

*The Business Partnership, Minnesota Chamber, and other business coalitions recently argued against more government involvement in health care, advocating instead that business must enhance market forces and stated “so now we must begin.”*

*Citizens League Policy Director Bob DeBoer recently sat down with J. “Sean” Kenney, the President and CEO of the Labor Management Health Care Coalition for the Upper Midwest to talk about health care reform in Minnesota.*

*Kenney has led purchaser coalitions for almost 30 years in Minnesota and in Michigan, the Minnesota Coalition in 1980s, the Greater Detroit Area coalition in 1990s, and with the Labor Management Health Care Coalition for the past six years. This interview has been edited for length and clarity.*

**Minnesota has been “beginning” to reform the health care system for 25 years:** Market reform has not produced a better health care system or a better quality of care

**Bob DeBoer: What has been the biggest barrier to creating a market in the medical care system over the last 25 years?**

Sean Kenney: Business has never used its core business model and thinking and applied it to health care. There is a disconnect in the market place. They have not bought on quality and value. Most of their energy has been on the cost of their health plan or their risk for insuring a population. Where are the CEOs and the CFOs exerting their leadership on health care? It is not only a business issue but a major community and civic issue.

**BD: Why do you think that is? Do they have the tools to do so?**

SK: They can use the fundamental thinking that they use everyday in running their business and apply it to their health care supply chain. That would produce more and different insights than they use right now.

Why don't they do it? One, they don't see it as their core business, and two, they are afraid they are going to get sucked in to a very complicated morass, so they defer to their HR benefits people.

If you look at most businesses, there is a warranty/liability that is associated with their core business. Take an extreme example: Medtronic. If they don't make a quality product to insert in the body, they have lawsuits facing them in their supply chain or they've got image issues. Business, by not using a business model [in regard to health care] doesn't incur any of that liability right now. And I am not saying they should, but what has been missing are two things: One is – where CEOs and CFOs need to be engaged – to view their employees as assets in light of their health status, their quality of life and their productivity, something that has been compromised by an imperfect health care system. Two, is their civic responsibility. You hear praise for business leaders in Minnesota for the work in Itasca Project and things like that. How they have stepped up in public education efforts etc., but health care is not there yet. Society is being robbed by this

imperfect system that affects business profitability; how much we can spend on education among other things.

**BD: So you don't think that business behavior is naturally going to change in this area because of what you have just outlined?**

SK: It is certainly a challenge that hasn't been answered yet, but maybe should be put out there: where are the CEOs and CFOs? They should look at their experience over the last 25 years: continuing double-digit cost increases; a supplier-controlled market and little purchaser clout. Their workers are increasingly frustrated with health care directions.

They [CEOs] should be motivated by the fact that this is a system that exists with perverse incentives: you screw up and you get paid more, and their business is paying people more to deliver inefficient, poor quality care--an anathema to good business practices.

**BD: That does get to the point about information that the Citizens League outlined as a major conclusion in our report [Medical Facilities, April 2006]: we concluded the market is supplier driven and we don't seem to have information available in a meaningful way to really go at these systemic changes. How do we start getting there?**

SK: What would work, once again, is if business were to take their basic business model that is now applied to their suppliers and apply it to health care.

Instead of doing business with 11 heart centers, [purchasers could say] I want to know the three best. Give me your outcomes and I will use my advocacy/support system to get my employees there. It could all be done without getting publicly reported data. That's the business model of getting required information from suppliers (i.e. no information equals no business). This also rewards better performing suppliers with volume and dollars.

I'd argue that the next step is to get the government to be the vehicle that requires that information, publicly reported, risk-adjusted—so that both the purchasers, who have been unbelievably weak about requiring it, nevertheless get it as part of a public mandate, and the end consumer would also have access [to information] to make informed decisions.

**BD: Isn't that more responsive to the times we are currently in? Where employers simply are not offering as much coverage as they have in the past because of the financial pressure? Where more decisions are going to the individual consumer?**

SK: How can anyone with credibility argue that they are pushing for the so-called "consumer-directed health care system" when the purchasers, on behalf of the worker and the community, haven't gotten the information? Now they are going to tell Joe Consumer, "Here is your financial risk, go get it." It [the information/decision point]

can't be there: either the purchaser has to supply it for them, or we have to invest in a public sector change that makes it universally available.

**BD: So you would agree that information is at the core, initially, of any market or regulatory reform?**

SK: Look at the basic principles of Economics 101: what makes a marketplace? If I got it right, it is perfect information, a multitude of suppliers so you have choice, and financial incentives to make your decisions. We have the financial incentives. We have the choice (we have excess capacity), but we don't have information to make a quality judgment.

In the absence of public information, our group, the labor-management health-care coalition, has implemented a program to assist workers, their families, and their primary care doctor to access specialty care based upon demonstrated "best in class" clinical outcomes.

The approach we used developed out of a business supply-chain model at Honeywell in the 1980s. They certified "best in class" specialty providers based upon clinical performance and provided "patient advocacy" to the family member to make sure they got the best quality physician and team for their condition. The program deals with some of the most costly care, where there is excess supply capacity and tremendous variation in quality. Getting the best quality is a win for the worker/family, a win for the employer supported health fund and a win/reward for the best-performing providers.

Without such a program, referrals are often based upon an inadequate evidence of quality. Unfortunately, in some cases, economic affiliations between a referring clinic and a specialty provider system serve as the basis for the referral, not quality evidence.

**BD: Would you say it becomes reputation and advertising? How are we making these decisions now?**

SK: Absolutely. Here is another whole issue of where consumers are at a huge disadvantage. A lot of specialty referrals are made by your primary care doctor, right? Some of those, many of those, are made on economic relationships with who they are referring you to and the average public isn't informed of that.

For example, my son just had a major heart procedure with Mayo. He checked with his health plan, just to be sure. They said, "Oh no, you are going to have to have a primary care referral." He called his clinic which happened to be a highly regarded group practice, and they said, "We don't refer to Mayo, we refer to another system," and it happened to be local health system. Long and short, we found a way around the barrier, but Joe Consumer would be put in that chain.

And why are they referring to that provider? Because they have an economic tie-in. Is that based on evidence that you are going to get the best care there? No. You don't know

what their outcomes are and they don't know it on the outside [to make their decision] to refer. It is economically driven. Now is the public informed of that when you go into a group medical practice for primary care? Are you informed of that? We think that needs to be looked at by the attorney general's office or the legislature. Either you disclose that up front, or you don't do it.

**BD: What you are talking about here is really what isn't covered by the Stark Laws.**

This isn't self-referring [Stark Laws]; this is referring within your integrated system. Most clinics are aligned with one of the systems. If I am in the Allina system, I am going to refer you for heart to Abbot Northwestern, North Memorial or United. Now, how do I know as a patient my doctor is referring me to one of the best three in Minnesota? The answer is that he or she [the doctor] doesn't know and they are doing it based on the economic relationship of an integrated system. Point being, average consumer doesn't know that. I trust my doctor. I am going to go where he or she tells me I should go. The one point [the Labor-Management Coalition] are making is: if it is an informed marketplace, then it isn't just driven by financial consideration but includes quality and value.

We don't think the doctor is being an obstacle. [The doctors] would probably step back and say, "All things being equal, I would like to refer you to the place where I think you are going to get the best outcome. I don't want to be constrained by my hospital having a relationship with another provider." Doctors, I think, would be big allies if we elevated this issue because they are behind the eight ball. It tells you how dysfunctional the market is.

**BD: So you are saying that even doctors don't have the information to operate on quality, or they don't have the ability to refer outside based on evidence?**

Evidence-based referral. It's a good concept. A great concept. You should be referred where the evidence says that you are going to get the best outcome, which in most specialty areas is going to cost less for whoever is paying, so it is a win-win. It is not the idea that if you want better quality, you are going to pay more.

**BD: Even though we have some groups—such as business coalitions--in place now that focus on purchasing, and we have some groups that are starting to focus on quality, like the Governor's Q-Comp and ICSI. . .**

SK: ICSI has been coming out with guidelines for 15 years and it is notable nationally, but what forces require those guidelines to be followed? It is voluntary. Aside from some very well-motivated practitioners that want to be sure they are paying attention to them, they mostly sit on shelves.

**BD: So, in your view, this kind of voluntary era may have passed as far as getting to an information system where we can get quality outcomes?**

SK: It is not going to happen from the buyers to the suppliers. They have a long way to go to purchase on quality and value. More efforts are expended on report cards and efforts to improve health care performance among all providers than on buying from the best.

Report cards won't get us there for a whole bunch of reasons. What you have to do is find out who is the best in class and give them your business. That is power market force. And then you are also rewarding the providers for doing a great job.

Now in the case of [Minnesota's] Q-Care and the current efforts like Bridges to Excellence, the first year they were rewarding doctors who got 10 percent to the mark of all of the recommended protocol (I think it was an ICSI guideline) for diabetic care.

Why 10 percent? Because the average for Minnesota was 6 percent then. Every time I raise this, people say the governor's Q-Care is going to get to 40 percent in 2010. I'm saying, "How many years until we get to 95 percent?" And that's just diabetes – while very important – how does this get translated to all the other disease categories? Heart? Cancer? High-risk pregnancy? Orthopedic? Hip replacements?

And when you step back and look at that, you say we are going to be gone from this earth by the time we get one-tenth of the way there. It is not the model for change. There is a lot of effort directed at looking like we are doing something, but it is not fundamentally changing the marketplace.

This has been going on for 25 years in Minnesota. In your recent Citizens League report on medical facilities, you reference Walter McClure, Ph.D. He clearly articulated the market change needed in the mid-1980s: define and buy from the best quality. It got national attention as the "buy right strategy," but market forces never acted on such a basic strategy.

And now there are new voices saying, "We must begin to make the marketplace work!"

**BD: Switching gears to capital facility decisions. What changes have you seen in the approach to those decisions in the last 20 to 30 years? Is that similar to care quality?**

SK: Minnesota has been all over the map. We have been a leader in fostering change in the capital area and a leader in dropping such change. ... Minnesota was the first state in the country, I believe, to enact Certificate of Need (CON) because of the combination of our unique Metropolitan Council and spirit of public planning. We were the first state to drop CON. Why? Because in the early 1980s business leaders were saying that is the wrong way to try and get public scrutiny and regulation of the supply chain. Let the marketplace take care of that!

Now roll forward about 25 years to 2007, look at the capital expansion in recent years without many controls, including from the "marketplace." Let's take my favorite: heart care. We have 11 heart centers and the hospitals have in many cases been expanding their

capacity in that area to the point where we have much excess and duplication throughout the state and the purchasers and the public pay for this excess. This dilutes volume which translates to reduced quality of outcomes, and reduced productivity.

Business leaders are left to conclude that the marketplace is not working. In fact, business leaders serving on boards of hospitals may even be encouraging further perverse competition and marketplace conditions.

**BD: The Citizens League study committee on medical facility expansion 2005-06, found that no one seemed interested in a return to a CON model...but it sounds like there might be some important questions left unanswered. We have had some discussions that if government isn't going to be active in some way on this, nothing is going to change. Would you agree?**

SK: I agree with that statement. There are two levels of government involvement, one is to make sure the information is there and transparent for both the purchaser and the public, so that they can consider taking whatever action may be in their interest. Such transparency exists in other business and safety institutions, such as the SEC and the FAA.

Another level would be to go back and actually regulate the behavior of capital decision-making and I don't think there is a lot of political will for that.

I think you used the Walt McClure quote [in the Citizens League report] right on target – we know that [supplier] interests have a way of co-opting that level of regulatory behavior. It has happened before and it will happen again, so the middle ground would seem to be getting objective evaluation of capital expansion by a group that is arms length from the supplier interests and represent the broader purchaser-consumer-public interest.

I can go maybe one step further. We have in our quasi-regulatory mode in the environment, the environmental impact statement (EIS) where a body would go and say, “If this happens, here are the first order, second order, third order possible consequences.”

A case in point: when I served the purchaser coalition in Detroit in 1993, purchasers were faced with a situation where eight new open-heart surgery centers would be developed by hospitals in addition to the 28 already online in the state. Purchasers banded together and compiled information on what the excess would cost in dollars and diluted quality for the public. This included the auto companies, utilities, conservative Michigan Gov. John Engler, and UAW and AFL-CIO leaders. They agreed upon legislation to forestall all such expansion in the future and acted to get current applicants to honor the future provisions.

This coalition met with [the hospital] administrators, CEOs, their doctors and the trustees. In some cases, all of them backed off early on. In a lot of cases, the doctors and the

administrators were adamant to go ahead. But it was the trustees who got motivated by purchaser demands to say this expansion is not in the community interest and it is not in our interest for survival. The line was drawn [by the coalition] to say, “If you build this unneeded center for heart care, not only will we not send you our patients for heart care, we will not send our patients for any care.” *Build it and we will not come!*

**BD: That is part of the thinking behind the Minnesota Medical Consumer Council. It could send these high-profile signals representing a lot of purchasing power to say “build it and we won’t come.”**

SK: Right. I would predict if a neutral body had reviewed all of the evidence for a proposed Maple Grove hospital, I wouldn’t be surprised if it were concluded that it was not needed in the community interest. However, this would need to include purchasers, public interests, and government all working together.

**BD: Really? Even in the case where the Department of Health said there was a public interest in building the Maple Grove hospital. Was it based too much on geography and population?**

SK: I would argue that it was almost totally based on that. If you look at any newspaper account, all the evidence [in support] and the quotes were based on the need to follow the population and make it more – I’ll use the word – convenient. That is such a weak criteria for that kind of an expansion. It is perverse in the marketplace and the fact is that it proceeds from a number of assumptions, and the big one is that people don’t want to travel far for their health care. While that is certainly true for primary care, when it comes to major hospitalization and specialty care, we would argue the evidence is very strong that when people know there is increased potential for an excellent outcome, they will very willingly travel to the selected institution.

**BD: Leading from that I wouldn’t want to avoid the question that is in front of us today: the need for a new U-Fairview Children’s Hospital.**

SK: I think if it was looked at from the perspective of the new model that the Citizens League is proposing, I would guess that there would be strong evidence that it is not needed.

We now have Minneapolis, and Gillette is at St. Paul Children’s – they are combined. They were urged to sit down with the University. Who urged them to do that? They got together on their own, which was prudent. It didn’t go anywhere.

Now the public is going to watch this perverse supplier competition play out, with both capital costs and quality implications. A process such as what I think the Citizens League approach could lead to would be one of two things. One would be a government regulatory approach that would say, “We aren’t going to accept the answer that you can’t work together. Any new expansion to a dedicated Children’s Hospital is going to happen through cooperative agreement between existing hospitals. Some will certainly argue that

this gives too much power to existing hospitals/franchises. The answer is that we are not talking about a “business good” but public good. We need to say “we aren’t going to tell you how to do it, we are going to tell you that you can’t do it unless. . .”

That force is not at the table right now. Whether that has to be promulgated by a regulatory force or whether a volunteer public interest group such as the Citizens League can say, “It should not be built,” I don’t know.

Maybe the latter approach would carry enough public sentiment. Unless it gets to the point where the purchasers and civic leaders see evidence that capital expansion is not needed and is not in the interest of the public nothing will change. It will take some combination of regulation and marketplace for this to happen.

Purchasers, both public and private, need the means and political will to say “build it and we won’t come.”