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Opinion Article

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By Design: Aligning Structure with Values to Impact Outcomes in a Public Utility Model

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Abstract

The lived experiences of thousands of health care providers demonstrates an inconguence in values while giving us a tremendous amount of information - if we listen. At every level behaviors are compromised in a structure when the values of the providers are not aligned with the system. Over time, statistics as well as disease become so normalized that the status quo dominates perceptions and inhibits action. The United States will continue to have mediocre to poor outcomes unless the ethical foundation of the system is fundamentally altered to profit on wellness.

"You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete."

Buckminster Fuller[1]

There is a tremendous gap between the health care we want to deliver, and the care we provide. This chasm exists at the most fundamental level because the values of the system are not aligned with the values of practitioners. Significant change in health care delivery will not occur until we acknowledge the current reality and create a new structure.

It is well known that "the ethical dimension of individuals that is essential to a system's success."[2] However, the reality is that in our current model, the ethics of administrators, physicians and nurses are not aligned and can be routinely compromised– as validated by narratives told at every level

1. After understanding that three avoidable deaths were caused by staffing levels below the 25th percentile, a board of directors decided to make no staffing changes because of the imminent

impact on revenue. Safety is optional.

2. Administrators hired new nurses instead of seasoned nurses because they were cheaper. Operation scheduling gave priority time slots to the highest reimbursed surgeries. Leadership is compromised.
3. The more operations a surgeon performs, the more money he/she makes. Referral quotas are offered to incentivize physicians[3]. Surgery is a profitable commodity.
4. Staffing-to-patient ratios are supposedly benchmarked to acuity, but that is not always reality. We tell nurses to care for their patients as if they were their own family member – but then when they ask for additional staff to provide that same safe care, they are told, "Sorry, it's not in the budget". Moral distress abounds.
5. I ordered a thyroid ultrasound, but my patient called me right back, upset that it was going to cost her $1450 when she had a $2000 deductible. I then called the center and asked for the cash price – $150![5] Extortion is common.

These are the lived experiences of good people whose behavior is compromised because they are humans working in a system whose foundational values are mis-aligned.

Problem

Our current disease care system is an extremely profitable business, and this inherently generates a conflict of interests, as well as values. Who do we primarily serve? The patients, or the investors? Stories like these occur daily in hospitals across America because the answer to this critical question is an uneasy silence.

Numerous companies, private equity firms and conglomerates reap immense financial rewards from disease which is so profitable that health care is one of the top three recommended investments for 2021. Bloomberg Businessweek observed in May 2020 that the United States healthcare system "has seen Wall Street investors invade its every corner, engineering medical practices and hospitals to maximize profits as if they were little different from grocery stores."[4] Is health a commodity?

The result of these investments is increased private wealth, but not the improved health of Americans[6]. We have an epidemic of depression and anxiety[7], record homelessness[8] and imprisonment[9] and almost half the nation suffering from one of the top five chronic diseases that cost our health[10] care system over 1.1 trillion dollars[11]. Sickness has been normalized. There were no media blitzes in 2020 about the 600,000 Americans who died from cancer[12]– far exceeding the mortality rate that same year from COVID. Statistics are grim, outcomes are mediocre[13], expense is costly, yet we continue to try to manipulate 'processes' in a system designed to tolerate (if not encourage) illness.

One example is obesity. Weight loss profits exceed 6 billion dollars as companies prosper pushing the extra 500 calories/day from processed foods, while obesity costs our health care system 480 million dollars a year[14]. Yet last year the US Census found that 5.6 million households had trouble putting food on the table in December, and 22 million Americans said they did not have enough to eat the week prior[15]. Meanwhile, health and life insurance companies invest billions in fast food companies[16]. By design, hunger and obesity exist side-by-side with vested interests trumping the best interest of our citizens. While the free market is a hallmark of the American culture, leaders have an ethical obligation to shift incentives to wellness.

Because hospitals are in competition with each other for "customers", a culture of secrecy has evolved. As a patient safety expert, I have seen this grief and devastation firsthand. Up to 400,000 deaths occur annually from completely preventable and avoidable errors[17] [18]. We delude ourselves by expecting that hospitals will risk their reputations to be transparent[19]. The reality is that hush money is routinely paid under the table for settlements, and hospitals are not held account able[20]. By design, a culture of silence prevents us from

learning from our mistakes and harms the patients we are supposed to heal.

The outcomes of disease, huge profits, and errors are a direct result of the structure we created and then politicized[21]. Efforts to make any significant impact on the processes have failed to improve the health of Americans because the problem is in fact, the hierarchical structure[22]-which is not designed to keep Americans healthy, but rather to react to sickness and disease. Despite the Healthy People 2020[23] goal that Americans live "longer lives free of preventable disease, disability, injury, and premature death", we are the first industrialized country whose lifespan is decreasing.

By design, the current disease care structure spends nearly $4 trillion a year on illness[24]. By design, we are bankrupting our country and hemorrhaging 18% of our GDP for health care costs and mediocre outcomes[25]. By design, we pay one-third on administrative overhead[26] while exhausting doctors and nurses in the process and hurting our patients[27]. The outcome is clear and dismal as our life expectancy shortens[28]. But the most concerning fact of all is that none of this is new information to policy leaders.

Aligning the values of practitioners with the system will require a radically new structure – one that is hardwired to profit on wellness.

Fueled by rising premiums and deductibles, a Pew Research study found 63% of Americans believe the government has the responsibility to provide health care coverage for all[29]. Americans have no idea, however, that this will be impossible mainly because we won't have the workforce. By 2025, over 75,000 primary care physicians will retire, as well as 504,000 nurses[30]. There is no plan in place to address this critical shortage. In 2020, over 80,000 qualified applicants for Bachelor and Master's programs in Nursing were rejected due to faculty shortages and institutional budgets[31]. Without nurses and doctors Americans will grow even sicker, and the economy will suffer financially[32].

So far, the current political narrative surrounding health care reform has been limited to three possibilities: remove and replace the Patient Protection Affordable Care Act by implementing Universal Care; remove the PPACA; or incrementally improve the existing PPACA. But there may be another solution.

Ideally, what we needed during the pandemic was an integrated, state-based, regional system that could have responded quickly and effectively to the onset, prevention, and vaccination phases of the COVID crises; a structure that is apolitical and has an independent responsibility to the public thereby fostering trust. This structure by its very nature would generate confidence because 1) it would be locally administered by providers known to the community, 2) accountable and transparent to the public, 3) and profit on wellness. One possible solution is the public utility model.

Defining Public Utility

The public utility model is a structure that is designed to improve the health of Americans and align practitioner values. By definition, a public utility enterprise is one that provides certain classes of vital services to the public like sewer, water, heat and sanitation[33]. In 2016 and 2021 there was an outcry that broadband internet also falls into this category[34]. But not health?

Legal Precedence

The Public Utility Holding Corporation Act of 1935 was enacted because electricity was viewed as a commodity to be enjoyed by some, but not a vital public service available to all. Leaders perceived the inequity. Electricity had many of the same issues we are facing in health care: cost, distribution of resources, access, and fragmentation. Franklin D. Roosevelt set precedence on over-inflated, ineffective services when he proposed the public utility solution[35].

When a community is not satisfied with the service rendered or the rates charged by the private "entity", it has the undeniable basic right…to set up… its own governmentally owned and operated service. FDR[36]

The Institute of Medicine report of 1999 fell on deaf ears[37], as did subsequent reports. Nurses are suffering and leaving[38], profits are soaring[39], providers are stressed and depressed[40], and various regions have almost no services[41]. Our outcomes are tragic, and humiliating compared to other nations[42], and the rural system is disintegrating as more and more hospitals close[43]. We are clearly beyond the point of a scolding as a nation, and as Liz Fowler, PhD, Director of Centers for Medicare and Medicaid states, "at a crossroad".

To date, health care has thrived as a business and as a commodity. The missing link that would restore balance to our system is health care as a service. Nurses and physicians have a front seat to pain and suffering and recognize that we all have the same pre-existing condition: we are human. The current structure we created and endorse has no vested interest in improving the health of the community as evidenced by our citizens declining health. Lucrative profits from illness, health disparities, and unnecessary loss of human life have become the norm. The choice then, is to accept reality and advocate for considering other models that provide long term, tenable solutions.

Health Care as a Public Utility

Dr. John Silver proposed an adapted utility model which aligns the values of the practitioners with the system by accomplishing the above listed goals[45]. The ethical dimension of practitioners would not be compromised in a system whose structural integrity is built for wellness; and whose philosophical foundation recognizes that health care is a shared vital need.

The organizational design of this system would be state-based systems led by interdisciplinary regional councils with nurse practitioner or physician led clinics, so that every American would have a primary care provider onboard - as recommended by a recent advisory panel[46]. A system of collaborative care clinics reporting to a regional authority and affiliated with a major university would be the foundation for the adapted public utility model. Financing would be provided by individuals, as well as state and federal funding. Shareholders would profit by investing in the infrastructure.

Just as water, electric and sewer companies have an infrastructure, a public health utility would have an infrastructure that addresses social determinants at a local level. Because behavioral habits are difficult to shape through policy, primary care clinics led by nurse practitioners/physicians would have a behavioral health care manager and psychiatric consultant on staff. The Collaborative Care model developed at the University of Washington has already demonstrated in numerous studies over more than 20 years that a primary care led delivery care model as described above dramatically improves outcomes[47]. It works. What doesn't work, is endorsing a system where enormous profits come from investing in disease, while expecting the outcome of wellness.

The public utility model is familiar, apolitical, regionally administered, equitable, and has a vested interest in creating healthy communities. For this pragmatic solution to become reality, however, policy and health care leaders must publicly acknowledge that health care is primarily a human service – and then act accordingly. In an exclusive system designed to profit on illness, this will be a monumental challenge. But it can be done.

As Americans, our commonalities far outweigh our differences. We all want to see the cost of healthcare lowered, our crumbling infrastructure modernized, and our communities made safer. Senator Curt Schrader (R)

Figure 1

<SIDE BAR> Goals of an Adapted Public Utility System

1. Equitable access appropriate to the communities needs as confirmed by public surveys completed every 6 months by the County Public Health Department (PHD)
2. Quality evidence-based care as documented by single standards as documented by policy and practice manuals updated annually in every clinic
3. Equitable, targeted, and evidence-based distribution of resources determined by the county public health

department in response to needs survey

4. Nurse led interdisciplinary administration so that the system is congruent with their values and maximizes their skill sets as documented in Job Descriptions
5. Equitable and positive outcomes verified through data submitted monthly to the Public Health Regional organization overseeing each clinic
6. Cost efficiency at a local level verified by PHD and at a national level by a decrease in GDP health spending
7. Social accountability and a mandate for direct public reporting as demonstrated by readily available public data submitted monthly to regional PHD in charge of each clinic and made easily available to the public

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