HEALTH CARE'S THIRD PARTY PAYER:

INTERLOPER OR FACILITATOR?

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Thank you, _____, and good morning:

Public issues seem to have a life all their own.

To those of us whose job it is to follow issues closely, they seem almost organic.

They begin like seedlings, observed and understood by only a few.

Then they are nurtured by public opinion, events, political forces and the media.

Finally, they reach a critical mass at which point they burst forth as top-of-the mind concerns of the public-at-large.

I believe that, because of cost containment, health care is now going through a gestation period that will ultimately result in making it a major issue of the next presidential election.

Already, Senator John Heinz of Pennsylvania, Chairman of the Special Committee on Aging, has charged that DRGs are not doing everything they were designed to do; that DRGs are causing elderly patients to be discharged "quicker but sicker."

Recent media coverage is reinforcing this claim, and even extending it beyond the elderly to include the poor and uninsured.

Consider, for example, "The Billfold Biopsy," brought to you last march by Mike Wallace and the 60 Minutes staff. The place: Parkland Memorial Hospital, a public hospital in Dallas, Texas. The subject: how poor and uninsured patients are denied treatment or admission to private hospitals.

Then, there is the NEW YORK TIMES Op-Ed from January 23rd titled, "Medicine Makes A Wrong Diagnosis," where Dr. Fazlur Rahman, Chief of the Hematology and Oncology

Department at the Angelo Community Hospital in San Antonio, Texas, describes his experience with a 65-year-old woman, a Medicare patient, dying of cancer. According to the article, the diagnosis grouping for this patient allows for only 5.9 days of hospitalization and $1,865 worth of medical care. The hospital has already spent nine times that amount.

"So here I am," he writes, "her physician, at a loss about what to do with her. She is unable to go home, the nursing home won't take her back and she cannot stay in the hospital. Her case is not unique. In short, Medicare's payment system is not working. It puts doctors and hospitals in the awkward position of denying crucial care or losing money."

It also, I believe, puts third party payers in the position of practicing medicine -- and in that position they are clearly interlopers.

Dr. Rahman summed up the dilemma this way: "We cannot deny the need to curb high medical costs. But how can we justify a remedy like this? As a compassionate society we must make a decision, here and now, whether we have a commitment to the elderly or whether we will abandon them when they need us most."

And finally, in the NEW YORK TIMES MAGAZINE just two Sundays ago, Dr. David Hilfiker, a physician and writer, authored a lengthy article titled, "A Doctor's View of Modern medicine."

His view is grim. While he acknowledges and gives credit to the exceptions, he believes the bottom-line orientation of doctors, hospitals and third party payers will victimize the poor.

He writes: "At some deep level, I think, we physicians know something is wrong. We are invested with enormous trust and confidence predicated ultimately upon our role as healers who place the patient above our own personal needs. The monetization of medicine strikes at the heart of this trust. As patients gradually recognize that their physician is getting rich from the services rendered, the very core of the relationship is shattered."

He writes later: "We have stepped away from the basis of our profession. And as we continue to follow this course, ultimately we will abandon the poor."

These are powerful, emotional messages. They are also powerful and emotional issues.

And I expect health care issues such as these will gain greater exposure in the media as time goes on. There will be more charges, more anecdotal evidence that the system is not working as it should. And the issues will be imbued with an even greater sense of emotionalism and urgency than exists today, more than enough to fuel the campaign fires of politician and social activists from coast to coast.

It is plain to see that the cost containment is becoming a driving force in bringing health care to the forefront of our national consciousness.

Still, the fact that health care costs are a major contributor to the massive federal deficit that burdens our country is reason enough to contain health care costs today and in the future. We

cannot, and should not, return to a system that allows costs to spiral upward without a semblance of control. That is to say, DRGs, in one form or another, will remain a way of life.

But perhaps the pendulum has swung too far.

DRGs, as currently set forth, have their problems. The apparent failure of DRGs is that they do not take into account the varying severity of illnesses or the accompanying complications that so often arise. And these failures are stoking a fire that stands to engulf medical professionals in a controversy the likes of which they have never known.

But DRGs are not immutable.

They can be changed to the address the variables hat are cracking the seams of the system. And when physicians stop fighting the inevitable, when they come to understand that the not-so-good-old days are gone forever, they can help affect this change. They can become part of the solution. Moreover, they must do it now so the pendulum can swing on a more balanced arc between cost containment and quality care.

It may seem presumptuous of me, a non-health care professional to present my views on this subject. But I do have some minimal credentials that entitle me to an opinion: my company's involvement in the public relations aspects of health care, my status as an associate member of the Academy, and my responsibility as a CEO of an organization that provides medical benefits to 1,800 employees. I plead, therefore, somewhat greater interest in the field than say, the typical man in the street.

But when I review what's being said and written about health care, my approach is naturally from the viewpoint of communications.

It is from that viewpoint that I see the issues surrounding health care gaining speed in every quarter.

Our Public Affairs Department at Burson-Marsteller recently completed a major study on health care cost containment as it affects the corporation – another entity that frequently acts as interloper in the health care delivery field.

Yet after extensive interviewing and review of more than 40 corporations, we found that companies which were most successful in reducing health care costs were those which had enlisted their employers <u>as allies</u> in solving the problem.

The report concluded that at the corporate level, communications may be a more effective method of achieving cost-containment than administrative edict. Incidentally, we titled the report, "Second Opinion."

Now let me offer you a second opinion on how you as physicians can do something about the crisis in health care costs.

The cornerstone of my suggestions is to build constituency support for improvements in the current health care system.

And make no mistake about it. Constituency support can be a most powerful force. Consider, for example, social security, as sacrosanct an institution as exists in America today. It has become sacrosanct because the ones who need it most, and the ones who will need it soon, can marshal their forces and make life miserable for those politicians who wish to see it reduced in size and scope.

It is a similar process that I envision for health care.

First, you must understand that sick people vote too. So do the elderly, the poor and the uninsured. They already have a big stake in the system because they are the ones most affected by it.

Therefore, physicians can help mold these groups into constituencies that support and call out for a more rational and encompassing health care system. Their audiences: congressional officials, such as Senator Heinz, who are already speaking out and are in a position to affect change; their own representatives and senators, and other influentials who depend on various publics for guidance and are responsive to them.

Second, physicians must educate the larger population of health care recipients who will soon become senior citizens. They, too, have a stake in DRGs although their's is not so immediate.

Educate is the key word here because, despite the media coverage, people do not fully understand the problems until they or family members experience them first hand.

And finally, third party payers are constituents as well. Physicians must work with and give guidance to these health care gatekeepers. They must help third party payers define entitlements and understand, then implement, policies that address the variables that have fallen through the cracks in the current system.

But building constituency support is no easy task. It is a task made more difficult now that the credibility and image of health care practitioners are in question.

In his remarks before the Iowa Medical Society House of Delegates, Dr. Joseph Boyle, president of the American Medical Association, stated that fewer than three of 10 people think doctors in general charge reasonable fees. No more than two of 10 people think doctors really try to hold their charges down. Almost four of 10 people harbor the notion that physicians think they are better than other people. And only one-third of the people surveyed agree that doctors spend enough time with them, explain their problems to them adequately and really care.

Which means, two-thirds do not.

Clearly, there is a credibility and image problem.

And, as Dr. Hilfiker wrote, when it strikes at the heart of the trust that is supposed to exist between patient and physician, the very core of the relationship is shattered.

So what can physicians do? They must first rebuild their credibility and image. Only then can they mold constituency support for changes in the system.

And how can they do it?

The answer, which should come as no surprise to you, considering the source, is better communications. And the message to be delivered and demonstrated is that cost effective quality care is a physician's number one priority.

Better communications begins first with individual physicians, which brings up another problem of sorts.

It has been my observation that physicians historically have been poor communicators. They didn't have to be good communicators when the relationships of the past were based on the attitude that "Doctor knows best." There was always something mystical about the medical profession which precluded in-depth discussion of treatment or payment with patients. Perhaps there was a touch of arrogance as well. It strikes me that the stereotype of a physician who writes illegible prescriptions may be somewhat symbolic.

Communications between physician and patient should no longer be regarded as an optional service provided by those who are so inclined. It is now part of the job description, just as the ability to diagnose, to read x-rays, to medicate properly are elements of a physician's traditional roster of skills. It is no longer sufficient for doctors to be excellent practitioners; they must now be excellent communicators as well.

This new fact of life also comes at a time when there is a surplus of physicians. Many physicians have assumed a marketing posture to build their practices. Why not take advantage of marketing techniques to build credibility and image so the groundwork for constituent support can be laid?

Let me give you one small example of what I mean.

My sister, who lives in Memphis, Tennessee, recently cut her finger badly enough to require stitches. As the blood dripped on the kitchen floor, she first thought of calling her family physician whose office was about 20 minutes away. Then she remembered that a walk-in clinic in a shopping mall not five minutes from her home had recently opened for business. When she got there, a physician stitched up her finger and asked her to come back four or five days later to have the stitches removed. Not expecting to have any contact with him until then, she was surprised when the doctor called the next morning to see how she was doing.

That little effort spoke volumes. Here was a physician who cared enough to check up on a patient he had met for the first time the day before. Now my sister will remember him because of that extra effort, and she will not hesitate going back should the need arise. Was he

performing a marketing function? Was he establishing credibility or building his image? Or was he simply a caring person?

It doesn't matter. He succeeded in accomplishing them all.

In general, I believe other physicians can also do the same thing with greater disclosure and more frequent communications contact with their patients.

Patients need information. They need to trust their physicians so they can make decisions based on that information. And providing it in some depth and with greater frequency will go a long way in building that trust and establishing the physician's credibility.

In a similar vein, too much confusing information is apt to leave people feeling helpless, overburdened, frustrated and sometimes abandoned. This, too, is occurring with the changes that have taken place in health care.

But as we like to say, where there is confusion, there is opportunity.

The physician is a patient's single most important contact when it comes to health care. That being the case, physicians have the opportunity and the ability to lead their patients through a system now viewed by many as a morass of interlopers and complications. In general, if physicians can use communications to help patients through this maze, everyone wins -- the patient, who learns how the system works and how to benefit from what it provides; and the doctor, whose credibility is enhanced. The doctor also gains an ally and a potential constituent who can argue for improving the system.

Essentially, this means becoming the patient's advocate and agent for dealing with the system.

It also means demystifying the system and demystifying medicine, answering questions in plain English rather than medical jargon that patients find intimidating and difficult to understand.

It means spending more time with patients; taking that extra step to explain the cost containment situation, even helping patients with their insurance documents.

Patients should feel that doctors are approachable and want that kind of contact. Doctors then become a resource, a credible resource, whose opinions can be trusted.

This holds true when communicating with third party payers and administrators, as well as peer review organizations. All these interlopers are here to stay. Like patients, they depend on physicians for guidance. Give it to them. Don't fight them. Become part of the solution.

If this sounds like a description of a service industry, you're right, that's exactly what it is. That really is what the physician's job as health care provider has become.

Now, I realize that many physicians are generally busy people. They will need help fulfilling these added responsibilities. And I believe physician associations can provide that help by

developing communications tools for physicians to use with their patients. Videotapes, brochures, newsletters, flip charts -- whatever is appropriate.

Associations should also offer educational programs for doctors so they understand why they must communicate more, and how to do it. In fact, communications should be a medical school requirement, and I understand that Dartmouth is currently considering a pilot program to address that need.

Associations should also play a role in improving the image and credibility of physicians beyond offering them tools. They should also play a role in building constituencies.

Associations can meet these needs by offering out-reach programs such as symposia, open forums and school or professional meetings.

And they must educate the media. Media can't report what they don't read, see or hear.

Associations must make sure they are in the loop of information resources media have at their disposal. And this must be done proactively, with frequent communications, updates and backgrounding sessions with editors and reporters. That is the only way your messages will get to media, and through them, to the public at large.

Without a doubt, there is a lot of work ahead, but the work must be done. And it will require a collective effort. Whatever rivalries exist between the parties responsible for health care must be set aside. Things are not going to return to pre-World War II days ever again.

The most important thing I can tell you today is that physicians must get started right away. There is no time or excuse to dawdle. The issues will not go away unless something is done immediately to affect changes in the system. At risk is the credibility of the profession and the care of those who need it most.

In short, the medical profession has changed, and its use of communications must change with it. The stakes are too high to do otherwise.