A Practical Roadmap for the Perilous Journey from a Culture of Entitlement to a Culture of Accountability

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In a *culture of entitlement* there is the belief that one deserves certain rewards, rights, and privileges based on tradition or past achievements. In contrast, in a *culture of accountability* rewards, rights, and privileges are only earned based on the merits of one's current behaviors and actions and the measurable results they produce. The transition from a *culture of entitlement* to a *culture of accountability* is a perilous journey because rights and privileges are no longer automatic, and the "entitled party" usually feels disappointed, angry, or mistreated.

A culture of entitlement is deeply embedded in the US healthcare system: patients believe they are entitled to state-of-the-art care regardless of their unhealthy lifestyles; physicians believe they are entitled to a high degree of clinical autonomy and historical levels of compensation regardless of the outcomes of their patients; hospitals believe they are entitled to be reimbursed at the highest rates in the world regardless of their inefficiencies or the results they produce; and suppliers (e.g., insurance and pharmaceutical companies) believe they are entitled to high margins regardless of the relative value they provide to the system.

This culture of entitlement has driven per capita healthcare spending in the US to twice what our peer countries spend on healthcare (Davis, Schoen, and Stremikis 2010). It has driven healthcare costs to a point where neither the public nor private sectors can continue to absorb the historical rate of cost growth. And it has called the question as to whether the US healthcare system is creating sufficient value (i.e., outcomes per unit cost).

In recent years, more data on the value created by the US healthcare system have become available, and the early numbers are not good. According to McKinsey, in 2006, the United States spent $2.1 trillion on healthcare, more than twice what the nation spent on food and more than China's citizens spent for all goods and services. In addition, adjusting for economics, health status, and other factors, the United States spent $650 billion more on healthcare than expected when compared to peer countries. Hospital and physician care accounted for almost 85 percent of the spending above expected levels, with drugs, health administration, and insurance comprising the remained components of excess spending (McKinsey 2008).

The primary driver of this excessive cost appears to be the salaries and revenues of providers and suppliers. For example, McKinsey estimates that for inpatient care, "revenue per equivalent admission" accounts for $54 billion in excess costs compared to peer countries (McKinsey 2008). This is driven in part by the cost of nurses

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who are paid 36 percent more than their peers in other countries, adjusting for per capita GDP (McKinsey 2008). On average the price of the same drug is 50 percent higher in the United States than in other peer countries. Based on a multiple of per capita GDP, primary care physicians in the United States are paid 46 percent more than physicians in peer countries, and US specialists are paid 67 percent more than their peers (McKinsey 2008). It is no wonder that the combined physician and hospital fee for a normal infant delivery in the United States is twice that of most peer countries (IFHP 2010).

Given the relatively high investment in input costs, one would expect a commensurate benefit in outcomes; however, this does not appear to be the case. According to the Commonwealth Fund study, "The US health system is the most expensive in the world, but comparative analyses consistently show the United States underperforms relative to other countries on most dimensions of performance" (Davis, Schoen, and Stremikis 2010).

Data on life expectancy versus cost by country provide further support for the argument that the outcomes produced by the US healthcare system are not commensurate with the high level of spending.

Finally, the high variability in care raises questions as to whether everyone is getting appropriate care:

1. The rate of mastectomy versus lumpectomy in North Carolina varied from 0.4 per 1,000 Medicare beneficiaries in the Wilson HSA to 2.7 in the Goldsboro HSA (Brownlee et al. 2011).
2. The rate of coronary artery bypass surgery ranged from 8.9 per 1,000 in McAllen, Texas, to 1.9 per 1,000 in Pueblo, Colorado (Brownlee et al. 2011).
3. Nonradiologist self-referrers of medical imaging are 2.48 times more likely to order imaging than clinicians with no financial interest in imaging equipment (Fischer 2011).
4. Despite clinical practice guidelines recommending against it, 53 percent of heart attack patients received a stent more than 24 hours after having a heart attack (Cortez 2011).

The often-quoted disparity in the per capita cost of care of Medicare patients in McAllen and El Paso, Texas, has raised many eyebrows. Recent research from Franzini, Mikhail, and Skinner (2010) shows that, while per capita Medicare spending was 86 percent higher in McAllen than in El Paso, the per capita spending for Blue Cross patients in McAllen was actually 7 percent less than in El Paso. The authors concluded that their study is "consistent with Dr. Gawande's finding (2009) that our healthcare system has created a 'culture of money'—in which some providers may overuse profitable Medicare services when there is [unconstrained] diagnostic and procedural discretion and clinical latitude" (Franzini, Mikhail, and Skinner 2010).

A recent study of value of healthcare services in Massachusetts conducted by the state's attorney general found that the difference in prices paid by insurers to the

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lowest-paid physician group and the highest-paid exceeded 145 percent, and the difference in hospital payments exceeded 170 percent. The attorney general concluded that this wide variation in the payments made by health insurers to providers is not adequately explained by differences in quality, complexity of services, or their characteristics that might justify variation in prices. The study notes, "Instead prices reflect the relative market leverage of health insurers and healthcare providers" (AGO 2011).

In his recent speech to the American College of Surgeons (ACS), Senator Mark Kirk summarized the government's position on the current healthcare system: "Every group that relies on federal funding should expect a 10 to 20 percent drop in that funding." When Dr. L. D. Britt, president of the ACS, warned that such cuts could send some healthcare providers into a "tailspin," Kirk replied, "The tailspin is the US economy. There is a new audience at play," Kirk said, referring to US creditors. "The judgments they render, they are swift and severe" (Robeznieks 2011).

Nobody is at fault for the lack of value delivered by the healthcare system. The behavior of the members of the healthcare community is based on the current system of incentives. McKinsey (2008) noted that the participants in the US healthcare system are behaving quite rationally given the incentives—or as Paul Batalden stated (McInnis 2006), "Every system is perfectly designed to produce the results it gets." For this reason, most of the major reform initiatives being proposed for the healthcare system—such as value-based purchasing, ACOs, and bundled payments—are focused on changing the incentives from utilization and entitlement to value and accountability.

At best, changing the culture of an organization or industry is painful, for it always meets with a resistance movement that tries to preserve the entitlements of the past. But if not recognized and managed, cultural transformation can be terminal for an organization. An organization can find itself ill-equipped to deal with the new market realities either because these new realities are not recognized or because the changes are resisted by key internal stakeholders.

Through the implementation of value-based purchasing, reduced reimbursement, and data transparency, health systems are being steered on a perilous journey from entitlement to accountability. The healthcare literature is overflowing with tactics and strategies that sound great on paper and may be working in Cleveland, Ohio, or Chicago, or Rochester, Minnesota, after decades of trial and error, but there is little evidence that these proposed solutions will work in most healthcare communities immediately. Michael Porter provides excellent advice on how to increase the value in healthcare. He notes, "Improving performance and accountability depends on having shared goals that unite stakeholders. In healthcare, the absence of clarity about goals has led to divergent approaches, gaming the system, and slow progress in performance improvement. Rigorous, disciplined measurement is the best way to drive progress" (Porter 2010).

Some refer to this shared goal to unite stakeholders as "true north" (Toussaint 2010). To maximize performance under the traditional model, most health systems'

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strategic behavior can be characterized as operating a financially strong health system by maximizing revenues through pricing and volume growth, the provision of a broad range of services, and meeting the individual clinical and financial needs of each physician.

The new true north is clear: *Operating a financially strong, high-functioning health system that consistently achieves optimal measurable value (i.e., outcomes/cost) for every patient.*

The following are practical steps that a health system can implement to begin the long journey of transformation.

1. Dispassionately analyze the market and conduct regular briefings for board members, physicians, employees, and the community on the structural changes in healthcare occurring at the local, state, and federal level.
2. Designate a group of physician leaders to be the clinical transformation task force. Use this group as a sounding board and to lead implementation efforts to establish an unambiguous course for change with straightforward targets.
3. Make sure you have the right people in the right seats and that they are committed to this new direction. While it is good to have different points of view, when the organization decides to move in a certain direction, it cannot have members of its leadership team resisting the change.
4. Focus the organization on tactical excellence in areas that provide value to your customer. Develop accountability measures for every specialty and hospital department. Initially this data should be blinded, but designate a time in the future when all results will be transparent. Note: The health plans and the government have already begun publishing an ever-increasing amount of unblinded outcome data by hospital and physician.
5. The chief medical officer or his designee should be held accountable for the performance of all hospital-based physicians and medical directors and should routinely measure and manage their performance.
6. Base compensation for employed physicians should be modified to include patient satisfaction, system performance, and cooperation with system initiatives. These highest-paid employees in your health system must understand that their ongoing employment is contingent on providing measurable value to the patient rather than considering this a criterion for achieving a bonus payment.
7. Select a few high-volume Medicare DRGs and initiate a process for designing care to improve cost and quality and reduce readmissions. Pick a redesign methodology; many health systems are using Lean. Consider a bundled payment demonstration if the health system and physicians share a common vision for decreasing cost and improving quality (and probably getting paid less per unit of service than under fee for service).

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8. Develop a three-year plan to break even on Medicare reimbursement. Establish best-practice performance metrics for every department of the hospital, and hold the managers accountable for meeting or exceeding these targets.
9. ACOs: Buyer beware. Webster defines *risk* as "hazard, danger, peril; exposure to loss, injury or destruction." While it is true that there is a theoretical opportunity to make more money by doing less, we learned in the mid-1990s that organizations that take the financial risk for the health of the population can end up much worse off than if they did nothing. After decades of observing healthcare providers that successfully take risks, it is clear to me that the critical competencies needed to successfully take risk include
   a. physicians who share a common electronic health record system and point-of-care protocols,
   b. a culture focused on reducing utilization of hospitals and high-end interventions,
   c. a strong base of primary care physicians,
   d. selective use of specialists based on the efficiency of the care they provide, and
   e. a robust, mature (expensive) infrastructure.

Since most health systems do not possess these competencies they should limit their exposure to risk and test these competencies on the employee population of the health system. If a health system wants to be in the Medicare risk business, consider joint-venturing a Medicare Advantage Plan with a local payer.

As Henry Kissinger said, "The task of a leader is to get his people from where they are to where they have not been" (Sidey 1980). Define your true north, and begin the journey from entitlement to accountability by taking practical, incremental steps described above. Enjoy the ride!

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