Stuart Altman Discusses the Future of Hospitals – Hospitals In Focus Transcript

Chip Kahn: [00:10] Thanks for joining us for Hospitals In Focus. I'm your host, Chip Kahn. Today we continue our conversation with one of the foremost experts on health policy, Stuart Altman. In this episode we will examine the future of hospitals and the services they provide in a rapidly changing world.

Looking into the future, Stuart, we see there is variation between markets. One city is not the same as the other, but in terms of the big, funding mechanisms, Medicare, Medicaid, there's commonality across the country in terms of the stresses on those hospitals and physicians trying to deliver care. This movement from inpatient to outpatient we've been talking about, on the one hand hospitals have been very committed to it and made their positioning in markets with it, but still it's not the same in terms of the total financing of the hospital. We also have over time, and from our perspective here at the Federation, government policy that's reduced the growth in Medicare payment and Medicaid payment.

The stresses on the hospital are very great and the question is, "Into the future, how are we going to make this work?" I'll just give one anecdote. With those on the regulatory side, or from insurers, the payers and purchases of healthcare, they can look at a particular procedure, let's say a knee replacement and argue, "Gee, I can get it done in a hospital and it's going to cost X, or I can get it done at the surgery center across the street and it's going to cost Y." And make an argument that, "Well, maybe the hospital's too expensive for that," and a lot of... There are a lot of pressures from that.

At the same time, just to sort of sink it to an anecdote, a few weeks ago a friend of mine was very, very ill and I was worried about him and I finally said, "We're going to the hospital." We went to the hospital. When I was standing over him, his blood pressure was 197 over 80. He was a sick guy. Fortunately, he only spent about a week and a half in the hospital and he was provided really wonderful care, and he's at home now and he's recovering. But, for some people, you've got to have that inpatient service when someone's really critically ill. Yet, the way this all works with this changing environment, and particularly concerns about the cost of things, how are we going to keep the hospital going as an enterprise?

Stuart Altman: [02:57] Well, okay, forgive me, since I do have various roles, and one of my roles, as you pointed out is the chairman of the Health Policy Commission in Massachusetts. And I've also served, as you pointed out, responsible to help support how the payment system runs for Medicare. I will try to be as neutral as I can, but I need to put this into some perspective, because whether you like what I'm saying or not, this is what I think is going to happen. And that is... The good news that we've been talking about is that the funding mechanisms in

America, the support, the changing structure of American hospitals and its changing mission have also been the most open ended funding mechanism the world has ever seen.

Every other country lives with a much more constrained flow of dollars than we do. It isn't like people are dying in the streets and it isn't like their hospitals are terrible, but those hospitals and healthcare systems have had to function in a much more constrained financial environment, which we have not function.

Well, I'm sorry to tell you for reasons I'm going to explain, this is coming to an end in America and we, you, your organization, us, are going to have to figure out a way to continue to provide high quality care not with less, but with a slower rate of growth. And the reason is very simple, but not simple.

Increasingly, 50% to 70% of the patients in an American hospital are being supported by government insurance, Medicare and Medicaid. This is happening regardless if of the Affordable Care Act. The aging of our population, the Baby Boomers reaching 65 few years ago. The fact that we have an increasing percentage of our population that requires Medicaid, because they can afford private insurance.

As we move out into the future, what we are seeing today, which I never thought we would see, is a growing gap between what private insurance pays for the same services that government pays. In many hospitals, if not most hospitals, the gap between private payments for the same type of service and what government pays is a 100%. It's one thing when 30% of the patients are government and 70% are private.

If government restrictions payments, because after all, government has to depend upon tax moneys, and as you have seen, we are not very willing to allow our taxes to go up to support these organizations. So government by necessity are being forced to constrain what they pay.

As the percentage that's government increases and the percentage that is private decreases to 50/50, if not 60/70% government, the ability of having the private sector supplement the amount of money is deteriorating. There is almost no predicting growth in the private insurance market over the next 20 years. All of the growth in the population and disproportionally the patients is going to be government, and there is no way that you can expect government to continue to pay the rates that the private sector is paying.

We have no choice. The amount of money that is going to flow into the healthcare sector, not only hospitals, the growth rate is declining already.

Between 2000 it grew... If you take every five year segment from 2000 to 2005, the amount of money flowing into the hospitals is almost... The healthcare was almost 50%. It was cut in half between 2005 and 2010 down to 25%, and now it's like 22% and the estimates are it will be like 20%, 15%.

The dilemma and the activity that we're going to have, the healthcare system is going to have to deal with is how to continue to provide high quality care and access to good care without the growth in the resources that they've seen over the last 50 years. That is going to be the challenge. We are going to figure out a way to do things for the less, whether it's done in the hospital or in some other place. So that we will pay for the other side, because on the other side there is this some amazing technology and drugs coming online, which are very expensive. Plus the idea that as we get older, we need more human services. Not only in the hospital, but in the post-acute world.

We have no choice and I'm going to hold you personally responsible, Chip, for figuring out a way to make sure that I get good healthcare.

Chip Kahn: [08:18] Well, I'm getting up there myself at Medicare age, so I have the same concern. Yeah, and I think this issue of the high cost of new therapies is really a troublesome one. The [CAR-T 00:08:32] cancer therapies, which are really precision therapies for particular people's DNA, is coming online now and many of these therapies can only help a few thousand people now, but will have broader implications very soon. These therapies, both include hospitalizations and MRIs and other kinds of tests and diagnostics as well as treatment, it's very expensive. So we do have the crossing of advances in science and the availability of funds that's probably different than over the last 40 or 50 years when the money was usually there when it was needed to provide the basis for the foundation for the advances.

Stuart Altman: [09:23] Absolutely. I think... You're absolutely right, so we have no choice. The more normal stuff, the knees and the hips and stuff like that is just the beginning. We have to figure out a way to do these things for the less, so that we have wherewithal to do the kind of things you're talking about, cancer and related, which is a big thing.

Look at the amazing progress we've made with heart. My father died 20 years ago for a condition that I have as well and was because of the new technology and the new drugs and the new techniques that I was able to have the open heart surgery and be out of the hospital in five days.

Yeah, it isn't like we don't need the hospital of the future, but I think the reality is that the flow of dollars... I'm not saying that it's going to actual decline, but

the growth is going to decline. And so, yeah, we got some real challenges facing this industry going forward.

Chip Kahn: [10:30] Let's follow up this question of balancing, because, particularly, as I said, much of healthcare is local, and you've been spending a lot of your time recently focusing on Massachusetts, the Boston, particularly in your job at the Commission. Looking forward, and obviously in terms of Boston, you have a place with the ultimate in high tech.

Stuart Altman: [10:58] Yeah, sure

Chip Kahn: [10:58]Medicine and these great facilities.

Stuart Altman: [10:59Yeah.

Chip Kahn: [10:59}How do you see us contending with this balancing act of keeping what we need, whether it's in terms of assuring my friend that had the really critical illness being cared for and then these new technologies that can help those with cancer and other illnesses. How are we going to make that all work to make that institution stay around?

Stuart Altman: [11:22] Well, you... You see, you sort of articulated the issue, the problems that I face, so let's... As you know, Chip, I was a fed, I was Washington guy. I didn't even know we had states. We worried about... We were Washington, we worried about what Medicare did, we worried about government policies. But over the last 10 years it is true that I have increasingly focused a lot of my energies on what's going on in Massachusetts and I've also studied what's going on in other parts of the country, in Maryland, in California, and I give a lot of talks around the country in smaller communities.

While I don't think it's fair to say that healthcare is local totally, there are a lot of aspects of healthcare that is local, even though we have these big national programs like Medicare that tries to have a more similar payment structure. But even Medicare itself has significant differences by region and area, so let's understand this.

Here's Massachusetts, and we are, no question about it, we are in many respects the leader of high tech medicine in America. Which made us the most expensive state in the United State, which made us the most expensive place on the planet for healthcare. But increasingly, the state of Massachusetts and the people that pay the bills said we can't afford to continue to grow at the rate we're growing. We want to maintain the quality of care that we provide. We

want to continue to be the leader of healthcare. We have a phenomenally biotech industry that feeds so much and stuff like that. But we want to...

What the state of Massachusetts did, and so far it's working, is that in 2012 it said, "We want the state total healthcare spending to grow by no more than the growth in the state income," which used to be around three six, 3.6%, and now we've actually cut it back to 3.1. This is total spending, this is not just government, this is private, this is out of pocket and so on. But we want to do it without destroying or even hurting the high tech side. Now, how are we trying to do it?

One of the issues that we face, and I think in different forms it's happening all over the country, is that too larger a percentage of the patients were winding up in our most expensive facilities. Services that could be provided decently in community hospitals, in outpatient departments that were not totally linked into the high tech hospitals.

What we are trying to do with some success, but limited success, is to prevent the total elimination of the community base, so we talk about local. Now, in a local is local. You come to Boston and you could... We had so much of these academic [inaudible 00:14:29] in downtown Boston, and people were traveling not only half hour, or 45, two hours for fairly routine care. Babies were being born rather than in the community hospital going in. Children who had fairly minor conditions were coming in to children's... We have these wonderful institutions, and I think it bears fruit of what you were saying.

We have to figure out where to do things. When a patient is sick like your friend and like I was, yes, you need to be in a high tech, the state-of-the-art institutions. But where it is fairly routine, you have pneumonia, you have a normal gallbladder operation, you don't need to be in those high tech places. You shouldn't have to pay those kind of rates. And therefore we are to make sure that the highly expensive institutions do not disproportionally grow relative to the others. Yes, we should be doing more telemedicine and we should see restructuring of care outside of the tradition. In doing that, we can save money and make sure that some of that money gets reinvested in the high tech places. And if we don't do that, what's going to happen is the whole place is going to melt.

You know what? And as I said, I think it's working slowly. We are beginning to reinvest in our community hospital. We haven't done enough and we're involved in a big discussion about how to pay for care outside the big academic centers and who should pay for what. I don't want to give you the impression that we've solved all these problems, but I think we have a much better picture

of what's going on and we also have some of the mechanisms to do it. But we're trying to do it in a non-regulatory way. We don't have price controls in Massachusetts, but we have this benchmark which says, "We don't want any sector to just grow out of proportion to the other." And then my commission, what we do is monitor that and when we see one sector growing disproportionally, it's not that we say, "You can't do it," we call them in and say, "What's going on? Can't you do it a different way? Can't we do that?"

We have grown... While we were, not only the most expensive state, but we were growing faster than any other state five years ago. Now we're the fourth slowest growing state. Again, it's a balancing act. I don't want to see Massachusetts deteriorate from being number one, but I do want, and I'm being asked to make sure that in staying one we do it within the financial capacity of the state to support it.

By the way, I think this needs to be done at the state level and it needs to be done by other states, and we're getting very much interested. We've had the state of Delaware come to us, and I went down to Delaware and worked with them. State of Connecticut has changed, California, the state of Washington. It is... Other states are beginning to realize, as you pointed out in the beginning, that they have special responsibility. The state of Maryland is one of the oldest, if not the oldest states that are trying to balance how much they spend on hospital and total care.

A lot can be done at the state and local level, and maybe, maybe that's the right place. So each state can deal with its delivery system given... Not every state looks like Massachusetts. Many of them don't have the academic medical centers, so they have a much reacher community hospital. Not only that, even the practice of medicine, while it is a science, there were big differences in how we use care in different part of the United States, which is a good thing. But then each state and area needs to deal with its own set of issues. But we also need the Federal Government to play a role. This cannot be done totally by the states. What Medicare does and what it doesn't do is very important.

Chip Kahn: [18:47] I think one of the points you made, and maybe this is a good way to conclude our discussion, is back in the 80s, I can't remember, I think that was the period, you said there was a point where there was some question, "Would this institution of the hospital survive?" And you described how those leaders of the hospital industry figured out their role in the context of the financing and the science and the whole foundations of a healthcare.

I think what you're now giving us is a way to look towards the future, but we have to admit that if there's anything essential for a community, it's having that

hospital, having that emergency room, having that care available that people expect at the level they expect. But the overall environment, the overall provision and how care's delivered is going to change and evolve, but the hospital is proven itself to be essential and a pretty tough institution in terms of figuring its way through the way it serves its patients and being a resource for patients.

Stuart Altman: [19:56] No, I think you hit it right. I am getting a little older and in more need of healthcare than I used to be, but I have faith that the leaders of the healthcare will figure it out. But it's going to be tricky. I don't want to minimize the issues. It's much easier to innovate and in an environment of ample resources than to do it in an area with constrained resources. But unfortunately, I think the environment that we're going to face over the next many years is going to be much more constrained resources. As you pointed out, on one side are constrained resources, on the other side very expensive technologies that are coming online. But I got faith in you and the industry that'll make it work.

Chip Kahn: [20:49} Thank you Stuart. Thank you for giving us your time this afternoon.

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