
Visions for the 21st Century: New Horizons, New Health Care

Tim Porter-O'Grady

The millennium brings with it an opportunity to see the world within the terms of reference into which it is going. The demand for leadership is to be able to see and translate the future of health care within the framework of the new age. The obligation of leadership is to be able to embrace the challenges a new age brings to health service and to embrace what it requires the leader and the provider to become. Key words: *future, health care, leadership, nursing*

THE MILLENNIUM serves as a demarcation point in the history of humankind. While it is primarily an arbitrary point of reference, it does serve to remind us all of the distance humanity has traveled since the advent of recorded history. This is especially true in the last one hundred years. Never in the entire history of humanity has so much progress been achieved in so short a period of time.¹

The Industrial Age has yielded the means that provided the tools that have radically altered the human condition and changed the ambient factors and circumstances of life in ways that are unparalleled at any time in human history. During this past century the majority of people in the world have moved from a predominantly agrarian culture to an industrial society evidenced by huge growth in urban centers and technological pursuits. The majority of work at the end of the Industrial Age is service or technologically driven, as opposed to the manufacturing and product-based activities common at the outset of the past age.²

Crossing over the millennium into a new century is symbolic of the journey of human history and serves as a reminder of the significance of change and the impact on how people live their lives and what they have become. The passage of time has not just changed what people do—it has changed who we are. It is not an issue of embracing the entry into a new age; it is a time that demands instead recognition of what is required to live well and to thrive.³

What is happening and has been for the past twenty years is the demand to see the world in the way into which it is unfolding, from the perspective of the becoming rather than the leaving of the passing age. The problem for most of us is that we are so formed and inculcated in the insights, behaviors, and patterns of the Industrial Age

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that it is difficult to truly incorporate the new patterns and behaviors essential to thriving in the age into which we are all quickly moving.⁴ The new age is becoming so different from the age we are leaving that it requires people to see it differently and live in it with an entirely changed mental model and applied framework.

There is no greater evidence of this change in the frame of reference for the age than in health care. Perhaps there is no other component of society that has seen as much growth and development over as short a period of time. In less than sixty years the entire landscape for health service has been so radically altered that it has transformed all members of society. From public health to high-tech intervention, the quality and tenure of life have been enhanced to such an extent that the current generation of "baby boomers" can expect to live until they are one hundred years of age.⁵

The three major converging forces—sociopolitical, economic, and technological—have operated to alter the landscape for health service in the past half-century. While the change has appeared gradual, it has become radical in the past two decades and has accelerated to a level that is untenable in the present time. Indeed, we are now on the verge of a whole new script for health service. Created out of the chaos imbedded in the pace of current transformation in health care are the seeds of a new script for service and a new foundation for the structuring of the health care system for the foreseeable future.⁶

There are essentially three major elements of transformation that are working together to change the framework for health care:

- The major technological innovations that are changing what is possible and

the resources necessary to make a significant difference in the quality and quantity of a person's life.

- The changing economic and value foundations that are driving the delivery system to reconfigure service to assure the right balance between resource use, service, and obtaining sustainable outcomes.
- The reconfiguration of the delivery of health services from a hospital-centric format for service delivery to an increasingly health-based script composed of low intensity, minimally invasive, and chemically based processes for treatment.

Each of these three indicators carries with it significant impact on the kind and quality of health services for the near future that is radically altered from what we have grown to expect and upon which the American society has built its perception of what is appropriate and right about health care.⁷ The onset of a new age for health care is fraught with many problems in that the script that is emerging is creating such deep changes that both provider and patient are not ready for what they imply. Furthermore, there is a general feeling that what is happening is inappropriate and will result in something that is less than acceptable based on previous notions of health service delivery. The noise that results creates a backlash that forces both providers and consumers to focus on those things that do not measurably add to the improvements or essential transformations of health service within the context of a new model for health care.⁸

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the demand it creates. The challenge for health leadership is to be able to both see and respond to the changes that are occurring within the context of where the changes take us, rather than from where they have taken us. Perhaps one of the reasons that the highest rate of turnover in health care is among chief executive officers (CEOs) is their inability to both perceive and lead the systems of service in a direction and manner that is fundamentally different from that for which they were trained and with which they had become familiar. The familiar is now foreign and the status quo is now a dangerous place to be.⁹

The challenge for leadership is to conceive models of service and roles for the professions that are fundamentally different from those that had become the mainstay of their work in the past. The day of the hospital-driven, patient-based, and dependent model of health service design is now fairly much dead. What has not caught up with this reality is the practice of the professions and the construct of service delivery. The patient is no longer staying for the wide range of interventions and processes to which the professions have now become attached, and the professionals have not yet mourned the loss.

We are watching the end of health care as most providers know it. The framework for thriving in the emerging age is the recognition that it is no longer about doing more

with less but instead about doing and being different. The work of leadership is not assuring that the staff can survive the current chaos in health service. It is instead about designing new ways of working and living in a paradigm for health service that bears little resemblance to that into which most of us began the work of our professions.¹⁰

A Technology Script for the Future of Health Care

There is perhaps no influence that has had a more visible impact on the unfolding of health services in this current time than technology. Over the last sixty years new technology has radically altered what we could and did do for those in need of intervention. From the introduction of modern day surgery, to the computerized machines of diagnosis and intervention, to the chemo- and pharmacotherapeutic processes so common a part of health service today, we are living the science fiction that was once only the gleam in a health provider's eye. Today we are living what was the science fiction of two decades ago. And the rate continues to accelerate.¹¹

In a matter of a few years we will move from surgical intervention for coronary artery disease to pharmacotherapeutic processes that will do the job of clearing or keeping clear the arterial pathways in a way and at a cost that will virtually eliminate current interventions. The lipitrophic (fat and cholesterol reducing) drugs will themselves significantly alter the need for surgery and single-handedly change the focus of intervention from surgery to medicine.

The same can be said regarding the treatment of cancers, especially those of the

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breast and prostate. New medicines now in the final stages of preparation will become the methods of choice for treating these cancers and will usher in other drugs that will better treat other kinds of cancer.

This is not tomorrow's technology; it is today's. The question for providers is: Are they ready for how these and other emerging technologies will change who we are and what we do?¹²

The question for nurses is: Are they ready to give up old models of service and clinical focus? Are nurses ready to adapt to a framework of service that does not create patients, result in dependencies, nor support residency in institutions currently populated by nurses in numbers that are quickly becoming untenable?

The interesting thing about today's nursing shortage is what it is saying to nursing leadership that they have not yet discerned. Filling beds with patients will no longer be the goal of health service. Creating more positions to serve those beds will never result in enough patients available to sustainably fill them. And this is a good thing. The current bed-based schizophrenia in health care is short-lived, as newer approaches make these procedures increasingly obsolete. Those with sufficient vision already recognize how seeing nursing's current circumstance as a shortage is inadequate. It is, instead, a necessary reconfiguration of services to drive more firmly in the direction of creating newer models of service that no longer require resident, long-term, bed-based approaches to care.

The patient is changing, too. Internet technology is now making it possible for patients to get medical information from the computer in their own home. The issue this

creates for the professional is that the physician or nurse is no long the sole source of accurate medical information; nor are they the most complete source to the consumer. Consumers can access all the information regarding an issue of concern to them, not simply that bit of information professionals have provided that is limited by our personal capacities to have or to use it. Patients can now bring that information with them, along with the associated questions they might have, and request that the professional help them understand and apply it in a way that has meaning for their lives. It is a far different role for the health professional to assist the patient with access rather than to be the source of the patient's information as they once were. Partnership now becomes the major skill-set for the professionals at a time when their history has not prepared them for this role. Now both consumer and provider must play within a different accountability—the consumers assuming ownership for the decisions of their life and the providers with the accountability to assist with the better accessing of what the patient needs.¹³ Clearly, this is a journey of considerable work and time, yet one that technology is making increasingly a requisite of the age.

A New Perspective on Value

The major shift in the financial configuration of paying for health care over the past two decades has created a significant alteration in both the process of payment and the means of funding health care. While the jury is still out as to whether it is a better or worse way to finance health care, it is different. The primary reality, however, is that some change in the mix of payment strategies for

health service was bound to happen. The age, however, creates some different emphases regarding the economics of health service over the next two decades. The development of the computer chip allows us to manage huge aggregates of data and to correlate one data base with another. This ability now creates a new requirement for health systems. No longer can financial and clinical data be assumed to be separate and unique, requiring different data processes for their management. The truth is that both are essential foundations for obtaining sustainable value in health care. Obtaining value for those we serve demands good integration of the information infrastructure.¹⁴

This focus on value, however, requires a different mind-set on the part of both payer and provider. Value must be in balance if it is to be sustainable. Balancing the value equation becomes the major task in creating a renewable service framework for health care.¹⁵ The three elements of the equation are resource availability, quality outcomes, and service activities. Only in creating a continuous and cybernetic interaction between each of these elements of the value equation are the underpinnings of sustainability present. Too great emphasis on any one element and the other two will pay the price. Too much focus on any two of the elements and the third is compromised. The work of providers is to keep the equation in balance. This is harder to do than to talk about.

Resources are never unlimited. There are always constraints. A society must sort out how to balance the distribution of its hard-earned resources. There are many interests that must be addressed if the quality of the social enterprise is to be continuously ad-

vanced. Whatever the decision, the parameters have lingering implications for what is available to meet the social mandates of the society. Health care falls within this context in both the private and public sectors. Once that political process has been played out and resources are set, the only choice left is how to use it most judiciously for assuring the health of society. This framework is fraught with challenge. The right strategic priorities and service focus are critical to assuring the viability of a system. It is here that the connection with the other two elements of the value equation must be obtained. Leadership now must assure that the resources increasingly paid in advance of their being used obtain the most value for the system and those it serves. It is here that the outcomes or the product of the use of resources must be determined. In times past we looked at the allocation of resources based on what we were going to do with them. In today's world we look at the viability of resources based on what product will be obtained from them. The focus is on the result, on the product of service rather than simply focusing on the process of service. The outcome now informs the use of resources and focuses them in ways that were never a part of the former process.

The third component of the value equation, service, now must resonate with the distribution of the resource and the determination of the intended product. It is now, finally, the obligation of the system to assure that there is a good fit between the product of health care and the process or work of health service providers. The service is now moderated by the outcome it is intended to produce *from the perspective of the outcome*. The

outcome informs the service and the provider's role is to assure that action and process always lead to the outcome that is directed and that gives form to the work.

This focus is a major source of discomfort to nurses. We have always valued our role in light of what the role did, not from the perspective of what it achieved. Nurses, no doubt, had an impact on outcomes, but few outcomes were claimed by nurses, making it difficult to determine what component of impact could be applied to the nursing contribution. As a result, nurses play a small role in finding the balance in the value equation. It is no longer acceptable not to tie the service and work of the discipline to the value it advances and how it directly affects the balancing of the value equation.

It is, of course, impossible for any one discipline to ever again assume it can work to balance the value equation unilaterally. Balance is achieved through the concerted contribution of each of the stakeholders to the work of health care. Never again can any one discipline dictate or direct alone the outcome of its work. The convergence of the work of each discipline is so essential to the complexity of comprehensive service that the conversation and confluence between their efforts are now requisites of their ability to thrive. The providers now must work at the same table constructing the protocols and processes that most efficiently and effectively get to the desired outcomes within a prescribed set of financial parameters. This is both new work and hard work and assumes that they recognize their shared reality and make space in their own agendas to do this necessary interdisciplinary work.¹⁶

A New Foundation for Health Care

The hospital as we know it is no longer the center of the health care system. While the hospital remains the largest real estate component of health service delivery and accounts for the vast majority of the infrastructure of service, its current configuration is dated. Much of the infrastructure of the traditional hospital is now a liability instead of an asset, and it grows even more threatening to the viability of the system every day it remains unaltered. This is not to suggest that the structure called the hospital will dissipate. To do so would be a colossal waste of resources. It is what it will become, however that is critical to the time.¹⁷

Classical examples abound in health service regarding the truth of the existing burden of too much hospital infrastructure. For example, two major California medical centers merge to create a large health system with more beds than patients to fill them. Leadership knows that beds have to close but the political ramifications and perils associated with who should sacrifice the bed drag on for several years. While the argument ensues, the revenues continue their inevitable decline until more than \$90 million are lost and an entire hospital must close to compensate for critical decisions that were not made in a timely fashion. This represents many stories that can be told in every state about the need to reconfigure health services in a different way, yet systems pay a heavy price because either the insight or the courage to make the necessary changes is absent in the leadership. It is no wonder that the highest rate of turnover in health care is among CEOs.

The script for health service is radically changing. New therapies and approaches to health service are now demanding different responses from the leadership in order to create a close fit between the design of the system and the services that will emerge there. New clinical processes continue to make the late-stage, sickness-based interventions less the template for the future provision of health services. The financial reconfiguration of health services now calls for a different approach to the consumers of care. Consumers must be engaged in a partnership of decision making that will change their and the providers' role forever.

Partnership is increasingly a health script that forms the foundation of the future relationship between consumer and provider. If a sustainable health system is to continue, it must now focus on health rather than wait for illness to drive the consumer to the system. The cost and risk are too great for both the system and the consumer. Just look at the demographics if there is any doubt as to the impact of not changing the system.

"Baby boomers" now comprise the largest single cohort of the American population. They are beginning to age in great numbers. This cohort will age all at once and place increasing demands on the health system. If health care remains focused on the treatment of illnesses as they arise, it will be quickly overwhelmed by the demands of this group. In this scenario it will not be long before the system can no longer support the kind of demand this large component of the population will make on it without a major refocusing of its service structure. The health system simply does not have the fiscal or service resources to respond to this cohort's current configuration of demand.

The demands of this population will also be affected by changes in technology and economics.

A few of those considerations are:

- the increasing portability of consumers and providers, including the therapies, techniques, and technologies that support this
- the radical independence of the aging baby boomers and their strong need to control their own lives and circumstances
- the ability to replace high-intensity intervention with low-intensity chemo- or pharmacotherapeutics at a lower cost and with reduced threat to the independence of the aging population
- an increasing awareness that, unlike thirty years ago, the wealthiest segment of the population is made up of those over the age of fifty, who have more disposable income than at any time in history
- the acknowledgement that the segment of the population over age sixty is growing at a faster rate than any other component of society, thereby shifting political power to the elderly

These accelerating considerations are fomenting to create the conditions for an untenable health system in the not too distant future. It is simply not possible to support a health system that does not change its relationship to what it does and for whom it works. This requires that the whole construct for health care change if the country is to continue to thrive over the next century.

The consumer must keep in mind the demand and ability of technology to influence and change the content of health service. The

leaders and providers of health service must be constantly vigilant to the impact of the growing influence of technology over the design of health services for the foreseeable future. Most of the health service advances have been embraced, but it is inevitable before long that a backlash will erupt over the ethical and moral issues of who gets what, how health care will be paid for, and how those disadvantaged through no fault of their own will be treated. The emerging realities of radical health service reconfiguration will bring to the fore all those questions that have not been asked yet.¹⁸

Conclusion

The ideas presented in this article have just scratched the surface of the transformations swirling around the health care enterprise. Suffice it to say, they have just begun. Yet in a significant way these transformations are the signposts of an emerging script for health services. With scientific and technological opportunities expanding at a quantum rate, there is no possibility that health service will

remain simply more of the same. Nurses, physicians, and others can only guess how these emerging realities will alter forever the work of health service provision. The agenda for leadership is how it will create the demand and conditions for confronting the conflict between professional attachment to past practice and the growing demand for a different context and content for health services. Are leaders correctly reading the signposts of the future and putting the correct picture together in preparing the system for radical transformation?¹⁹

The future is always unfolding. Periodically the elements that influence what it will become converge and create the conditions before the means and adequate structure is in place. We are in just such a situation today. The primary role of the leader in this circumstance is twofold: (1) meet the demand of the requisites for a new health system and (2) create the conditions and requisites for a change in the personal and professional behaviors of those who must live with the change. After all, it is the leaders who must give it commitment and content if change is ever to be sustainable.

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