Clinicians are From Mars and Administrators are From Venus-The Case for Reduction of Clinical Variation in Our Health Care System.

A combination of both a financial and patient care focus is a popular model employed by many healthcare systems. The moniker of "cost effective quality healthcare" has been many healthcare systems' mantra and this hybrid approach can and does yield positive results. It is a delicate balancing act that requires constant administrator and clinician effective oversight. It also is dependent upon a myriad number of controllable and non-controllable factors including patient demographics, patient satisfaction, reimbursement, collection rates, length of stay, and patient access. However, if any one or more of these factors is not optimized, it can devolve in the long term with many unpredictable and deleterious consequences that threaten a healthcare system's survival. Institutional restructuring and workforce reductions can be viewed as outward manifestations of this disequilibrium.

The concept of standardizing/reducing costs in our healthcare system is not new. Historically since 1982, diagnosis related group (DRG) inpatient payments have taken into account treatment costs, labor and non-labor components. Treatment costs that are based on complexity of disease states are standardized. These are added to labor and non-labor components which are based on geographic differences that reflect wages and hospital location respectively. Other factors that are added to the DRG rate include cost outliers which factor in cases with extremely high costs and disproportionate share payments for hospitals that treat a large percentage of low income patients.

Conversely, clinicians have primarily focused on patient care and placed a premium on it by expanding it and embracing new and expensive technologies. New drugs, molecular testing and state of the art instrumentation have a price tag which can potentially burden a hospital financially, already operating on a razor thin margin. It is estimated that physicians control 80% of all healthcare costs.[1] They can drive up costs by ordering unnecessary and expensive tests and embracing the latest technology without factoring in cost and clinical efficacy. One out of every four Medicare dollars, more than $125 billion, is spent on services for the 5% of beneficiaries in their last year of life.[2]

Medicare, Medicaid, and the Affordable Care Act have provided hospital administrators verifiable data regarding medical costs among healthcare systems nationally. To reduce their cost structures on an inter institutional basis, they have adopted additional quality and cost reduction strategies including LEAN and SIX SIGMA methodologies that eliminate unnecessary variation often without clinician input. This has not appreciably slowed down the cost of medical care in the United States which is estimated to approach 20% of the GNP. The Commonwealth Fund Survey ranks the U.S. as having the most expensive health care system in the world, but ranks lowest in terms of efficiency, equity and outcomes. [3]

---

[1] Timothy B. Norbeck, *Drivers of Health Care Costs*, in *A Physicians Foundation White Paper*, 2 (Nov. 2012)
[2] http://time.com/money/2793643/cutting-the-high-cost-of-end-of-life-care/ (last verified Mar. 13, 2018)
[3] http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror (last verified Mar. 13, 2018)

The cost to treat a community acquired pneumonia in the United States is known. However, the cost to treat that same pneumonia within the same hospital by different clinicians can vary widely with no good explanation nor better clinical outcome. Mandating universal use of treatment protocols based on best practice would mitigate that clinical variation. Furthermore, it would reduce costs by standardizing treatment regimens. Lastly, clinical outcomes would be improved by the adoption of standardized treatments based on best practices that are supported by the current literature This process can be extrapolated to all medical services including capital equipment acquisition, consumables, and labor costs linked with that standardized protocol for treating that specific disease entity. This physician driven process multiplied hundreds of times within the same institution has the potential to transform whole healthcare systems on a regional and ultimately national basis. Greater efficiencies, lower costs, and better clinical outcomes will optimize the relationship between administrators and clinicians. As a result, they would be truly delivering cost effective quality healthcare.