

SPECIAL REPORT

# Detecting BS in Health Care 2.0

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## *Disclosure*

This presentation contains no BS. Moreover, it was not composed in any facility manufacturing BS.

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# Introduction



In our initial report “Detecting BS in Health Care,”<sup>1</sup> we identified our top ten BS concepts and trends within the health care industry, and encouraged our readers to hone their “BS detection skills.” Many of you have let us know that we “left some BS on the table.” For example, there are more Old English terms for BS that we missed—such as babble, bafflegab, bilge, blather, blarney, bosh—and these are just from the b’s.<sup>2</sup>

There is so much potential BS and so little time to refute it. The “BS Asymmetry Principle” states that the energy needed to refute BS is exponentially bigger than what it takes to produce it. Moreover, research suggests that not only is BS easier to produce than to refute, it also spreads faster and farther than the truth due to social media, and is compounded by the existence of a “New Age Bullshit Generator” that effortlessly spews out this stuff.<sup>3</sup>

Beyond that, we committed the cardinal sin among academics of doing an incomplete review of the BS literature. The preponderance of BS is reflected in the numerous monographs, articles, and symposia on the topic, such as:

- *The Rise and Fall of Strategic Planning; Billion Dollar Lessons.*<sup>4</sup>
- Articles in the *Wall Street Journal*, *Scientific American*, and *Judgment and Decision Making.*<sup>5</sup>
- Articles in the *Journal of Experimental Social Psychology* (March 2018) showing that people spread BS when they feel obligated to have an opinion regarding a topic they know nothing about (and when they feel they won’t be challenged on it) — what is referred to as “The Ease of Passing BS Hypothesis.”<sup>6</sup>
- Session at the Annual Conference for Personality and Social Psychology (Spring 2018) on “Bullshitting: Empirical and Experiential Examinations of a Pervasive Social Behavior.”

We’re standing on some pretty broad shoulders of others who are knee-deep in this stuff.

We realize, of course, that just like movie sequels, this second edition isn’t likely to live up to the first. Our first go-around went after the low-hanging BS—stuff that everyone knows is real BS. This time around we make bolder assertions about other possible forms of BS—including some sacred cows—that might make some readers uncomfortable.

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## Varieties of BS

In our previous report, we suggested the need for a screening mechanism to identify widely touted slogans, platitudes, and unrealistic aspirations with little or no empirical support. We provided some examples, but we realize that we did not deliver on the premise that (mixing metaphors) there is a way to sort the wheat from the chaff when it comes to detecting BS. This report offers some examples of what we think will be an important distinction in this effort—the difference between *total BS* and *partial BS*.

By *total BS*, we mean concepts and slogans with no socially redeeming value because they have no supporting evidence, are conceptually vacuous, and/or logically inconsistent. These empty vessels are nevertheless fairly common and more arrive every day, but they also tend to be easy to spot and ephemeral (though often replaced by a new version of total BS). *Partial BS*, by contrast, may have supporting evidence in some contexts, but are widely misused and wildly stretched to become a universal sentiment to be applied without further thought or qualification. Because there is an element of truth to this latter set, they tend to be harder to pick out *a priori* and more durable in management and policy discussions.

Below we provide some examples of both categories. BS muddies the waters (depending on your definition of “mud”) but we hope to offer some filters for greater clarity. As in our previous report, we introduce each type of BS with a picture and offer the reader an opportunity to identify the underlying problem.

# 1



# 1

## Buzz: *total BS*



One of us recalls a speech before a large forum in the 1990s whose key theme was “buzz.” The speaker, a Wharton grad no less, noted that the disruptive startups of the day possessed the all-important quality of buzz. By this he likely meant that they were the talk of the town, the words on everyone’s lips, the topic of conversation at cocktail parties, and the cover story of all the trade magazines. It didn’t matter that no one really understood why these companies warranted all of this attention (they didn’t, actually); instead, it was the external appearance and excitement that counted.

Buzz is synonymous with fads and fashions. The health care industry is saturated by such collective movements. Currently, the buzz is all about the unusual vertical combinations taking place. The granddaddy of all such combinations may be the joint endeavor by Morgan Stanley, Berkshire Hathaway, and Amazon. There are also efforts to combine pharmacy benefit managers (PBMs), pharmacies, and insurers (CVS-Aetna, Express Scripts-Cigna). The Advisory Board calls these new vertical combinations the start of health care’s “Turducken era” (combining a turkey, duck, and chicken). CEOs support these strange partnerships by stating, “Together, we can do something differently.” Losing a lot of money and failing all over again doesn’t seem all that different to us.

Another buzzword is “risk.” CMS wants providers to accept it. CEOs say they want it. Doctors want to avoid it. Not sure what this all adds up to. Sounds like the “top-down” BS problem we identified in our earlier report.

Friedrich Nietzsche’s sage comment seems relevant here: “Madness in individuals is rare, but in groups...it is the rule.” When traditional growth strategies (like mergers and acquisitions) fail or are blocked by regulators, go after the shiny new object. That happens to be vertical integration. And if others are doing it, firms want to avoid a FOMO moment (and maybe a Maalox moment) by being left behind. Hey, why let your competitors lose all that money by themselves? Welcome to the party! There is certainly safety in numbers, especially when you have to justify all of these actions (and losses) to the Board.

# 2

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# 2

## Scale Economies: *partial BS*



During the 1990s, Wall Street analysts justified every health care merger based on economies of scale. We liken “scale economies” to Helen of Troy — the rationale that launched a thousand mergers. Unfortunately, many people have not read *The Iliad* and don’t know who Helen of Troy is; the closest they come is Brad Pitt.

The term “scale economies” gets repeated so often that everyone assumes they must exist and must be true. This is known as the “illusory truth effect” whereby repeated statements are more believable than statements heard once. It is true that small firms often have high total costs because they must pay for fixed or setup costs just to get going and to exist. However, many people conclude from this truth that, if firms get big enough, there must be some more efficiencies somewhere. Thus, hospital systems, large physician networks, huge insurers, big pharma, etc. must all have some redeeming features. What many people don’t realize, however, is that most health care firms are people-intensive and thus lack scale economies beyond a relatively modest size. More than half of all hospital costs are labor; nearly all of physician practice costs are labor; and many of the costs in pharmaceutical firms are largely labor once you leave manufacturing.

In classic economic theory the idea of economies of scale is that they may happen at a single “plant,” for example, an electrical generating station. But do they occur in organizations that get bigger by combining plants (even ones of optimal size)? Once you get beyond engineering production, what is left? Business historian Alfred Chandler wrote an entire volume on the subject (beware: it is thick, and there is no CliffsNotes).<sup>8</sup> We can try to summarize it for you in a sentence or two. Scale economies rest on running a higher volume at faster speed over a reduced infrastructure. For a multi-hospital system to achieve such economies, this would mean closing down several hospital sites, firing lots of people, consolidating their patient volume in a reduced number of sites, and implementing faster patient throughput processes and automation to shorten lengths of stay. This would be real consolidation. As far as we know, only a handful of systems in North America have done this to date. The reason they don’t is that closure of a site just invites competitors to fill the void.



# 3

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# 3

## Roll-ups: *total BS*



Roll-ups are a favorite strategy for forming horizontal chains of organizations. Entrepreneurs start by buying one outfit; buy another under the promise of combined market power and scale efficiencies; and then continue on a grander scale as they form a behemoth. Entrepreneurs attract new targets and investors based on these promises (and maybe equity); they satisfy Wall Street analysts by virtue of combining the earnings of the acquired firms to show “growth.” The enthusiasm of the latter motivates new targets and investors to join the party. It is akin to a Ponzi scheme, as Uwe Reinhardt once pointed out.<sup>9</sup>

Roll-ups have a rather ignominious origin. Wayne Huizinga (of BlockBuster fame) kicked it all off by combining garbage hauling companies in the late 1960s into a company called Waste Management. Considering what followed, he got the name right. Health care companies got into the act during the 1960s-1970s by forming hospital chains and again during the 1980s-1990s by forming “physician practice management companies” (PPMCs). No one bothers to mention that all of these health care roll-ups have failed to improve quality and reduce cost. They are now making a comeback, fueled mostly by the Affordable Care Act and funding from private equity. Not surprisingly, the promises of roll-ups today look eerily like the promises floated in the 1980s and 1990s. As we have noted elsewhere, those responsible for the past debacles have either died or retired, leaving the current set of managers and investors in the dark to possibly repeat the mistakes of the past.<sup>10</sup>

# 4

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# 4

## Synergy: *partial BS*



This has got to be one of the most frequently used (and overused) terms to support new corporate strategies — and also one of the least understood. The word stems from the Greek word *suneisis*, which means “your rivers of understanding flowing together.” We are not sure corporate strategists have this in mind. Usually, they utter the simplistic phrase “ $1 + 1 = 3$ .”

The closest analogy that comes to mind is a good marriage. In such cases, there can indeed be synergy with the strengths of one party complementing the weaknesses of the other, fostering better decision-making, having to buy only one set of china, and having one good set of ears and one good set of eyes at the cinema. Of course, roughly half of all marriages end in divorce (not much synergy there), and half of the remainder are unhappy (not much synergy there either). So sometimes synergy works in marriage and in business, but often it does not. “Assortive mating” helps both kinds of unions but is neither necessary nor sufficient for success. What is key is that there actually be synergies (or, in econ-speak, “economies of scope”) so the whole is better than the sum of its parts—but not just because prospective partners wish it to be so.

What happens when synergy meets corporate strategy? If you are tempted here, you might want to read Alfred Chandler’s book again. Or you might consider the extensive literature on corporate diversification. After roughly 50 years of research, the answer to the question of whether diversification improves firm performance is, to quote George Carlin, “definitely no yeah.” Some diversification may help but not a lot; there is an equal amount of evidence that staying focused in one area is pretty good too.

More recently, a new kid on the block has emerged to pump life into the old beast: “adjacencies.” Such moves resemble the new types of vertical integration described above. But some new rationales are now espoused (described next). It seems that all of these illustrations of BS found in the health care industry overlap one another. This means we have multiples of BS, or BS compounding.

# 5





# 5

## One-stop-shop / cross-selling: *partial BS*



Many companies that diversify aspire to sell multiple products to the same customer. Customers can get all their shopping needs taken care of with one stop (and one swell foop). The purported advantages of such convenience trump all other considerations, such as: (1) do customers go shopping for bundles? (2) are each of the products best-of-breed or at least good enough in the buyers' mind to be bought as a bundle? (3) do customers trust you enough to believe that you are selling them something good across the board? (4) are customers willing to abandon their former suppliers/sites to go with you? But of course, why worry about what the customers think? "One-stop-shop" is a kick-ass strategy that sounds cool.

There are some historically successful health care institutions who do sell many things at one site: we call them hospitals. But this does not mean that adding more snow to the snowball will necessarily make more sense. There are limits, and they depend on whether combination helps production (a place that treats really sick patients well may be unable to slow down and treat not-so-sick patients cheaply) and what consumers are looking for at a single site.

This strategy has permeated many sectors of the health care industry—from suppliers who have diversified into many different technologies and product lines that they want to sell to hospitals, to physician offices that offer their own in-house ancillary testing (lab, xray), to PBMs and pharmacy chains that ally with insurance companies to deliver community-based health care services around a retail clinic hub where the local pharmacist now supplements or replaces the vanishing primary care physician.

One doesn't have to look too far to see the limits of this strategy. If providers wanted to offer one-stop-shopping for medical care, large multispecialty group practices would be the rage. Instead, they have remained a stagnant, minor percentage of all physician groups for decades. There is no evidence that patients have voted with their feet and left behind single-specialty practices to migrate to such groups.

Too often suppliers diversify into multiple product lines to grow (not necessarily to improve customer service or satisfy patient needs). To justify their expansion and perhaps quell fears of regulators, they develop the rationale of one-stop-shopping. Like many corporate strategies, these forms of BS are merely cover for the desire to grow.

# 6

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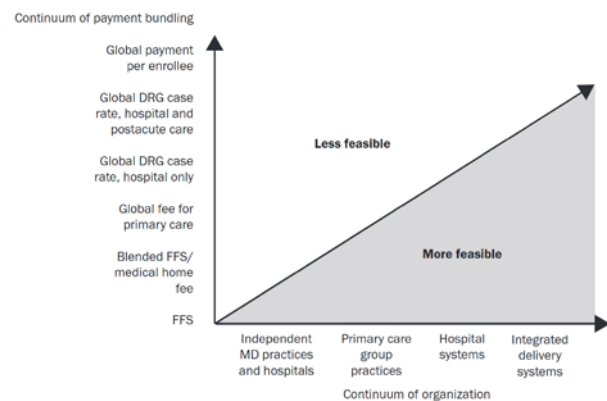


# 6

## Transformation: *total BS*



The most overused term in health care during the past decade has been “transformation.” The term first came about when, using a Cartesian graph, the Commonwealth Fund described the industry’s dual migration from fragmented to integrated providers on the X-axis and from fee-for-service to alternative payment models on the Y-axis. It has been more recently popularized as the movement from “volume to value.” There are multiple books on the topic, including *Prescription for the Future: The Twelve Transformational Practices of Highly Effective Medical Organizations* (note the number of possible types of BS in the title).



Source: *Health Affairs*, 2009. <https://www.healthaffairs.org/doi/10.1377/hlthaff.28.2.w238>

So, what’s wrong with transformation? Not all transformations end up well. Just ask Gregor Samsa who, in Kafka’s novella *The Metamorphosis*, wakes up to find himself changed into a giant bug. People forget that Gregor’s first thought upon seeing his new “form” is that he hates his job.<sup>11</sup> This sounds a bit like doctors and their view of transformation. Moreover, some transformations do not indicate progress, just a change in state. A tadpole turns into a frog, but that doesn’t make the frog superior in any way, just different.

There are more serious issues with the notion that health care is currently undergoing a transformation. First, the evidence does not support it; indeed, the pace of change along both the X- and Y-axis in the Commonwealth Fund’s graph is remarkably slow. Second, there is no necessary correlation between what is going on along the two axes. Third, it is not clear that this transformation is associated with improvements in quality or reductions in cost suggested by its proponents. We have devoted considerable effort to this critique elsewhere.<sup>12</sup>





# 7

## Physician Alignment: *partial BS*



Perhaps the most overused phrase in the literature on integrated delivery networks (IDNs) since the 1990s is “physician alignment.” Everybody uses the term and assumes that alignment results from putting these networks together. Hardly anyone bothers to define the phrase, however, let alone study it empirically. The handful of studies that have done both suggest the emperor has no clothes. Alignment turns out to be a multi-dimensional construct, often built on trusting relationships and involvement in key decisions, that rarely flow from putting physicians on salary or building alliance vehicles to partner with the medical staff. Using terminology from the quality literature, integration “structures” (employment, alliances) are only weakly coupled with integration “processes” (trust, involvement).

What consumers really want and need is a thoughtful method of coordination, a way of directing them to the next logical step until they can be cured or stabilized and then go home. In the old days, this was done (not so well) by physicians referring to their pals; in the modern era we have had some promising but no proven new models (talk about transformation!) that actually improve the patient journey.

But why worry about such niggling details? The study of integration has now morphed to focus on “physician engagement,” an equally amorphous term. Turns out engagement is the new alignment — with the same degree of rigor and substance devoted to the topic. Those spouting physician engagement today apparently did not live through the 1990s’ era of alignment.

The bigger problem facing alignment and engagement enthusiasts is that physicians are, (according to many reports) burned out by EMRs and quality metric reporting, disillusioned with medical practice, and reluctant to embrace alternative payment models. One major reason why some physicians seek hospital employment is to escape all of the crap going on in their practices (including managed care, risk contracting, etc.). Transformation will need to proceed by dragging some unhappy campers along kicking and screaming. This is real alignment.

# 8

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# 8

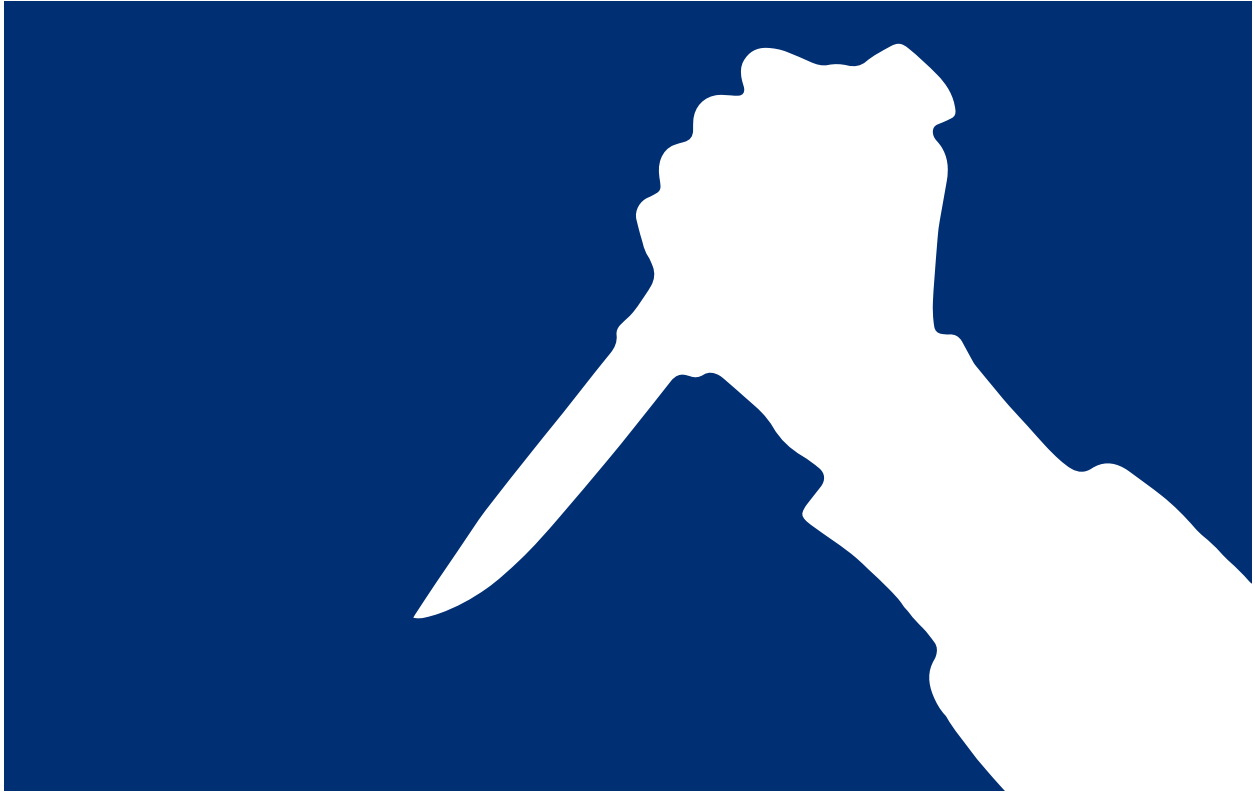
## Patient Engagement: *partial BS*



Why stop with engaged physicians? Why not have engaged patients? Engaged patients are one of the cornerstones of the “consumerism” movement in health care. Patient engagement means that individuals are concerned about their health status, are motivated to do the right things (you know, not be couch potatoes), are conversant with their providers, and compliant with their providers’ recommendations. Patients may also be willing to seek out information on their providers, consider the cost and quality rankings of alternative hospitals, and make cost-effective choices regarding their sites of care.

As Wayne Campbell (of *Wayne’s World*) adroitly observed: “It might happen. Shyeah! And monkeys might fly out of my butt.” Most of the scenarios above do not seem to happen that often; if they do, they occur primarily among the “worried well.” The patients who are most at risk, those with multiple chronic conditions, are perhaps least able to act like consumers and demonstrate the level of engagement that advocates are looking for. Instead, these patients are burdened with a host of health, financial, and social problems that undermine efforts to be more proactive. Many patients do not want to be engaged: they just want to go home.

Consumerism is also blunted by third-party insurance coverage. First, such coverage can limit the consumer’s financial exposure. Second, efforts to promote consumer behavior by getting patients to have more “skin in the game” through higher deductibles and co-pays often result in deferrals of needed care. Not sure that is the type of consumer behavior we are looking for.



# 9

## Killer App/Breakthrough Technology: *partial BS*



Our prior report highlighted the hype about “disruption.” One area where this BS problem frequently surfaces is with technology. To be sure, some remarkable technologies have (dare we say) transformed care by making it higher quality and lower cost—such as minimally-invasive gallbladder surgery, ambulatory surgery centers for less-acute conditions, and perhaps LASIK. But this term gets tossed around so freely that it has become meaningless, stretched beyond the limits of realism to the realm of hopes. Every new advance in cell therapy and gene therapy is heralded as disruptive, especially when you see the price tag. Never mind that these new therapies have limited applicability to small numbers of patients (which is why they cost so much).

The bigger issue with disruptive technology is that it is usually insufficient to disrupt by itself. To improve productivity, disruptive technologies require concomitant changes in the organization of medical work. This point—embedded in the longstanding literature on “socio-technical systems” (STS)—has been forgotten and/or ignored. The reason why it may be ignored is that changing the social system to “fit” with the new technology takes a lot of time and money. It may also require executives to work with physicians and alter how the latter practice medicine—places where many executives fear to tread. It’s much easier to just focus on the “shiny new toy” and hop on the Gartner hype cycle.

# 10

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# 10

## Big Data: *BS* (right now, but too soon to tell which kind)



In February 2018, *The Economist* devoted its cover page to “How Data Will Transform Health Care.” The article suggests that Apple, Google, Facebook, and Microsoft are poised to “disrupt” the health care industry through new apps, big data, and artificial intelligence (found in abundance at any mall).

To be honest, we are not sure what “big data” look like. John Glaser, who teaches our health care IT course at Wharton, spreads his arms far apart and says it’s “this big.” We have both done a lot of empirical research with large-sized data sets, but have never considered them to be big data. Big data often means having more sources of information about a patient, including the patient’s genetic profile, diagnostic tests, sociodemographic characteristics, and medical utilization. This seems to fall under the “more is better” rubric. It certainly underlies the “All of Us” initiative that the NIH has recently launched.

So, what’s the problem here? Well, for one thing, everyone assumes that big data (like the EMR of ten years ago) will be a silver bullet that helps to solve a lot of our problems. How will this come about? More information and information from more sources will help us to triangulate the problem and shed more light on the possible solution. One pitfall here, however, is that more data is not a solution in itself. As others have previously argued, “big data” does not necessarily confer “big understanding.” Big data may instead just give you more noise from which you have a harder time distilling a signal. To be useful, big data will require theories of (a) what is associated with what and (b) what causes what. It is not clear to us that the corollary to big data, “analytics,” supplies these missing ingredients.

Another issue is that more statistical power (observations) is needed on the two parties closest to the delivery of health care: the doctor and the patient. If big data does not provide this, we are left with a lot of data on a small sample that may not tell us much.

We suspect there is more *BS* behind big data, but are not smart enough to sniff it all out. We leave it to our readers (and “open innovation”) to help us out.

# 11

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# 11

## Platform: *total BS*



The term “platform” has come into vogue among health care system executives. Witness the “number one takeaway” from the 2019 JP Morgan Healthcare Conference held recently in San Francisco: “it’s the platform, stupid.”<sup>13</sup> This represents yet another “tectonic shift” underway in which hospitals move away from buying more hospitals and physician practices to “leverage the platform and resources they have in place to become a hub for both health and healthcare in the future.” This entails “leveraging research, big data, expert clinic insights and artificial intelligence to create new value.” Apparently, the idea is to stop conquering new frontiers and try to make the most of what you already have. This may represent “taking a break” disguised as a novel form of progress.

As far as we can recall, the use of the term platform in health care began with medical device companies (like Medtronic and Guidant) that made successive versions of pacemakers and defibrillators. Every few years, they would develop a new technological platform—roughly defined as a bundle of technologies that served as a base upon which product iterations might be made in the short-term to continually interest physician customers (i.e., “there is something new in the bag”)—often based on the circuitry and software in the device.


Now we are applying this more broadly to providers of “services,” dropping much of the hard technology angle, and aggregating a LOT of buzzwords. This appears to be the “new” platform—things an organization is already doing that are somewhat related and might be used for some new purpose. We have already dealt with many of these buzzwords, in this and our previous report. If we add many of these things up, hopefully we have more than just a lot of BS but now something meaningful. This smacks to us like the Republican and Democratic Party “platforms” developed every four years. Just as political platforms present party members with a set of loosely related sentiments and proposals, so a health care system platform lists the things it can offer to the population it serves and hopes it means something.

Is there an as yet undiscovered cache of tools or techniques that can allow providers to make more of what they have? The ability to find nuggets of correlation in massive data sets (patients with disease X appear to do better with treatment Y than with others) may be one, although we are not sure. But beyond some islands of clinical improvement, what is it, exactly, that can leverage financial results or market share that has so far been undiscovered? Feel free to enlighten us and health care executives.

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