

# **Reducing Costs: Execution is critical**

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## *Prelude*

Every few years hospitals, regional hospital systems and other healthcare providers find themselves in the position of having to reduce operating costs to maintain financial viability. In the late 70s HMOs negotiated lower prices causing a decline in hospital revenues, putting pressure on costs. In the late 80s, Medicare and Medicaid reimbursement followed suit. In the late 90s and until recently, the booming stock markets and growth in real estate values helped maintain high re-imbursement for providers. That boom has come to an end, certainly for the foreseeable future.

Hospitals are forced yet again to cut costs, this time deeper than before and very likely on a permanent basis.

Having been involved, directly and indirectly, in cost reduction efforts for over 40 hospitals and health systems over the past 22 years, and for a number of non-healthcare organizations prior to that, I found that sticking to a few basic sound principles works best.

## *A necessary evil*

Hospitals are now faced with the prospect of having to reduce costs more than they ever have in the past two or three decades. This pressure is the result of three things occurring simultaneously:

- **A drastic decline in the wealth of individuals and corporations** resulting from a large drop in the value of real estate and value of stocks and savings. This decline reduces spending on healthcare by individuals and corporations. It also reduces government revenues, putting pressure on Medicare and Medicaid funding. Experts estimate that a full recovery in the stock market and real estate may take years.
- **A substantial reduction in the availability of credit and investment funds.** The financial industry has seen a re-alignment as great if not greater than anything experienced in recent history. With this re-alignment, financial institutions are returning to the practice of lending money only to financially sound businesses and individuals. This realignment may last for many years.
- **A worldwide economic recession that may last for a few years.** The recession has resulted in many job losses some of which are permanent as companies go out of

business. The possibility of “deflation”, with a precipitous fall in prices of goods and services, has raised concern.

With these pressures, hospitals will find themselves in the position of having to rely on their own margins for financial viability and for funding capital investment. Revenues have already seen a decline and will continue as consumers cut back on spending and payors reduce re-imburement.

“An industry database of 550 hospitals found their third quarter results .....swung to a 1.6 percent average loss, from an average 6.1 profit margin a year ago”

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By Linda A. Johnson – THE ASSOCIATED PRESS

Faced with these realities, healthcare organizations will need to reduce operating costs to generate margins that can sustain viability and fund capital needs.

***Designed to fail***

There is a body of evidence that confirms that most business failures are the result of inadequate execution of plan rather than poor plan design. This applies to all private businesses and public entities.

- Douglas K. Smith, Management Consultant and author of many business books on delivering results, also speaks of how 4 out of 5 business failures result from inadequate execution. He states that "100% of the failures come from habits of linearity -- that is, any and every executive who continues to think they must first have a complete design and only then begin implementation will fail. With certainty."
- Larry Bossidy and Ram Charan, authors of a best seller entitled “Execution – The Discipline of Getting Things Done”, have very similar experience.
- My own personal experience over 30 years in Management Consulting for many healthcare organizations confirms this trend – execution is key.

With that in mind, healthcare organizations will need to substantially shift their efforts and resources towards execution, rather than focusing on the design of their cost reduction plans. Effective execution must allow for ongoing modification of the plan design based on what is working and what is not.

***If a cost reduction plan looks good and the recommendations appear sound, it will almost certainly fail if execution competency and capacity are not significantly greater than those of design.***

### ***No track – no destination***

Let us start with some basic concepts of cost reduction in hospitals. A typical hospital or health system has three cost components. Labor costs, which represent approximately 60% of total costs, include compensation paid to employees (salaries, overtime and benefits). Non-labor costs, which represent approximately 25% of total costs, include all purchased goods and services (e.g. supplies, medications, office services, food and fuel). Fixed/finance costs represent approximately 15% of costs. Fixed/finance costs include depreciation, interest expense and insurance.

- Reducing labor costs involves reducing average wage per hour (e.g. skill mix change or hourly wage reduction), reducing hours worked, or reducing benefits.
- Reducing non-labor costs involves reducing the unit cost of purchased items or services or reducing the volume of purchases. Unit costs can be reduced through standardization of items and substituting “off brand” and generic items among others methods.
- Reducing fixed/finance costs involves taking on more risk, changing the accounting rules, changing the capital structure, or reducing the rate of interest on borrowed money.

Cost reduction will likely involve all three cost components if annual costs are to be reduced by anything greater than 5%.

***Remember - there are no other ways of reducing costs other than those mentioned above.***

There are “tactics” on how to reduce costs. For example, reducing the length of stay will result in actual cost savings if, and only if, the number of FTEs or number of hours paid and supplies consumed are actually reduced.

Another example is “reducing waste”. This will result in cost reduction if, and only if, the waste corresponds to a real and measurable reduction in (1) supplies used on the floors, and/or (2) number of full time equivalents (FTEs) involved in conducting these “wasteful” activities. Re-allocating labor hours to other activities ***does not save costs and never will***. It might result in more effective residual work, or in a few other cases to an increase in revenue.

In order to reduce costs, hospitals use differing approaches. The time taken varies by approach. It typically takes 2 to 6 months to prepare a plan and a further 6 to 24 to execute it. Among the most common approaches for cost reduction are:

- **Budget reductions.** Asking each department to cut its expenses by a certain amount or percentage. This approach often includes a hiring freeze and elimination of discretionary spending (e.g. travel).
- **Process involving multi-disciplinary teams.** Creating teams of managers and staff to evaluate tasks, activities and practices and modify those to be more efficient. This practice has had many names over the years, including downsizing, operations improvement, operations excellence, re-engineering, business process redesign, clinical effectiveness and a multitude of others.
- **Closing one or more services.** Conducting detailed financial and market analysis to determine if a line of service is absolutely necessary. This requires answering two questions: (1) is it currently losing money/can it ever make money, and (2) is it critical to the strategic positioning and operations of the hospital? If a service is closed, a proportional reduction in overhead cost allocation (e.g. finance, human resources, plant maintenance) takes place.
- **Changing the organization structure.** Reducing the number of executives and managers in the organization by reducing the number of layers and increasing the span of control.
- **Reducing financial and fixed costs.** Restructuring the financial overhead of the organization including debt burden and insurance liabilities.
- **Outsourcing activities or processes.** This typically impacts administrative services (e.g. IT), support services (e.g. housekeeping) and sometimes clinical areas (e.g. emergency medicine).

Hospitals may sometimes undertake cost reduction efforts in-house (i.e. without outside help). At other times, they hire outside consultants who can provide an objective point of view, deal with difficult problems and “take the blame”. It is akin to hiring a personal trainer to help one become leaner and stronger. Consultant fees can be relatively small (a few thousand dollars for an individual) or very large (several million dollars when a major national firm is hired).

The risk of trying to reduce costs in-house is possible failure of the effort. This will most likely result in a deteriorating financial situation and even to default or bankruptcy. At that point in time, a receiver or a turnaround firm may be required to restructure the business.

The risk of hiring a consulting firm for cost reduction is not achieving an attractive ROI on the consultant's fees. In-house management engineers typically provide an ROI of at least 50 times, whereas a large national consulting firm may provide an ROI of only 1 to 3 times. If the consulting firm fails to deliver on the cost reduction objectives, senior management, boards and others involved in the decision may find themselves in the difficult position of having authorized large expenditures for a meager, or worse yet, a negative ROI.

The outcome of any cost reduction plan is usually many (tens or hundreds) of specific ideas/recommendations that reduce costs. These recommendations, which relate to labor, non-labor and finance, could have a relatively small or large impact on costs.

Some examples include:

- Replace white with unbleached paper towels in bathrooms - small impact on non-labor costs.
- Develop a strict and relatively narrow drug formulary - large impact on non-labor costs.
- Reduce the number of secretaries in the executive suite by creating a secretarial pool - small impact on labor costs.
- Change the RNs to LPNs skill mix by changing the care model - large impact on labor costs.
- Renegotiate the interest rate or change the depreciation schedule for computers - medium impact on finance costs.

All of these specific recommendations require tracking on a real-time basis during implementation to ensure that results are actually achieved and are tied to financial statements and results.

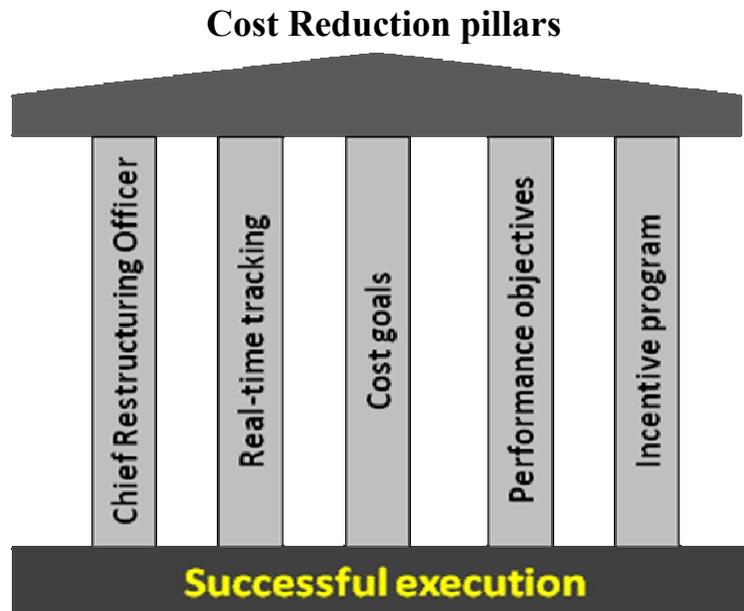
***In all cases, it is imperative to reduce costs in a real and measurable fashion otherwise it is nothing but an intellectual exercise.***

### ***Less is more***

Management theory about the attention span of humans suggests that the rule of seven applies to most of us. In other words, we can pay attention to approximately seven items at a time. More than that and we are not likely to see the "woods for the trees". Fewer, and we may miss something important. For the average person though, seven (range 4 to 10) is the mid-point.

We have also learned over the years that the 80/20 rule works well if you want to get results quickly and effectively. 80% of the benefits can be achieved by dealing with the top 20% of the items.

With these two rules in mind, a successful (“drop to the bottom line”) cost reduction effort requires the following five pillars:



1. Appoint a **senior executive** with the responsibility of successfully reducing costs based on the recommendations developed. This executive should have the skills of a tough enforcer, i.e. someone who wants to be respected for carrying out a difficult task, not someone who wants to be popular. This executive can be an in-house individual (e.g. the CEO, COO, CFO or even a Board member) or an outsider – a consultant or interim executive who acts as **chief restructuring officer (CRO)**. Choosing an outsider is dictated by lack of the necessary core competency internally or the need for an outsider to take the heat, i.e. “the hired gun” model.
2. **Track** all cost reduction recommendations in **real-time** to ensure early corrective action for recommendations that are slightly off plan. If a particular recommendation appears to be failing altogether – and some do – timely replacement by another of equal value is necessary to ensure overall success. This task requires discipline as there could be hundreds of individual recommendations each with its own implementation plan.

3. Create new **cost goals** by department/functional area and for the institution as a whole based on all approved recommendations. These goals can be weekly, monthly or quarterly. A few non-cost goals will also be needed to ensure that cost reductions are not occurring at the expense of service and quality. Again, limit the number of goals to between 4 and 10 for each department/functional area and for the organization as a whole. It is also helpful to compare these goals against similar metrics at competitive and peer institutions - commonly referred to as benchmarks.
4. Build the tracking of individual cost reduction recommendations and the departmental/organization goals into the **performance objectives** of all senior executives and managers. Management by objectives (MBO) programs have worked well in the past.
5. Tie the performance objectives to an **incentive program** for senior executives and managers. The incentive program may include significant bonus or promotion. Failure to meet performance objectives should lead to appropriate corrective action.

All five items above are information rich, have a symbiotic relationship, involve multiple participants, and are time sensitive. Fulfilling these specifications requires the use of web-based or network-based software tools to:

- Track all recommendations in real-time
- Track all goals and benchmarks in a balanced scorecard
- Tie the outcome of the recommendations and measures to individual executives/managers and their compensation.

Multiple software tools can, and have been, used for each of the three items above. However, a single web-based software tool incorporating all of them is more efficient and effective. A web-based tool can provide real-time information and can be updated from any location, which is a necessity for managing the implementation of individual recommendations.

***If cost reduction is your main objective do not “clutter” it up with other objectives or you will fail at everything. Using a comprehensive web-based tool can provide you with the necessary focus.***

## ***Summary***

A cost reduction effort is as successful as the actual measured results – anything else is wishful thinking. Given that a cost reduction effort is unpleasant at best, and wrenching at worst, it is critical to ensure successful implementation so as not to expose the employees to unnecessary repetition of the process.

Stick to the five principles for successful implementation and your chances improve significantly.

Finally, though a cost reduction effort is painful for all employees, especially those who lose their jobs, the end result is a viable concern that can ensure stable and gainful employment for the remaining majority.

## ***About the author***

Saad Allawi has spent the bulk of his professional life working in performance management, including 22 years with healthcare organizations. He has authored many articles, as well as a book chapter on healthcare re-engineering. He also co-authored the “100 Top Hospitals” study in 1993, for which he still serves on the advisory board. His experience with performance improvement in healthcare and other organizations led him to co-found Performance Logic (Portfolio Management and Performance Tracking software for the Healthcare Marketplace). Now, with the increased pressure on costs, he is sharing the experience gained from involvement in over 40 healthcare cost reduction efforts.

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