress, and business groups are viewed slightly less favorably, while drug companies, health insurance firms (including managed care organizations), and trial lawyers are seen as "villains" that have a negative impact on healthcare. Interestingly, Mr. Scott does not believe that the shift in the Senate from a Republican to Democratic majority will have much of an impact on the healthcare agenda, although the potential for additional gridlock may result in a larger role for regulatory activities.

Healthcare Heroes and Villains



Before the terrorist attacks, the 2001 health agenda was dominated by the following:

- Patients' bill of rights

  Debate over this legislation represented a classic political battle over money between managed care organizations and trial lawyers; few argued their positions out of a sense that it was the right thing for the patients.

- Prescription drug benefit
- Medicare reform
- Workforce shortages

In addition, a whole host of minor issues were on the agenda; these issues, while not necessarily of national relevance, were very important to particular constituencies.

After September 11, virtually all of the major issues were wiped off the health agenda, to be replaced by a response to bioterrorism. (In addition, other issues, such as an economic stimulus package and airport security, replaced healthcare as a priority.) Few people know exactly what the legislation related to bioterrorism will entail; everyone is scrambling to learn on the job and figure out what to do. Mr. Scott believes that a bill co-sponsored by Senators Kennedy (a Democrat) and Frist (a Republican) will drive the agenda in 2002, since it has bipartisan support and Senator Frist is a respected physician who has earned his colleagues' trust on medical issues. Current estimates as to how much will be allocated to bioterrorism range from $1.3 billion to $7 billion; in reality, no one really knows yet what it will cost to effectively respond to the threat.

Unresolved Issues for 2002

Because the terrorist attacks pushed major healthcare issues off of Congress' priority list in 2001, several major issues will re-emerge on the agenda in 2002.

Issue #1: Workforce Shortages

Hospitals and other healthcare organizations are having a very difficult time in attracting and retaining workers, with nursing being the most widely publicized area of shortage. Between 1983 and 1998, the average age of working registered nurses (RNs) increased by 4.0 years, from 37.7 to 41.9. In hospitals, the average age increased even more (5.3 years). In fact, RNs are aging at a rate that is more than twice as fast as in all other occupations in the U.S. economy. A large part of the problem is that young people are not going into nursing anymore, as evidenced by a 41% drop in the number of RNs under the age of 30 over the 1983–1998 period. (During the same period, the number of people under the age of 30 in the general workforce fell by only 1%.)

The problem is only going to get worse. By 2010, the average age of an RN will increase another 3.5 years, reaching 45.4. At that time, approximately 40% of RNs will be age 50 or older.

Unfortunately, prospects for legislative action in 2002 remain mixed. A crowded legislative agenda, including the war on terrorism, have carried over into 2002. In addition, some influential individuals have doubts as to the extent of the nursing shortage. Finally, the hospital industry has not helped its cause by initially focusing its lobbying efforts on securing additional Medicare payments. The early message to Congress—"just give hospitals more Medicare dollars and the problem will be solved"—did not mesh well with the nursing lobby message that emphasized poor working conditions as a major reason for the shortages.

Fortunately, hospitals now seem to understand that they must change their approach. Senator Clinton, a Democrat from New York, introduced legislation to address the nursing shortage; it remains to be seen what will happen to that bill.

Issue 2: Medicare Prescription Drug Benefit

The debate over a Medicare prescription drug benefit will also command attention in 2002. To understand this debate, it is important to recognize three facts about the issue:

- Only 34% of seniors presently do not have coverage; the remainder have some coverage through a previous employer (24%), a Medicare HMO (12%), Medicaid (8%), a Medigap plan (17%), or some other form of coverage.
- Drug expenditures are increasing at a rate faster than the overall health budget. Since 1992, drug expenditures have risen from roughly 5% of total health expenditures to nearly 11%. Medicare's overall expenditures grew by 10% last year, with drugs accounting for a large part of the increase.
- The primary driver of increased drug costs is increased utilization, not price inflation.

Given these facts, the policy questions related to a Medicare drug benefit include the following:

- **Who should be covered?**

  The two parties have different political philosophies with respect to this issue. Democrats favor a social insurance model that covers all seniors, while Republicans would like to focus on those without private coverage.

- **What should be covered?**

  This issue splits along geographic rather than party lines. Some factions want to create a national formulary; others want to only cover generics or therapeutic equivalents (when they exist). Political lobbying and donations will play a large role in the outcome.

- **How should prices be set?**

  Republicans favor market pricing while Democrats want government-set prices, as occurs under the Medicare program.

- **How can costs be controlled?**

  Current cost projections do not take into account coverage for the majority of the baby-boomer population. If coverage of these baby boomers is included in present-day calculations, the costs may appear prohibitive, thus undermining any efforts to pass legislation. (Of course, as Mr. Scott noted, if legislation is passed, these costs will ultimately be incurred.)

These issues are very complex and may prove difficult to resolve. Thus, it is quite possible that no action will take place on a prescription drug benefit in 2002.

Conclusion

The events of September 11 changed the way things are done in Washington, DC, at least temporarily. How long this change will last, and how events will play out, cannot be determined at this point. As a result of the terrorist attacks, bioterrorism became the only major health issue on the 2001 legislative agenda. In 2002, a few additional issues—namely workforce shortages and a Medicare prescription drug benefit—will likely be considered, although the complexity of issues related to the drug benefit may prevent any action.

Finally, Mr. Scott encouraged hospital board members and CEOs not to sit on the sidelines during these debates, especially those related to bioterrorism. Congress needs to hear the industry's ideas and insights.

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