EDITORIAL

“The Dirty Dozen”

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Each year, I have the privilege of standing at the podium in front of more than 640 persons to kick off the annual Population Health Colloquium, which is a meeting that our college has been hosting in Philadelphia for the past 13 years. The meeting has grown in size and stature. It is an important annual event on our college calendar, and it serves as our primary national networking event, in addition to bringing speakers in our field from all over the country to Philadelphia.

I would like to share with you my opening comments from earlier this spring as we debuted the 2018 Population Health Colloquium. What follows is an edited version of my comments.

This year, I’ve decided to reflect on what is really “new” since the last time we were together in this great city. I’ve called my brief overview “The Dirty Dozen,” after one of my favorite movies with that name about World War II—the 1967 flick featuring Lee Marvin, Telly Savalas, Jim Brown, and Donald Sutherland. Perhaps some of you also share my appreciation for this film.

Allow me to list the dirty dozen, in no particular order of their significance, but rather according to issues that have helped to define the past 12 months:

1. More Americans are uninsured today than when we were last together in this great city, and it appears that the current administration is waging nothing short of a war on the poor. Many speakers in the 2 days ahead will explain this unfortunate fact in some detail, but work requirement rules for Medicaid beneficiaries are among the weapons used in the war on the poor.1

2. The Secretary of Health and Human Services, Alex Azar, and the Centers for Medicare & Medicaid Services Administrator, Seema Verma, spoke recently at the Healthcare Information and Management Systems Society meeting in Las Vegas, NV. I was pleased to read about their 2 presentations, because it seems a sea change from their predecessor, the now-disgraced former Secretary of Health and Human Services, Tom Price. It seems that the secretary and the administrator have embraced bundled payments and have publicly acknowledged that the road to redemption is about going from “volume to value,” from profligate testing to a more evidence-based practice that seeks to align with the stated philosophy of our college, which is “no outcome, no income.”

3. I was scratching my head with regard to the recent criticism of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) by the normally quite reasonable colleagues who make up the Medicare Payment Advisory Commission (MEDPAC). Although we could all quibble with alternative payment models and merit-based incentive payment systems—the core components of MACRA—the fact that MEDPAC would be so publicly critical of the only health policy legislation in recent memory that passed with bipartisan support remains an enigma. I have never argued that sacrificing the good on the altar of the perfect makes any sense in our business.

4. New mergers have come to light, such as CVS’s purchase of Aetna, and Cigna’s public notification that it intends to buy Express Scripts. We are in a wholly different world than even 1 year ago, on the heels of the failed previous mergers between Aetna and Humana, and Cigna and Anthem. Is this a true sea change, because it represents vertical and horizontal integration? It is simply too early to tell, but significant changes are afoot, and more mergers and acquisitions in our business will no doubt be on the table in the coming months.

5. A relatively unknown Marine Corps veteran named Conor Lamb won the 18th congressional district in Pennsylvania in a nail-biting election. Mr Lamb, a Democrat, ran a smart campaign in a Republican district by bemoaning the destruction of Obamacare.

Follow-up polls noted that this stance won him many political points, and indeed healthcare was top of mind for most voters in this previously “red district.” Is this a harbinger for November 2018?

6. We are still struggling to create outcome measures that are sensitive to the social determinants of health. Many smart health services researchers, policymakers, and others have weighed in in the past year. Indeed, our College of Population Health has also opened 2 research centers, one at the Lankenau Institute for Medical Research on the campus of Main Line Health in suburban Philadelphia, and the other in downtown Johnstown,
The past year was pivotal in that Americans are sicker than ever before, and our average national life span has decreased, while the diseases of despair—depression, alcoholism, and drug abuse—have increased. Despite spending nearly 18% of the world’s largest economic engine on health, these statistics are sobering.

8. More organizations are seeking the services of a newly minted Chief Population Health Officer (CPHO). Our college, along with colleagues at Numerof & Associates in St. Louis, MO, were among the first to sculpt the creation of this new role and to document its dissemination into the marketplace. Nearly every week I receive a job description for a CPHO-like individual at a delivery system someplace in our great country. I sense a trend.

9. Private equity money is flowing into healthcare at an unprecedented level. Private equity funding goes beyond new technology as investors are buying physician practices of all sizes and shapes and in many different geographic areas. These investors may know something we don’t; in an industry with nearly $1 trillion of waste, these savvy buyers believe that they can reform our broken system and, in so doing, make a relatively quick profit. For anyone who has attended the JP Morgan Healthcare Conference early in the winter in each of the past several years, this should come as no surprise. When we meet again, I hope next year, one wonders who will be the last person in private, solo, fee-for-service practice remaining in our great country?

10. We’re moving from the “Triple Aim” to the “Quadruple Aim,” that is, to consider “clinician burnout” as a bona fide part of the Triple Aim, which was first described by Donald M. Berwick and colleagues nearly 10 years ago. Regrettably, physician opioid addiction and suicide are at numbers that far outpace almost any other profession in the country. Recent editorials, including heartbreaking stories in the New England Journal of Medicine, highlight the need for more resources to ameliorate clinician burnout. Other evidence suggests that doctor burnout increases the number of errors, and that greater attention to this need has an economic return on investment.

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References

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