Keynote "Roadblocks to Change"

By Sherry Glied

In her keynote speech Sherry Glied, Professor and Dean of the Wagner School of Public Services, New York University, USA and former Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services, Washington D.C., USA elaborated on „Roadblocks to Change" for current and future health care systems.

In previous sessions during the morning it became clear that healthcare is very dependent on the local context it is embedded in. However, a common goal of all healthcare systems is the strive for better value in healthcare. The questions that need to be asked in light of this goal are why don't we emulate the best performers? Why are some healthcare systems doing better than others? And rather controversially, is the healthcare sector uniquely inept in achieving its goals?

Sherry acknowledges that asking if the healthcare sector is more inefficient than others is rather difficult to answer due to the lack of comparison to other industries. However, recent research in management is emerging by looking at the quality of management, productivity, and movement towards the best. But how to do this?

To gain more in-depth insight in this area of interest, work that has been done in management research provides some interesting results. The results of an international standard survey that was administered to managers across various settings showed that the scores for management in healthcare vary but average roughly the same as management in manufacturing industries. The ranking for countries are the same for manufacturing and healthcare, with a singular exception for the UK where hospital management ranked better than manufacturing management. Thus, Sherry concluded, that managers in healthcare are not uniquely inept, as the quality of managers is not the problem.

In a second step, Sherry looked into hospital productivity by comparing productivity of hospitals treating heart attacks as example with productivity in other settings. However, there are only few studies examining the efficiency in other industries. Surprisingly, ready-mix concrete was found to be the only other comparable industry. What both industries have in common is that they are both extremely localized and do not compete across vast geographic areas. Although markets are similar, dispersion of ready-mix concrete productivity is far more than for hospitals.

In a third step, Sherry looked into the movement towards the best by looking at the question how much market share do hospitals have that do well? The answer to this question is simple: they do attract more patients. This results most likely from transfers from other hospitals as the market reallocates patients to hospitals with better survival outcomes but not necessarily better cost outcomes.

In summary, what can be learned from these examples is that size really helps. Management quality does improve with size of the hospital and number of sites. However, looking at average physician offices, management scores might be lower, given their relatively smaller size. Moreover, NHS research shows that more competition leads to better management practices. So, overall healthcare systems are not uniquely inept, given size, organizational form and competitive landscape.

But if efficiency in healthcare should be improved there is a need to move to new structures with properties described in literature, such as organization that are locally competitive, can achieve relative scale between or within markets and be able to enable some level of customization to treat individual patients. However, some of the exemplary US models, e.g. Kaiser Permanente, Mayo Clinic or Intermountain Health System, do not have these properties. More specifically, they are mainly geographically limited and are regional monopolies.

One example that Sherry used to illustrate the effect of new structures to the healthcare audience was Starbucks Coffee. Before Starbucks opened there were already many coffee shops, bad ones as well as good ones, a similar snapshot of the current competitive healthcare landscape. Although Starbucks does not offer the best coffee, since its emergence in 1990, overall quality of coffee in the market has improved. However, the increase of quality in coffee in the market was not the result of a new innovation in coffee or better management, but rather because of the invention of a new organizational form that deployed resources differently. So why don't we have a Starbucks in healthcare?

According to Sherry, the answer to this question is threefold:

First, because of the famous 80/20 rule. According to the 80/20 rule, 20% of customers account for 80% of the business. In healthcare, the numbers can be defined even more precisely, having 1% of healthcare users account for 25% of the expenses, also known as the 25/1 rule. Therefore, healthcare systems are focusing on selection rather than on optimizing processes. Money is gained by selecting the right patients, whether it be through cream skimming or hot spotting.

The second problem are politics. Hospitals are a focal point and doctors have unparalleled political access. Moreover, advocacy groups that influence politics are representatives of sick people. This poses a selection bias on current politics as the 1% of patients make a greater impact than the rest. For healthcare management, it is easier to go to the person who controls the money and power than looking into organizational change.

The third problem is inertia. Medicine has been around much longer than coffee and the physician-patient relationship is perceived as sacred. A sick patient will not change their doctor. Furthermore there are many entrenched interests and stakeholders who would prefer to maintain the current fee-for-service status quo.

What can be done to overcome these problems? According to Sherry it is first of all important to not build policies around hospitals. A lot of what is happening in healthcare is focused around hospitals as this is where the money is. However, utilization of hospitals is dropping and healthcare systems will fail to make substantial impact if they move top down from hospitals. In other words, it is important to not only focus on the sickest patients but to get the focus of managers on the broader systems.

In her speech, Sherry offers several ways to move towards this goal. First, in her opinion it is important to weaken incentives in healthcare systems. Good incentives in healthcare combine 3 sets of payment: case-based payments that reward efficiency but also strong incentive for selection; quality-based payment, which are very difficult to measure; cost-based payment which reduces incentives for efficiency as well as selection. Second, friction in healthcare systems need to be reduced which would make it easier for patients to switch doctors. Patients should have access to their medical records. Although, legally allowed, this is not yet common in practice. Third, Sherry advocated for changing medical education towards multiple sites training, exchange training in other countries and broadening the perspective of medical students by exploring how things are done in other

areas. This will promote innovation. Last but not least, Sherry suggests to provide more quality information to providers so they can make better decisions on behalf of their patients. As providers are professionals they will care about how well they are doing and this information might incentivize their own improvement in effort to be better.

Sherry concludes that the goal is not only to think towards how policymakers can do better in achieving these goals but also how the big forces in the markets can work towards providing better care.

During the discussion, Sherry elaborated further on the suggestion to make quality information available to the providers. She emphasized the importance to distinguish between quality information that is available for the provider and what is available for the patient. From a patient perspective it is important to have all relevant information available on the medical record that would allow to switch doctors. This should basically include test results. Whereas, quality information for providers should include performance indicators compared to their peers.

The importance of looking into the trainings for medical students in light of challenges caused by scarce resources and an increasing amount of scientific information that needs to be taught in a limited amount of time was also emphasized during the discussion.

Another important point that was raised throughout the discussion was the need for new organizational forms. The form of retail and urgent care that was presented at the pre-conference workshop of this forum was deemed optimistic, simply because it is a new form. However, these forms need to extend beyond urgent care and replace primary care. Maybe they will become a new medical home that does not close at 5 or 6pm and is more accessible and convenient to patients while reducing their burden.

Sherry was asked about her thoughts on the focused factory model within healthcare. In her opinion, it could run well in a narrow set of areas and could do well. But the question is if it will have enough scale and have enough competition to spur greater efficiencies and management innovation? Only having one will mean relying on the good faith of the person running them. But how many geographic regions can do this? It seems like there won't be so many outside of major metropolitan areas.