CHAPTER 2

The US Health System in Vivo

In the 1973 film, *Sleeper*, Woody Allen plays the part of the owner of a New York City health food store whose minor procedure in a New York hospital goes awry and he is frozen. Two hundred years later he is awakened and asks for a breakfast of organic honey, tiger's milk, and wheat germ. The scientists are astounded by his request but remember such food was considered healthy back in the 20th century. The dialogue then continues with the scientists stating that they are surprised that folks back then did not realize that the healthiest foods were deep fried fat, steak, cream pies, and hot fudge. How does this relate to the present chapter?

In the last chapter I presented a somewhat academic view of the health system with a fair amount of data about demographics, health expenditures, hospitals, ambulatory care, and other related subjects. In the first edition of this book, I used this chapter to review the real world of health care by commenting on a sample of health-related newspaper articles that appeared in the year 2003. Now, more than 6 years later, I decided to use this chapter in a comparative way, that is, to revisit the news stories of 2003 to see if what is presented as the last word in 2003 is indeed the last word on the subject. So, inspired by Woody Allen, I want to see if the real answer is wheat germ or hot fudge! My focus in this chapter will be on technology and clinical developments, fraud and abuse, health systems and quality, and finances.

As a manager, it is imperative to be au courant with what the public knows and be able to respond to any board, staff, or public inquiries about these matters. For example, when I was CEO of a health system, one of the morning television shows presented a segment on automatic

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defibrillators. Several hours later a few of my board members (including the chairman) called to ask about these devices, inquiring about their cost, availability, and, of course, how many we owned. I immediately needed to be a "quick study" on the subject. Within weeks, I was also asked to set up demonstrations and was required to make a presentation to the board on whether we should purchase and install the devices throughout our facilities. The lesson here is simple: Not only must managers be on top of the professional literature (which often tends to be both academic and a trifle dated) but they also must be tuned into the popular media, particularly the major dailies and news magazines.

TECHNOLOGY AND CLINICAL DEVELOPMENTS

The health system and its components are both the beneficiaries and victims of technology. The benefits of technology are often obvious, such as safer and better drugs, procedures, or devices. The negatives are often less visible, such as when a drug or medical device passes through the US Food and Drug Administration (FDA) process and is introduced, only to be found several years into use to have such negative side effects that it must be recalled and eliminated from the market. Consider the following seven articles and what they might mean for the health system, including those people receiving care, those providing the care, and those paying for the care.

1. Alzheimer's drug: On June 15, 2003, *The New York Times* reported that families with loved ones with Alzheimer disease were turning to memantine, a drug not approved by the FDA in the United States but used in Europe, for treating the disease.[1] Like legions of people before them, these families were desperate because conventional treatment had failed. Similarly, in the world of cancer therapy, people have tried numerous alternative cures, the most famous of which is laetrile. Inevitably, some of these therapies work, for reasons sometimes unknown. However, the issue the health system must contend with is still who should get these experimental,

[1]Desperate families embrace unapproved Alzheimer drug. *The New York Times* (June 15, 2003), p. 1.

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unapproved treatments and who should pay for them. The answer is that usually only the wealthy can afford to go outside the traditional system; rarely will insurance or governmental programs pay for these alternatives. Since 1992, the federal government has been trying to deal with many of these issues through its National Institute of Medicine–based National Center for Complementary and Alternative Medicine (NCCAM) (and its predecessor, the Office of Alternative Medicine) that, according to its Web site, is focused on "exploring complementary and alternative practices in the context of rigorous science, training complementary and alternative medicine researchers, and disseminating authoritative information to the public and professionals."[2] All of these goals were to be met in 2003 with a budget of $114,149,000, or less than 50 cents per American!

UPDATE: Memantine is still around and one of the drugs used in the arsenal against deterioration from Alzheimer disease. While its use in the United States seems without controversy, the same is not true in the United Kingdom which might raise some issues in the future. Specifically, since September 2007, the British National Institute for Health and Clinical Excellence has recommended against the use of memantine for moderately severe to severe Alzheimer disease except in the case of clinical trials. Finally, an update on the NCCAM. In fiscal year (FY) 2005, the NCCAM budget increased to its all-time high of $123.1 million, decreasing in FY 2007 to $121.6 million, and down again slightly in FY 2008 to $121.5 million. Obviously this office is not the favorite child of the National Institute of Health nor is it merely keeping up with inflation!

2. Sunscreen study: On June 3, 2003, the *Daily Hampshire Gazette*, my Northampton, Massachusetts hometown paper—and one of the oldest dailies in America—reported a *Los Angeles Times* article about Australian research finding that regular daily use of sunscreen, not just smearing it on oneself when going to the beach, will dramatically reduce the incidence of precancers of the skin.[3]

[2]Data retrieved (n.d.) http://from www.nccam.nih.gov/about/.
[3]Study of sunscreen. *The Daily Hampshire Gazette* (June 3, 2003), p. C2.

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The same study debunked the value of beta-carotene supplements to prevent skin precancers. Here we see an existing over-the-counter "supplement" that can help prevent a serious and expensive problem. This is an opportunity for the health system to utilize the tool of health education to save people the anguish and discomfort of skin cancers and also save the system the expense of dealing with the problem. Similarly, the system could educate people about the waste of money involved in using beta-carotene to stave off precancers (although it may have other important functions in a diet). Unfortunately, here as elsewhere, even though sunscreen may be an excellent form of preventive medicine for many consumers, I am unaware of any health insurance program that would pay for a sunscreen prescription.

UPDATE: Despite the value of sunscreen in preventing skin cancers, insurance companies still are not paying for this product. And, both using sunscreen and which sunscreen to use has become more confusing. A *Consumers Report* study in July 2007 pointed out that several of the tested products did not meet expectations for ultraviolet-A (UVA) protection or, to put it another way, the consumer does not always get what they pay for.[4] Adding further confusion to the equation is a report that came out of the Environmental Working Group that finds that some of the ingredients in many brands of sunscreen both irritate the skin of up to 20% of users.[5] On the question of beta-carotene and sunscreen, we have even more confusion. A 2008 German meta-analysis concluded that supplemental use of beta-carotene for a period of 10 weeks would help provide effective protection against sunburn.[6] So what is the answer? The right brand sunscreen with the least irritants liberally schmeared—early and often! Once again, a serious job for health educators.

[4]Data retrieved (n.d.) from http://www.consumersreport.org/cro/home-garden/beauty-personal-care/skincare/sunscreen-7-07/overview/0707_sunscreen.htm.
[5]Data retrieved (n.d.) from http://www.ewg.org/node/18707.
[6]Data retrieved (n.d.) from http://www.eufic.org/page/en/page/LS/fftid/Beta-carotene-supplements-may-help-prevent-sunburns/.

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3. Hormone therapy: A page 1 article in the May 28, 2003, issue of the *Boston Globe* reported that, after years of study, it was found that the risk of dementia doubled for women who took hormone replacement therapy (HRT).[7] For women going through menopause, the issue of whether to take replacement hormones has been a controversial and anxiety-ridden decision. Current research now contradicts earlier findings that suggested HRT not only had a dramatic effect on mitigating menopausal symptoms but also reduced the susceptibility to certain ailments such as heart disease. This new finding, though, indicates a slightly elevated risk of dementia associated with the drug. The dilemma is still in the hands of the consumer. She must make the final choice, often between what her physician may advise and her own limited knowledge. From a systems perspective, we have one final issue: The hormones prescribed by the physician will be covered by insurance (if there is a drug benefit); but any natural solutions, such as those found in the increasingly proliferating health food stores, or other self-care strategies, such as diet and exercise, will not have any subsidy through health insurance. Perhaps it is best to recognize that health insurance is primarily sickness insurance.

   UPDATE: With regard to HRT and dementia, the latest word from the National Institutes of Health is that dementia symptoms are not slowed down by HRT. Still this murky area continues to be investigated.[8]

4. New delivery system for the flu vaccine: Building a better mousetrap is often a good idea with significant benefits for everyone, except owners of the old traps. For most of us, taking a flu shot is a less-than-pleasant experience: Roll up the sleeve, turn your head, feel the alcohol swab, then the needle, and finally, we are done. When I was in the Navy, it was a regular assembly line with some type of compressed air gun delivering the shot. At last, as reported in *The New York Times*, a civilized approach developed in the 1960s will become widely available almost 40 years later. The system will simply be a mist sprayed up the nose, much like

[7]Study ties hormone therapy to more risk. *The Boston Globe* (May 28, 2003), p. 1.
[8]Data retrieved (n.d.) from http://www.nlm.nih.gov/medlineplus/ency/article/007111.htm.

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taking a nasal decongestant. The manufacturers expect to heavily promote this product, whose cost is estimated at $50–55 per dose compared with $10–25 per injection dose, by advertising in the pre-flu season.[9] For managers and consumers, the issue, as demonstrated by the flu mist system, is why there is such a time lag in getting new technology to the market. Several answers are suggested by this case. First, the FDA goes through its own process of scrutinizing new technology. In the case of the mist, the difference is not merely turning the vaccine into an aerosol but is the use of live vaccine compared with the dead viruses introduced into the system via the needle. Second, the live vaccines "have been engineered to survive in the cooler temperatures of the nose but not the warmer temperatures of the lungs. It provokes the immune system but does not cause serious disease."[10] So, to begin with, there are the technical and clinical issues that must be addressed. Next there are the financial issues that inevitably involve Wall Street. A major new product costs money in terms of production and marketing, and promoters of such a project need the backing of analysts and investors. In essence, then, it sometimes takes decades between the invention of the new mousetrap and its first sale.

UPDATE: According to the Centers for Disease Control and Prevention (CDC) this innovation not only works as well as the traditional vaccine but, in fact, works better for healthy people ages 2 to 49! An incidental, but not insignificant, side benefit of this form of dosing the public is that health workers can give it without the typical protective gear of gloves and masks.[11] Progress!

5. Aspirin—Back to the basics: Although the idea of new technology certainly has its attractions, sometimes the older technology or drugs do just as good a job at a fraction of the cost. On June 11, 2003, the *Wall Street Journal* reported on a study published in the *Journal of the American Medical Association* that found that the relatively new high-tech drug ticlopine (at a cost of $100 per month) works no better than aspirin (at a cost of $10 per month)

[9]FDA backs flu vaccine given by mist not a needle. *The New York Times* (June 18, 2003), p. C4.
[10]Ibid.
[11]Data retrieved (n.d.) from http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5306a1.htm.

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in preventing the recurrence of strokes in African Americans.[12] How is it that the health system allows the development of expensive new drugs or technology that are essentially a replacement for equally efficient older drugs or technology? A cynic would answer that it is all about profit. The companies see a market, make a slightly different product, and hope to capture the old market. A research scientist might say that his or her profession is always looking for a more efficient or elegant formulation to attack a significant problem, and that the new product may indeed have special benefits like reduced side effects or a better delivery system. For example, my favorite antibiotic is Zithromax, a drug similar to erythromycin but more expensive. I like the Zithromax because, unlike other antibiotics that require me to take the pill 4 times a day for 10 days, Zithromax has me taking 6 pills: 2 the first day and 1 every day thereafter. The Z-pak, as it is called, is more convenient and perhaps more effective because of higher compliance . . . but that remains to be studied.

UPDATE: Good news. Almost nothing has changed except now Zithromax is available as a generic drug, azithromycin, at 30 to 50% less than the cost of the brand drug. Aspirin still is the wonder drug.

6. Technology and unanticipated consequences: How many of us would choose to have surgery if we knew the consequences would be a brain injury? From a *New York Times* article of May 13, 2003, we learn about "pumpheads."[13] Pumpheads are the unfortunate people who suffer brain injury as a result of being put on a heart–lung machine during open-heart surgery. Although it is not exactly clear what the cause of the injuries are, some surgeons are responding by doing the bypass surgery without using the heart–lung machine, a procedure known as off-pump surgery. Here we have an example of a problem (heart blockage), a solution (bypass surgery), the unanticipated consequence (pumpheads),

[12]Antistroke drug performs no better than aspirin. *The Wall Street Journal* (June 11, 2003), p. D6.

[13]Heart pump and brain injury: A riddle deepens with time. *The New York Times* (May 13, 2002), p. D1.

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and, finally, a search for an alternative route (off-pump surgery). Unfortunately, the last word will not be written on this issue until at least 2006, when the government will have completed a study comparing the two approaches. Once again, as in the case of treating prostate cancer, the consumers are left to making an uninformed decision guided only by their relatively uniformed practitioners, whose judgment is usually based on their own limited experience, and their equally uninformed (and arguably self-interested) insurance companies.

UPDATE: It appears that the study mentioned earlier has been completed and the results are "in process" (telephone interview with VA Medical Center, Tampa, FL). In some senses technological developments have made the findings of this study less significant because of the use of totally endoscopic coronary bypass surgery (TECAB). While not available everywhere, nor appropriate in every case, such developments promise to minimize the "pumphead" issue.

7. A new world of surgery: Minimally invasive surgery (MIS) is described in a *Boston Globe* article as such a significant breakthrough that "it constitutes a shift in practice so profound that its effect is akin to the arrival of anesthesia 150 years ago."[14] MIS is now used throughout the body system, including gynecological surgery, neurosurgery, cardiac surgery, and urologic surgery. The article points out that heart mitral valve repairs used to involve foot-long incisions followed by the breaking of the breastbone in order to access the heart valve. Hospital stays lasted 5–6 days with a 2-month recovery time. MIS for the same problem involves a 2-inch incision, use of miniature cameras and instruments, a 2-day hospital stay, and a 2-week recovery.[15]

   UPDATE: MIS is becoming more the standard than the exception. For example, the da Vinci system of robotic surgery offers more procedures with fewer side effects and less shaky hands (www.davincisurgery.com)!

[14]As tools of surgery shrink, training expands. *The Boston Globe* (June 27, 2002), p. E1.
[15]Ibid.

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The brave new world of medicine is upon us and, for managers, the changes will be enormous. As we learned in Chapter 1, we will need fewer beds for more people, more and better equipment, and certainly people with different training than before. For consumers, we will see a quicker return from the sick role and hopefully a better quality of life.

FRAUD AND ABUSE

Although the subject of fraud and abuse will be dealt with extensively in later chapters, I do want to introduce it here because it represents such an important new development in the healthcare field. Although sleaze has always existed, the availability of huge reservoirs of insurance and government funds has taken corruption in the health field to a new level. The following articles and commentary provide a glimpse of this problem. This section is organized in two parts. Part I presents some historically interesting cases from various publications and Part II focuses on recent fraud and abuse actions in Florida—often thought of as the epicenter of such activities. And while it would be nice to report that fraud and abuse have decreased in size and scope since the first edition of this book was prepared, unfortunately, that not has happened. In fact, it is probably getting worse!

Part I: Historical

- Fighting fraud in Boston: The big picture about fraud in the health industry was presented in a page 1 *Boston Globe* article stating that amongst federal prosecutors, Boston lead the way on fighting fraud.[16] The statistical chart presented with the article illustrates that in 2000 the National Medical Corporation settled the government's suit against them for a variety of charges, including kickbacks and unnecessary tests and therapies for the sum of $486 million. Additionally, four executives were convicted of conspiracy to defraud the government. In 2001, the fraud unit settled with TAP Pharmaceutical for $855 million. In this instance, TAP had been involved in illegal marketing and pricing of leuprolide (Lupron), a drug used for prostate cancer. In 2003, two drug giants, Bayer and

[16]Prosecutors here lead in health fraud cases. *The Boston Globe* (May 13, 2003), p. 1.

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GlaxoSmithKline, settled with the government for more than $350 million. In both instances, they had intentionally overcharged the government for medications.

- Illegal marketing: Another drug giant, Parke-Davis, is in trouble with the government for the alleged illegal marketing activities of its epilepsy drug gabapentin (Neurontin).[17] In this case, the drug manufacturer allegedly provided illegal marketing trips and tickets to physicians under the guise of educational programs. The government's case will be based on the company's conduct, thought to be an illegal inducement to prescribe its drugs. Part of the problem with this activity is that the government says it was an inducement to use the drug for various ailments, such as bipolar disorder, rather than the ailment for which the drug was initially designed. Such so called "off-label" uses have a significantly positive impact on the drug company's bottom line. The line between aggressive and legal marketing and illegal marketing activities is still not clear and, until it gets well-defined, we can anticipate many more similar government lawsuits.
- Faulty medical device for treating aneurysms: As reported in the June 13, 2003, edition of *USA Today*, a medical manufacturer, EndoVascular Technologies, agreed to pay a fine of $92.4 million and plead guilty to "covering up thousands of incidents in which the device malfunctioned and might have led to 12 deaths and 57 emergency surgeries nationwide."[18] In this instance, the company's balloon-like device had been approved by the FDA in 1999 and suspended in 2001 after some anonymous tips about problems. Aggressive marketing activities, including covering up the details of the problems, led to the criminal charges. Once again, one must wonder whether less attention to sales goals and more attention to quality of the product would have been in the company's long-term interest. Additionally, one must raise the issue of surveillance systems for new medical devices—after all, but for the anonymous tips, the defective products might still be on the market!
- Poor patient care leads to divestiture: An Albany, New York, nursing home company was required to divest itself of its eight nursing

[17]US filing backs suit against drug firm. *The Boston Globe* (May 25, 2003), p. D1.
[18]Medical firm fined $92M in coverup. *USA Today* (June 13–15, 2003), p. 1.

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homes after state investigators found that it had falsified its business records and provided substandard care to the home's residents.[19] The owners are not only being forced to sell but also to pay over $1 million in fines and penalties. Nursing homes are among the most regulated sectors of the health system and, because of their large volume of Medicaid and Medicare business, come under both federal and state scrutiny. In recent years, many states have become increasingly aggressive in using significant penalties in order to change the behavior of nursing home owners and operators. As this case illustrates, the penalties can even include driving an owner out of business.

- Nonprofit medical center not exempt from problems: Even distinguished, world-famous institutions such as Massachusetts General Hospital (MGH) fall under scrutiny for fraud and abuse issues. For example, on June 19, 2003, it was reported by the *Boston Globe* that MGH would "pay the federal government $75,000 to settle allegations that it defrauded the Medicare program by billing for neurological services when no senior physician was present."[20] According to the article, there were instances where Medicare was billed for a physician's services while the doctor was away in Bermuda. For a healthcare manager, this raises the simple question: How does this happen? Unfortunately, too often, personnel appear to be on automatic pilot and impute information when it is missing . . . and this is where the trouble begins. For example, I was once investigating a woman's complaint about the care her father was receiving in a nursing home. In reviewing the chart I noticed that the nurses were consistently reporting the same dietary intake and status each day despite the facts that the man had lost a significant amount of weight (also recorded) and the daughter stated he had no appetite. What was occurring was that the nurses, at the end of their shift and hurrying to leave, made similar entries on this man's records as well as on every other person's record on the unit. The lack of attention in this case led to the man's hospitalization, as well as not only a subsequent change of staff on the unit but also a significant amount of in-service

[19]Operators must divest themselves of eight nursing homes. *Adirondack Daily Enterprise* (June 1, 2003), p. 2.

[20]Hospital to pay $75,000 settlement. *The Boston Globe* (June 19, 2003), p. B2.

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reeducation. If a lawsuit had been filed, those medical records would not have served the cause of the nursing home!

- Executives' problems: Two unrelated articles demonstrate the problems that both cause and result from the issues of fraud and abuse. In the first, a HealthSouth financial executive joined 11 other company executives in pleading guilty to a variety of charges about financial irregularities in the company.[21] The case itself, involving a chain of rehabilitation hospitals, began with investigation of illegal behavior in 1996 and by the summer of 2003 was far from resolved. The second article is equally troubling. Even though Jeffrey Barbakow was the executive who was brought in to clean up and run Tenet Healthcare in 1990 after it ran afoul of the government, he could not survive a new set of regulatory problems and subsequent loss of investor confidence.[22] This article reminds us that once an organization is stained by fraud and abuse, that stain has a way of affecting everyone, even the clean-up brigade. As will be shown in the chapters on corporate compliance, both an organization's reputation and the reputation of those that work there are best served by ethical and honest behavior.

Part II: Florida—the Epicenter!

The state of Florida spends more than $16 billion to provide health care to over 2 million people through the Medicaid program. It is currently estimated that approximately $2 billion of these monies are spent on fraud, abuse, and waste. The prime investigatory and prosecutorial responsibility for this abuse and fraud is the Office of the Attorney General of Florida and its Medicaid Fraud and Control Unit (MFCU). In its annual report for FY 2007–2008, the MFCU received 1094 complaints, many from the state's own Agency for Health Care Administration. Of these complaints, 569 were related to Medicaid fraud while the remainder were Patient Abuse, Neglect, and Exploitation cases (PANE). In FY 2007–2008, these 1094 complaints eventually became 391 opened cases of which 283 were fraud and 108 abuse. Eventually, 62 of these cases were sent for prosecution with 32 of these cases being focused on Medicaid fraud and 30 of the cases about abuse.

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[21]Former executive at HealthSouth pleads guilty [electronic version]. *The New York Times* (May 6, 2003); retrieved December 8, 2004.
[22]Troubled Tenet Outs Chairman Barbakow. *The Boston Globe* (June 28, 2003), p. D2.

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One section of the annual report is entitled "Significant Case Highlights." Two of the cases focused on recoveries from large corporations: Walgreens and Merck. In the Merck case, Florida was part of a global settlement relative to rebates that were due Medicaid programs for three prescription drugs. (The Federal Medicaid Drug Rebate Law requires manufacturers to provide the state Medicaid programs with the lowest price for drugs for its recipients.) In the case of Walgreens, the drug chain was found to have switch dosage forms for several of its medications. Thus, it too was part of a multistate settlement. A common pattern of fraud in abuse was found in those cases where providers obtained the names and identification numbers of Medicaid recipients and then went on to bill for a range of services that were not provided. For example, in Broward County, a respiratory therapist was convicted of billing for services to children and not providing those services; in Palm Beach County, a transportation company filed false trip tickets and found that the company had filed false claims to the tune of $423,000; in Tampa, a company billed Medicaid for personal care services for mentally disabled people but never provided those services; and, in the Tampa area, a home medical company submitted claims to Medicaid for services and equipment either not provided or provided in a substandard way. Other patterns included those where a patient or patients were systematically abused, Medicaid was billed by a physician when the physician was out of town or even out of the country, a registered nurse billed Medicaid for drugs for hospitalized patients and then used the medications for herself personally, two certified nursing assistants stole credit cards from residents and then used the cards for their personal items, and where a licensed contractor billed Medicaid for bathroom renovations for a disabled man and the work was either not done or done in a substandard manner. One more example from this listing is that of a group out of Miami that was involved in a $15 million fraud. In this instance they were providing intravenous immune globulin (IVIG) for HIV patients. Typically, a patient gets this therapy once per month. In this case the clinic was giving the therapy three times per week. Other charges against this group included billing Medicaid for $69,000 for ultrasounds for minors that were never administered. The state of Florida also claimed that the clinic owners then took the Medicaid money and laundered it through a series of phony corporations.

The year 2009 also started off with a bang. On January 15, 2009, the Florida Attorney General announced that his state was taking part in the global settlement with the pharmaceutical company Eli Lilly over illegal

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marketing and unapproved off-label uses of the drug olanzapine (Zyprexa). In monetary terms, this was a $35.6 million fraud recovery for Florida and $738 million nationwide. In February the Attorney General announced four cases. In one case the owners of a drug store in Hialeah, Florida, were arrested for defrauding Medicaid out of $1.6 million by selling diverted drugs that had been paid for by the Medicaid program in New York. Another pharmacy case involved billing Medicaid for $268,000 worth of prescription drugs that were never given to any recipients. In Palm Beach, a physical therapist was arrested for submitting over $100,000 in claims for services never provided. Similarly, a physician in Miami was also arrested for submitting $75,000 worth of claims for undelivered services. A final case in these first 2 months of 2009 involved a scheme whereby two people submitted false claims to Medicaid for services never rendered, but in this case that entice eligible Medicaid recipients to participate by providing legitimate identification numbers and getting a kickback for this cooperation.

Florida is also the epicenter of Medicare fraud activities. For example, on January 8, 2009, a man who owned and operated two Miami area medical clinics pleaded guilty to Medicare fraud of more than $5 million. This person, who several years earlier had been found guilty of defrauding Medicare by his activities in the durable medical equipment business, acknowledged in his guilty plea that his clinics were established for the purpose of defrauding Medicare. To make his scheme work, the clinic owners conspired with a network of other people including physicians, patients, phlebotomists, and a wholesale pharmacy. Together this group billed for HIV services that were either not provided or unnecessary. In another scheme, three other Miami physicians and three other healthcare workers were arrested in February 2009 for providing either unnecessary HIV treatments or billing for services that were not provided to Medicare beneficiaries to the tune of $10 million.

Unfortunately, the scam artists smell money in both the Medicare and Medicaid programs and have found myriad ways to collect money and not provide services. The amount of dollars drained from the health system not only to pay the fraudulent claims but also to police the unlawful behavior of a few "bad apples" is significant but necessary. For example, the state of Florida has 232 full-time equivalent employees specifically devoted to the MFCU.

Finally (almost on cue for the writing of this text), on March 9, 2009, the *Miami Herald* published an article titled, "Lax scrutiny allowed

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Medicare fraud to flourish in Miami-Dade." The article described the activities of 18 durable medical equipment company owners in Miami who, in January 2007, were arrested and closed, only to be allowed to reopen 6 months later (after appeal) and then to be indicted months later for submitting over $10 million in false claims. In the end, the government has not been able to reclaim much of the money and, in some instances of Medicare fraud, the swindlers have fled the reach of American law, typically by heading to Cuba.

HEALTH SYSTEMS AND QUALITY

The standard model for examining quality in health care involves a three-part analysis: structure, process, and outcome. This model assumes that optimal care will be achieved when the proper structure exists. For example, to deliver quality radiology services it is necessary to have the right equipment, staff, and physical facilities. Process examines how that care is delivered. Were appropriate laboratory tests ordered for the likely problems? Were the tests done in a timely fashion? Were the results properly recorded and transmitted to the appropriate people? Were the tests properly done? Last, we have the true issue: outcomes. What were the expected clinical outcomes? Were they attained efficiently and effectively? We are now in a period of heavy government and foundation investigation into the area of outcomes research. This research is leading to clinical protocols and a potential standardization that could have some positive benefits. One issue that will likely be on the board for decades is inequity of care due to socioeconomic status. As one of the following articles indicates, the gap between the poor and wealthy is still with us.

- Quality of care: Perhaps one of the most significant articles on quality of care was a research report published in 2003 in the *New England Journal of Medicine*.[23] The authors of this study of the medical care of 6712 adults found that "participants received 54.9% of recommended care."[24] There was considerable variation, depending on both the mode of care and the condition. For example, if

[23]E.A. McGlynn, et al. The quality of health care delivered to adults in the United States. *New England Journal of Medicine*, 348 (2002), 2635–2645.
[24]Ibid., p. 2641.

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good quality care dictated medication, then 68.6% of the people received that care. However, if good care recommended counseling or education, only 18.3% received that care.[25] The article also reported considerable variations with clinical conditions. If the condition was senility, cataracts, or breast cancer, the patients received the quality of care they should have approximately 75% of the time. On the other hand, many common conditions fell below 50%: diabetes mellitus (45.4%), urinary tract infection (40.7%), dyspepsia and peptic ulcer disease (32.7%), atrial fibrillation (24.7%), hip fracture (22.8%), and alcohol dependence (10.5%).[26] All of this suggests that there is considerable work to be done for both consumers and managers. The managerial responsibility is to ensure that the organization's staff provides the best quality care possible and that the organization has the resources to ensure that that quality is provided. While most organizations have internal quality control protocols such as quality assurance committees, few organizations raise the bar to include the boards in quality discussion. Some years ago, as part of a program I was taking in England on the British health system, I visited one of the London teaching hospitals. In a discussion with a medical professor, I raised the issue of quality review. My frame of reference was the United States' hospital quality review system, consisting of a series of committees such as medical records, tissue, and credentials. The professor answered me by saying they had no need for such committees because of their continual daily oversight of each other. Frankly, I did not buy that answer then and still believe in the adage that foxes cannot guard chicken coops. As this article points out, despite the assumed best intentions of practitioners they do not deliver the best quality care in a significant percentage of the time. Management that sees its role as central to quality can make an impact on this problem.

- The burden of poverty: For those health professionals working with impoverished clients, there is a special challenge associated with the connection between economic status and health. This connection was highlighted in a Massachusetts Department of Public Health study reported on in the *Boston Globe*. It found that

[25]Ibid., p. 2642.
[26]Ibid., p. 2643.

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two of Massachusetts's poorest communities, Lynn and Lowell, were dramatically less healthy than the affluent communities of Newton and Brookline.[27] The primary statistic used in this report was the premature death rate: Newton's was half that of Lynn. This finding is neither atypical nor unexpected. The poor have fewer dollars to spend on health care and generally have less access to that care. The clinical problems, behavioral issues, and other barriers that the less economically fortunate deal with make it imperative that the health system respond to these needs in a more efficient and effective way than it has done to this point. My own experiences with impoverished communities in New York and New Orleans, particularly prison inmates, suggest that we can and must do better![28]

Figuring out what works and what does not is still a central question.

- The pharmacist's role: The health system is certainly not merely about doctors, nurses, and administrators. In fact, billions of dollars are spent on self-medication. Everyone from massage therapists to faith healers and grandparents provide advice on health issues. Pharmacists are major league providers of advice and dispensers of nonprescription remedies and, certainly, prescription drugs. In Hollywood, Florida, a local pharmacy tests for bone density, cholesterol, and hypertension. The pharmacist is well known for his suggestions on everything from snoring to menopause. He typically suggests a range of herbal remedies and usually has quite satisfied customers. With regard to prescription drugs he, like most pharmacists, is available for consultation, but the bulk of the information comes in the labeling. For example, a prescription medication from Walgreens comes with an information sheet that includes the medication, directions for use, ingredient name, common uses of the drug, information on how to use the drug, cautions, and side effects. In New York state, the role of the pharmacist has been taken to a new level. Rather than merely being required to ask a patient whether he or she has questions about a drug, they will now have to meet with every patient about a new prescription. In this counseling

[27]Report underlines burden of poverty. *The Boston Globe* (May 28, 1903), p. B1.
[28]S.B. Goldsmith. *Prison health: Travesty of justice* (New York: Prodist, 1973).

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session they will "talk to every patient about the name, description and purpose of each drug. They will also discuss the dosage, any special precautions, techniques for self monitoring, storage requirements" and a host of other matters.[29] Fortunately for New Yorkers, a practice is now in place that will no doubt increase drug compliance and will likely result in better quality care. As this section illustrates, quality is a complex issue, and one that requires teamwork from all components of the system. The physician can write the prescription and usually give the patient a very short commentary on the medication. The pharmacist, though, is in the best position to offer substantive information and help the patient in using the drug most effectively. It is unfortunate that the pressures on the health system are such that it requires state or federal regulations to get professionals to do what they have trained for.

- Medicaid and quality: On July 7, 2003, *The New York Times* reported on a US General Accounting Office study that found that 11 of 15 states were operating suboptimal quality Medicaid programs with the funding and blessing of the federal government.[30] Quality assurance under the Medicaid program is a state responsibility that operates with federal rules and guidelines. Unfortunately, quality is something that happens at the grassroots level, and no level of inspection can ensure true quality. A quote from Professor Rosenbaum of George Washington University captures the essence of the quality dilemma: "States prepare good plans of care for Medicaid recipients, but there's no follow-through to see if people get the care. States assume that home and community care will save money, without realizing that it takes real money to monitor the quality of care."[31]
- Effectiveness of treatment: One issue related to quality that is being addressed by the Obama administration is that of effectiveness of treatment. A section of the $787 billion economic stimulus bill that was passed in February 2009 provided $700 million to the Agency for Healthcare Research and Quality to study the comparative effectiveness of treatments of disease. The language of the bill states that the

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[29]New rules for N.Y. pharmacists enacted. *Adirondack Daily Enterprise* (July 1, 2003), p. 9.
[30]Report criticizes federal oversight of state Medicaid. *The New York Times* (July 7, 2003), p. C8.
[31]Ibid.

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funding should be used to "conduct, support or synthesize research that compares the clinical outcomes, effectiveness, and appropriateness of items, services and procedures that are used to prevent, diagnose, or treat diseases, disorders, and other health conditions."

FINANCES

In Chapter 1, I provided an overview of health finances from a national perspective. In this section, a summary of articles will examine how money is affecting providers and beneficiaries of care. The inherent dilemma presented in these articles is that money is the fuel oil of the system and must come from somewhere—business or government. It is obviously easier to find the money in a good economy. But in a bad or uncertain economy, costs must be controlled, and healthcare expenditures are not sacred cows.

- Health costs slowing: In a page 1 article, the *Wall Street Journal* provided an analysis that suggested healthcare costs are slowing down because of a shift to generic drugs, increased substitution of outpatient surgery for inpatient (and, by definition, hospital) surgery, and decreased health benefits.[32] The article goes on to raise the most common argument/analysis; that is, if people are responsible for their own healthcare costs through copayments and deductibles, they will be more careful about health expenditures. Perhaps the question to ask is: Why does the *Wall Street Journal* put healthcare finances on its front page? The answer is that health expenditures are a significant part of any organization's budget, and controlling expenditures is a prime function of management. In my CEO days I, too, was faced with the problem of health benefit expenditures. Although I would have loved to provide Lexus-level benefits to each employee, I had to compromise with the budget and provide Ford Escort-level benefits (at least I avoided going to the used Yugo level).

  UPDATE: On March 5, 2009, President Barack Obama articulated the issues facing the nation relative to healthcare costs at the opening of the White House Forum on Health Reform. He stated the following:

[32]Rate of increase for health costs may be slowing. *The Wall Street Journal* (June 11, 2002), p. 1.

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"We're here today to discuss one of the greatest threats not just to the well-being of our families and the prosperity of our businesses, but to the very foundation of our economy—and that's the exploding costs of health care in America today. In the last eight years premiums have grown fours times faster than wages. An additional 9 million Americans have joined the ranks of the uninsured. The cost of health care now causes a bankruptcy in America every 30 seconds . . . . Medicare costs are consuming our federal budget . . . . Medicaid is overwhelming our state budgets." The President then went on to say that the biggest threat to the economy of the country was the "skyrocketing cost of health care."[33]

- Hospitals in deep trouble: The first few years of the 21st century have not been kind to many large healthcare providers. For example, in the nursing home industry, five of the eight largest nursing home companies have filed for bankruptcy. HealthSouth, a large chain of rehabilitation hospitals, with various fiscal and regulatory problems, was another company heading toward bankruptcy in 2003.[34] The stain from these bankruptcies has spread throughout the health industry, eroding public confidence in investing in this sector of the economy, which further weakens the industry. Hospitals also have not fared well in this economy. The problems in Massachusetts were presented in an article reporting that many hospitals were in deepening financial straits because of both lower patient volume and poorer insurance coverage for treated patients.[35] One aspect of the problems for many hospitals nationwide is the fiscal problems that the states are facing. Inevitably, state budget cutters look to Medicaid payments to balance their accounts, and that balancing often takes a toll on nursing homes, hospitals, and clinical providers of care. Another aspect is simply that of disease. As the article stated, a hospital in the resort area of Cape Cod saw a decline in its revenues because of a mild flu season.[36] In a related piece, the *Boston Globe* reported that Waltham Hospital, after serving that community

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[33]Retrieved (n.d.) from http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-at-the-Opening-of-the-White-House-Forum-on-Health-Reform/.
[34]HealthSouth bankruptcy could come this summer. *The New York Times* (April 30, 2003), p. C2.
[35]Weakening bottom lines worry hospitals. *The Boston Globe* (May 14, 2003), p. C1.
[36]Ibid., p. C6.

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for 117 years, was expected to close.[37] Unfortunately, a few months later, the hospital did close, and developers were in the process of using the land for housing and perhaps some type of medical office building and surgicenter. Although Waltham Hospital is one of hundreds of hospitals that have closed throughout the country, others have survived by downsizing or merging. Sometimes it takes years before a community knows what will happen to a closed institution. For example, in Miami Beach, St. Francis Hospital stood essentially vacant for years as discussions continued about turning the building into a geriatric facility, a medical office building, housing, and so forth. Eventually, close to a decade later, the hospital was razed to make way for an upscale housing development. In New York City, Mount Sinai Hospital was reported to be having its share of financial problems, with a 2002 deficit of $72.5 million.[38] By contrast, in 1997, the hospital had a profit of $30 million. A consultant's analysis of the problems at Mount Sinai found "flawed billing systems cost Mount Sinai tens of millions of dollars, even as it pursued ambitious expansion and building plans and paid its top executives salaries, detailed in tax records, that many experts say were unusually high for a struggling nonprofit institution."[39] Everything was complicated for Mount Sinai because of its relationship to its medical school and a merger with New York University's Medical Center. Finally, what is perhaps most disheartening about the Mount Sinai saga is that it was managed by some of the most talented executives in the country and had a board comprising many people who are considered the senior financial "geniuses" of New York City.

UPDATE: The second decade of the 21st century is certainly not a promising time for many hospitals. Indeed, if you Google the term "Hospital Bankruptcies" you get 467,000 hits. Among hospitals that have recently sought Chapter 11 protection are two in Hawaii, the Michael Reese Hospital in Chicago, and the Pontiac, Michigan–based North Oakland Medical Center. With debt mounting nationally and the possibility of more Medicare and Medicaid cuts plus a rapidly

[37]Waltham Hospital to be closed. *The Boston Globe* (May 14, 2003), p. C6.
[38]How a venerable hospital helped undermine its own fiscal health. *The New York Times* (April 2, 2003), p. A19.
[39]Ibid.

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growing number of uninsured individuals, it is anticipated the bankruptcy courts will be visited by more hospitals in the future.

- Hospital desperation in troubled times: Calling an airline or hotel for a rate is a challenging experience. With the airlines, it's the 21-day advance, 14-day advance, 7-day advance, 3-day advance, restrictions, no restrictions, and so forth. At the hotel, it's the rack rate, then the discounts: AAA, AARP, corporate, government, frequent hotel user, and so forth. With hospitals we also have a discount structure, with bulk purchasers, usually HMOs, getting the best price. The fiscal problems facing hospitals has caused them to charge the uninsured a full price with no discount and then to aggressively pursue collecting those charges. This practice has come under increased public and governmental scrutiny and resulted in the hospital trade association, the American Hospital Association, urging its members to review their practices and "stop using harsh bill-collection tactics that reflect poorly on the industry."[40] Unfortunately, some of those who bear the greatest burden of the financial woes in the industry are employees who see their health benefits being constantly eroded. This area will be examined next.
- Employee health benefits and health costs: Health benefits are often an area of major payroll expenditures for any business. It is frequently said that the automobile's manufacturing costs include more expenses for health benefits than for steel. This concept has industry reexamining the entirety of the health benefits and puts health benefits on center stage for any negotiations. At General Electric, the union declared victory when it was able to maintain the employee's contribution to health insurance at 18% for the first year of the contract rather than the 30% desired by management.[41] With estimated costs of $6500 per employee, the difference is a contribution of $1170 per year versus $1950 per year. For the company, not getting its way involves a $13 million bottom-line expenditure that it had hoped to transfer to employees. A different

[40]Hospitals urged to end harsh tactics for billing uninsured. *The Wall Street Journal* (July 7, 2003), p. A9.
[41]G.E. union cites deal to curb workers' share of health costs. *The New York Times* (June 18, 2003), p. A16.

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strategy employed by industry is to promote healthy employees. One group of employers announced that they would fight obesity because, as the medical director of Ford Motor Corporation noted, it takes "an amazingly large portion of the $3 billion" that the company spends on health care.[42] National estimates by the director of healthcare management at Ford are that employers are spending $13 billion annually on weight-related problems, including disease and lost productivity.[43] Another strategy used by industry is the limitation or elimination of health benefits for retirees or disabled employees. In Massachusetts, NStar, the energy public utility, cut back on health benefits to retirees as a strategy to eliminate some of its $20 million increase in its healthcare expenses.[44] In another Massachusetts situation, a lead article in the *Wall Street Journal* focused on the Polaroid Corporation's decision to fire employees who were on disability and thus save the costs of providing them health care.[45] What was perhaps most shocking about the article is that more than 50% of 723 large companies surveyed would fire an employee after some period on disability; indeed, 27% dismiss them immediately after they go on disability.[46]

UPDATE: In the troubled economic times of the second decade of the 21st century, employee health benefits have become fair game for cutbacks. These cutbacks could come in the form of lesser coverages, more deductibles, or, as in the case of postal workers, higher employee contributions. In 2009, The United Auto Workers made significant concessions to Ford when it agreed to an all-inclusive hourly rate of $55, which also reduced the Ford contributions to health benefits for retirees. For providers, such reductions may mean decreased usage and more uncollectible accounts receivable. Finally, in May, 2009, another chapter opened with the Chapter 11 filing by Chrysler Motors and the major control of Chrysler that will now

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[42]Employers plan obesity fight citing $12 billion-a-year cost. *The New York Times* (June 18, 2003), p. C2.

[43]Ibid.

[44]Healthcare for life, with exclusions. *The Boston Globe* (June 27, 2003), p. C1.

[45]To save on health-care costs, firms fire disabled workers. *The Wall Street Journal* (July 14, 2003), p. 1.

[46]Ibid.

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> be exerted by its majority shareholder, the United Auto Workers. For those of us in health care, I think the old quotation that is often considered both a blessing and a curse is applicable: "May you live in interesting times."

In this chapter, as well as in Chapter 1, I have provided both a data-driven and a human-focused overview of the health system and its issues. It is now time to narrow the focus of this book on management and the health industry by examining in the next two chapters a managerial view of the healthcare industry and the beginning of all managerial efforts; that is, setting objectives for what we do.

Case Study 2-1

SMOKING!

Dr. Sheila Atkins, the health officer of the City of Louisburg, is in the process of proposing a citywide ordinance that would totally ban smoking in all public spaces such as restaurants, hotel and hospital lobbies, trains, trolleys and buses, supermarkets, and any other establishment that employed more than three staff. Louisburg is a city of 100,000 people and is located in a state that has vehemently opposed smoking bans. If this ordinance was to be enacted, it would be the first in the state. A public hearing on the ordinance is being planned for the beginning of the following month.

Ever since her appointment as health officer, Dr. Atkins has worked assiduously to educate and legislate on a wide variety of health issues such as obesity, diabetes, and drunk driving. The few times she has proposed health-related laws, they have been greeted with indifference and not enacted. While recognizing that a ban on smoking may be quite unpopular amongst the citizens of Louisburg, Dr. Atkins is firm in her belief that such a ban will be in the best interests of the Louisburg residents. Indeed, her view on this matter was reinforced by a study from the Harvard School of

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Case Study 2-1

Public Health and the Massachusetts Department of Public Health released that found that 600 fewer people in the state had fatal heart attacks and they traced the decrease in fatalities directly to a statewide ban on smoking.

Assignment: Dr. Atkins is responsible for organizing the public hearing in front of the city council on her proposed ordinance. What suggestions do you have in terms of speakers who could strengthen her position as well as what opposition should she expect?

Case Study 2-2

HOSPITAL-ACQUIRED INFECTION

On a snowy winter afternoon, State Senator Millicent White was crossing the street in front of the State Capitol when she was hit by a speeding taxicab. By-passers and Capitol police rushed to her side to offer aid and support. Within five 5 minutes of the accident, EMS personnel arrived and followed their standard protocol for trauma victims, which included a check for lacerations, abrasions, fluid (including blood) loss, pain, and shock. Senator White was breathing easily but having pain in her neck and back. Following a neurological assessment that found her awake and responsive, they immobilized her with a rigid cervical collar and placed her on a long backboard. Next they started a normal saline IV and transported her to the university hospital emergency room where, upon further examination, it was determined that she had sustained a fractured hip, a broken leg, and a fractured wrist. Surgery

(*continues*)

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Case Study 2-2

followed. Prior to the surgery she was catheterized and, within a day of the surgery, she developed a urinary tract infection that required her to extend her hospital stay for several days.

During her recovery and rehabilitation, it came to her attention that her infection was likely the result of a hospital-acquired infection. In fact, although she was not medically trained, she recalled that it appeared to her that the nurses were handling the catheter in a somewhat sloppy way such as allowing it to sit on unsterile tray.

Senator White has decided to hold public hearings on hospital-acquired infections, which she claims generates unnecessary deaths, hospital days, and costs to the health system of the state.

Assignment: Assume that you have been asked to make a presentation at Senator White's public hearing on the subject of hospital-acquired infections. (By way of background please review the Pennsylvania Health Care Cost Containment Council's report on hospital acquired infections. This is available on the Internet as: www.phc4.org/reports/hai/06/.)

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