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Searching for the True Cost of Health Care

Providers Look to Cut Waste With Detailed Cost Tracking

By MELINDA BECK

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Most doctors and hospitals have only a vague idea what it costs them to deliver care, experts say. Prices are generally based on what payers will pay, with little relation to cost.

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Several leading health systems aim to replace that chaotic pricing system with one based on the true cost of delivering care. Armed with that information, they believe they can reduce health-care costs from the inside, by identifying inefficiencies, rather than accepting arbitrary payment cuts.

The philosophy is: If you can measure it, you can manage it.

Step by Step

M.D. Anderson Cancer Center, the Cleveland Clinic, the Mayo Clinic and other top hospitals have embraced a process, advanced by two Harvard Business School professors, called time-driven activity-based costing. TDABC involves mapping out every step involved in delivering a medical service, from a simple blood draw to a complex surgery. Researchers determine what personnel and equipment are needed, what their costs are per minute and how many minutes are involved. They tally the costs for all the steps, allocate a share of overhead expenses and add in a profit margin to determine the true cost.

"None of this is rocket science. It isn't even calculus—it's regular math," says Thomas W. Feeley, an anesthesiologist who used TDABC measure the cost of treating head-and-neck cancer patients at M.D. Anderson from 2009 to 2011.

He and his colleagues identified and calculated the cost of delivering 160 different services patients might receive during the course of their treatment, usually about a year. The results were eye-opening, says Dr. Feeley, who heads M.D. Anderson's Institute for Cancer Care Innovation.

For one thing, a patient's first visit cost M.D. Anderson significantly more than it charged patients, due to the extended discussions and testing involved. Another revelation was that some hospital staffers were performing tasks that could be done by others for much less.

By reducing such inefficiencies in one area of care, the preoperative anesthesia center, M.D. Anderson was able to trim the center's staff by 17%, increase the number of patients assessed by 19% and lower cost by

46% without changing the quality of care.

M.D. Anderson plans to use the same process to assess the cost of every kind of cancer care it delivers. But it is not yet prepared to disclose those dollar amounts—or to use them to change billing procedures. "We have to make this transition very carefully," he says.

One Size Doesn't Fit All

Indeed, integrating that approach into the current health-care payment system with all its price negotiation and cost shifting won't be easy. Critics argue that hospital overhead costs are too complex to allocate accurately and that patients are too varied in their needs to fit neatly into standardized units of time and care.

Michael E. Porter and Robert S. Kaplan, the Harvard professors who pioneered using TDABC in health care, say that ideally prices should be based on the value for patients—not the volume of services provided. Value should be measured by dividing the real cost by outcomes over an extended cycle of care.

"Under such a system, a primary-care physician might be paid $10,000 a year to manage a diabetes patient —and prevent a $100,000 emergency-room visit," says Mr. Kaplan.

"This is a big leap for the field," says Mr. Porter. "We've been flying without instruments and rewarding the pilot for crashing."

A growing array of health systems are experimenting with value-based methods in pilot projects. Profs. Porter and Kaplan's team at the Harvard Business School have used TDABC to evaluate the cost of repairing cleft lips and palates at Children's Hospital in Boston, torn rotator cuffs at Brigham and Women's Hospital in Boston and heart problems at the Mayo Clinic. The team is also working with the Cleveland Clinic to measure efficiency and outcomes in a variety of programs and is studying hip and knee replacement costs at 30 sites around the country.

For now, such projects aren't practical for many hospitals. "Cost-accounting systems are exceedingly complex and expensive for hospitals to perform," says Rich Umbdenstock, president of the American Hospital Association. "But eventually that's the only way you'll be able to price things on a realistic basis."

Ms. Beck covers health care and writes The Wall Street Journal's Health Journal column. She can be reached at melinda.beck@wsj.com.