Setting the Stage: Today's Healthcare Challenges

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Abstract

This chapter summarizes the key issues facing all healthcare leaders—how to improve quality, expand access, and manage (ideally lower) costs. Every major healthcare system struggles to balance these, especially restraining costs as technology increases, populations age, and governments seek to expand healthcare access. The theme of this book is that these challenges present healthcare leaders with the need to manage simultaneously for the short-term, while also investigating longer-term, transformational change. In this way, leaders can learn to embrace future uncertainty, not flee from it.

Challenging Leaders for Generations

The delivery and payment of healthcare services entered the modern age when Germany enacted compulsory sickness insurance in 1893, soon to be followed by Austria, Hungary, Norway, Britain, Russia, and the Netherlands. Other European countries, including Sweden, Denmark, France, and Switzerland, subsidized the

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mutual benefit societies that workers formed to protect income against wage loss due to illness and infirmity rather than payment for medical expenses, which came later (Palmer 1999). Early healthcare programs were originally conceived as a means of maintaining both incomes and political allegiances of the working classes; only a select few programs became regarded as "universal" for their country's residents, such as Britain and Sweden.

Through World War I, healthcare insurance efforts in the United States were voluntary, utilizing private means to cover the costs associated with chronic or acute care. No legislative or public programs existed. Although Theodore Roosevelt supported a healthcare program, believing that no country could be strong with people who are sick and poor, he was unable to gain sufficient Congressional support for a federal healthcare policy.

In the early 1900s, the American Association of Labor Legislation (AALL), seeing the gains of working-brethren in Europe, began supporting healthcare insurance coverage for their members. In 1915, they created a legislative bill to cover expenses for physicians, hospitals, nurses, maternity, and worker death benefits; funds paid by workers, employers, and the state would support dependents.

As was to typify US healthcare policy initiatives over the ensuing nearly 100 years, multiple constituencies had a hard time agreeing on a common agenda. The American Medical Association (AMA) initially stood behind the AALL healthcare coverage legislation. However, due to disagreements within the AMA on specifics of physician payment, the AMA soon withdrew its support.

Similar discord within the labor movement occurred when the American Federation of Labor denounced compulsory health insurance, concerned that a government-based health insurance system would weaken union-power. The commercial insurance industry, whose primary revenues were based on coverage for funeral and other death benefits, also opposed this bill due to challenges to the bill's death-benefits schemes. As a result, nothing came of these early efforts.

With the advent of World War I, political ideology precluded financing compulsory social services that in any way appeared similar to German "sickness funds." In the 1930s, the focus changed from financing healthcare to providing healthcare services. At this time, medical costs for workers were regarded as a serious problem. Rising healthcare costs provided the stimulus for several public and private efforts to attempt to transform the US healthcare system.

Fast forward to the early 1960s when healthcare transformation again dominated Congressional and public debate. Through several political compromises, Medicare and Medicaid were born in 1965, offering public health insurance for those over age 65 and low-income populations. States slowing began to roll out implementation of Medicaid throughout the late 1960s and early 1970s.

> The problems we face today are a direct consequence of actions that we failed to take yesterday. Since Teddy Roosevelt first called for reform nearly a century ago, we have talked and we have tinkered. We have tried and fallen short, we've stalled for time, and again we have failed to act because of Washington politics or industry lobbying (Obama 2009)

Today, the US healthcare system is one of the most technologically advanced in the world. But while the United States is perceived as a global healthcare leader and spends much more on healthcare than other countries, its outcomes and rates of mortality are at best comparable to those of the developing world. As with most other major economies, the United States continues to grapple with how citizens can access high-quality healthcare at a reasonable cost.

Why Is Healthcare So Perplexing to Local and Global Leaders?

Innovation and transformative change in healthcare differ in many ways from innovation in other industries. In most industries, access to innovation is readily accepted, and the economic forces of supply and demand govern the rate of change. For example, smartphones revolutionized communication and multiple related industries. In India, roughly 75 % of the population accesses a mobile telephone. In Kenya, payment and banking services are more ubiquitous on mobile platforms than in many developed markets. As a result, government payment and support transfers to remote areas is dramatically increasing, while reducing transfer inefficiencies and graft in both countries.

Innovations in healthcare, on the other hand, are ripe with tension about whether access to these innovations is a basic human right or a privilege for those who can afford them. The tension between healthcare as a universal right and healthcare as a commodity or "privilege" that should be paid for individually is at the root of much of today's complexities in many healthcare systems. This tension drives how healthcare is consumed, paid for, experimented with, and delivered. In addition, normal market conditions of supply and demand that lead to greater efficiency and higher quality seem sadly lacking in healthcare (Porter and Teisberg 2006). As one writer dryly commented, if other industries operated like healthcare:

- Banking: Automated Teller Machine (ATM) transactions would take days or months because records would be unavailable or misplaced.
- Home Building: carpenters, electricians, and plumbers would work from different blueprints, with little coordination.
- Shopping: prices would not be posted and the price would vary widely within the same store, depending on the source of payment.
- Automobile Manufacturing: warranties for cars would not exist. Factories would not monitor output and would not have the data or incentive to improve production line performance or product quality.
- Airline Travel: each pilot would be free to design his or her own preflight safety check, or not to perform one at all. On average, one jumbo jet would crash each day and result in no changes to the system (Braithwaite 2014).

Today, the United States is not alone in its struggles with improving access, lowering costs, and improving quality. Around the world, countries face challenges to care for aging populations, manage more prevalent chronic diseases, and improve

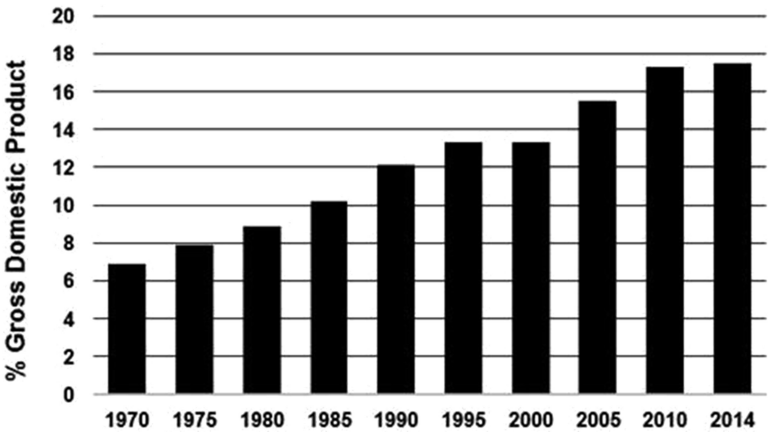

Fig. 2.1 Average percent of gross domestic product spent on healthcare, US, 1970–2014

access to basic medical advances. The "iron triangle" of healthcare—access, quality, and cost—where one can improve two out of the three—but rarely all three simultaneously—seems to bedevil every healthcare system.

The persistence of these issues and the snail-like or nonexistent pace of change led to this book. At the heart of today's issues, lie four questions:

- **WHY** change?
- **WHAT** to change?
- **HOW** to change?
- **WHEN** to change?

We will examine each of these questions in more detail throughout the rest of this book. In summary:

Why Change?

The answer is simple: the current situation is untenable.

Technology advances are ever more expensive, and big data systems collect more data but do not necessarily communicate the right information at the right time to the right party. At least in the United States, players scramble to forge alliances deemed as essential to survive in an ever more chaotic healthcare economy. Providers deliver care in a variety of settings; payers pay for care with a variety of plans. Patients and providers are both confused. Manufacturers of healthcare products face increasing challenges regarding how to recoup their costs of research and development. Politically polarized, local, regional, and federal constituencies are

unable to forge consensus on the best way forward. Overall, these are uncertain times, with problems that increasingly defy incremental solutions.

Trend lines show healthcare spending moving higher and at an increasing rate, as shown in Fig. 2.1 (CMS 2015). What was troubling a few decades ago has become increasingly unsustainable. The impact of rising healthcare costs causes problems throughout the United States and global economies (Economist 2015). Simply put, resources devoted to healthcare preclude availability of resources to improve infrastructure, educate the population, or spend in other ways. For example, in Massachusetts, according to past State Treasurer Timothy P. Cahill:

> The universal [health] insurance coverage we adopted in 2006 was projected to cost taxpayers $88 million a year. However, since this program was adopted in 2006, our healthcare costs have in total exceeded $4 billion. The cost of Massachusetts' plan has blown a hole in the Commonwealth's budget (Bandow 2011).

The same holds true in private industry: the US auto industry faces a competitive disadvantage because of its comparatively large expenditures for healthcare benefits compared to other foreign automobile companies. Rising healthcare costs and their displacement effects underlie the calls for reform. As shown in Fig. 2.1, US healthcare costs have risen dramatically over the past 40 years.

Both governments and healthcare organizations have begun to make efforts to shift or at least reduce the healthcare cost "upward creep." For example, the United States has begun to experiment with healthcare financial incentives that pay for outcomes—such as "risk-based, capitated arrangements" that pay a per-member-per-month rate to providers—rather than pay for inputs, as typified by the historic fee-for-service arrangements permeating the US healthcare system. In the United Kingdom, the National Institute for Health and Care Excellence (NICE) establishes the treatments and drugs the National Health Service (NHS) will support and fund. Approaches like this emerge through a fundamental shift from paying for volume to paying for value and for outcomes, as well as trying to connect compensation for services provided and outcomes realized. Data and information on costs and consumption are slowly becoming much more transparent and generally available—to providers, regulators, and consumers.

The question is: will incremental changes be sufficient or do organizations and healthcare leaders need to embrace transformational change if healthcare systems around the world are to improve access, increase quality, and manage (ideally lower, at least in the United States) costs? This book argues for transformational change.

What to Change?

Three specific areas stand out.

Transforming healthcare organizations. Reflecting on the last 100 years, we see dramatic shifts in medical innovations to improve health, but organizations often

adopt those innovations at a slow, evolutionary pace. New procedures can take decades—or medical generations—to become standards of practice.[1] New drugs, on average, take over a decade to go from initial identification to market launch, at over a $1 billion in R&D costs. While research in fields such as genetics and nanotechnology holds the promise of groundbreaking results, realizing those results more rapidly will take far more funding, time, and collaboration.

Yet, even given the barriers, change is possible—change that can set the path for further innovations. While change is hard, the case example in Chapter 9—Buprenorphine Integrated Care Delivery Project—is indicative of how creative teams use new tools, such as telemedicine, to drive more cost-effective, accessible care. Changes such as these can be leveraged and used by healthcare leaders as demonstration projects to help transform healthcare.

Transforming healthcare delivery. The strong influence of human factors and "decision traps" complicates achieving change in healthcare delivery (Kahneman 2011). One prime example of this influence is "evidence-based medicine." On the surface, having strong evidence for a procedure or treatment plan makes sense. But in reality, providers and patients are often slow in following new evidence, especially data that challenges existing orthodoxies (Gawande 2013). On average, following established protocols will yield the best results—but how can a clinician be sure it will be best for a specific patient in a specific situation?

Also, changing healthcare delivery systems can run counter to the natural tendency to "stick with what got us here." Finding solutions that both support short-term, operational requirements, while allowing for longer-term, more transformational change should bridge the gap between past and future requirements.

Finally, consumers armed with information (though not all of it quality information) influence delivery—or over-delivery—of care. Willing or compliant practitioners driven by past payment systems, too, influence care delivery.[2] In the United States, this situation generates large numbers of often-unnecessary tests, procedures, and prescriptions. Change is occurring: for example, changes to medical-service compensation models. But much more change is needed in delivery and payment models.

The case studies in Chapters 6-13 highlight real-world examples of significant change aimed at counteracting these trends. Chapter 9, for example, summarizes how a major teaching hospital collaborating with a community-based medical practice was able to provide comprehensive healthcare services to a disadvantaged population, thereby facilitating improved clinical outcomes, reduced chronic disease burden, enhanced health-seeking behavior, and improved family and community health dynamics.

Transforming healthcare financing. Healthcare payment systems are equally challenging. In most healthcare systems, the national or federal government can

[1] See the amusing, yet challenging article by Dr. Atul Gawande (2012).

[2] Fee-for-service, in the United States, for example, see the section: *Transforming healthcare financing,* below.

radically change healthcare through regulations and payment systems; achieving the necessary political support for such changes is daunting. In the United States, for example, while politicians continue to battle about the merits of the Affordable Care Act (ACA), new options for payment models are being tested, such as Accountable Care Organizations (ACO), Patient-centered Medical Homes, and Accountable Communities of Health (ACHs). ACOs are entities including hospitals, physicians, and other healthcare professionals responsible for delivering coordinated patient care for a defined population, not just individual patients. Rather than being paid for each service intervention, providers are typically rewarded based on group outcomes, including reduced hospital visits, increased quality, and management of chronic diseases. The Patient-centered Medical Home is a care delivery model in which the primary-care physician is responsible for coordinating treatment to ensure patients receive the care they need when and where they need it. Accountable Communities of Health build on these ideas by developing shared community health goals and bringing together public and private entities to achieve identified health metrics.[3] But these are nascent models, indicative of the range of experiments underway rather than the optimal solution(s).

How to Change?

Given the challenges faced by healthcare systems, and the lack of a clear way forward, it is no surprise that the future is highly uncertain. For any organization—within or outside of healthcare—the problem is how to balance the need for short-term improvements to keep current operations functioning … while simultaneously launching transformative initiatives that can substantially improve the likelihood of long-term success. It is, as one often hears, akin to creating the airplane of the future while flying the prop-plane of the past.

Different organizational challenges require different magnitudes of improvement, which, in turn, result in different types of change. At the low end of the change scale is *incremental change,* which results in small, ongoing improvements in current processes, resources, and organizational elements (Kaplan and Haas 2014). A higher magnitude of improvement, often referred to as *radical redesign,* looks beyond narrow or siloed processes and redesigns the way work is done across an organization. At the top of the scale is *transformation*. In this mode of improvement, discontinuous change occurs, often by taking totally new directions or introducing disruptive technologies into existing business models. (Uber, and its impact on the taxi industry, is a good example.)

[3] In Washington state, for example, ACHs will (1) establish collaborative decision-making on a regional basis to improve health and health systems, focusing on social determinants of health, clinical-community linkages, and whole person care; (2) bring together all sectors that contribute to health to develop shared priorities and strategies for population health, including improved delivery systems, coordinated initiatives, and value based payment models; and (3) drive physical and behavioral healthcare integration by making financing and delivery system adjustments, starting with Medicaid (Washington State 2015).

Magnitude of Improvement	Type of Change	Example
Small and local	Incremental	More efficient intake system in an ER or physician's office
Large and cross-organizational	Radical redesign	New, more efficient and effective care model that improves patients' outcomes from intake to discharge and beyond
Major and disruptive	Transformation	New reimbursement model throughout a delivery or healthcare system

Fig. 2.2 Level of organizational change and corresponding magnitude of improvement

Figure 2.2 distinguishes between levels of change and magnitudes of organizational improvement in healthcare.

Around the world today, countries struggle to care for aging populations and pay for new drugs, technologies. Healthcare consumers want improved access, greater quality, and lower costs, but the necessary trade-offs and the pathways forward are far from clear. And while other nations, such as Norway and Sweden, are much further along than the United States in their use of electronic medical record (EMR) systems, most countries struggle with data accessibility across all healthcare components that could inform treatment protocols, day-to-day administrative decisions, and longer-term transformational efforts.

Hospitals scramble to forge alliances deemed essential for surviving in an ever more chaotic healthcare economy. Pharmaceutical companies are combining in unprecedented numbers, at often staggering costs. Patients and providers are both confused about healthcare insurance options. Overall, these are uncertain times, with problems that increasingly defy incremental solutions.

In the midst of these tumultuous times, healthcare leaders grapple with future challenges and opportunities. The old adage, "If you are a hammer, everything looks like a nail" is too often typical of the strategic initiatives pursued by various healthcare players.

The level of strategic change required today is transformative. But note that incremental change and radical redesign are still required—it is just that those two modes of change, while necessary, are not sufficient. Transformation of organizations is needed to reach a tipping point that will result in broad, industry-wide transformation. Here is the rub: organizations know well how to change incrementally, and many can manage radical redesign. But precious few know how to be successful in transformation. Enabling organizations to achieve transformation is the challenge—and promise of the rest of this volume … while balancing the needs for the short-term, the need to "keep the doors open and business running."

When to Change?

Again, the answer is simple: Change *now!*

If you want to improve your organization's chances for long-term sustainability, start transforming now. It all begins with a well-designed strategic planning process and successful execution. We know it's possible—as the included case studies outline:

- Chapter 7: A large, primary-care practice underwent a major, transformational organizational and cultural change to meet the future demands of changing healthcare systems and the Affordable Care Act.
- Chapter 8: An architect created a new, integrated healthcare master planning process that aligns strategy, finance, and operations for hospitals and providers as they design and develop new facilities to meet the needs of healthcare into the future.
- Chapter 6: A major hospital redesigned its organizational and financial structures to improve its service line offering, yielding efficiencies, higher quality standards, and improved patient satisfaction.

They changed; now you can too! Chapters 3-5 discuss the building blocks needed, from an appropriate approach to transformative strategic planning to the keys for successful execution. Chapters 6-13 summarize examples where different groups within the healthcare ecosystem used these tools and frameworks to drive significant change.

Now, it's your turn: Transform!

Questions Healthcare Leaders and Teams Should Ask

As healthcare leader and author Quint Studer explains, "At one time the healthcare industry operated in a state of episodic change. Today, we've moved to a state of continuous change" (Studer 2013).

Chapter 2 offers a glimpse into why we believe healthcare leaders need to embrace transformational change, balancing short-term requirements (incremental change) with longer-term needs, to be successful in the future. To start on this journey, healthcare leaders should ask themselves and their teams four questions:

1. Why change?
   - What are critical challenges you see in the future?
   - Can you handle these with your current operations, actions, or do you need to assess radical or transformational opportunities?
2. What to change?
   - What are the critical areas in your organization that need to evolve in the future?
   - What current activities will you continue, and what new efforts, capabilities might you look to evolve in the future?

3. How to change?
   - Will you look to make short-term incremental changes … medium-term, more radical changes … or longer-term transformational changes and why?
   - How will you know if changes are successful … what are your goals in undertaking?
4. When to change?
   - Is there a "burning" platform—we have to change now!—or can you take a more gradual approach? Is this true for all your organization's activities?
   - What might be "triggers"—internally or externally—to shift the urgency of change?

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