Why our healthcare system is broken
Part I - Our infrastructure

Our healthcare system wasn't always broken. In fact, for many years, since the end of WWII, it served the needs of the majority of the American public and was the envy of much of the rest of the world that was grappling with setting up government-sponsored systems of healthcare delivery. Some national healthcare systems like those in Scandinavia were vaunted as "forward-thinking" and worth emulating, but the United States stuck with its largely private model although President Harry Truman called for a national health insurance fund back in 1945. (Before him, President Theodore Roosevelt had national health insurance as part of his election campaign in 1912.) Twenty years later, on July 30, 1965, President Johnson signed Medicare into law and today over 63 million Americans are covered by it. The cost of the plan has been steadily creeping upwards and is expected to account for around 18% of our total federal spending by the year 2028.

In practice, no person living in the United States can be denied life-saving or emergency medical care, but the system does not give equal access to non-life threatening care. Where you live and your financial status determine healthcare availability and affordability. Such is not the case in government-run national healthcare systems. According to the Centers for Medicare and Medicaid Services (CMS), the cost of healthcare in the U.S. is approaching nearly $4.0 trillion or around $12,000 for every man, woman and child. The industry represents over 17% of our Gross Domestic Product.

The U.S. healthcare industry is comprised of: healthcare providers (hospitals, clinics, doctors and healthcare workers); healthcare insurers, medical research institutions, pharmaceutical companies, medical instrument manufacturers and governments (both state and federal). Our physical healthcare service infrastructure (hospitals) is a mix of aging and newer private and state-run facilities most of which are located in high population density areas. Nearly all get some form of federal subsidy or grants.

There are many special interest organizations that exert significant influence on America's healthcare system and on our lawmakers. Among them are physicians' organizations like the AMA and lobbying groups representing the insurance and pharmaceutical industries. Patients' rights organizations are a relatively new phenomenon but are gaining in popularity. Back in 1945, our population was relatively small and young. There were 140 million of us so the system wasn't overburdened. Twenty years later that figure was 193 million. In 2020, our population increased to 331 million of which around 50 million are over the age of 65. This is four times as many elderly citizens as there were at the start of the 1900s.

We are in trouble because our infrastructure is in trouble.

Our country's infrastructure capability has not kept pace with our growing and aging population. Our doctors are retiring and our nurses are choosing different career paths. They're switching to becoming traveling nurses, jobs that can pay them double what they're earning at hospitals or clinics (traveling nurses can make up to $115K/year). Private practice physicians are a vanishing breed. Most doctors across the nation have chosen instead to become employees of private companies in order to be free from onerous liability insurance costs and to get the equivalent of 'signing bonuses' with generous employment packages. Hospitals, especially those within 100 miles of our southern border, are seeing their emergency rooms fill up with 'undocumented' (illegal) immigrants due to the immigrants' inability to get affordable health insurance. To add to ER overcrowding, America's hospitals now have another challenge to deal with…insufficient Intensive Care Unit (ICU) beds due to the increased demand for them by patients suffering from the Coronavirus.

Why were there not enough ICU beds? Didn't we have ample experience with previous epidemics and viruses to know that we needed to expand our facilities? Or was it because of the 'lean' (and many would say, *mean*) healthcare delivery model hospitals chose back in the 1980s?

The *Lean Model* was introduced to alleviate some of the 'financial tensions' inherent in the business of healthcare. Here is a summary of an excellent article by Dr. Brent James in the publication 'Health Catalyst' about the Lean Model. "The survival of healthcare organizations depends on applying lean principles. Organizations that adopt lean principles can reduce waste while improving the quality of care. By applying stringent clinical data measurement approaches to routine care delivery, healthcare systems identify best practice protocols and incorporate those into the clinical workflow. Data from these best practices are applied through continuous-learning loop that enables teams across the organization to update and improve protocols–ultimately reducing waste, lowering costs, and improving access to care." Dr. James goes on to say, "Clinicians often focus on patient outcomes, regardless of cost. The financial office, on the other hand, responds, “No money, no mission.” Healthcare is still a business. To resolve that dynamic tension, healthcare systems have tried several approaches. In the 1980s, healthcare organizations used Activity-Based Costing (ABC) systems that had been successful in other industries."

In short, healthcare providers focused on standardization and tried to eliminate waste by only concentrating on the demonstrated core needs of the day (especially as they relate to the expansion of ICU beds which can be extremely costly). This is normal for any profit-making industry, but when it comes to healthcare, standardization and leanness don't always translate into better or even adequate patient care, especially for those patients and their care requirements that don’t fit neatly within the narrow confines of what constitutes the 'standard.' Because of this model and the insufficient ICU spaces and ventilators to help Covid-19 patients, for example, American hospitals couldn't satisfy the demands placed on them. Neither were they staffed up for them which has led to 'nurse burn-out' on a nationwide scale. And it's not just hospitals that are affected by the lack of healthcare providers. Doctors' clinics, particularly those specializing in dermatology and pulmonology, have six-to-eight-month long waiting lists in many states.

Finally, there is the detrimental effect that mergers and takeovers of existing healthcare providers are having on both workers and patients. Constant changes in corporate cultures, new pricing and patient surcharges like 'facilitation fees' in addition to patient co-pays are doing nothing to help ease the pain and confusion felt by the public. These corporate buy-outs are escalating the vertical integration of the industry. They are not improving our infrastructure or reducing the cost of care. If anything, they are compounding its problems and doing nothing to improve the *quality* of patient care. In Parts II and III of this series we will explore the history of - and pitfalls associated with - doing nothing to solve our national healthcare crisis and our options for reversing its downward spiral.

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