Are We Stifling Innovation?

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So much of what we call management consists in making it difficult for people to work.

—Peter Drucker

The aggregation of power among healthcare systems, covertly cradled under the mantra of improving efficiency, increasing access and enhancing value (bending the so-called 'cost curve'), embodies an existential threat to both creation and adoption of disruptive and cost-effective technologies. This disruption in innovation will ultimately interfere with doing more of the right things rather than doing the wrong things more effectively. The seismic shift in hospital-based employment models for physicians restricts physician participation in competitive ventures, actively disincentivizes collaboration, dampens free trade and directly inhibits innovation. In addition, group purchasing organizations (GPOs) further degrade innovation by restricting free trade and creating artificial barriers to market entry. Their unique congressional exemption to anti-kickback statutes allows manufacturers to provide GPOs with 'administrative fees' (frequently characterized as kickbacks by opponents) designed to block competitive products. We believe that the dramatic cost reductions necessary to transition to more effectively deliver care can only germinate and flourish in an environment conducive to innovation that focuses on outcomes, questions the status quo, embraces teamwork, is inspiring and welcomes experimentation.

The transition to an 'employed' model of healthcare, in and of itself, does not necessarily preclude an innovative environment. What is clear is that the rate of increase in the number of non-physician healthcare administrators is greater than

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the increase in the number of physicians over the last 35 years (3200% administrator growth versus 150% physician growth), which has limited physician opportunities to participate in management and to innovate and optimize healthcare delivery. Hospital consolidation recorded a record 115 transactions in 2017 (with over 30 valued at greater than 1 billion in revenue) and is trending to a 15% year-over-year increase in 2018. Consequently, the growth of large healthcare networks, many with market power over insurers and referring physicians has resulted in a dramatic shift towards a direct physician employment model. Private or group practice models decreased an astonishing 17% from 48% to 31% in the last 5 years and new orthopaedic surgeon graduates became employees of a hospital or health network 14% of the time in 2002 versus 41% of the time in 2012. Such direct employment models often significantly limit or completely capture consulting or royalty-bearing opportunities, further crippling innovation. Annual physician surveys show growing dissatisfaction with bureaucracy and the tenor of the hospital–physician relationships with nearly 50% more physicians describing the relationship between hospitals and physicians as negative. Such environments either preclude or disincentivize both innovation and value creation and may promote apathy and maintenance of the status quo, which is ultimately detrimental for patient care.

While hospital system consolidation and physician employment have been shown to enhance bargaining power of the health system due to size and reduced competition, a perhaps larger threat to innovation is the power and protection that GPOs enjoy in the current marketplace. Vizient, the largest GPO, controls up to 30% of all medical supply expenditures and in aggregate, the four largest GPOs together represent 90% of all medical supply spend. While aggregating hospital spend would certainly lower expenditures if the process was competitive, the current structure of GPOs borders on anti-competitive and, as such, stifles innovation. Briefly, GPOs are exempt from anti-kickback legislation and universally charge medical supply companies an ‘administrative fee’ that is simply passed onto the consumer and furthermore seek and charge a ‘premium’ fee for sole source relationships that restrict choice, raise cost, limit competition and prevent small companies with innovative products from competing in the market. This artificial restriction in the supply chain has led to drug and supply shortages (sterile saline was sole sourced in many cases from Baxter Corporation in Puerto Rico, which suffered catastrophic damage from Hurricane Maria), which can negatively impact patient care. A recent analysis from Johns Hopkins exposed anti-innovative behaviour from GPOs that prevented a new pulse oximeter from Masimo from entering the market, as Tyco International had paid for market exclusivity from GPOs in the form of premium administrative fees.

Innovation should be at the core of our strategy to control healthcare costs along with process improvements and decreasing variability. We must vigorously evaluate our environment to ensure that we have aligned our structure and incentives to promote a free market dedicated to ensuring we are doing more of the right things. Ultimately, we have a responsibility to shift the focus back to creating an environment in which success is measured by the value we provide to patients.