CHAPTER 12

Implementation Strategy and Planning

Health care delivery, like politics, is all local. No matter how good the policy analysis is, the selected strategy will fail unless it adapted for and elicits the support of its local implementers. Health care exhibits deep contrasts in the adoption of new ideas. It is notoriously slow to change in some areas, yet adopts technology very rapidly in others. Some argue that the adoption of new technologies is driving up costs, whereas others argue that failure to adopt new technology is partly responsible. Christensen et al. (2000) used the health care industry as an example of the need for disruptive technology to come in and overcome inertia. Their model applies very well in some areas, such as health information technology, but not in others, such as noninvasive surgery.

Dopson and Fitzgerald (2005) have published a very interesting book about the "implementation gap" for evidence-based health care in Britain's National Health Service, where centralization of management and financing would seem to create a more hospitable setting for change than the decentralized U.S. system. They point out that this failure to achieve what has been carefully planned "has a long-standing place in the analysis of public policy" (p. 36). Some would argue that failure to implement is merely political bargaining as usual at the microlevel; however, empirical studies suggest that implementation is a separate stage of the change process (Torenvlied & Thomson, 2003).

The policy process must both include consideration of how to implement the decision and be designed to promote that implementation. The Australian government considers implementation so important that it established a Cabinet Implementation Unit in late 2003 within the Department of the Prime Minister and Cabinet.

LEVELS OF IMPLEMENTATION FAILURE

Sometimes plans are unrealistic. Sometimes there is a failure to execute critical elements of certain plans, whereas other plans are foiled by much more subtle (all too human) innovation adoption problems. Still others are simply overtaken by events—wars, budget crises, changes of government, competing technologies or ideologies. Many social programs started at the federal level with great effort failed in the field over time.

> *Our legislators develop and adopt certain social programs that so often seem to miss their intended objectives. It is sometimes tragicomic to read the laws of entitlement, such as the one guaranteeing equality of education for the handicapped and exceptional children, and then see how they work out in group homes, classrooms, and clinics. Some have blamed public parsimony. Others would cite professional narrowness, individual insensitivity, and bureaucratic myopia. But much of the blame falls on the haste with which public policy is adopted, implemented, and then displaced by new policy* (McLaughlin, 1984, p. 83).

The "deinstitutionalization" effort of the 1970s is a good example of failure to execute. After early antipsychotic drugs became available, the inpatient populations of psychiatric hospitals began to decline. The community mental health centers that were to serve those released from mental institutions were up and running in many areas and Medicaid and Medicare provided some funding, but the promised resources that had been put into psychiatric hospitals never arrived in the community in sufficient quantity to provide both direct care and supportive services such as housing and employment training. An entire new population of homeless individuals appeared in our cities, and the terms *revolving door* and *bag lady* entered the public vocabulary. Hospitals and community centers were not coordinated, but were separate systems that often competed for the same resources. Furthermore, many Community Mental Health Centers

drifted away from the goal of supporting deinstitutionalization of the mentally ill and began serving a much broader spectrum of patients. "Once trained, however, the vast majority of these professionals decide to provide psychotherapy for people with mental health problems rather than treat people who were mentally ill" (Torrey, 1997, p. 185). It is not easy to keep well-intentioned policies from going off the tracks. As the saying goes, "The devil is in the details." One attempt to turn that mental health system around and focus it on the target population of the persistently and severely mentally ill is the effort to introduce evidence-based medicine reported in **Case 12-1** later in this chapter.

IMPLEMENTATION PLANNING

Implementation planning arrives early and stays late. The chapter on political feasibility emphasized the importance of involving all stakeholders, including implementers. An Australian Cabinet Implementation Unit (2005) process guide referred to two implementation processes: (1) implementation assessment, which contributes to the documentation that accompanies the submission of a proposal to the cabinet, and (2) implementation planning, which continues that process in much greater detail once the decision is final. **Figure 12-1** shows the stages of the implementation planning process. Several of these topics—scope, funding, risk management, and schedule—may also be inputs, alongside program objectives, outcomes, and governance considerations, to the strategic decision-making process.

Scope of Work

This is a major consideration during the proposal and decision-making stages, but it should also be reviewed after the decision. Policy making is an art, and the "who, what, where, when, and how" may have changed either subtly or substantially. Implementers must be made aware of what was actually approved. There is a saying that the camel was intended to be a horse, but it was designed by a committee. Note the result: The camel is highly adapted to its environment, but it is something quite different from a horse. Consequently, it needs a very different management approach to operate it and evaluate its ultimate performance. In the latter stages of implementation, one needs to establish lines of authority and accountability for implementation and consider how the effort interacts with other initiatives and programs already under way. It is also important to consider

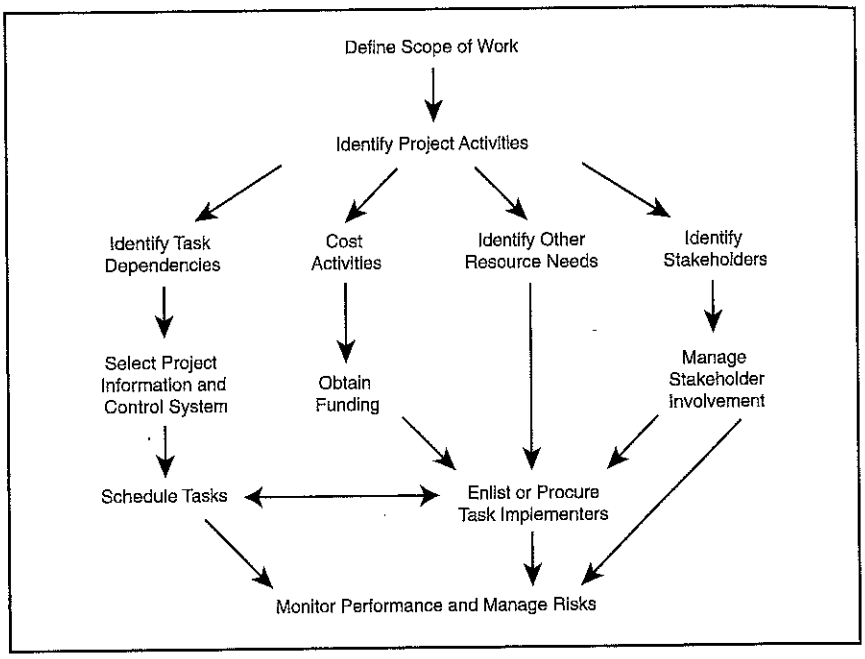

FIGURE 12-1 Guide to Preparing Implementation Plans

whether the new policy can be effectively implemented using existing organizational structures, management systems, and funding approaches or whether it is necessary to innovate in these areas as well.

Defining Project Activities

This stage is a detailed analysis of the tasks generated by the implementation requirements of the policy. Political decision makers are likely to establish some important dates (milestones) for implementation, dates that may or may not be achievable. Then the implementing organization must get to work:

- Identifying the tasks that must be performed to implement the effort, such as submitting a detailed budget, hiring personnel, finding office space, issuing rules and regulations, establishing advisory committees, and specifying information reporting requirements. This is something called developing a Work Breakdown Structure

- Identifying the units and individuals responsible for each task and gaining their commitment to complete the task within a specific time period
- Establishing reporting responsibilities for the status of each task
- Including coordination tasks as well as intradepartmental tasks
- Developing a master schedule and an estimated time of completion for the project and mechanisms for monitoring progress.

Depending on the complexity and urgency of the project, the project implementation staff may choose to use any one of a number of project management techniques and their accompanying software to show what the resulting project schedule would be and whether this is likely to meet the original target. If that is not the case, then the implementation planners may decide to undertake a number of efforts to "crash" the project and remain on schedule. This process works best when the estimate of the duration of each activity comes from its responsible implementer, building further commitment to estimate realistically and to then meet one's own estimates.

There are many systems for project planning and scheduling, often using the acronyms CPM (critical path method) and PERT (program evaluation and review technique), that enable the staff to build a feasible schedule and to track performance, updating that schedule as the effort moves along. Microsoft Project is one such program that is usually readily available.

Funding

Few proposals get considered without a cost figure attached; however, there are a number of steps to be taken once that figure is approved. Congress authorizes much more initiatives than it funds. For example, in 1998, Congress passed, and President Clinton signed, the Ricky Ray Hemophilia Relief Act, which authorized a compassionate payment of $100,000 to each hemophiliac infected between 1982 and 1987 from contaminated blood products, or to their families if they had died. This was to compensate for lax government control of the blood supply. The authorization bill did not include the funding required, estimated to be $750 million, but only after considerable effort by advocacy groups was $75 million appropriated in fiscal year 2000, $100 million in fiscal 2002, and $475 million in other bills. By the time the program terminated in 2005, $559 million had been dispersed.

Stakeholder Engagement

Implementation must include a review of who the stakeholders are, including the following:

- Who needs to be kept informed?
- Who needs to participate in what detailed planning activities?
- Who can be an opinion leader or champion of the program?
- Who needs further training and motivation?
- Who can be an enabler?
- Who can be a blocker and needs to be co-opted?

The implementation planners must identify what messages to send to whom from whom, their frequency, and their content (see **Table 12-1**). Should it be delivered personally, by e-mail, through the media, through a representative, etc.? After those coordination and communication tasks are identified, they must also be scheduled either as discrete events or on an ongoing basis.

TABLE 12-1 Communications Strategy Tool

Key stakeholder	Desired commitment and strategy for securing commitment	Key messages that need to be delivered	Responsible officer

Source: Cabinet Implementation Unit, Dept. of Prime Minister and Cabinet, Canberra, Australia Commonwealth © 2005.

Enlist or Procure Task Implementers

Key resource needs should have been identified by this point in time, especially because the funding requirements have to be based on a schedule of the resources needed, especially personnel, equipment, and support systems. There may also be other less tangible resources that are mission critical, such as office space, computers and communication equipment, loaned personnel, and contractor personnel with special skills. For example, it is a frequent practice for contractors to assign their most competent personnel to preparing and marketing the proposal, but then substitute less experienced, less skilled, and less costly personnel as the work gets under way. Implementation managers must then fight to get the quality people and services that they expected originally.

Monitor Performance

The policy proposal usually specifies the quality and quantity of outcomes anticipated and may refer to the process and outcome measures to be used; however, the implementation planners may still have to develop, validate, and install measures and measurement systems to monitor progress and suggest improvements as the implementation proceeds. When planning for quality assurance measures, implementers should also keep in mind the kind of data, information, and documentation that will be needed to conduct an evaluation after the policy has been implemented.

When it comes to sequencing these implementation activities, there is no magic order. Many have to go forward in parallel from the proposal stage, with adjustments being made to each as problems and opportunities are encountered. New technology or results from ongoing studies may lead to program changes after the policy makers have completed their work. If so, the implementation team should then adopt them, but inform the policy makers of the change so that there will be no big surprises when the effort is being reviewed (e.g., during a site visit). The list of implementation activities offered here is quite detailed, and it is up to the implementation team to decide how much to invest in each activity. Not every stage will be relevant to each policy area, and the systems necessary to plan and monitor some of these stages may already be in place. The budgeting and scheduling functions should be basic management activities everywhere.

Manage Risks

The Australian *Guide to Preparing Implementation Plans* (2005) suggests that likely risks include:

- Unclear objectives and deliverables
- Unrealistic schedules
- Shortages of key resources—funds, people, equipment
- Lack of infrastructure and supports
- Lack of agency internal capacity.

Whatever the risk, the planning process needs to assess the likelihood of the risk occurring, its severity and impact, how to mitigate it, and who is responsible for preventive measures, for monitoring, and for action when it is needed.

SETTING UP TO SUCCEED

There is ample evidence that implementation is enhanced by adopting a process that involves implementers early and builds their commitment to the plan. Health care is going through a transition from a professional model that emphasizes individual responsibility, autonomy, and accountability toward an organizational one, hopefully one where organizational learning and transformation are norms. To succeed at this, a number of things need to happen, including:

1. Shared responsibility is accepted. Team leaders and members at all professional levels must come to share overall responsibility while still accepting individual responsibility for assigned tasks. The industrialization of health care often means that treatment processes are carried out by multiple actors whose actions must be coordinated.
2. Leadership takes place at multiple levels. The team involved in developing a policy must have facts about how the system works at the operational levels as well as the strategic level. Many developing countries still suffer from the system developed by the British Colonial Office for managing the Empire. Government consisted of mostly locals organized into two cadres: one, the civil service, developed policy, whereas the other, the health service, for example, implemented it. A small group of British officials controlled the flow of information from one to the other. The policy makers produced brilliant analyses that circulated in files held together with red ribbon (called *red tape* by

the English), but these analyses often proved unworkable for implementers in the field. It was an efficient way to use a small expatriate staff, but it did not necessarily produce effective delivery systems. All too many policies and plans have become "shelf art," sitting there unused because implementers do not see them as practical or relevant.

3. People understand the core business and technical processes, values, and mission of the organization. Participants must be knowledgeable and consistent in their decision making about policies and implementation. If policies and processes are not performing well, it is often useful to start a dialogue about process, values, and mission. Policies and processes do not bolt out of control. They silently drift away from the optimal as individuals and groups make incremental local adjustments in response to local events, stimuli, and negative experiences. The example above how one process moved away and failed to move back.
4. Expectations are managed. Some participants will be optimistic and expect too much, whereas others will be pessimistic or cynical and expect too little. Wilson and McLaughlin (1984) suggested that one needs to work out a psychological contract with the participants in planning that recognizes the scarcity of resources that might be involved and directly addresses the WIIFM (what's in it

The Origin of a Policy

The labor, delivery, recovery, and postpartum nursing team at a community hospital was reviewing their procedures and their cost items in order to become more competitive in their city. One policy that puzzled them was sending 100% of the placentas to the pathology laboratory after delivery. They kept asking around for the source of that rule and found that it stemmed from an incident many years earlier. At the time the daughter of the chief of obstetrics was having a difficult delivery and encountered a problem that might have been handled more effectively if the placenta from her delivery had been saved and analyzed. The angry chief thoroughly chewed out the OB nursing staff for not saving it. To avoid such a confrontation in the future, the nursing supervisor instituted the rule that all placentas would go to pathology. Both the chief of obstetrics and the nursing supervisor had long since retired, but the rule lived on. The three obstetricians currently practicing at the hospital developed a set of criteria for sending placentas to the laboratory. This new rule decreased the number of pathology reviews of placentas by 95%, resulting in substantial cost savings to the patients and the hospital.

for me?) question. **Table 12-2** provides their outline of the factors that such a psychological contract might consider. In essence, the contract specifies what each party gets from the exchange beyond monetary considerations.

5. Planning is continuous. The health care environment is continuously changing. There are many more opportunities and challenges than most organizations can take on at any one time. Through functional and cross-functional teams, managers involve providers and others in setting priorities, developing and evaluating alternatives, and meeting the many new challenges (Carroll & Edmondson, 2002).

TABLE 12-2 The Psychological Contract Under Scarce Resources

Employee Gets

- Performance standards to meet that represent realistic tradeoffs between funds, personnel, schedules, and service levels
- Personal courtesy and respect
- Supportive environment
- Meaningful and purposeful work
- Reasonable conflict and tension levels, mediated by clear standards for priority setting and evaluation of work
- Personal development opportunities
- Professional and organizational recognition for good work
- Security, as long as funds are available
- Processes for psychological contract change that reflect changing resource conditions

Organization Gets

- An honest day's work, at least
- Loyalty to the organization
- Initiative, especially in resource use
- Job effectiveness and efficiency in meeting overall organizational goals
- Flexibility and willingness to wear multiple hats under tight staffing
- Acceptance of reasonable tradeoffs among professional norms and organizational needs
- Participation in psychological contract change processes that reflect changing resource conditions

Source: Wilson & McLaughlin, 1984, p. 310.

6. Orientations are prospective rather than retrospective. Dopson and Fitzgerald (2005) and Senge et al. (1994) observed that behaviors and beliefs take time to change and require both abstract reasoning and experiential reinforcement. It is often easier to do things the way they have always been done. Looking to the past for precedent is usually a rational step in assessing a situation, but there is little assurance that what an organization has been doing is effective or will be so in the future. "Transforming leadership continually brings forward the vision of the future organization and indicates how the organization can get from where it is in the present to where it wants to be in the future" (Upshaw et al., 2006, p. 201).
7. Performance is assessed and rewarded. Effective policy change requires that the organization be prepared to commit real resources and have in place support mechanisms for recognizing creativity and innovation. Personnel evaluation processes and procedures must be in place to encourage implementers, as well as policy makers, to seek new ways to get things done and to prepare for the changing future.

THAT ALL-IMPORTANT START

Getting implementation started right is critical. If a team is involved, especially a multidisciplinary one (which would be the case for just about anything clinical), plan to offer leadership throughout the team formation cycle, which usually progresses through the following four stages:

1. Forming
2. Storming
3. Norming
4. Performing

Forming

The team needs to understand fully the factors behind the policy change and how it links to the institution's strategies. The team's initial efforts should be well-supported and include tasks that are carefully chosen to build a shared experience of success. At this stage, the team must also consider whether it includes representation of all the important implementers.

Storming

Because health care settings are complex and have many built-in tensions, the team often starts with a tendency to begin blaming, finding fault, or expressing distrust of others. The members have to be kept focused on their task until they begin to understand it and accept each other's viewpoints.

Norming

The group can set up norms of operation. For example, how decisions get made and work allocated. Do we vote? Do we have to have a consensus? What do we have to clear with higher authority? Do some professional groups have veto power?

Performing

After the barriers at each of the preceding stages are dealt with, the team can get on with its assigned tasks effectively or, having addressed them and failed to get over them, seek further guidance or facilitation.

PROVIDING FOR PERIODIC REVIEWS

Major change projects often require that multiple teams go forward in parallel. Again, one or more of these may veer off on its own path, and thus, it is important to stage periodic review sessions in which each team reports what it is doing, the progress it is making against measures such as budget and schedule, and what implementation barriers it is experiencing. This process enables senior policy overseers to assess overall progress and make adjustments to the current plan where necessary. It also allows the individual team leaders to see where they needed to interface with other teams in order to meet their objectives and how to adjust their efforts to what they learn at the review. The larger and more complex the project, the more important these periodic reviews become. For more about problems of implementation relating to project coordination and communication, it can be useful to review the literature on the fatal accidents that NASA has experienced.

IMPLEMENTING POLICIES THAT AFFECT CLINICAL DECISION MAKING

One of the more problematic areas for implementing policy involves getting professionals to change the way they carry out professional tasks. This has been a topic of concern to those who study quality of care, do

continuing professional education, or sell pharmaceuticals and other supplies to the health industry. The move toward greater use of evidence-based medicine is a case in point. **Case 12-1** reports on an attempt to achieve change in the public mental health sector. Those responsible tried to do everything possible to induce change, but their results were limited. They started with strong top management support, they brought together academic experts and clinical opinion leaders to sanction adoption of the newer evidence-based practices (EBPs), and they then held training programs for those who would be the implementers; however, after their efforts had gone on a while, they reported that:

- After the key driver in the system, the top person, left, many seemed to act as if "this too would pass." The change agents noted that retraining of state agency staff was essential if implementation efforts were to be sustained.
- The middle layers of the state bureaucracy did not seem to "own" the change, perhaps because it upset existing relationships and power bases or because it was imported from another state.
- "There was a need for alignment of state-level policies, funding and systems to support implementation statewide." Tangible drivers such as changes in payer service definitions, service fees, and budget allocations were called for. Without these wake-up calls from the funders, it was easy for the implementers to argue that they were already using "best practices" and ignore the rigorous implementation guidelines associated with the evidence-based service definitions emphasized at the federal level.

This case study is very consistent with the case studies reported elsewhere. For example, Dopson and Fitzgerald (2005) provided a meta-analysis of a number of studies of implementing EBPs in the UK Health Service, in which Ferlie's (2005) concluding summary emphasized the role of leadership, organizational support, and the differences between *knowledge* (i.e., information) and *practice.*

> *In the best case examples, there appeared to be a circular relationship between research evidence and experience—they reinforced each other and were woven together. At other times, there was a tension between craft knowledge and formal evidence. It should be remembered that clinical practice contains an element of judgment and tacit knowledge more reminiscent of craft skills than traditional*

> *conceptions of science. It may be unwise to force a stark choice between the two modes (experience or science), but there may be a need to balance both* (Ferlie, 2005, p. 188).
>
> *So knowledge in action is, for us, evidence that has been converted through social processes into locally accepted knowledge, which is then put into use and leads to evidence-based change in working practices* (p. 190).

Paul Batalden at Dartmouth has suggested that professional training include a microsystem approach to continuous improvement in health care, operating alongside issues-centered and organization-centered efforts. Mohr and Batalden (2006) identified eight dimensions of an effective, improvement-oriented microsystem (a teaching clinic or hospital service):

1. Constancy of purpose
2. Investment in improvement
3. Alignment of role and training for efficiency and staff satisfaction
4. Interdependence of the care team to meet patient needs
5. Integration of information and technology into work flows
6. Ongoing measurement of outcomes
7. Support from the larger organization
8. Connection to the community to enhance care delivery and extend influence

THE POSTMORTEM

Assuming that the group doing the analysis and planning is going to be doing this kind of thing again, it is critical to review the group's own performance. This postproject analysis should be done by the planning group if the project was small- or medium-sized or by an independent evaluator if it was large or mission critical. Evaluation should study two aspects of the project—process and outcome. Process analysis should take place relatively quickly after the final report is delivered and should ask this question: "If we had to do this analysis project again, what would we do differently?" Because this can be threatening interpersonally, adding a little humor would not hurt.

The outcomes assessment part has to wait until the outcomes are evident. It can only be justified for major policy proposals that were actually implemented; otherwise, a second analysis might be needed to focus on what we might have done differently to get the proposal implemented. The failure to implement might be primarily due to outside factors. Either way one should be able to go back through the analysis and see how well the group defined the situation, assessed the technology, outlined the economics, adjusted to the political system, planned the implementation, and presented the product to the decision makers. Such a review is a key to improved organizational learning about policy analysis.

CONCLUSION

There is no silver bullet to make implementation easy; however, the elements of successful implementation are pretty well known. They involve top management consideration and support. They require understanding of the social context in which change takes place. Would-be implementers must focus on the players, their roles, their barriers to action, and the roles of leadership in bringing about change. It may be difficult to balance how much to invest in studying these influences before the policy decision is made and how much to leave until later once the political and financial compromises have been worked out. From an academic viewpoint, all of these should be worked out so that strategic policies are not derailed by the implementation details; however, decision makers are usually not comfortable with that level of detail as they deal broadly with a wide range of issues. They are very uncomfortable with surprises after the fact, but they do not want to be bogged down reading the fine print either. That is just a managerial reality. Perhaps the best answer is to turn to the experienced presenters on the team who know the behavior patterns of key decision makers and ask for their assessment of the appropriate level of detail to present at each stage.

WORKING OUT YOUR OWN SCENARIOS

We can push the policy envelope by considering some extreme scenarios against the status quo and seeing what kind of a health care system might result; however, as noted in Chapter 7 on technological forecasting, getting single-event estimates is only one step in the process. An event may be acceptable on its own, but its interaction with other events may result in an aggregate outcome that is totally unacceptable. For example, encouraging kidney transplants for end-stage renal disease patients is one thing, but if the supply is totally inadequate and that promotes a sizable international traffic in involuntarily harvested human kidneys, would that be unacceptable? Later here we have set up an illustrative example with multiple scenarios to compare.

Let's look at the following five scenarios, three of which are extreme:

A. Extrapolating current trends
B. Extreme reliance on free market
C. Extreme industrialization
D. National economic crisis resulting in major tax code reform
E. The Emanuel-Fuchs proposal

By way of illustration, we have provided event predictions for 15 boxes in **Table 13-1** for the first four of these scenarios. A rational person can certainly come up with others, and thus, we have included Table 13-2, which encourages you to build your own, redefining the scenarios and then assessing the impact of a set of events that you are free to augment.

Scenario A: The Status Quo Extrapolated

As you look down column *A* of Table 13-1, you see that not much new is happening to reduce costs. We might expect to see some responses as funding becomes more and more of a problem, namely, reductions in malpractice insurance costs and international competition to reduce prices of some procedures. There are also possibilities that as consumers and insurers find it harder and harder to pay their bills, provider incomes will fall further, along with institutional contribution margins. Information technology (IT) will move into place, but it may still be subject to the complaint of Brailer that despite increased deployment of health IT, the motivation to share information in still lacking (Cunningham, 2005). Thus, one might see some internal waste and medical error reduced, but a very high investment cost

TABLE 13-1 Building Some Scenarios for Cost Reduction

Change / Scenario	A	B	C	D	E
1. Remove provider incentives to overutilize	N	N	N	Y	
2. Major changes in staffing requirements	N	Y	Y	Y	
3. Major reductions in provider and staff incomes and contribution margins	?	Y	N	Y	
4. Reduced costs of malpractice coverage	Y	?	Y	Y	
5. International competition reducing prices	Y	Y	?	?	
6. Constraining treatment choices to those most effective and efficient	N	N	Y	Y	
7. Encouraging labor substitution where process can be industrialized	N	Y	Y	Y	
8. Empowering primary car providers to control utilization and self-referrals	N	N	Y	Y	
9. Increasing supply of providers to levels in other countries	N	Y	N	?	
10. Increased waiting periods and other devices to increase competition	N	N	Y	Y	
11. Increasing use of IT to reduce waste and medical error without constraining competition	?	Y	N	?	
12. Global budgeting of hospitals and other institutions to ration capital, perhaps on a regional basis	N	N	Y	Y	
13. Community rating and no-fault health insurance, perhaps with tiered premiums	N	N	N	Y	
14. Stripping away less essential services or covering outside health insurance system	?	?	Y	Y	
15. Return of more voluntarism in the health sector	N	Y	N	N	

Y = likely, N = not likely, and ? = not predicted

Scenario A is the extrapolation of the current trends in the current system.

Scenario B is the case of an extremely strong move toward a free market health care system.

Scenario C is the case of an extremely strong move in the direction of industrialization and corporate governance of health care.

Scenario D is the case of a major economic crisis that leads the country to a major overhaul of government programs, including health care, and major changes in the tax code such as shift from the income tax to a value-added or some other form of consumption tax.

Scenario E provides all citizens a voucher for basic health coverage replacing current insurance and Medicaid and ultimately Medicare. It would be financed with a value-added tax and add administrative systems to oversee coverage, technology assessment and quality measurement and to replace the current tort system for malpractice with administrative law.

and then find relatively little immediate impact on operating cost. Some major changes might occur on the funding side, so you might want to repeat the exercise with an added set of rows representing programmatic changes on the funding side.

Scenario B: Extreme Reliance on the Free Market

Here we would be likely to see little or no action to reduce costs, except to increase the competitive pressures from foreign competition and to increase the supply of providers. The primary argument for consumer-centered health care—that consumers will make choices to lower their own costs of care—is not addressed in this listing. Again, you might want to repeat the exercise with some events related to consumer-driven health care as an additional set of rows; however, the lower the resulting profit margins and professional incomes, the more providers are likely to improve efficiency to compete on cost, resulting in staffing changes, better use of information technology for scheduling and coordination, and more use of volunteers.

Scenario C: Extreme Industrialization

Under the corporate, industrializing scenario, the resulting oligopolistic firms will likely try to resist and/or seek protection from a number of cost-reduction pressures, such as foreign competition and increasing the supply of providers. At the same time, they will likely make a number of internal policy choices that limit provider options, restrict capital investment, constrain institutional budgets, and break jobs down into repetitive tasks doable by lower level, lower paid personnel. They will also be likely to resist and lobby against measures to limit overutilization, as long as those limits affect their revenues.

Scenario D: National Economic Crisis Resulting in Major Tax Code Reform

In this scenario, the nation is in severe economic difficulties and radical change is in the air. The number of uninsured has skyrocketed, and something has to be done. That is when federally administered universal coverage might have a chance of coming in, especially if the tax system were to be restructured at the same time to emphasize consumption-based taxation and eliminate the health care income tax deductions. At the same time, there is likely to be a much higher level of regulation affecting choices of treatments, capital availability, and staffing coupled with community rating. Resources will be very tight; thus, waiting lines will lengthen, and there will be pressures to put hospitals on fixed

budgets, reduce services that are not absolutely necessary, and concentrate specialized treatment capacities to increase throughput and effectiveness.

Scenario E: Emanuel and Fuchs Proposal

In a one-page *Fortune* article, Emanuel and Fuchs (2006) suggested, "How to cure U.S. health care." They offered a comprehensive five-part program, the centerpiece of which would be a health care voucher for every citizen currently under 65 years old. It would cover currently accepted levels of care with existing or new health plans. Each individual would then have a choice of 5 to 10 plans that would have to accept all comers.

The vouchers would be paid for by an earmarked 10% value-added tax that would be offset by replacing current employment-based insurance premiums, Medicaid expenditures, and individual and corporate tax deductions for health care premiums. Medicare recipients would be grandfathered (so to speak) under the current system, but those in the new program would stay with it past 65 years old, and Medicare would gradually be phased out.

To administer it, there would be a new system of federal and regional boards, much like the Federal Reserve System, to provide accountability, specify and modify the benefit package, and oversee technology assessment and quality evaluations. Malpractice cases would be assigned to a separate administrative system that would adjudicate and pay claims and oversee linkages to quality measurement and the licensure process. We have left column *E* of Table 13-1 blank for you and your colleagues to assess and fill in.

Interpreting Table 13-1

As you can see, virtually every scenario has elements that U. S. patients would strongly object to and is likely to generate strong opposition from one or more interest groups. That is why the most radical departures from current trends of more intramarket competition and more industrialization are likely to occur only if there is a general meltdown of the economic system, evoking new, strong domestic leadership with the will to take the government in a very different direction; however, it is apparent that each of the first three scenarios is weak in terms of its likely effects on health care costs, and ultimately, draconian measures may be taken. In other words, nothing is likely to work until the society either runs out of money or reaches some consensus as to when enough health care is enough. Economists differ on whether that will be 10, 20, or 25 years from now (Hall & Jones, 2007).

CHAPTER EXERCISE: WORKING WITH YOUR OWN SCENARIOS

We purposely offered scenarios that omitted some key policy possibilities (like consumer-oriented health care) in hopes that you and your associates would undertake your own evaluative process and (1) flesh out your own list of changes to be tried, (2) match them against your own list of scenarios, (3) debate the effects of each change on the outcome of each scenario, and (4) come up with your own concepts of what would or would not work in the United States under various conditions. **Table 13-2** is provided for that purpose. We do not have pat answers. Most have been tried somewhere in the world with mixed results. What would you want the United States to try next, perhaps on a small scale, to see how it works here?

SO, WHAT IS LIKELY TO WORK?

One takeaway from this exercise is that quite radical change is unlikely to happen until the U.S. economy is threatened by other events, and health care is seen as a part of the total package of changes that includes revisions in our tax code and is part of a compromise designed to deal with bigger overall problems. Short of that, we are likely to see incremental changes with a forecast increase in the proportion of the gross domestic product devoted to health care. Regardless of the party in power, health care is likely to take a back seat to national security, immigration reform, reduced dependence on foreign oil and the related replacement of much of our automotive stock, and inflationary pressures because of lack of savings and the rising cost of interest necessary to attract foreign capital. The one likely exception may be efforts to extend some form of coverage to all, especially to more children. Along the way, we will probably see some offsetting federal efforts to strip out of Medicare and Medicaid some services that are not essential to health and safety in the short run, some positive effects from prevention programs, and increased experimentation with pay-for-performance. In the short run, maintaining even the current level of covered lives will come from the efforts of state and local governments. These efforts will probably center on cost-effective, basic-level health insurance pools that small businesses and by some of the working poor can afford. The pressure on both low-income working families and older people to pay a higher percentage of their income for health care will continue, and the benefits available to the disabled and the unemployed are likely to atrophy further.

TABLE 13-2 Your Exercise on Building Cost Reduction Scenarios

Change / Scenario	A	B	C	D	E
1. Remove provider incentives to overutilize	N				
3. Major reductions in provider and staff incomes	?				
	?				
5. Reduced costs of malpractice coverage	Y				
7. Constraining treatment choices to those most effective and efficient	?				
16. Encouraging labor substitution where process can be industrialized					
17. Empowering primary care providers to control utilization and self-referrals					
18. Rationing capital available to institutions					
21. Increased waiting periods and other devices to increase competition					
22. Increasing use of IT to reduce waste and medical error without constraining competition					
23. Global budgeting of hospitals and other institutions, perhaps on a regional basis					
24. Community rating and no-fault health insurance, perhaps with tiered premiums					

Y = likely, N = not likely, and ? = not predicted

Scenario A is the extrapolation of the current trends in the current system.

Scenario B _____

Scenario C _____

Scenario D _____

Scenario E _____

Why Not an Unraveling?

In January 2006, in advance of President Bush's State of the Nation speech, *The Economist* published a scathing review of the U.S. health care system, including a forecast of a "great unraveling."

> *With employers limiting their commitments and government unable to fund its commitments, America's health system will unravel—perhaps not this year or next, but soon. Few health experts deny this. Nor do they disagree much on the sources of the problem. Health markets are plagued with poor information, inadequate competition and skewed incentives.*

We suspect that such an outcome is still a number of years away for the following reasons:

- Measures undertaken in the interim will have some effect.
- Overall growth and efficiency improvement in other sectors would enable consumers to choose to allocate a larger proportion of the gross domestic product to their health care.
- Inflation in other sectors, such as energy, could divert interest and support.
- Employment in the health sector is healthy.
- Temporizing is the name of the game.

Measures Undertaken Will Have Some Effect

Although measures such as consumer-driven health care and the growth of integrated health systems are unlikely to solve the problems of the health sector, they will, like other measures before them, have some effect in slowing the rate of growth. Efforts to improve quality of care and introduce evidence-based medicine will have some impact and so will efforts to get comparative information to consumers and payers. Reductions in provider incomes, although personally painful, are unlikely to reduce the care available and may increase productivity. Introduction of IT may do the same. Given enough time, these many small improvements will have some cumulative effect, especially if institutions focus on a more limited range of patients and diseases and gain more efficiency for themselves.

Inflation in Other Sectors Could Offset the Impact of Health Care Growth

Despite the opposition of the Federal Reserve, politicians may find it advantageous to allow a higher level of inflation in the economy, bringing growth to the rest of the economy and to tax revenues. If there are some constraints on health care expenditures at the same time, the inflation rate in the overall economy might approach or surpass that of the health care sector and reduce the burden of added costs. International lenders may require more repayment of loans and force more favorable exchange rates, raising the costs of foreign goods, so that health care does not seem quite so expensive in comparison.

Employment in the Health Sector Is Healthy

As the proportion of national income devoted to health care increases, we will see more and more employment in that sector. Like most other service sectors, health care employs a large number of individuals of moderate and low income. Continuing industrialization will mean that some higher income workers will be displaced by lower income workers as some tasks become rationalized and can be handled routinely.

One risk to the country of having health care get so big is that a large proportion of the population will have their aspirations tied to the growth of that sector. Major cutbacks in expenditures, whether caused by improved quality and productivity or taken arbitrarily, will trigger a pushback by the affected employees. The growth of the health care sector is not a negative event from an employment point of view, especially as manufacturing and information-related service jobs continue to move out of the country.

Some economists are beginning to argue that health care expansion is the key to maintaining employment and that a substantial proportion of the population will be willing to spend a greater proportion of their income on health care because they attach a high subjective utility to their own longevity and care (Cutler et al., 2006; Hall & Jones, 2007). The problem with such growth is that it will continue to force the transfer of wealth away from the young, the healthy, and the poor and toward the older population, the sick, and the professionals. At some point, those footing the bill will begin to object strongly to these transfers, and we will see much more

stringent measures to control expenditures and reduce those transfer rates (Kolata, 2006b). This is especially likely to create a political backlash if the income gap between low-wage workers and higher income knowledge workers and managers continues to expand.

Temporizing Is the Name of the Game

Enough said.

CONCLUSION

The United States is unlikely to undertake major health care reforms at the federal level in the near future. The states will continue to lead the reform effort, but focus primarily on improved access. A number of tweaking changes to reduce costs will move forward, but major cost reductions will not take place until the states get into financial trouble. Only if there is a general economic recession and a problem financing state budgets and the national debt are there likely to be radical changes. Employers may support the notions of value-based care, especially transparency in pricing, and an end to price discrimination. The position of specialists is likely to weaken as primary-care providers are asked to reduce waste and improve efficiency, and capital-intensive, rare, and complex procedures are concentrated at selected sites, often outside traditional market areas.

This chapter emphasized the importance of putting event forecasts into scenarios to highlight how events and measures will interact. Five illustrative scenarios were considered dealing with the status quo ante, more industrialization, more governmental involvement, and more of a free market; however, even these were not examined exhaustively, and further examination would be expected.

Available measures and expected adjustments are likely to delay the anticipated "unraveling" of the health care system. As it grows, people may become increasingly concerned about upsetting the economy with radical measures. The issue that will have to be faced will not be the size of the sector, but the distributional effects of its growth, the equity concerns of transfers of income from the young on behalf of the old and from the poor and middle class toward the wealthy. These will generate pressures to reduce waste and overall cost in the health sector as payers resist further premiums or taxation.