Paul H. O'Neill

Invited Testimony

United States Senate
Committee on Finance

The Honorable Charles E. Grassley, Chairman

March 8, 2006

Mr. Chairman and Members of the Committee:

It is an honor to be asked to testify before this distinguished body on an issue of such vital interest to the future of our Republic. American health care policy is in desperate need of reframing and rethinking based on a return to first principles. This committee sits at the intersection of policy issues that must be acted on together in order to produce a coherent and workable framework for a better future for Americans and America. Fundamental tax reform, financial security for retirees and access to medical care for all Americans are not separate subjects. In the absence of coordinated policy and legislative action by this Committee, there is no hope.

There are three primary imperatives.

First, stop tinkering at the margins of a variety of ill-defined problems with tax policy. Refocus finance policy simply and powerfully on the biological human need at the core of all of this: ensuring that every American has access to health care services, equitably and efficiently. To do so, I would pass a law mandating every American to purchase a base level of health care coverage. Those that have a certain level of income and wealth must not only carry coverage, but through a simplified, fundamentally reformed tax system, provide financial support to help those who don't have the means to fully finance their own coverage. This step would pierce several myths that serve to obscure our path forward in healthcare finance. These include the notion that the government creates social benefits from some magic pot of money that it doesn't first take from the people. A second paralyzing myth is that employers provide health care benefits, rather than the reality that they take dollars that would otherwise be available for compensation and act as a rather inefficient and increasingly spotty pass-through for insurance benefits. If we enacted my approach, the resources to pay for health care stay attached to the people who generate them, insurance assumes its proper role as a spreader of the financial risk associated with uneven distribution of illness and incidents, and society can succeed in ensuring equal access to health care services for every American, which is the entire point. (To make this work, the insurance market must again be required to perform its

social purpose – spreading the financial risk that is associated with the uneven distribution of illness and injuries, rather than remain the risk-avoidance industry that policymakers have allowed it to become.)

My second set of recommendations flow from the truth that achieving full access to health care for everyone in society is in part a function of how much health care costs. Unless we get more value from each dollar we invest, we are unlikely to achieve access for every American. On this front, the evidence is increasingly clear that if health care providers performed at the theoretical limit of organizational performance, we could reduce the costs of care by 30%-50%, while substantially improving outcomes. Yet, the federal government has only tip-toed toward the ideas and approaches to capture value on this scale that have been demonstrated in every field of human endeavor. I am proud to say that we had success of this scale during my time as CEO of Alcoa, and that I have been part of early demonstrations that this is possible in health care. To achieve those 30%-50% gains across the country, this body should ensure that health care performance goals are set that are worthy of this nation, and that the conditions of transparency and accountability necessary for rapid learning and improvement are fully in place for the quality of care, for the cost of care, and for learning from "things gone wrong" (safety).

I'll provide details on these conditions later in my testimony. But let me highlight one recommendation to jump-start the nation. I would immediately fund a study of five outstanding American hospitals that systematically details how all of their operations are performing when measured against perfection, and indicates the process problems that create the gaps between the current performance of any particular process and the ideal. Since 1999, when the Institute of Medicine pierced our national complacency regarding the safety and performance problems that afflict our hospitals, the industry and policymakers alike have seemed paralyzed about what to do to close the gap. The type of "Total Value Opportunity Study" I describe is a tool used often in private enterprise to map how to actually gain safety, quality and cost improvements of the scale we need, and I believe it could provide the missing "connective tissue" for health care.

My third imperative is to embrace the connections between solving this problem and solving the other social dilemmas that rest squarely in the lap of this Committee. For example, I have advocated a "return to first principles" approach to solving the Social Security shortfall, in the *Los Angeles Times*, and in numerous speeches and interviews. Here is the basic premise. If we invested $23,000 on the day each American child was born and allowed the magic of compounding to do its work, when that child turned 65 years old they would have an annuity in excess of $1,000,000 to support their life needs. This assumes a very conservative 6% annual rate of return. The level of income such an annuity would throw off (in excess of $80,000 per year) would give real meaning to the idea of financial security for every American retiree by providing completely for all of their needs, including health care, food, clothing, shelter and transportation.

In short, if this body commits to stop trafficking in fictions with the American people, and commits to anchor finance policies to the most economically efficient ways to produce value, you have a chance to transform the vast and certain human pain associated

with our present social dilemmas into American success stories that will be recognized for generations.

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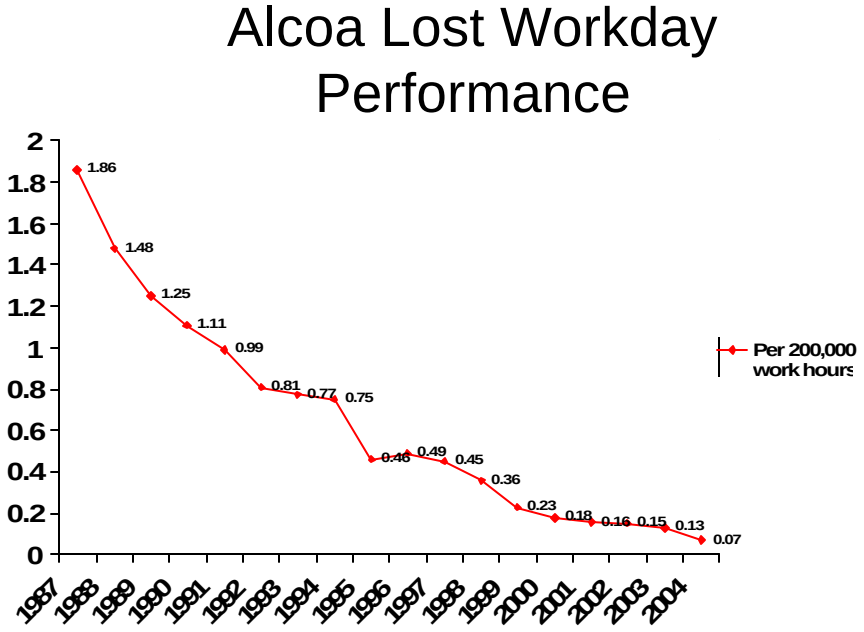
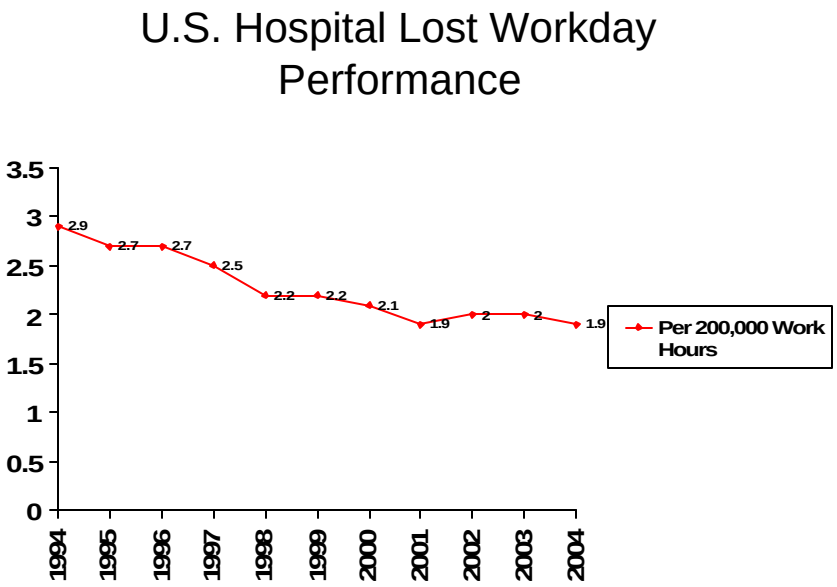
Before elaborating on the conditions necessary to capture the 30%-50% value that is presently being lost in health care activities, let me provide some background on my standing to address the topic.

Many of you know that my involvement and interest in health and medical care spans more than four decades. Early in my career, at the Veterans Administration, I created some of the first systems analysis models to help optimize the health care that our veterans received. At the President's Office of the Budget, I helped create an analytic system for considering what investments could give the federal government the most return for its dollar in actually improving health care outcomes. I was also responsible, with some of you and your predecessors, for implementing a few of the major health care programs that have done so much good for the American people, but have also had such significant unforeseen consequences.

After leaving the Ford Administration, I set out to test in the private sector the ideas that I believed could lead to the creation of great value across any dimension of human activity – great social value, great human value, and great economic value. In my second assignment, as CEO of Alcoa, I got the chance to put my ideas fully into practice. I committed myself and the company to the notion that we could become the best at everything we did by committing ourselves to becoming the first injury-free workplace in the world. Much like this Committee may be doing at this moment, Wall Street scratched its head for years at the notion that human values, safety performance and financial success could somehow be connected. Yet, as we progressed toward our goal of complete safety, we gained the human bonds and the deep skills at understanding and improving our processes that every one of our people applied to transform us from a threatened company in 1987 to an increase of 800% in market value by 2000, an increase that was sustained through the bursting of the economic bubble. We did become the safest company to work for in the world, despite the presence of tremendous hazards in the workplace, and the fact that we were more than 120,000 people working in more than 30 countries, many with terrible health and safety records. Today, Alcoa's lost workday rate is more than twenty-seven times smaller than the average American healthcare institution. What I understood – and Wall Street didn't – is that it is people that produce value in any enterprise, and that people will respond to a set of values and proven ideas and principles to produce unbelievable increases in performance.





As Alcoa flourished, I felt that I had proven my hypothesis regarding what ideas would create true social value across very complex enterprises, in any discipline. The sector in our society that was obviously crying out for rapid improvement was health care. Accordingly, in 1998 I joined other leaders in Pittsburgh to create the Pittsburgh Regional Healthcare Initiative, one of the most ambitious efforts to radically improve the performance of the health care system in the United States. We set out to eliminate healthcare-acquired infections and medication errors within three years. What we did

achieve was notable – a more than 65% drop in central-line associated blood stream infections, widespread sharing of information on medication errors, and stronger community learning systems in heart surgery, among other areas.

But while many in Pittsburgh were satisfied with this rate of improvement, including our largest hospital system and academic medical center, I was not, because they were not comprehensive or embedded as new ways to think and work in the DNA of the organizations. I believe we need three to five health care institutions where the leaders are determined to use the ideas of systems analysis in every aspect of their enterprises to act as model sites for the rest of the nation to learn what it will really take to solve our health care crisis on a sustainable basis. Accordingly, a year ago I and a few associates founded a small enterprise named Value Capture to partner with just a few health care CEOs around the country to help them achieve these results. We are working with Richard Salluzzo, MD, CEO of the Wellmont Health System in Eastern Tennessee, and Cliff Orme, the CEO of LifeCare Hospitals of Pittsburgh, and considering engagements with several others. In working with these determined leaders, we have yet to observe a process that could not be improved by a minimum of 50%.

Having provided this background, here are more detailed recommendations for my second imperative: how the federal government can create the conditions necessary to capture 30%-50% better return on our investments in health care through the applications of systems principles to health care operations.

1. Set national performance goals at the limit of what is theoretically possible, focusing on safety and quality, and pursue them with vigor.

Unfortunately, the federal government rarely sets performance targets at all, let alone setting them at the theoretical limit of human attainment. The result of not insisting on the elimination of fundamental problems with the performance of the healthcare system is more of the same, or worse. For example, there are clear reasons that the appalling healthcare-acquired infection rate – affecting approximately 1 in 12 people admitted to the hospital -- has been steady or increasing for decades. The only common database that comes close to a shared learning system for these infections has been the Centers for Disease Control's NNIS system, which due to lack of mandate and budget constraints has covered less than one-tenth of the nation's hospitals. Within that database, infection types constituting more than 50% of the total number of infections that occur in hospitals are not counted at all. Unsound "cost benefit" reasoning is used to justify this exclusion. This is a sorry state of affairs. Yet, if the federal government were to say that we are determined as a nation to eliminate healthcare-associated infections within five years, and make sure each leader in the system, from the head of Medicare to each hospital CEO, were held accountable for establishing the urgent and comprehensive learning systems necessary to make rapid progress, the glaring inadequacies of our present efforts and thought processes would be quickly surfaced and flushed out of the system. I'd like to stress the importance of carefully structured accountability. National goals that are just slogans are useless, even dangerous.

I strongly recommend focusing national performance goals on safety and quality measures, despite the fact that driving out waste to make healthcare access affordable is an integral objective. Health care organizations to date have reacted to cost pressures by driving themselves by goals unrelated to the quality of their care. Measures derived from perverse financial incentives, such as "average length of stay," dominate the industry. These goals are not rooted in human biology and healing, the very point of the healthcare system. Accordingly, focusing on them threatens to destroy value rather than create it, by creating incentives for behaviors unassociated or disassociated from healing. In addition, the healthcare workforce is much less motivated by cost savings than they are by improving care for patients, and by their own safety. This reflects the truth we demonstrated at Alcoa; give people goals that they find motivating, and they will apply the skills they learn in pursuit of them to every aspect of their work lives, including the financial aspects of the enterprise.

I also strongly urge you to set our nation's goals at perfection.

Most organizations make the mistake of establishing arbitrary benchmarks to define success. It is particularly glaring that benchmarking accepts a certain level of error or poor quality as "normal" when it comes to basic safety for patients in our health care system. If our goal would be to have "just" 4% of patients contract an infection while they're in the hospital to be cured, who among us will volunteer to be among the 4%? First in Pittsburgh, and now with a few health systems around the country, we're aiming at the "theoretical limit" of perfection, healthcare systems with zero hospital-acquired infections, zero medication errors, and the world's best patient outcomes in clinical areas like cardiac surgery, diabetes, depression, and obstetrics. We think those goals defuse defensiveness and blame, and keep people pushing forward. The question isn't whether we are "good" or "bad." It is, "What's the next step toward perfect?" It also drives one toward thinking, "How could we be sure this is done right every time?"

Finally, one reason most organizations don't set perfection as the goal (and so don't try to reach it), is that they believe that it costs too much to address the last few percentage points of error. This doctrine is enshrined by economists as the "law of diminishing returns" and also afflicts notions of federal spending priorities. Unfortunately, it's untrue and dangerous. The best organizations understand that excellence comes from getting really good at making improvements and solving problems "on the shop floor." They know that as they get toward zero defects, their progress tends to accelerate because they have built the capability and support systems for their staffs to excel.

Is progress on this scale possible in health care? Yes. Our associate Rick Shannon, MD, Chief of Medicine at one of Pittsburgh's largest academic medical centers, Allegheny General Hospital, has created a profound case study. Under his leadership, the ICUs he controls used systems principles to reduce one type of infection rate by 95%. How long did it take? Less than 90 days. How long has it been sustained? For more than two-and-a-half years. The approach has now spread to the hospital's other ICUs, and several other infection types. The financial impact on the hospital has been profound. To date, the efforts have saved the institution more than $2 million. We see similar gains being

realized across a number of systems problems with our current partners at LifeCare and Wellmont Health System in Tennessee. And Pittsburgh has shown that even with basic levels of cooperation and learning, infection rates will quickly fall by more than 60%.

The elimination of these problems is possible everywhere. But it won't happen everywhere until this government, led by this Committee, insists on it.

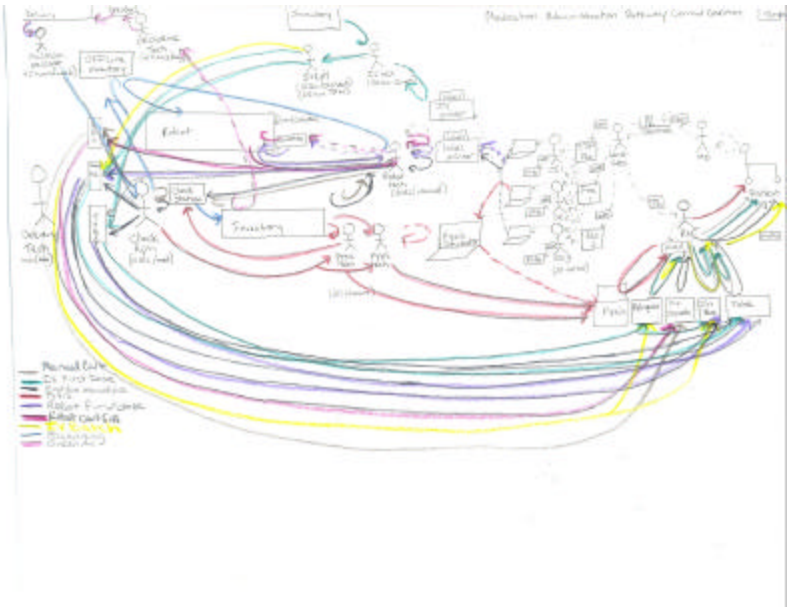
Once safety and quality goals are set, transparent reporting on progress down to the level of specific institutions is a useful accelerant. The early efforts of CMS to publicize health system performance across a few measures should be radically expanded. A few farsighted institutions are far ahead of the pack on recognizing that comprehensive disclosure of performance is helpful to the fulfillment of their mission. I would urge you to examine the safety and quality reporting of the Norton Health Care System in Kentucky at www.nortonhealthcare.com for an example.

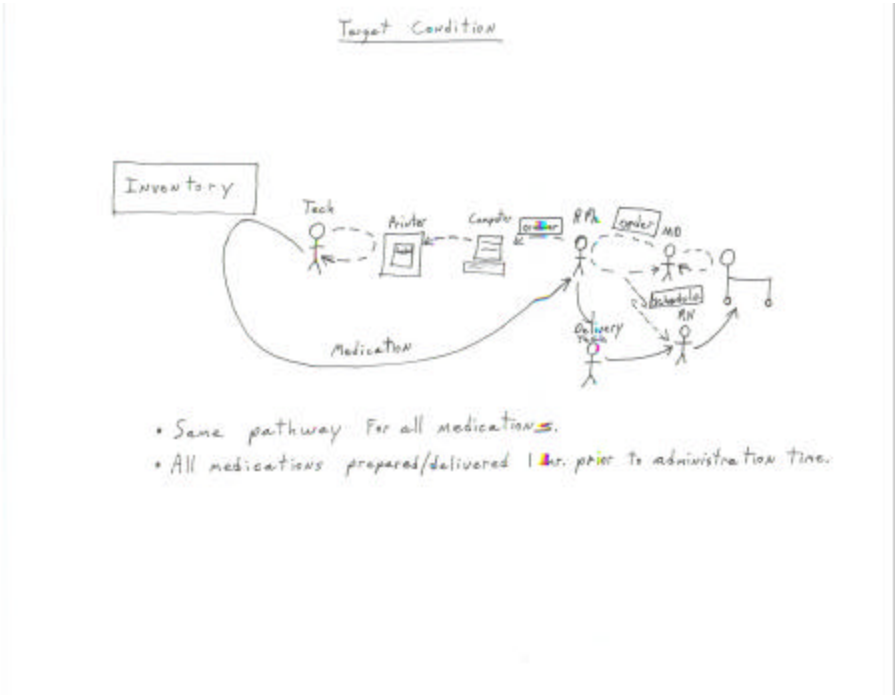
2. Commission a national Total Value Opportunity Study

I specified in the introduction to my testimony that a "Total Value Opportunity" study at five of the nation's leading health care institutions could ignite actual progress toward safety and quality goals across American health care by providing a much more concrete picture of where in specific health care processes much greater value can be captured, and specifying the "real world" improvements in the processes that would capture that value. By doing the study at acknowledged centers of excellence of various types (academic health centers, community and rural health systems), the results could not be dismissed. Experts trained in systems analysis (six sigma, lean manufacturing, Toyota Production System, activity-based costing) would be paired with medical authorities to conduct the study, which could be accomplished within 6-9 months of work at each institution.

To give you a sense of the picture that such a study would paint, here are process diagrams showing a) a typical hospital medication process, from the time the physician writes the order to the time the medicine is actually delivered to the patient; b) a far simpler, safer and more efficient "target condition" imagined by staff at the same institution.

The Current Condition





And here are two slides summarizing the clinical and financial implications of dramatic improvements in another process, infection control, produced by Dr. Shannon at Allegheny General Hospital in work that is an early prototype for the type of study I have proposed. The national study should associate each possible process improvement with resource consumption and finance implications:

	Traditional Approach FY 03	PPC Approach FY 04 Year 1	PPC Approach FY 05 Year 2	PPC Approach FY 06 (7 months) Year 3
ICU Admissions (n)	1753	1798 (+45)	1829 (+76)	1094
Atlas Severity Grade	1.9	2.0	2.1	2.2
Age (years)	62 (24-80)	62 (50-74)	65 (39-71)	64 (56-76)
Gender (M/F)	22/15	3/3	4/7	1 / 2
Central lines employed (n)	1110	1321* (211)	1487* (377)	1518*
Line-days	4687	5052*	6705*	6072*
Infections	49	6*	11*	3*
Patients Infected	37	6*	11*	3*
Rates (infections/ 1000 line-days)	10.5	1.2*	1.6*	0.49*
Deaths	19 (51%)	1 (16%)*	2 (18%)*	0 (0%)*
Reliability (# of lines placed to get 1 infection)	22	185*	135*	506*

The Losses Attributable to CLABs* are Staggering

- **Average reimbursement: $64,894**
- **Average Expense: $91,733**
- **Average Loss from Operations: -$26,839**
- **Total Loss from Operations: -$1,406,901**
- **Average Age: 56 years**
- **Average LOS: 28 days (5-86)**
- **Only three patients were discharged to home!**

*** Central-line associated blood stream infections**

3. Create a National Commission on Health Care Payment with two charges: A) End the profound cynicism of the healthcare pricing system; B) Fix the payment system to eliminate disincentives to "do the right thing."

Once we have a map of the way forward, making sure that how we pay for healthcare services helps us and doesn't hurt us is the next step. I would give a National Commission on Health Care Payment six months to produce action recommendations to Congress and the President necessary to solve the dysfunctions in how we bill and reimburse for health care services.

A. A destructive pricing and billing system:

Health care is the only industry that keeps two sets of books as a matter of course. The set of bills that are sent out by hospitals and others are a fiction. Contracts with insurers pay only a fraction of the listed price. Unless, that is, you don't have insurance. In that case, you're asked to pay full price. In Pennsylvania in 2004, hospitals were reimbursed 28.7 cents for every dollar they "billed." This was the exact rate of reimbursement they expected.

In addition to raising obvious issues of equity, this creates terrible problems on at least two other fronts. First, it consumes enormous resources throughout the system in a shell-game that destroys value rather than creating it. Hospitals are obsessed with exploiting loop-holes in their contracts with insurers and the federal government to "optimize" revenue, producing ever-more complicated and fictitious pricing schemes and "black box" financing systems that not only profoundly distract health care managers from actually delivering a better product, but actually add complexities and distortions that interfere with care. For example, across the country, efforts to optimize revenue from radiology services have produced Byzantine billing codes that are overwhelming to the physicians that order them and the nursing floors that enter the orders, and so produce innumerable dropped and confused orders that are changed in radiology departments, producing frustration and negative impacts on patient care.

Second, in my experience, if you ask people to work every day in organizations where major facets of their work are fictions, it has a corrosive effect on the whole enterprise. If we are not forthright about something as fundamental as what we charge and why, it eats at our sense of excellence and integrity.

I don't understand how the health care professions themselves can live another year with the current system. And if you have not yet read the current issue of *Health Affairs*, which includes two devastating articles on the current state and evolution of the hospital pricing system, I commend it to you and suggest that after reviewing it you as stewards of our national interest will not be able to live another year with the current system.

The President's push for transparency of health care pricing for consumers deserves strong support. Properly driven, the scrutiny that would follow disclosures would be extraordinary, and the broken health care pricing system couldn't withstand it.

B. Eliminate disincentives to "do the right thing" in our reimbursement systems.

The failures of the health care payment system to reward health care providers for doing the right thing for patients, or performing at better levels than their competitors, are many. I'll point to just two fronts for rapid action.

First, the unsustainable pace of health care cost increases is driven in large part by the increasing burden of chronic diseases such as diabetes on the American population. Today chronic disease accounts for 75% of all health care costs, according to the Institute of Medicine and the Centers for Disease Control and Prevention. In turn, combating chronic disease effectively requires much more effective primary and preventive care. Yet, if you look at our payment systems, you will see that we are paying hundreds of millions of dollars every year for patients to undergo advanced procedures – many of which have been proven by the literature to be "washes" in whether they sustain life – while paying very poorly for effective primary care that would have helped stay the progression of the disease in the first place. A recent in-depth story by *The New York Times* identified what drives this sad state of affairs. A primary cause is the reluctance of commercial health insurers to provide effective preventive and chronic care benefits for diabetics, for fear that they will attract a disproportionate share of persons with diabetes. The insurance market exists to spread financial risk efficiently, yet we have allowed it to evolve in ways that insurance companies are allowed to avoid risk, with terrible impacts on human suffering.

It doesn't have to be this way. Over the past five years, the Veteran's Administration shifted its resources sharply toward primary care. They held their cost of care constant per patient at a time when general healthcare costs increased 50%, and dramatically raised the quality of care provided to veterans (a quality which sharply exceeds the performance of the rest of the American health care system). In Pittsburgh, the VA increased primary care for diabetics and has seen a corresponding 38% reduction in foot amputations. Will Medicare, private insurers and large health care purchasers have the guts to follow the VA's lead? Surely this panel can see that they do.

Second, while the intellectual infrastructure to "pay for performance" is evolving, the government's and private market's embrace of this ability has been tepid at best. The quality incentive programs that exist are typically less than 1% of annual revenue for a hospital, when hospital CEOs will tell you that at least 5% would be required to "get their attention." The Medicare/Medicaid program has launched a few payment experiments for physicians and hospitals, but they generally don't put enough revenue on the table to shift behavior. My staff can find only one physician group in the United States where it is possible for a doctor to make 30% more income by performing at the highest possible levels in the quality of care they provide their patients. The scale and scope of our so-called pay for quality efforts should be immediately and radically expanded.

4. Prejudice the health care system toward truth telling.

Rethinking our approach to medical malpractice is more important than the amount of assets it involves would suggest (perhaps 2% of direct health care spending). It should be a priority because the current system inhibits rapid learning from mistakes, which is the fastest and only way to radically improve all that ails our health care delivery processes.

Again, it is helpful to me to think of problems in terms of first principles. The first principle of health care for me is that patients should get the best possible quality of care, and should be absolutely safe. That means that when things go wrong, these incidents need to be exposed and learned from, immediately, so that they won't be repeated. Putting in place systems to speed the open flow of information about errors, poor outcomes and solutions was an important component of how aviation, nuclear power and Alcoa became safe enterprises.

It turns out that despite physicians' and hospitals' fears of lawsuits, openness about errors is what patients want most. A growing body of research and experience show that when something goes wrong, patients and their families want to feel like they've been leveled with, receive a full apology, and be assured that actions have been taken to prevent the same problem from happening to someone else. They are less likely to sue if they get those things than if they do not.

Two forces can be meshed to radically advance safety, quality, and efficiency. First, health care needs a "blame free" error learning system that can help health care workers learn from errors almost instantly across the country. Congress last year passed enabling legislation to create a national error reporting system that could fulfill this goal. I say "could" because a critical design decision remains. It is critical that in the current regulation-writing phase, the learning system be structured to allow every health care professional to be able to access and learn from it on an around-the-clock "real time" basis, at the granular level of each incident (with measures taken to protect the privacy of patients and anonymity of particular institutions, of course). It will be the tendency of bureaucrats, experts, and lawyers to restrict access to the database to a very few, who will scan for problems and issue periodic safety bulletins. Unfortunately, this approach doesn't work to produce safety in any complex organization or endeavor. Each individual actor knows the nature and risks of their work and workplace the best, and holding them accountable for learning and allowing them to learn on a constant, specific basis is the proven way to make them capable and responsible for creating safety in their own work.

To make this system truly powerful for eliminating injury, however, requires turning the current medical malpractice system on its head. Congress should create a genuine economic incentive under medical liability laws for caregivers to use the error reporting system for learning and rapid application. Here is what I propose. If mistakes are reported to the learning system and the patient within 24 hours of discovery, and measures to prevent the error from happening again are installed within a week, payments

to the patient could be limited to their economic damages with some basic adjustments for fairness. And those payments should be made by society, not individual providers. If an error isn't reported promptly to the patient and the national learning system, however, the provider could be subject to treble damages. This suggestion is something of a political inconvenience in the current political battle over medical malpractice in which neither side is proposing the right balance of relief and responsibility. But evidence across a number of domains – including worker safety on a national basis and my own experience at Alcoa – suggest creating the right incentives and disincentives for learning are necessary to set the conditions for rapid, steady, sustainable improvements in safety. And I do think this could be a "break through" approach to medical malpractice that moves us beyond the current stale posturing that is so tiresome to the American people and, I believe, each of you.

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To conclude, I want to reiterate the three major imperatives that face this committee in health care. First, stop tinkering at the margin of incorrectly characterized problems with tax policy, and attach the responsibility and resources for achieving equitable access to health care to each individual American. Second, deploy the proven ideas and principles of systems analysis to make it possible to capture the 30%-50% improvements in value per dollar invested in healthcare that are clearly possible. Third, use the same "return to first principles" approaches to address the other critical dilemmas facing this committee, such as Social Security and an inequitable, unworkable tax system, and you will see mutually-reinforcing improvements in the social and financial condition of the American people.

It has been a privilege to share these prescriptions and the experiences that inform them with this Committee. Appendices with additional details on my recommendations follow. I would be happy to answer questions and continue the discussion as you move forward to address our most urgent national problems.

Appendices:

1. Total Value Opportunity Proposal-Senate Finance Committee
2. Healthcare Issue Brief: Transforming Medical Malpractice
3. "Truth in Medicine," Paul H. O'Neill, *The Washington Post*, December 24, 2004
4. "What Health Care Can Be," Paul H. O'Neill, *Healthcare Financial Management*, June, 2005
5. "A New Idea for Social Security," Paul H. O'Neill, *Los Angeles Times*, February 15, 2005.