Paradox and Imperatives in Health Care

Redirecting Reform for Efficiency and Effectiveness

Revised Edition

Jeffrey C. Bauer

CRC Press
Taylor & Francis Group
A PRODUCTIVITY PRESS BOOK

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Dedicated to my sources of inspiration and courage to create

Gustav Mahler
Pierre Boulez
René Magritte
Sol LeWitt

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Chapter 1

Introduction: The Paradox

> Surely we will end up where we are headed if we do not change direction.
>
> **—Confucius**

Back in 2007 when Mark Hagland and I solicited comments on our original concept for a book about performance improvement, several health care executives responded with a question: Why would a provider want to cut costs or improve quality? After all, they argued, the reimbursement system does not provide incentives to reduce costs, and the rewards for quality can be pretty small with respect to the required effort. Reimbursement can even penalize performance improvement initiatives. These experienced leaders indicated no interest in reading a book on efficiency and effectiveness until the federal government required them to take action.

Other executives took the opposite position. They believed our proposed focus was important—so important that they had, in their opinions, already removed all the waste from their organizations. They probably would not read our book because there was nothing more they could do to save money

in operations. Nevertheless, they encouraged us to write it because they thought other hospitals needed to get the message. (We expected they also needed it. There is *always* room for improvement.)

We decided to write the book because most executives were in the middle, generally cynical but receptive to new perspectives and responsive solutions. They acknowledged the disincentives that have thwarted past efforts to change a production process or business model. However, they also sensed an unprecedented convergence of forces that compelled action. They wanted a practical guide that would help them survive and, it was hoped, thrive in a potentially hostile environment. All agreed that the status quo was unsustainable in the long run, but none anticipated the two seismic shifts that were just around the corner—the economic collapse of 2008 and the Affordable Care Act (ACA) of 2010.

Dark clouds have always hovered over the medical marketplace, but they had a silver lining in the past. Intense political action could always be counted on to reverse announced cuts in government health programs. Playing hardball with managed care plans would ultimately yield a viable contract, and reimbursement from private insurance could be counted on to compensate for Medicare's lower rates. Better collections procedures could be implemented to manage receivables and cash flow. Keeping revenue above expenses was never easy, but with hard work in the finance department, it could be done.

Key factors in this equation began to change, slowly but relentlessly, with the arrival of the twenty-first century. Government austerity and rapid increases in consumers' financial responsibility started creating an uncommonly gloomy outlook for providers' revenue. High-deductible health plans increasingly became the rule, not the exception. Receivables began rising precipitously, even for patients covered by good commercial insurance. Costs for supplies and labor also started increasing at higher rates. Regulations continued to grow in

number and complexity, with serious penalties for noncompliance. Troubling trends in national and international economics cast doubt on any prospects for improvement in public or private capacity to pay for health care. And, "medical tourism" began to draw a perceptible number of patients, with and without insurance, to hospitals in other countries.

The Paradox

The phenomenon of international medical travel points to the paradox of health care in the United States. Americans can often obtain a better deal buying individual medical services in other countries. At home, they spend more on health care than their counterparts anywhere else in the world, both individually and collectively, yet their country is found at or near the bottom of lists that rank the return on investment in medical spending for developed economies. Every other modern country spends significantly less on health care than the United States and generally has a healthier population.

In terms of rational economic theory, the country with the highest per capita expenditures on health care ought to be the country with the healthiest people. But, common sense is contradicted by the facts. The US economy allocates a bit more than 17% of gross domestic product each year to its medical sector, yet its residents do not live as long or as well as those of three dozen comparable countries that devote 12% or less of their economic resources to hospitals, doctors, drugs, and related goods and services. Other developed, postindustrial countries produce at least as much health for their populations with approximately 30% fewer resources (i.e., 17% reduced by 30% is approximately 12%).

Even though its national leaders persistently proclaim the United States has the world's best health care system, economic and epidemiological data show it does not. However,

the paradox has an exception that proves the rule and supports the positive focus of this book: The world's best providers of health care are based in the United States, and the rest of the world knows it. Foreigners do not come permanently to the United States just to obtain better health care; they emigrate for other reasons. However, they frequently come to the United States as reverse medical tourists when they need the best health care for a life-threatening condition (admittedly, when cost is not a consideration).

Independent, private health systems based in Rochester (MN), Houston, Boston, Cleveland, New York City, Danville (PA), Oakland (CA), and a few other American cities are internationally recognized for providing the world's best health care—even though they are located in a country that does not. To add irony to paradox, these systems grew out of local initiative and individual vision, and they are extremely different in the way they are organized and managed. They represent the best of American innovation and diversity. Yet, not one of America's world-class medical enterprises was created in response to government imperatives, and they have continued to thrive independent of federal reforms—another key point reflected in this book and its recommendations.

On the one hand, the health care delivery system in the United States is plagued by serious cost, quality, and access problems that are not being solved by law or regulation. On the other hand, some American providers deliver the best care in the world. I believe this paradox can be resolved, but the history of government-driven health reform over the past 50 years and political circumstances for the foreseeable future suggest that another approach is needed. If the United States truly aspires to international exceptionalism in health care, its leaders must take us in a new and different direction to create the world's best health care system—one that produces the top return per dollar spent on population health. This book proposes such a path.