VIEWPOINT

Era 3 for Medicine and Health Care

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Constant conflict roils the health care landscape, including issues related to the Affordable Care Act, electronic health records, payment changes, and consolidation of hospitals and health plans. The morale of physicians and other clinicians is in jeopardy.[1]

One foundational cause of the discord is an epic collision of 2 eras with incompatible beliefs.

Era 1

Era 1 was the ascendancy of the profession, with roots millennia deep—back to Hippocrates. Its norms include these: the profession of medicine is noble; it has special knowledge, inaccessible to laity; it is beneficent; and it will self-regulate. In return, society conceded to the medical profession a privilege most other work groups do not get: the authority to judge the quality of its own work.[2]

However, the idealism of era 1 was shaken when researchers examining the system of care found problems, such as enormous unexplained variation in practice, rates of injury from errors in care high enough to make health care a public health menace, indignities, injustice related to race and social class, and profiteering. They also reported that some of the soaring costs of care were wasteful—not producing better outcomes.

These findings made a pure reliance on trusted professionalism seem naive. If medical professionals were scientific, why was there so much variation? If they were beneficent, how could they permit so much harm? If they self-regulate, how could they waste so much?

Era 2

The inconsistency helped birth era 2, which dominates the present. Exponents of era 1 believe in professional trust and prerogative; those of era 2 believe in accountability, scrutiny, measurement, incentives, and markets. The machinery of era 2 is the manipulation of contingencies: rewards, punishments, and pay for performance.

The collision of norms from these 2 eras—between the romance of professional autonomy on the one hand, and the various tools of external accountability on the other—leads to discomfort and self-protective reactions. Physicians, other clinicians, and many health care managers feel angry, misunderstood, and overcontrolled. Payers, governments, and consumer groups feel suspicious, resisted, and often helpless. Champions of era 1 circle the wagons to defend professional prerogatives. Champions of era 2 invest in more and more ravenous inspection and control.

This conflict impedes the pursuit of the social goals of fundamentally better care, better health, and lower cost. The best route to these goals is the continual design and redesign of health care as a system. When the ethos of professionalism clashes with the ethos of markets and accountability, immense resources get diverted from the crucial and difficult enterprise of re-creating care.

The tactics of eras 1 and 2 reflect deeply held beliefs. The clash will continue unless and until those beliefs change and stakeholders act differently as a result.

Era 3

It is time for era 3—guided by updated beliefs that reject both the protectionism of era 1 and the reductionism of era 2. Era 3 requires 9 changes, at least.

First, Reduce Mandatory Measurement

Era 2 has brought with it excessive measurement, much of which is useless but nonetheless mandated. Intemperate measurement is as unwise and irresponsible as is intemperate health care. Purveyors of measurement, including the Centers for Medicare & Medicaid Services (CMS), commercial insurers, and regulators, working with the National Quality Forum, should commit to reducing (by 50% in 3 years and by 75% in 6 years) the volume and total cost of measurements currently being used and enforced in health care. The aim should be to measure only what matters, and mainly for learning.

With that focus, all health care stakeholders could know what they need to know with 25% of the cost and burden of today's measurements enterprise. The CMS has, to its credit, removed many process measures from programs, but progress toward a much smaller set of outcome measures needs to be faster. Such discipline would restore to care providers an enormous amount of time wasted now on generating and responding to reports that help no one at all.

Second, Stop Complex Individual Incentives

Aligning payment systems and incentives with triple aim goals for organizations makes sense, but payers and health care executives should declare a moratorium on complex incentive programs for individual clinicians, which are confusing, unstable, and invite gaming. The CMS should confine value-based payment models for clinicians to large groups. A moratorium would require placing more trust in the intrinsic motivation of the health care workforce and putting more effort into learning and less into managing carrots and sticks. For many, if not all, clinicians, the best form of individual payment to support a focus on need is, simply, salaried practice in patient-focused organizations.

Third, Shift the Business Strategy From Revenue to Quality

Maximizing revenue continues too much to dominate the business models of health care organizations. That reflects short-term thinking. A better, more sustainable route to financial success is improving quality. This requires mastering the theory and methods of improvement as a core competence for health care leaders. It also requires that the CMS and other payers continue to un-

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link incomes from input metrics, such as "relative value units" for specialists' incomes, which are not associated with quality and drive volume constantly upward.

Fourth, Give Up Professional Prerogative When It Hurts the Whole

From era 1, clinicians inherit the trump card of prerogative over the needs and interests of others. "It's my operating room time." "I give the orders." "Only a doctor can…." "Only a nurse can…." These habits and beliefs do harm. Although most clinicians richly deserve respect and gratitude, the romantic image of the totally self-sufficient physician no longer serves professionals or patients well. The most important question a modern professional can ask is not "What do I do?" but "What am I part of?" Those who prepare young professionals should nurture that redirection from prerogative to citizenship. Physician guilds should reconsider their self-protective rhetoric and policies.

Fifth, Use Improvement Science

Modern quality sciences offer a sterling alternative to the hostility and misunderstanding that inspection, reward, and punishment create. For those methods to work, they have to be used, but for the most part, health care still does not use them. Four decades into the quality movement, few in health care have studied the work of Deming, can recognize a process control chart, or have mastered the power of tests ("plan-do-study-act" cycles) as tools for substantial improvement. Yet, proof of concept is apparent in leading organizations that are using quality improvement strategically. Academicians should make mastery of improvement sciences part of the core curriculum for the preparation of clinicians and managers.

Sixth, Ensure Complete Transparency

Although measurement has become excessive and needs to be streamlined, transparency is nonetheless essential. The right rule is: "Anything professionals know about their work, the people and communities they serve can know, too, without delay, cost, or smokescreens." Congress should provide further resources and direction to the CMS to make its vast trove of data much more readily available at much lower cost to clinicians, organizations, communities, and patients who can use that information to improve care. Commercial insurers should do the same with their data, and regulators should remove barriers like gag clauses and Employee Retirement Income Security Act (ERISA) ambiguity about who owns claims to allow data on value and quality to be widely accessible, even while raising the bar on privacy and security. All states should adopt all-payer claims databases. Professional societies and clinicians should abandon traditional opposition to absolute transparency.

Seventh, Protect Civility

The rhetoric of era 1 can slide into self-importance; that of era 2, into the tone of a sports arena. Neither supports authentic dialogue. Medicine should not, as happens too often in Washington, DC, substitute accusation for conversation. Proponents of era 3 should heed the advice of Waller, who noted, "Everything possible begins in civility" (Robert Waller, MD, former president and CEO of Mayo Clinic, written communication, January 31, 2016).

Eighth, Hear the Voices of the People Served

The more patients and families become empowered, shaping their care, the better that care becomes, and the lower the costs. Clinicians, and those who train them, should learn how to ask less, "What is the matter with you?" and more, "What matters to you?" "Coproduction,"[3] "co-design," and "person-centered care" are among the new watchwords, and professionals, and those who train them, should master those ideas and embrace the transfer of control over people's lives to the people. That includes paying special attention to the needs of the poor, the disadvantaged, and the marginalized, and firmly defending health care as a universal human right.

Ninth, Reject Greed

Health care has slipped into tolerance of greed and it has to stop, through volunteerism when possible, through strong regulation when not. Rapacious pharmaceutical pricing, hospitals' exploiting market leverage to increase prices, profiteering physicians, and billing processes that deteriorate into games with consultants coaching on how to squeeze out more profit all hurt patients and impair trust. Era 3 needs much more restraint. For starters, willing pharmaceutical companies, equipment manufacturers, hospitals, physicians' organizations, nursing leaders, and consumer groups should convene to define and promulgate a new set of forceful principles for "fair profit and fair pricing," with severe consequences for violators. Professional organizations and, importantly, academic medical centers should articulate, model, and fiercely protect moral values intolerant of individual or institutional greed in health care.

Conclusion

Era 1 is the era of professional dominance. Era 2 is the era of accountability and market theory. Let era 3 be the moral era. Era 1 enthusiasts will find that prescription abrasive. Era 2 devotees will find it naive. But the discord is not helping clinicians, communities, or patients. Without a new moral ethos, there will be no winners.

ARTICLE INFORMATION

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