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Part 1

Still Time For a Healthcare Industry Reinvention

By Allen Weiss, MD, MBA, FACP, FACR
March 28, 2023

Sharing an Almost Unique Perspective — Putting the Hospital Out of Business

I have been both a frontline officer and a staff officer at a health system. I started a solo practice in 1977 and cared for my rheumatology, internal medicine and geriatrics patients in inpatient and outpatient settings. After 23 years in my solo practice, I served 18 years as President and CEO of a profitable, CMS 5-star, 715-bed, two-hospital healthcare system.

From 2015 to 2020, our health system team added 0.6 years of healthy life expectancy for 400,000 folks across the socioeconomic spectrum. We simultaneously decreased healthcare costs 54% for 6,000 colleagues and family members. With our mentoring, four other large, self-insured organizations enjoyed similar measurable results. We wanted to put our healthcare system out of business. Who wants to spend a night in a hospital?

During the frontline part of my career, I had the privilege of "Being in the Room Where It Happens," be it the examination room at the start of a patient encounter, or at the end of life providing comfort and consoling family. Subsequently, I sat at the head of the table, responsible for most of the hospital care in Southwest Florida. [1]

Many folks commenting on healthcare have never touched a patient nor led a large system. Outside consultants, no matter how competent, have vicarious experience that creates a different perspective.

At this point in my career, I have the luxury of promoting what I believe is in the best interests of patients — prevention and quality outcomes. Keeping folks healthy and changing the healthcare industry's focus from a "repair shop" mentality to a "prevention program" will save the industry and country from bankruptcy. Avoiding well-meaning but inadvertent suboptimal care by restructuring healthcare delivery avoids misery and saves lives.

RESPONDING TO AN ATTACK

Preemptive reinvention is much wiser than responding to an attack. Unfortunately, few industries embrace prevention. The entire healthcare industry, including health systems, physicians, non-physician caregivers, device manufacturers, pharmaceutical firms, and medical insurers, is stressed because most are experiencing serious profit margin squeeze. Simultaneously the public has ongoing concerns about healthcare costs. While some medical insurance companies enjoyed lavish profits during COVID, most of the industry suffered. Examples abound, and Paul Keckley, considered a dean among long-time observers of the medical field, recently highlighted some striking year-end observations for 2022. [2]

Recent Siege Examples

Transparency is generally good but can and has led to tarnishing the noble profession of caring for others. Namely, once a sector starts bleeding, others come along, exacerbating the exsanguination. Current literature is full of unflattering public articles that seem to self-perpetuate, and I've highlighted standout samples below.

- **The Federal Government is the largest spender in the healthcare industry and therefore the most influential.** Not surprisingly, **congressional lobbying was intense during the last two weeks of 2022 in a partially successful effort to ameliorate spending cuts for Medicare payments for physicians and hospitals.** Lobbying spend by Big Pharma, Blue Cross/Blue Shield, American Hospital Association, and American Medical Association are all in the top ten spenders again. [3, 4, 5] These organizations aren't lobbying for prevention, **they're lobbying to keep the status quo**.

- Concern about consistent quality should always be top of mind. "Diagnostic Errors in the Emergency Department: A Systematic Review," shared by the Agency for Healthcare Research and Quality, compiled 279 studies showing a **nearly 6% error rate for the 130 million people who visit an ED yearly.** Stroke, heart attack, aortic aneurysm, spinal cord injury, and venous thromboembolism were the most common harms. The defense of diagnostic errors in emergency situations is deemed of secondary importance to stabilizing the patient for subsequent diagnosing. Keeping patients alive trumps everything. Commonly, patient ED presentations are not clear-cut with both false positive and negative findings. Retrospectively, what was obscure can become obvious. [6, 7]

- Spending mirrors motivations. The *Wall Street Journal* article "Many Hospitals Get Big Drug Discounts. That Doesn't Mean Markdowns for Patients" lays out how **the savings from a decades-old federal program that offers big drug discounts to hospitals generally stay with the hospitals.** Hospitals can chose to sell the prescriptions to patients and their insurers for much more than the discounted price. Originally the legislation was designed for resource-challenged communities, but now **some hospitals in these programs are profiting from wealthy folks paying normal prices and the hospitals keeping the difference**. [8]

- "Hundreds of Hospitals Sue Patients or Threaten Their Credit, a KHN Investigation Finds. Does Yours?" Medical debt is a large and growing problem for both patients and providers. **Healthcare systems employ collection agencies that typically assess and screen a patient's ability to pay**. If the credit agency determines a patient has resources and has avoided paying his/her debt, the health system send those bills to a collection agency. **Most often legitimately impoverished folks are left alone, but about two-thirds of patients who could pay but lack adequate medical insurance face lawsuits and other legal actions attempting to collect payment** including garnishing wages or placing liens on property. [9]

- "Hospital Monopolies Are Destroying Health Care Value," written by Rep. Victoria Spartz (R-Ind.) in *The Hill*, includes a statement attributed to Adam Smith's *The Wealth of Nations*, "that the law which facilitates consolidation ends in a conspiracy against the public to raise prices." **The country has seen over 1,500 hospital mergers in the past twenty years** — an example of horizontal consolidation. Hospitals also consolidate vertically by acquiring physician practices. As of January 2022, 74 percent of physicians work directly for hospitals, healthcare systems, other physicians, or corporate entities, causing not only the **loss of independent physicians but also tighter control of pricing and financial issues**. [10]

The healthcare industry is an attractive target to examine. Everyone has had meaningful healthcare experiences, many have had expensive and impactful experiences. Although patients do not typically understand the complexity of providing a diagnosis, treatment, and prognosis, the care receiver may compare the experience to less-complex interactions outside healthcare that are customer centric and more satisfying.

PROFIT-MARGIN SQUEEZE

Both nonprofit and for-profit hospitals must publish financial statements. Three major bond rating agencies (Fitch Ratings, Moody's Investors Service, and S & P Global Ratings) and other respected observers like KaufmanHall, collate, review, and analyze this publicly available information and rate health systems' financial stability.

One measure of healthcare system's financial strength is operating margin, the amount of profit or loss from caring for patients. In January of 2023 the median, or middle value, of hospital operating margin index was -1.0%, which is an improvement from January 2022 but still lags 2021 and 2020.

Erik Swanson, SVP at KaufmanHall, says 2022,

> ***"Is shaping up to be one of the worst financial years on record for hospitals. Expense pressures — particularly with the cost of labor — outpaced revenues and drove poor performance. While emergency department visits and operating room minutes increased slightly, hospitals struggled to discharge patients due to internal staffing shortages and shortages at post-acute facilities," [11]***

Another force exacerbating health system finance is the competent, if relatively new retailers (CVS, Walmart, Walgreens, and others) that provide routine outpatient care affordably. Ninety percent of Americans live within ten miles of a Walmart and 50% visit weekly. CVS and Walgreens enjoy similar penetration. Profit-margin squeeze, combined with new convenient options to obtain routine care locally, will continue disrupting legacy healthcare systems.

Providers generate profits when patients access care. Additionally, "easy" profitable outpatient care can and has switched to telemedicine. Kaiser-Permanente (KP), even before the pandemic, provided about 50% of the system's care through virtual visits. Insurance companies profit when services are provided efficiently or when members don't use services.

KP has the enviable position of being both the provider and payor for their members. The balance between KP's insurance company and provider company favors efficient use of limited resources. Since COVID, 80% of all KP's visits are virtual, a fact that decreases overhead, resulting in improved profit margins. [12]

On the other hand, KP does feel the profit-margin squeeze because labor costs have risen. To avoid a nurse labor strike, KP gave 21,000 nurses and nurse practitioners a 22.5% raise over four years. KP's most recent quarter reported a net loss of $1.5B, possibly due to increased overhead. [13]

The public, governmental agencies, and some healthcare leaders are searching for a more efficient system with better outcomes at a lower cost. Our nation cannot continue to spend the most money of any developed nation and have the worst outcomes. In a globally competitive world, limited resources must go to effective healthcare, balanced with education, infrastructure, the environment, and other societal needs. A new healthcare model could satisfy all these desires and needs.

Even iconic giants are starting to feel the pain of recent annual losses in the billions. Ascension Health, Cleveland Clinic, Jefferson Health, Massachusetts General Hospital, ProMedica, Providence, UPMC, and many others have gone from stable and sustainable to stressed and uncertain. Mayo Clinic had been a notable exception, but recently even this esteemed system's profit dropped by more than 50% in 2022 with higher wage and supply costs up, according to this Modern Healthcare summary. [14]

The alarming point is even the big multigenerational health system leaders who believed they had fortress balance sheets are struggling. Those systems with decades of financial success and esteemed reputations are in jeopardy. Changing leadership doesn't change the new environment.

Nonprofit healthcare systems' income typically comes from three sources — operations, namely caring for patients in ways that are now evolving as noted above; investments, which are inherently risky evidence by this past year's record losses; and philanthropy, which remains fickle particularly when other investment returns disappoint potential donors. For-profit healthcare systems don't have the luxury of philanthropic support but typically are more efficient with scale and scope.

The most stable and predictable source of revenue in the past was from patient care. As the healthcare industry's cost to society continues to increase above 20% of the GDP, most medically self-insured employers and other payors will search for efficiencies. Like it or not, persistently negative profit margins will transform healthcare.

Demand for nurses, physicians, and support folks is increasing, with many shortages looming near term. Labor costs and burnout have become pressing stresses, but more efficient delivery of care and better tools can ameliorate the stress somewhat. If structural process and technology tools can improve productivity per employee, the long-term supply of clinicians may keep up. Additionally, a decreased demand for care resulting from an effective prevention strategy also could help.

Most other successful industries work hard to produce products or services with fewer people. Remember what the industrial revolution did for America by increasing the productivity of each person in the early 1900s. Thereafter, manufacturing needed fewer employees.

PATIENTS' NEEDS AND DESIRES

Patients want to live a long, happy and healthy life. The best way to do this is to avoid illness, which patients can do with prevention because 80% of disease is self-inflicted. When prevention fails, or the 20% of unstoppable episodic illness kicks in, patients should seek the best care.

The choice of the "best care" should not necessarily rest just on convenience but rather objective outcomes. Closest to home may be important for take-out food, but not healthcare.

Care typically can be divided into three categories — acute, urgent, and elective. Common examples of acute care include childbirth, heart attack, stroke, major trauma, overdoses, ruptured major blood vessel, and similar immediate, life-threatening conditions. Urgent intervention examples include an acute abdomen, gall bladder inflammation, appendicitis, severe undiagnosed pain and other conditions that typically have positive outcomes even with a modest delay of a few hours.

Most every other condition can be cared for in an appropriate timeframe that allows for a car trip of a few hours. These illnesses can range in severity from benign that typically resolve on their own to serious, which are life-threatening if left undiagnosed and untreated. Musculoskeletal aches are benign while cancer is life-threatening if not identified and treated.

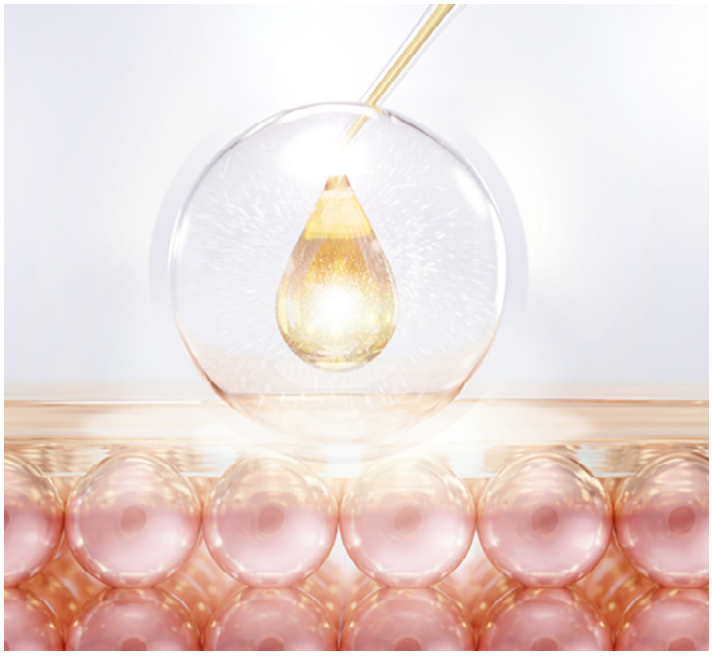
Getting the right diagnosis and treatment for both benign and malignant conditions is crucial but we're not even near perfect for either. That's unsettling.

In a 2017 study,

> ***"Mayo Clinic reports that as many as 88 percent of those patients [who travel to Mayo] go home [after getting a second opinion] with a new or refined diagnosis — changing their care plan and potentially their lives. Conversely, only 12 percent receive confirmation that the original diagnosis was complete and correct. In 21 percent of the cases, the diagnosis was completely changed; and 66 percent of patients received a refined or redefined diagnosis. There were no significant differences between provider types [physician and non-physician caregivers]." [15]***

The frequency of significant mis- or refined-diagnosis and treatment should send chills up your spine. With healthcare we are not talking about trivial concerns like a bad meal at a restaurant, we are discussing life-threatening risks. Making an initial, correct first decision has a tremendous influence on your outcome.

Sleeping in your own bed is nice but secondary to obtaining the best outcome possible, even if car or plane travel are necessary. For urgent and elective diagnosis/treatment, travel may be a



good option. Acute illness usually doesn't permit a few hours of grace, although a surprising number of stroke and heart attack victims delay treatment through denial or overnight timing. But even most of these delayed, recognized illnesses usually survive. And urgent and elective care gives the patient the luxury of some time to get to a location that delivers proven, objective outcomes, not necessarily the one closest to home.

Measuring quality in healthcare has traditionally been difficult for the average patient. Roadside billboards, commercials, displays at major sporting events, fancy logos, name changes and image building campaigns do not relate to quality. Confusingly, some heavily advertised metrics rely on a combination of subjective reputational and lagging objective measures. Most consumers don't know enough about the sources of information to understand which ratings are meaningful to outcomes.

Arguably, hospital quality star ratings created by the Centers for Medicare and Medicaid Services (CMS) are the best information for potential patients to rate hospital mortality, safety, readmission, patient experience, and timely/effective care. These five categories combine 47 of the more than 100 measures CMS publicly reports. [16]

A 2017 *JAMA* article by lead author Dr. Ashish Jha said:

> ***"Found that a higher CMS star rating was associated with lower patient mortality and readmissions. It is reassuring that patients can use the star ratings in guiding their health care seeking decisions given that hospitals with more stars not only offer a better experience of care, but also have lower mortality and readmissions."***

The study included only Medicare patients who typically are over 65, and the differences were most apparent at the extremes, nevertheless,

> ***"These findings should be encouraging for policymakers and consumers; choosing 5-star hospitals does not seem to lead to worse outcomes and in fact may be driving patients to better institutions." [17]***

Developing more 5-star hospitals is not only better and safer for patients but also will save resources by avoiding expensive complications and suffering.

As a patient, doing your homework before you have an urgent or elective need can change your outcome for the better. Driving a couple of hours to a CMS 5-star hospital or flying to a specialty hospital for an elective procedure could make a difference.

Business case studies have noted that hospitals with a focus on a specific condition deliver improved outcomes while becoming more efficient. [18] Similarly, specialty surgical areas within general hospitals have also been effective in improving quality while reducing costs. Mayo Clinic demonstrated this with its cardiac surgery department. [19] A similar example is Shouldice Hospital near Toronto, a focused factory specializing in hernia repairs. In the last 75 years, the Shouldice team has completed four hundred thousand hernia repairs, mostly performed under local anesthesia with the patient walking to and from the operating room. [20] [21]

THE BOTTOM LINE

The Mayo Brother's quote, "The patient's needs come first," is more relevant today than when first articulated over a century ago. Driving treatment into distinct categories of acute, urgent, and elective, with subsequent directing care to the appropriate facilities, improves the entire care process for the patient. The saved resources can fund prevention and decrease the need for future care. The healthcare industry's focus has been on sickness, not prevention. The virtuous cycle's flywheel effect of distinct categories for care and embracing prevention of illness will decrease misery and lower the percentage of GDP devoted to healthcare.

Editor's note: This is a multi-part series on reinventing the healthcare industry. Part 2 addresses physicians, non-physician caregivers, and communities' responses to the coming transformation.

AUTHOR

Dr. Allen Weiss is Chief Medical Officer for the national Blue Zones Project. Having practiced rheumatology, internal medicine, and geriatrics for 23 years and been President and CEO for 18 years of a 716-bed, two-hospital integrated system, Dr. Weiss now has a national scope focused on prevention.

After graduating from Columbia University's College of Physicians and Surgeons and subsequently completing his training at both the New York Presbyterian Hospital and Hospital for Special Surgery of Cornell University, he had a solo practice in Rheumatology, Internal Medicine, and Geriatrics for twenty-three years. He is recognized both as a Fellow of the American College of Physicians and a Fellow of the American College of Rheumatology.

Dr. Weiss's national commitments and honors include: named as one of the Top 100 outstanding physician leaders of healthcare systems by Becker's Hospital Review multiple times; chosen as a keynote speaker at numerous meetings; served five years on the Regional Advisory Council of the American Hospital Association; elected to the American Hospital Association Board in 2017; selected as Chairman of the Upper Midwest Vizient Board; and continues as a Director of American Momentum Bank. In 2005, he was invited to testify on information technology before the U.S. House Ways and Means Health Subsection.

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