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Interview with Mr William Ward

William J Ward, Jr is the director of the MHS Degree Programme in Health Finance and Management at the Johns Hopkins Bloomberg School of Public Health and Faculty Director, of the School's Sommer Scholars leadership programme. He is also a former senior healthcare executive with more than 20 years of experience in healthcare finance and operations. Prior to joining the faculty, he served for a dozen years at the Johns Hopkins Bayview Medical Center, which he joined in 1982 when he was selected to be the Chief Operating Officer of what was then Baltimore City Hospitals. He was a member of the Hopkins management team, which operated the hospital under a contractual agreement with the City of Baltimore.

Since leaving the Johns Hopkins Bayview Medical Center in 1994, Mr Ward has provided a wide variety of consultative services to clients throughout the United States (US). He has worked on projects overseas in the Caribbean, Latin America, Asia and the Middle East.

Mr Ward is also the author of two textbooks and numerous articles and has lectured widely on a variety of healthcare financial and operational subjects. He is a frequent speaker nationally on making the business case for clinical quality improvement. In addition to his work with the Bloomberg School of Public Health, he is a member of the faculty at the Johns Hopkins University School of Nursing. For over 20 years, he taught financial management at the University of Maryland, School of Nursing and continues to guest lecture there. Professional affiliations include the Healthcare Financial Management Association, the American College of Healthcare Executives, and the Maryland Association of Health Care Executives.

Most recently, he co-authored the 2006 Research Series monograph "Building a Financial Case for Clinical Improvement" for the Voluntary Hospitals of America. His latest article "Building the Business Case for Clinical Quality" was featured in the December 2006 issue of *HFM*, the journal of the Healthcare Financial Management Association.

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SMA News: You are faculty at Johns Hopkins Bloomberg School of Public Health. What makes Johns Hopkins such a successful hospital system?

Mr William Ward: Certainly the strength of the faculty and staff is at the heart of the success Johns Hopkins has achieved. Most successful organisations will point to the "best and the brightest" as a major factor in their success and Hopkins is no different. This is coupled with a strong sense of clinical innovation which, in turn, rests on a solid base of research and the translation of that research into day-to-day clinical application.

But sound clinical practice and a broad base of research alone will not guarantee success. Sound, prudent management is needed at both the executive level and at the department level and Hopkins has long had this. Attention to marketplace forces (reimbursement, regulation, technologic change, labour market issues and so on) is also essential.

Lastly, I think the integration of the various schools (public health, medicine and nursing) with the day-to-day functioning of the provider side rounds out the formula for success.

SMA: Please share your experiences teaching clinicians hospital administration and healthcare management. Any interesting anecdotes to relate, especially from your interactions with Singapore clinicians?

WW: One of the things I have seen in my 25 plus years of teaching is that clinicians are thirsty for the skills and knowledge they need in order to manage resources better. One of the most rewarding things I experience as a teacher is what I like to call "the light bulb effect" when you see the student light up at the realisation that they have finally understood a concept that has eluded them for years. My experience with clinicians in Singapore and quite a number of other countries is that they, too, seek more knowledge about how hospitals can be better managed and how budgets and finances work. When you think about it, a hospital is probably one of the most complex organisations on the planet and the ability for everyone involved in management, and even those outside of management whose actions impact the day-to-day functioning, to understand how the organisation works and how to get the most from limited resources, is quite a challenge in today's environment.

In a seminar room at Singapore Management University

SMA: What would you consider to be the essential skills that a clinician leader must have to be successful in straddling the clinical and administrative world?

WW: I think there are two sides to this coin. On the one side, management. You need skills in handling financial and other resources. On the other side, you need leadership which involves creating a vision and leading people to achieve that vision. Some divide the skills into doing things right (management) and doing the right things (leadership). If I have to pick just a few essential skills, I would say the ability to lead people and manage the financial resources are the two most important.

SMA: How can administrators and clinicians work better in today's complex world of shrinking budgets and rising expectations?

WW: I think administrators and clinicians need to work together. Clinicians need to understand the financial side of healthcare (reimbursement, proper budgeting techniques and so on) and administrators need to understand the clinical side (how nurses, doctors and others work to provide quality patient care). I often tell groups that the administrators need to spend time in the units seeing how healthcare really works. By this, I mean spending all day in a unit. You cannot learn how the ICU functions by spending perhaps 15 minutes during executive rounds just looking around to see what is going on. You have to be there to see the ebb and flow of work, to see the issues that doctors, nurses, technicians and others deal with on an hour-by-hour basis to get a real feel for the clinical side of the house. I often use

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More recently, clinicians have begun to understand how better medicine makes for better financial performance. They have always been the advocates for high-quality care, but they are finally learning how to articulate the financial case for improvements in quality; demonstrating with hard data that eliminating hospital acquired infections shortens length of stay, improves hospital throughput, and allows for improvements in revenue and cash flow.

the example of a grandfather clock. Think of the two sides of the clock as the clinical imperative and the financial reality. As long as the pendulum swings back and forth, the grandfather clock will keep good time. But if the pendulum sticks on either side of the clock, it stops keeping time. If financial decisions are made in a vacuum, without the recognition of the effect they will have on clinical functioning, bad decisions are made. Conversely, if clinical decisions are made without understanding the financial ramifications, we also stand to make bad decisions.

This does not mean, however, that patients should be turned away merely because they cannot pay. It just means there must be a realisation on the clinical side that accepting a patient who has no means of paying requires us to balance that patient with others who can pay. Sister Irene Krause, the late head of the Daughters of Charity Health System in the US once offered an interesting advisory: “No margin, no mission”. The meaning is clear: if you do not have profits (the financial side), you will not have a mission (the clinical side). But the opposite is just as true: “No mission, no margin”. Patients do not come to us to sample the cuisine in the cafeteria or to read the magazines in the admitting office. They come to us for quality, efficient patient care. And if we cannot provide that, no amount of financial acumen will save the institution.

In the US model, with our high cost and reimbursement challenges, we often find clinicians and administrators at odds over the best course of action. This makes it very difficult to work together. More recently, clinicians have begun to understand how better medicine makes for better financial performance. They have always been the advocates for high-quality care, but they are finally learning how to articulate the financial case for improvements in quality; demonstrating with hard data that eliminating hospital acquired infections shortens length of stay, improves hospital throughput, and allows for improvements in revenue and cash flow. They are able to demonstrate, finally, that high quality makes for both good clinical practice and good financial results and smart administrators are starting to listen.

SMA: What do you think of the Institute of Healthcare Improvement (IHI) and how does it help to bridge the gap between doctors focused on evidence-based medicine and administrators focused on business development plans?

WW: I think the IHI has done a great deal to improve the quality landscape in healthcare. They are not alone in this regard. There are a number of improvement collaboratives running all across the US, which have helped reduce catheter related bloodstream infections, ventilator associated pneumonias, and in other ways improve the quality of care. The question is how open administrators are to quality improvement. I do not think you will find any who would say they do not believe in quality improvement, but the fact is over the years quality improvement has not gained traction in healthcare as it has in other industries. Part of this may result from the fact that the literature generally promises sizable cost reductions as the result of quality improvements, but fails to deliver. As a consequence, administrators are sceptical at best. The reason cost reductions are not delivered is because the costs of running a hospital are largely (on the order of 90%) fixed and as such are very difficult to reduce. The potential for revenue generation as I mentioned in the previous question is a concept that is only just now being talked about. It is going to take some time to convert the masses but I think once they begin to see the positive financial results, even the sceptics will join the quality bandwagon.

SMA: Quality improvement in healthcare is an important concept but difficult to quantify.

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There have also been many reports on how quality indices are "gamed", that is, surgeons who refuse to operate on cases that have potentially worse outcomes, physicians who refer away their difficult cases, and so on. What is your experience in dealing with these issues?

WW: Clearly, this is an issue which must be dealt with if we are to achieve real improvement in the quality of care provided to patients. We cannot as a society refuse to deal with the difficult cases and thereby increase our quality scores. I have not specifically dealt with either organisations or individuals who have "gamed" the system, but I am aware that it is possible to do the right thing and not be rewarded. A hospital that I have worked with as a consultant for a number of years achieves excellent outcomes in the treatment of congestive heart failure. But under Medicare's soon to be enacted "pay for performance" methodology, they will be penalised because the way they go about achieving those positive results differs from what Medicare is looking for. The "pay for performance" system is based not on outcomes, but on inputs and approaches. In my opinion, that is wrong.

Mr William Ward and wife on vacation at the ocean.

As with most things in life, we have to be careful about the unintended consequences of potential actions. We could eliminate the gaming of the system, if we do not allow physicians to refer away difficult cases. But what if the referral is clinically appropriate? Do we run the risk of placing patients in danger because we do not allow referrals? It seems to me that we need to strike a balance. We should understand that physicians will refer more difficult cases to other more skilled practitioners and that this is not necessarily inappropriate. But we should not be so naïve as to think that physicians would not contemplate referring away a very difficult patient to keep their scores as high as possible. Perhaps there needs to be some kind of initial screening methodology that would determine whether a patient was high risk or low risk; similar to the way we rank some expectant moms as "high-risk OB." We could then make some sort of risk adjustment to the physician quality score.

SMA: Clinician or professional manager. Who in your experience has done better as hospital CEO?

WW: This is a most difficult question. I think the answer has less to do with whether the hospital CEO is a clinician or a professional manager and more to do with his or her leadership abilities. Frankly, I have seen physician CEOs who have done well and poorly and non-physician CEOs, as well, who have done well and poorly. The commonality that I note in the ones who do well is their ability to craft a vision and lead people to achieve that vision. They tend to be global thinkers who see the big picture and can communicate with all manner of audiences: maintenance mechanics, doctors, community members, board members and so on. They are decisive and not above taking prudent risk to achieve a worthy goal.

Above all, they understand the fundamental business of a hospital. That business is not the debits and credits of finance, but rather the provision of high quality, safe patient care for those who place their trust in the hospital and its caring mission. They understand the complexities of system thinking and that hospitals and healthcare are not about individual encounters but about processes and systems, which require a different approach than merely looking to run the most efficient department(s).

SMA: Unlike other forms of technology, advances in healthcare technology generally lead to escalating costs with marginal returns. Is it possible to have state-of-the-art healthcare while being fiscally conservative and preventing an increase in healthcare expenditure?

WW: Let me preface my remarks by saying that I am a big believer in the marketplace as a way

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of balancing supply, demand, prices, costs and so on. I think one of the reasons that technology has led to escalating costs is that the financial/ value equation does not work in healthcare as it would in almost any other endeavor. Consider the example of an airline offering a first class seat, but at a greater price than a coach seat. Consumers look at the value added and the extra they will be expected to pay and make a value judgment – the first class seat is either worth it or not. If the price is too high, they may decide that a coach seat for their six-hour flight is perfectly acceptable. On the other hand, they might look at that same seat and price and decide that it is worth it to them to be far more comfortable in first class than crammed in a smaller seat with less, if any, food and beverage service.

Now consider that same decision, but interject a third party who, instead of the consumer, will pay for the seat in either cabin. What consumer would turn down what amounts to a free upgrade and fly in a coach seat? This same dynamic applies to healthcare when the doctor ordering the use of the new technology need not pay for its use, the patient (the consumer) does not need to pay, and the third party (insurance company) picks up the bill? What patient or physician would decline the "free upgrade" to a newer technology?

In the US, the problem began decades ago, when insurance provided financial insulation for patients. As a result, they look at new technologies as extremely worthwhile since someone else pays for them. And physicians prescribe their use because they, too, are insulated against the high price of the new technologies. The way to break this spiraling cost increase is to reinsert the patient into the financial equation by giving them a financial stake in their healthcare decisions. If patients had to purchase insurance on their own instead of employers providing it, they would be more inclined to look at value added in making decisions about using new technologies. If I have a low risk of heart disease because of family history and lifestyle, I might decide not to take advantage of a non-invasive 64-slice cardiac CT. On the other hand, if I have a family history and some lifestyle markers (high BP, elevated cholesterol, sedentary ways and so on) I might decide the high price was worth it. My wife and I made this very decision and paid out of pocket for her cardiac scan a year or so ago. And thankfully so. We discovered some early signs of coronary artery disease and immediately began a programme of exercise, dietary changes, and medication to lower blood pressure and cholesterol to avoid the potential for a heart attack or worse. And in a few more years, we will likely again pay out of pocket for a similar scan. In our case, and without the insulation of insurance to pay for the procedure, we decided that the value of the technology more than outweighed the cost. That sort of value based decision making is relatively rare in a healthcare system like ours (the US) in which insurance insulates patients from the financial side of decisions. In essence, we look at the free seats in first class and ask "Why not?" But perhaps worse, we put the blame on the new technologies.

Michael Porter and Elizabeth Teisberg published a marvelous paper in the Harvard Business Review several years ago that deals with the concepts of competition and value in helping with the cost of healthcare.[1]

Can we resolve the problem? I am not sure. The cure, moving the cost of insurance premiums and the financial/ value decision-making back to the individual may be too painful.

SMA: Is the present method of remunerating doctors in the public/ private sector and not-for-profit institutions/ hospitals equitable to the various specialists (for example, cardiologist, rheumatologist, eye surgeon, orthopaedic surgeon and so on)?

WW: Not being a physician, this is hard for me to answer. But I have often heard physician colleagues observe that reimbursements are often procedure based and tend to favour surgical over non-surgical interventions. Perhaps more thought should be given to outcomes based payments. I do believe the old sage is correct that you get what you pay for, so I am wary of those who suggest we can save money by lowering physician reimbursements.

SMA: Is there a better way of encouraging good altruistic behaviour among the various doctors in one institution by using the remuneration instrument?

WW: Certainly money is a powerful influence, but I think there are better, more effective ways to influence behaviour. I seek to influence behavior

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by using date, clinical and satisfaction data, for example, to make my points. Physicians are used to looking at data and if one can display that data (with identities masked, but with the targeted physician seeing his or her data for comparison purposes), I think you stand a far greater chance of changing behaviour. It really comes down to the physician changing his or her own behaviour as opposed to me trying to "make" them change. I think there have only been two occasions in which I have directed a physician to do something – it is just not my style.

SMA: Is pay-for-performance applicable at the individual doctor level, team level, specialty level or not applicable at all to specialists especially those where "soft medicine", hard to measure/ quantify is the norm, rather than operations/ procedures?

WW: I think pay-for-performance can be applicable at any level if it is structured appropriately.

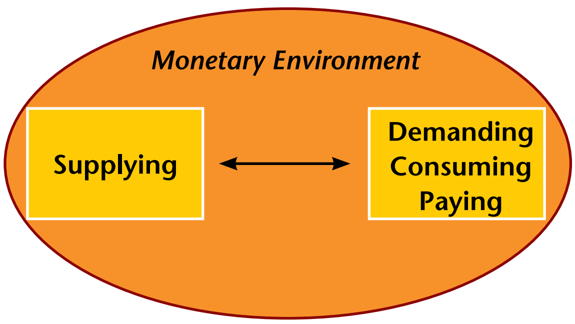
We have to be careful not to place doctors and hospitals at odds with each other as we have done in the past. We have seen what can happen when physician payments are based on patients being in the hospital and hospital payments improve if patients are discharged earlier. We destroy the collaborative efforts of both parties and that really compromises patient care. Certainly payments to both hospitals and physicians can be tied to quality outcomes just as we pay others for their quality services. If I took my car to the mechanic because the engine was not running smoothly and he did not fix it, I would not pay him. Similarly, I would not pay the grocery store for stale bread.

SMA: If primary care is weak in the US system, and patients continue to flock to specialists (at high costs and most probably inappropriately), what are the strategies to remedy this situation?

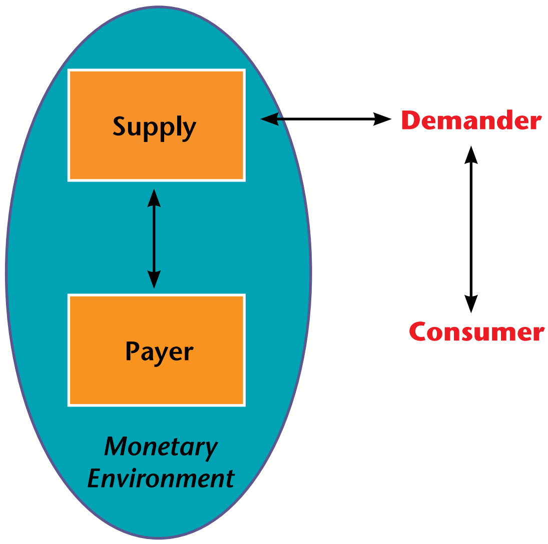
WW: Any remedy would have to involve some sort of financial incentive that makes primary care a good value for patients, even a better value than waiting and then going to see a specialist. I am not sure it can happen with the fractured payment system we have in the US in which not all the appropriate parties (the physician demander, patient consumer, hospital supplier, and insurance payer) are all in the same monetary environment. The two illustrations below can help demonstrate this.

In the normal economy, the demander, consumer and payer are the same entity and they exist in a monetary environment with a supplier. In this monetary environment, price moves back and forth to influence supply and demand, value, and other consumption factors. But in the healthcare economy, the parties are all separate and not all of them reside in the monetary environment, thus supply and demand, value and other consumption factors cannot be properly influenced. As I said before, if you can get the patient into the monetary environment so his or her decisions are based on value as opposed to that "free upgrade" mentality, primary care and healthier lives have a higher priority. ■

NORMAL ECONOMIC ENVIRONMENT



HEALTHCARE ENVIRONMENT



Reference:

1. *Porter ME, Teisberg EO, "Redefining competition in healthcare," Harvard Business Review, June 2004.*