Shut Off the Faucet and Stop Mopping the Floor

David B. Nash, MD, MBA
Editor-in-Chief, American Health & Drug Benefits
Founding Dean, Jefferson College of Population Health, Philadelphia, PA

The American Hospital Association (AHA), which is arguably America’s most important voice for hospitals, periodically holds an executive forum in major cities across the country. This gives the leadership of the association an opportunity to meet local leaders and to continue to hone the message as to the future of hospitals in a quickly evolving delivery system. In addition, it gives those local executives a chance to meet nationally prominent leaders from the AHA and others who may be invited to address each of the regional meetings. I had such an opportunity to address the Philadelphia meeting, and I’d like to share with you, our readers, the following abridged version of my lunchtime plenary comments.

Good afternoon and welcome to the home of the Super Bowl Champion Philadelphia Eagles! It’s just great to have an opportunity to address so many of our leaders from this region, many of whom I count among my professional friends. I had a Wharton professor who gave me a great recipe for a lunchtime talk, which will come in 3 parts. First, we will “point with pride” at our collective accomplishments; then, I will “view with alarm” developments locally and nationally; and I will “end with hope” about the future.

Point with Pride

We certainly have a lot to be proud of here, in the nation’s inaugural city, including that we are home to the American College of Physicians, the American Board of Internal Medicine, the National Board of Medical Examiners, and 5 academic medical centers.

Two of those medical centers have very large private medical schools, including Sidney Kimmel Medical College (of Jefferson University), and Drexel University College of Medicine. These 2 private medical schools, taken together, are training nearly 5% of America’s entire physician workforce. In addition, Philadelphia is the home of at least 3 National Cancer Institute–designated major cancer research centers that are all focused on what has been called the “moon shot to cure cancer.”

At the state level, we are lucky to be in Pennsylvania, home to the Pennsylvania Health Care Cost Containment Council, which recently celebrated its 30th anniversary. This unheralded but vital public agency is one of the most important sources for unbiased outcomes information about what goes on in hospitals across our great state. Its technical reports are the envy of the rest of the nation as they relate to outcomes measurement. I’ve always been a believer that sunshine is the best disinfectant, and one major way to reduce hospital-acquired conditions, for example, is to share the data in the most transparent way possible.

Finally, at the national level, another aspect that we ought to point with pride at, is that medical school enrollment is now, on average, 52% female across the nation. This is a sea change from when I trained nearly 40 years ago.

View with Alarm

Regrettably, there is a lot to view with alarm. Let’s start locally and end nationally. Back to Philadelphia: despite the economic engine created by what we locally call “meds and eds,” we have a gigantic population health challenge. If we look at the Robert Wood Johnson Foundation County Health Rankings, Philadelphia County—which is home to the City of Philadelphia, where we are having this wonderful conference—ranks last with regard to the health and well-being of its citizens. How could this be?

The answer is principally about poverty, because poverty is the key driver of poor health in our nation. In Philadelphia, nearly 25% of the population lives at the federal poverty level, and 50% of those people are in deep poverty: this translates to 400,000 citizens in a population of approximately 1.5 million individuals. We also have a huge underfunded pension expense that one day will cause the collapse of local government. Finally, in Philadelphia we have the largest disparity in life span based on ZIP code of residence. That is, a person who is born in Society Hill has an 88-year anticipated life span, but a person who is born in North Philadelphia has a 68-year anticipated life span. In fact, infant mortality in some of the ZIP codes in North Philadelphia exceeds the infant mortality rate in sub-Saharan Africa.

At the national level, we continue to spend money like a “drunken sailor” for healthcare, with healthcare
consuming potentially 20% of the gross domestic product by 2019. This equates to more than $10,000 per person, including children, on an annual basis. Experts believe that nearly 33% of the $3 trillion we spend on healthcare is of modest to no value.

To reduce per-capita cost, we cannot focus on cost alone. The only way to accomplish this laudable goal is by reducing waste. Waste comes in essentially 3 varieties—clinical waste, operational waste, and poor individual behavior.

Finally, although difficult to discuss in front of a group of accomplished hospital leaders, we must all look in the mirror and admit to ourselves that by all available accounts, medical errors remain the third leading cause of death in the United States. This is difficult for us to believe, given that the famous Institute of Medicine report, To Err Is Human: Building a Safer Health System, was published almost 20 years ago.1 Therefore, colleagues, we must turn to the future and end with hope.

End with Hope

The way we will end with hope is by shutting off the faucet rather than by mopping up the floor: that is, we have to embrace the Triple Aim, which Donald M. Berwick first described in 2008.2 By now, most of our readers are familiar with the Triple Aim, which includes improving the health of the population (by shutting off the faucet); reducing the per-capita cost, by reducing waste; and improving the individual experience of care, by truly engaging with patients across the spectrum of care. To improve the health of the population, we need to recognize the vital role that stable housing and good jobs play in the health of the population.

To reduce per-capita cost, we cannot focus on cost alone. The only way to accomplish this laudable goal is by reducing waste. Waste comes in essentially 3 varieties—clinical waste, operational waste, and poor individual behavior. The answer to the riddle is that we cannot fix the cost crisis by exclusively focusing on cost.

Finally, we have to improve the individual experience of care by carefully engaging with patients, and by using all the powerful new technologies at our disposal, including, but not limited to, telemedicine.

I have the privilege of being the dean of the nation’s first College of Population Health in the founding city of our country. I’m confident that you will help us to shut the faucet off, instead of continually mopping up the floor. It reminds me of a popular saying during the height of the Vietnam War, going back now more than 40 years: “If you’re not a part of the solution, you’re automatically a part of the problem.”

I hope our readers resonate with shutting off the faucet rather than mopping up the floor. The regional leaders at this important AHA executive forum were very enthusiastic about this presentation.

As always, I’m interested in your views. You can reach me via e-mail at david.nash@jefferson.edu.

References