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THE REMEDY

ADVANCING EVIDENCE-BASED HEALTHCARE DELIVERY IN A FRAGMENTED SYSTEM

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To my parents, Stanfort and Magnolia Webb, who, in the heart of the Mississippi Delta, gave birth to and nurtured ten children with unwavering love and resilience. Though limited in formal education and resources, they provided us with the richest gifts of all—strength, faith, and the enduring power of love and family. This book is a testament to their sacrifices and a celebration of the legacy they built from scarcity. Through the struggles and perseverance, they gave so much, not just to their children but to all they encountered.

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AUTHOR'S NOTE

I have spent my entire professional life inside the American healthcare system. My roles have not been those of a distant observer but rather those of a leader responsible for operations, organizational survival, performance, and, perhaps most importantly, the workforce. Over a combined four decades, I have worked in and led for-profit, nonprofit, and public hospitals. My leadership has guided organizations through crises and brought them back from the brink. I have seen firsthand the tension that persists between mission and margin, which defines so much of the culture of the US healthcare system.

This book originates from that vantage point. It is not an academic exercise, although it addresses essential research and evidence-based methodologies. It is not a political manifesto, though it addresses and confronts the policies and values that shape the healthcare industry's landscape. Instead, it is a sober exploration of the quandary of why the United States—known to be the wealthiest nation in history—continues to deliver poor health outcomes, inconsistent patient experiences, and exorbitant costs. The next obvious question is, What can be done about it?

I write this book not to assign blame but to highlight the forces at work and to challenge leaders and stakeholders from all aspects of our society to use their influence to take action. The solutions we need will not emanate from any single policy, legislation, or other source. They will come from formal and informal leaders, generally found in hospitals, clinics, communities, classrooms, boardrooms, and faith-based organizations, who are willing to rethink how we define and execute successful healthcare delivery in the future.

If you are reading this, you are part of the story. Whether you are a clinician, an administrator, a policymaker, an employer, a community leader, or simply someone who cares about the health of your family and neighbors, you have a role to play. My goal in writing this book is for the information within these pages to provide you with both the clarity to see the system as it is and the conviction to help shape what it can become.

Let's embark on a journey to understand the challenges and, subsequently, engage in interventions within our spheres of influence to improve how we care for our population's health. As you journey through this documented version of who we are as a nation, particularly in the context of healthcare delivery, be mindful that the only proper way to assess our performance is through health outcomes. Profits, volume, and market share are acceptable measures of business performance, but they cannot substitute for or replace the critical value of quantitative health outcomes. I welcome your impressions, reflections, and insights, which you can share via email or by scanning the QR code found at the back of this book. Thank you for allowing my words to accompany you as you navigate through to that final page.

PREFACE

"We will not leave you out!"

If we were to reorganize the way we provide healthcare to the US population using the tools in this book, we would be well on our way to remedying the fatal error the US made after World War II. It was then that, in the name of solidarity with the American people, we should have made healthcare a right for all, like every other industrialized nation on earth.

Our promise to the American people should be, "We will not leave you out!"

This scenario illustrates the adage "You cannot legislate morality." We understand from our daily experience with healthcare in the US that it is rife with fissures that need serious repair. Unfortunately, the underlying causal factors are not easily reachable, as they are deeply rooted in the halls of our Congress.

This challenge, however, does not mean that we cannot focus our attention on what *can* be done to remediate the problems of exorbitant costs and poor outcomes that too often manifest themselves in epidemic levels of disproportionate morbidity and mortality

for certain minority communities as well as marginalized and underserved populations.

My proposal is not to accept halfway measures but instead to begin our journey toward mitigating the effects of a dysfunctional US healthcare delivery system with a complete understanding that a permanent cure would require something akin to a universal healthcare model.

We already have the resources within our culture to address these challenges, including access to data, research, and evidence-based methodologies.

We already have the resources within our culture to address these challenges, including access to data, research, and evidence-based methodologies. These resources have long been at our fingertips. They are continually updated and made available to us by a large cadre of scholars and experts who consistently argue that there is a pathway forward for healthcare delivery if we have the will and the courage to implement evidence-based interventions.

This book shares an array of methodologies and tools that have been implemented in real-world settings and are illustrated as proven successes, demonstrating that it is possible to mitigate the effects of a dysfunctional healthcare system through the proper application of evidence-based methods. My four decades of experience in healthcare leadership, including three successful hospital turnarounds, are a true testament to the fact that this can be accomplished with the right approach.

In English, a remedy generally refers to providing temporary, situational relief of symptoms, while a cure is a one-time resolution that eliminates the problem. I already mentioned what would constitute a cure; however, after more than two hundred years of futile attempts, a universal healthcare model has not and likely will not become a reality in the US anytime soon.

Historically, the root use of the word *remedy* was as both a noun and a verb, referring to counteracting sin or evil of any kind or to a cure for a vice or temptation. In the fourteenth century, the definition expanded to include a treatment for a disease or disorder, a medicine, or a process that restores health, from the Anglo-French *remedie.*

Around that same time, *rectifien* meant to cure, heal, or remedy a bad or faulty condition. In the early fifteenth century, it meant to "set (someone) straight in conduct or behavior." Then, later in that era, *rectifien* referred to correcting an error, setting (something) straight or right (from Old French *rectifier,* literally "to make straight").

Incremental change has always been the way in America. So, choosing *The Remedy* as the title of a book whose time has come offers multiple dimensions. *The Remedy* accepts the premise that something is wrong with the system and provides evidence-based solutions along with widely accepted principles. It's not a total cure. But when we reset the way we distribute healthcare in America, we'll all be in a better place.

It is also a realistic and achievable alternative that summons the effort of the resource that has always been the saving grace in the US: the collaborative impact of the people.

INTRODUCTION

The American Healthcare System

The World Health Organization (WHO) put forth the definition of *health* in 1948, and it is still very relevant today. According to the WHO, *health* is defined as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.[1]

This definition strikes me as more than a statement about medical outcomes; it has a moral value. It implies that human beings are entitled not just to survive but to thrive; not merely to avoid illness but to seek a state of holistic health that includes body, mind, and community.

This vision finds a striking relationship to one of the most celebrated documents in US history, the Declaration of Independence.

"We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty, and the pursuit of Happiness."[2]

1 "Social Determinants of Health," World Health Organization (WHO), accessed February 13, 2026, https://www.who.int/health-topics/social-determinants-of-health.

2 "The Declaration of Independence," National Archives, accessed February 13, 2026, https://www.archives.gov/founding-docs/declaration.

These two statements originate from different worlds and vastly different eras, one from the culture of global health governance and the other from the developmental era of early America. Yet they connect on a shared truth: The ability to live fully, freely, and happily depends on conditions germane to human well-being.

Life, in the Declaration's sense, is not simply the daily functioning of the heart; it is the attainable conditions that allow a person to participate in family, community, and society.

Liberty is not merely the absence of incarceration; it is the freedom to speak, engage, and make choices, to pursue one's dreams and aspirations, and to shape destiny—freedoms that are not attainable without the health needed to enjoy them.

Finally, the pursuit of happiness is not a temporary joy; it is the lasting ability to seek meaning, purpose, and fulfillment, an ability that does not exist when health is compromised.

Our own history shows that societies that neglect their people's health essentially undermine the very rights they claim to protect. Epidemics, malnutrition, unsafe working conditions, poor living conditions, and a lack of equitable access to healthcare undermine both their liberty and their happiness. The signers of the Declaration—Thomas Jefferson, Benjamin Franklin, and John Adams—may not have spoken in the language of public health. Still, they obviously understood that rights are sacred when the conditions for human survival are absent. In the modern era, the WHO's definition amplifies what the Declaration implies: that health is not a privilege but a prerequisite for the capacity to fully enjoy all other rights and benefits.

This connection carries profound policy implications. Suppose health is paramount to life, liberty, and happiness. In that case, governments and policymakers have a responsibility to create conditions in which the concept of health can not only survive but also thrive.

This means ensuring access to clean water, nutritious food, safe housing, educational opportunities, and quality healthcare. It means protecting mental health on par with physical health and addressing the social determinants of health (SDOHs), such as poverty, discrimination, and environmental hazards, which are fundamental causes of health disparities and poor health outcomes. It also means recognizing that, according to research, healthcare accounts for only 20 percent of a population's health outcomes, while the remaining 80 percent of a population's health outcomes are attributable to[3]

We should be mindful that healthcare is not a cost to be minimized but an investment in the very freedoms that define a fair and equitable society.

- health behaviors,
- socioeconomic factors, and
- physical environment.

We should be mindful that healthcare is not a cost to be minimized but an investment in the very freedoms that define a fair and equitable society. A nation that safeguards its population's health strengthens its democracy, its economy, and its moral position. The WHO's vision and the Declaration's promise together form a union that points toward a society in which every individual has an equitable opportunity not just to live longer but also to enjoy the fullness of life, liberty, and the pursuit of happiness.

3 Rosemary M. Caron, *Population Health: Principles and Applications for Management* (Health Administration Press, 2017).

The Value of Health and Life

It was a Tuesday morning when Yolonda was brought into the emergency department. She was forty-two years old, a single mother of two, and she had been ignoring the crushing pain in her chest for nearly a week. She didn't have health insurance. She worked two part-time jobs, neither of which offered health benefits, and the thought of a hospital bill terrified her more than the pain itself. Statistically, medical debt is the leading cause of bankruptcy in the US.

By the time Yolonda arrived at the ER, her heart was in failure mode. The ER team moved quickly, stabilizing her and preparing her for an urgent lifesaving procedure. However, as so often is the case, the delay in seeking care had done significant damage to her heart muscle. Yolonda is one of the lucky ones; she survived. However, her recovery will be long, complicated, and expensive, which she cannot afford. It will certainly devastate her financially as she continues to seek a life for her two children and herself.

Statistically, Yolonda, who is African American, is more likely to die from a cardiovascular condition than her Caucasian male and female counterparts, as well as her African American male counterparts. According to the American Heart Association data, African American women face the highest heart-related mortality rate because they carry the greatest burden of cardiovascular risk factors and the lowest rates of risk-factor control, compounded by systemic social determinants and inequities that often delay diagnosis and treatment.[4]

Yolonda's story is not rare. It is the quiet, everyday tragedy of American healthcare: a system in which the fear of financial ruin and

4 National Association of Community Health Centers, "Action Guide: Population Health Management Risk Stratification," National Association of Community Health Centers, 2023, https://www.nachc.org/wp-content/uploads/2023/07/Action-Guide_Risk-Stratification.pdf.

proper access to healthcare can keep individuals from seeking lifesaving treatment, even in the wealthiest nation on earth.

A Nation of Wealth and Poor Health

The United States is a nation of palpable contrasts. We are home to some of the most advanced medical technologies in the world, the most highly trained clinicians, and research institutions that push the boundaries of science. Our hospitals can perform surgeries that were science fiction a generation ago. Our pharmaceutical industry develops lifesaving drugs that are exported worldwide, helping save lives in countries abroad. Yet, despite this abundance of wealth and resources, our health outcomes reveal a sobering reality.

The Commonwealth Fund's 2025 Scorecard on State Health System Performance found that even the best-performing US states—Massachusetts, Hawaii, New Hampshire, Rhode Island, and the District of Columbia—all fall short of the health outcomes achieved in peer nations.[5] Avoidable mortality rates in the US remain higher than in other high-income countries, and in many states, they are rising even as they decline elsewhere. Where you live in America still determines, to an alarming degree, your likelihood of living a long and healthy life.[6]

This is not a temporary system glitch. It is the predictable result of a system designed around a particular set of values. These values prioritize market allocation of resources over universal access and wealth accumulation over the guarantee of healthcare as a right.

5 David C. Radley et al., "2025 Scorecard on State Health System Performance: Fragile Progress, Continuing Disparities," The Commonwealth Fund, June 18, 2025, https://www.commonwealthfund.org/publications/scorecard/2025/jun/2025-scorecard-state-health-system-performance.

6 Radley, "2025 Scorecard."

Dubious

Referring to healthcare delivery in the US as a healthcare system is misleading because it lacks the defining features of what a system represents:

- shared purpose
- unified governance
- coordinated components

A properly functioning system is composed of various parts that work together collaboratively toward a common goal. It begins with the resources it utilizes—such as people, raw materials, money, or information—which are then processed and transformed into outcomes through a series of interactions. These activities produce the results or services that meet the needs of the people or customers that the system serves. An effective system employs checks and balances to monitor performance and adjust as needed. It will also have clear rules and guidelines, combined with effective leadership, to guide decisions and set goals and objectives.

Additionally, the system will be aware of external factors and key stakeholders that can positively or negatively impact its success, with plans and strategies in place to manage key relationships. In summary, the system is designed to produce outcomes driven by a shared purpose, ensuring that all efforts move in the same direction and that the whole works better than the sum of its parts.

Instead, US healthcare delivery is a fragmented collection of private insurers and third-party payers, government programs, and independent providers, all operating with conflicting incentives.

> Healthcare in the US is not a right, and it has never been.

As one might imagine, this structure and process are highly likely to produce poor outcomes, including inconsistent access, chronic health disparities, and the highest cost per capita (and overall) among industrialized nations. These conditions exist, indicating the absence of a proper system of integration, aligned incentives, and equitable distribution reform that would lead to better health for all.

In summary, the structure and process of healthcare delivery within the US are significantly flawed in their ability to achieve good outcomes, good patient experiences, and cost efficiency. To achieve success in these areas, individual systems and stakeholders must create their own subsystems. The methodology for designing an optimally effective model involves utilizing evidence-based knowledge and resources. Engaging science-based evidence models will help reduce the variation in healthcare delivery systems, both internally and externally.

Social Distributive Ethic

We should address the proverbial elephant in the room. The elephant that often goes unnoticed—in the sense that no one wants to acknowledge or address it—is that healthcare in the US is not a right, and it has never been. It is often implied to be a right, but in fact, it is not established in the Constitution or in statutes. The US is the only industrialized country where healthcare is not considered a right. Countries such as Germany, the United Kingdom, Norway, Canada, and other Organisation for Economic Co-operation and Development (OECD) nations recognize healthcare as a right.

At the core of the American approach to healthcare delivery is a social distributive ethic deeply rooted in capitalism. For those advocating for the plight of the underinsured, who believe that highlighting

disparities in health outcomes will persuade US policymakers and elites to adopt a universal healthcare system, it has yet to happen in more than two hundred years. Such a system would ensure that all individuals have the right to healthcare, regardless of socioeconomic status or ability to pay. Many well-intentioned leaders have attempted to move in that direction, but success has eluded them.

In the context of US distributive ethics, healthcare is often viewed through a lens that prioritizes individual wealth, market dynamics, and economic productivity. Access to medical services is frequently contingent upon financial capacity, reinforcing the notion that wealth justifiably influences the allocation of care. This perspective aligns with broader skepticism toward redistributive policies, particularly those that transfer resources from the affluent to the economically disadvantaged. Such measures are commonly perceived as threats to future wealth creation, potentially dampening incentives for innovation, investment, and labor. Moreover, the concept of healthcare as a positive legal right, under which every citizen is entitled to care regardless of ability to pay, is met with resistance from many who argue that it imposes unsustainable burdens on the economy. Critics say that guaranteeing universal access could lead to increased government intervention, reduced market efficiency, and hindered economic growth. These views reflect a distinctly American ethic, one that emphasizes personal responsibility and economic liberty over egalitarian redistribution and that often frames justice in terms of opportunity rather than outcome.

In contrast to the US approach to healthcare, other industrialized countries address it through a distributive ethic that emphasizes solidarity, equity, and social justice. In these nations, healthcare is generally viewed as a positive legal right, guaranteed to all citizens regardless of socioeconomic status. Redistribution is not only accepted

but often seen as a moral duty, justified by the belief that collective welfare strengthens social bonds and promotes long-term stability. Rather than viewing universal healthcare as a threat to economic growth, these systems tend to frame it as an investment in human capital, thereby ensuring a healthier, more productive population. Funding healthcare through progressive taxation or social insurance reflects a commitment to egalitarian principles, where justice is judged less by individual wealth and more by the fair distribution of essential goods. This approach highlights a fundamentally different ethical perspective, one that values collective responsibility and social equity over market-based allocation.

This social ethic is not unique to healthcare; it is woven into the fabric of American political and economic life. But in US healthcare, its consequences are stark: Millions are uninsured or underinsured, poor outcomes are common, and exorbitant costs are a reality.

As the late Princeton economist Uwe Reinhardt observed in his book *Priced Out,* the US healthcare debate is "not really about economics" at its core.[7] Instead, it is a moral question: "To what extent should the better-off members of society be made to be their poorer and sicker brothers and sisters' keepers in healthcare?"[8]

Other industrialized nations answered that question decades ago by embedding solidarity into their health systems as a right of their citizens. The US, by contrast, has never reached a political consensus on the distributive ethics of healthcare as a policy. Principle and the absence of that consensus continue to shape our policies, our institutions, and our outcomes.

According to Richard Epstein in his book *Mortal Peril,* establishing a legal right to healthcare, regardless of socioeconomic status or

7 Uwe Reinhardt, *Priced Out* (Princeton University Press, 2019), 1.

8 Reinhardt, *Priced Out*, 1.

ability to pay, could be counterproductive because it would detract from wealth accumulation. He further argues that prioritizing wealth creation would be far better for the future than a policy that insists on making healthcare available to all, regardless of their ability to pay.[9]

This position is not one a prevailing policymaker or politician would agree with or openly admit to; however, it remains a majority consensus on healthcare in the US. Taking such a position on distributive ethics for healthcare provides insight into the current culture in the US.

Healthcare is essentially a market product in the US—something that can be purchased for a fee, just like any other commodity. Understanding and accepting the social distributive ethic position for healthcare provides a backdrop for the culture and activities that drive the healthcare delivery system.

Hence, understanding the challenges and their origins positions leaders to impact how healthcare is delivered to patient populations positively. With a realistic view, they can focus more resources on areas that positively impact patient outcomes rather than hope that policies will someday change in favor of a universal healthcare delivery system.

In other words, it's time for stakeholders genuinely interested in improving health outcomes for patient populations to stop waiting for Superman and accept the realities of the social distributive ethic in healthcare within the US. Change and interventions can be effective only when there is a will and you understand the scope of the problem and the constraints.

The United States must reconcile its stance on the social distributive ethic of healthcare before the problem

This is not a political party issue.

9 Richard A. Epstein, *Mortal Peril: Our Inalienable Right to Health Care?* (Addison-Wesley, 1997).

of consistently high epidemic-level costs and poor outcomes can be adequately addressed on a grand scale with unity. Until then, stakeholders interested in addressing this problem will have to take up the mantle and act within their respective spheres of influence. The latter is possible; however, we have a system of selecting leadership through an election process that identifies the individual responsible for leading on national matters, such as distributing health-related resources to the population.

A self-correcting matter of healthcare rationing based on price, socioeconomic status, and ability to pay should not be permitted in the wealthiest nation in the world.

Simply put, elected officials and leadership should not be allowed to obfuscate their inherent responsibility of effectively addressing one of the most critical aspects of our existence: our health. This is not a political party issue. Members of all parties suffer under the fragmented, dysfunctional healthcare system. Cost and outcomes are two critical indicators that remind us that our healthcare system is a massive failure. The symptoms we encounter daily should be morally and ethically concerning enough that we move past our constant state of denial and address them comprehensively.

Why Policy Alone Will Not Save Us

Many well-intentioned leaders and advocates believe that universal healthcare will eventually arrive through sweeping policy reform. History suggests otherwise. The US has had multiple opportunities to adopt universal coverage: after World War II, when Medicare and Medicaid were created, and when the Affordable Care Act was enacted. Debates have arisen regarding the United States' decision to preserve a market-based system.

Resistance is not simply political; it is cultural and economic. Until those underlying values shift, policy change will be incremental at best. That means stakeholders cannot afford to wait for Washington to solve the problem.

THE COST OF INACTION

The stakes are high:

- *Healthcare costs continue to rise faster than wages and inflation.*
- *Chronic diseases now account for most deaths and healthcare spending.*
- *Health disparities persist across racial, geographic, and socioeconomic lines.*
- *Employer-sponsored insurance, the backbone of coverage for working Americans, is under strain as premiums climb.*

The Milbank Memorial Fund's 2025 Primary Care Scorecard underscores the urgency: Primary care now accounts for 4.6 percent of total US health spending, with Medicare spending allocated to it at only 3.4 percent.[10] This chronic underinvestment in the very sector best positioned to prevent disease and manage chronic conditions is a structural flaw that drives up costs and worsens outcomes.[11]

10 Yalda Jabbarpour et al., "V. Research: The Lack of Research Dollars to Study the Practice of Primary Care Is Limiting Evidence-Based Improvements in Care," Milbank Memorial Fund, February 18, 2025, https://www.milbank.org/publications/the-health-of-us-primary-care-2025-scorecard-report-the-cost-of-neglect/v-research-the-lack-of-research-dollars-to-study-the-practice-of-primary-care-is-limiting-evidence-based-improvements-in-care-2/.

11 Jabbarpour et al., "V. Research."

A Pathway Forward for All Stakeholders

The future of American healthcare will be shaped not in the halls of Congress but in the boardrooms, clinics, classrooms, and communities where leaders choose to act. Every stakeholder group has a role to play.

- Healthcare leaders: Align organizational strategy with population health outcomes, not just financial performance
- Employers: Demand value from health plans and invest in employee wellness
- Practitioners: Embrace team-based reimbursement to value-based incentives
- Health plans: Shift from volume-based reimbursement to value-based incentives
- Academicians: Train the next generation in systems thinking and population health science
- Faith-based leaders: Mobilize moral authority to address health inequities
- Hospitals and clinics: Integrate care across settings and disciplines
- Community leaders: Address SDOHs in partnership with healthcare providers
- Policymakers: Create enabling environments for innovation and collaboration

Evidence-Based Methodologies as the Foundation

Several proven frameworks can guide this transformation.

The Triple Aim framework helps improve population health, enhance the patient experience, and reduce per capita costs simultaneously.[12]

The Chronic Care Model offers proactive, planned, and patient-centered management of chronic illness.[13]

The Patient-Centered Medical Home and Patient-Centered Specialty Practice approaches provide coordinated, accessible, comprehensive primary and specialty care.[14]

Population health management utilizes data-driven strategies to identify risk, target interventions, and measure outcomes.[15]

Healthcare comprises two primary areas: the healthcare delivery system, which includes hospitals, clinics, etc., and physicians and clinical decision-makers.

Indirectly, insurers and third-party payers also play a critical role.

Modern-day physicians and clinical decision-makers adhere to treatment strategies grounded in evidence from clinical trials and other evidence-based methodologies, enabling access to best practices. Healthcare delivery systems, on the other hand, have demonstrated

12 Donald M. Berwick, "Disseminating Innovations in Health Care," *JAMA* 289, no. 15 (2003): 1969–75, https://doi.org/10.1001/jama.289.15.1969.

13 Edward H. Wagner et al., "Organizing Care for Patients with Chronic Illness," *The Milbank Quarterly* 74, no. 4 (1996): 511–44.

14 "Patient-Centered Medical Home (PCMH)," National Committee for Quality Assurance, accessed February 13, 2026, https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh.

15 David Kindig and Greg Stoddart, "What Is Population Health?" *American Journal of Public Health* 93, no. 3 (2003): 380–83.

minimal uptake of evidence-based methodologies for decision-making regarding the care of various patient populations.

This book will introduce and expand on why evidence-based methodology is the Holy Grail for healthcare delivery. The necessity for an evidence-based approach to healthcare delivery is driven by the current epidemic level of poor health outcomes and health disparities (fundamentally caused by SDOHs) and the continuous escalation of healthcare costs experienced in the US.

The variation that this approach can successfully address is a key causal factor for poor-performing systems. Too often, the result of fragmented care leads to high mortality, morbidity, and health disparities, all of which affect specific populations disproportionately. Each healthcare system in the US operates with its own independent structure and processes, resulting in high variation in health outcomes.

The purpose of this book is to serve as a guide for individuals with responsibility for the health outcomes of a population, regardless of size. It will provide insight into creating an evidence-based structure and process that is conducive to generating the desired health outcomes for a population. These are not just abstract theories or ideas. These are proven strategies I have personally employed throughout my four-decade career to significantly enhance healthcare access, improve community health literacy, improve the patient experience, reduce costs, and increase revenue.

These are not just abstract theories or ideas. These are proven strategies I have personally employed throughout my four-decade career to significantly enhance healthcare access, improve community health literacy, improve the patient experience, reduce costs, and increase revenue.

Adopting these models requires more than just technical changes; it demands a cultural shift. It involves redefining success in healthcare from focusing on maximizing revenue to prioritizing health outcomes. It means valuing prevention as much as treatment and equity as much as efficiency. It requires viewing healthcare not as a commodity but as a shared responsibility.

Finally, before we get too caught up in blaming one political party for the current state of our healthcare system, we must remember that both major parties (Democrats and Republicans) have controlled all three decision-making bodies (the Senate, the House, and the presidency) at different times. Yet, universal healthcare legislation has never been enacted. The point is that there is enough blame to go around without singling out one party as the sole culprit. We are still the United States of America, and when our fellow Americans are hurting, we should all show some compassion.

A Career in the Engine Room of Healthcare

I have spent four decades in healthcare leadership, working in various organizations: for-profit, nonprofit, and both public teaching and non-teaching hospitals. I have led three major hospital turnarounds, each in a different sector of the industry. I share those experiences in the first chapter, a rare 360-degree view of the American healthcare system.

In healthcare, you quickly learn that the noble image sold to the public is only half the truth. Behind the curtain, the process can be messy, imperfect, and often held together with sheer willpower and duct tape. Once you've worked in healthcare, you can't unsee it. You know precisely how the sausage is made, and sometimes you wish you didn't.

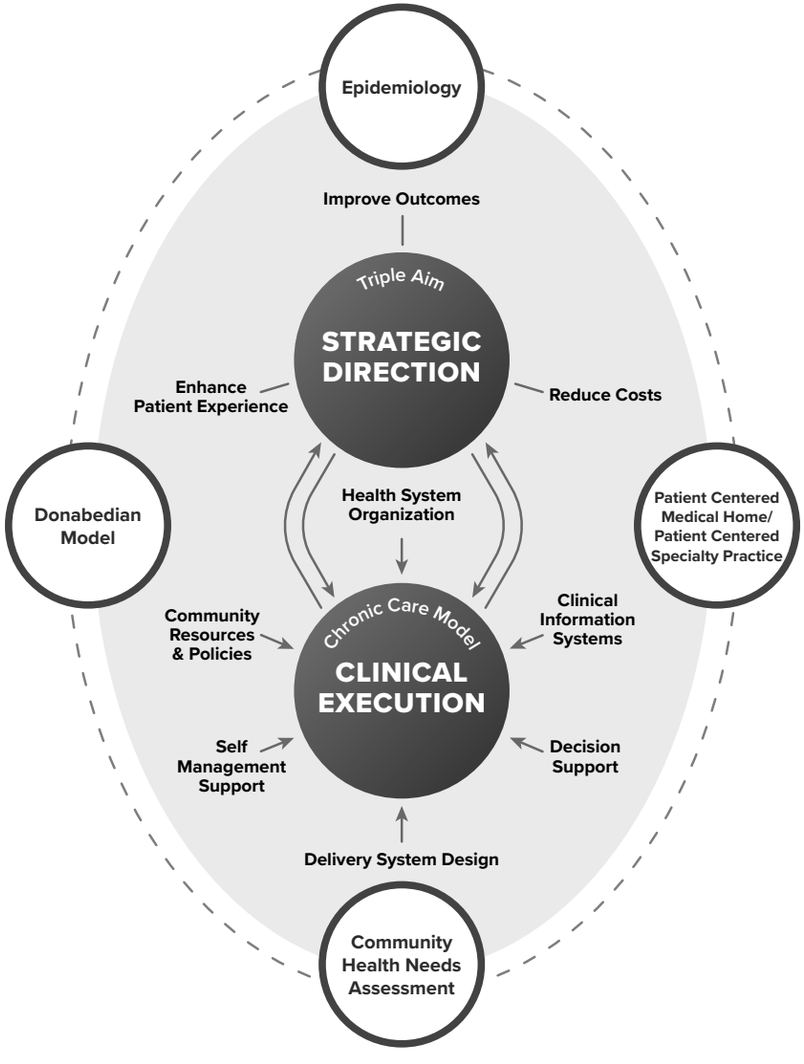
I have seen the system at its best, delivering miraculous recoveries, innovative treatments, and compassionate care that transforms lives. I have also witnessed its worst: patients turned away because they couldn't pay, communities underserved because they didn't have the right payer mix. Leaders are forced to choose between financial stability and fair access. These experiences have convinced me that the US healthcare system isn't "broken" in the way many believe. As unlikely as it may seem, the system is perfectly designed to produce the results it gets. The work can be messy, the system flawed, but in the middle of it all, you witness moments of humanity so pure that they make the chaos worth enduring.

A Call to Leadership

This book is not a lament. It is a call to action. It is an invitation to those who hold influence in organizations, communities, and policy circles to lead boldly, act decisively, and measure success not only in dollars saved but also in lives improved.

The US might never establish universal healthcare as a legal right, and that's not really what this book is about. However, within the current system, we can promote a culture and practice of care that is more equitable, effective, and sustainable. The reason for this approach is that we (employers, cities, counties, states, and any entities responsible for providing healthcare to a population) spend significantly more on healthcare under the current model than we would by implementing an evidence-based population health management approach.

Webb Health Equity and Sustainability Model™



*The **Webb Health Equity and Sustainability Model™** is an evidence-based framework designed to achieve population health management across organizations and communities. It integrates several proven theoretical frameworks, each with strong, predictable outcomes, into a unified closed-loop system that fosters alignment, maximizes synergy, and delivers measurable, sustainable improvement .*

CHAPTER 1

Understanding America's Healthcare Reality

In 1966, Reverend Dr. Martin Luther King, Jr., speaking at a press conference in Chicago at the annual meeting of the Medical Committee for Human Rights, said, "Of all the forms of inequality, injustice in health is the most shocking and inhuman because it often results in physical death.[16] His remarks were directed at highlighting the racial disparities and inequities in medical care and calling out various organizations for what he described as a conspiracy of inaction regarding civil rights in healthcare.

Dr. King had made a conscious decision to take the battle for justice beyond voting booths and lunch counters to a broader sector of the nation. He viewed racial injustice as being embedded in the systems and structures that were meant to enhance and preserve life itself.

He was focusing on the noticeable disparities in life expectancy between Black and White Americans, the segregation of hospitals and

16 Martin Luther King Jr., "Remarks to the Medical Committee for Human Rights," 1966.

healthcare systems, and the moral hypocrisy of the wealthiest nation in the world, which engages in preventable suffering and death based on race.

Dr. King was strategic in his efforts to elevate healthcare equality from a policy debate to a moral imperative. He was speaking directly to stakeholders with the power and resources to dismantle pervasive inequities in healthcare delivery. His categorization of injustices in health as a moral crisis affecting specific populations has since been adopted by various movements, from 1970s community health initiatives to twenty-first-century campaigns for universal coverage.

The Return

It was January 2015. The winter air carried a slight chill, a poignant symbol of the mix of emotions stirring within me. After twenty-five years in Memphis, I was preparing to leave behind a city that had become home. Memphis had shaped me in ways I hadn't anticipated when I'd first arrived, professionally, personally, and spiritually. It was where I met my wife, raised my family, built friendships that felt like kinship, and grew into the kind of leader I had always aspired to be.

Packing up my office and home brought a mix of emotions. Every photograph and each keepsake told a story. I reflected on the colleagues who stood by me through challenges and triumphs, the community I served, the many innovative programs and initiatives I helped launch, and the number of patients' lives I impacted over the years. I also cherished the sense of belonging I had built over a quarter century. Leaving Memphis wasn't easy; it felt like closing a beloved chapter of my life. But Nashville was calling.

The board of directors at Nashville General Hospital (Nashville's public hospital) had extended an acceptable offer, and I was at peace with my decision to accept it. Before me stood the opportunity to step

into the role of CEO of a hospital on the brink of closure, one that had served its community for more than 120 years and was now facing the scrutiny of metropolitan leadership, its future hanging by a thread.

It quickly dawned on me that this was not just a career move but a return. Driving east on I-40, I couldn't help but reflect on the symmetry of it all. Nashville was where my young adult life began, at Tennessee State University (TSU), where I wore the blue and white of the TSU Tigers, pounding the hardwood as a basketball player blessed with a full scholarship, dreaming of a future as a professional basketball player—which, as it turned out, was not meant to be.

Instead, my future would be shaped as a healthcare leader, following several twists and turns that, after ten years in Nashville, led me to the University of Alabama at Birmingham (UAB), where I enrolled in a graduate program in healthcare administration to pursue my second master's degree. I fully intended to return to Nashville after graduation; however, fate had other plans. One opportunity led to another, and before I knew it, thirty-two years had passed.

After decades of leadership experience, including two major hospital turnarounds and a return to UAB to earn a doctoral degree in healthcare administration, I was circling back to the city where I'd launched my adult life.

When I arrived for my first extended visit and tour of the hospital, the weight of its history seemed to press against me. The building was familiar to me because I recalled having a tonsillectomy at the hospital when it was known as Hubbard Hospital. The building now bore the scars of neglect: peeling paint, outdated equipment, and weary hallways. But all the while, beneath the surface, I saw something else—potential. The kind of potential that demanded every ounce of experience I had accumulated over the years. The challenges were immense: financial instability, political pressure, a scarce workforce

worn down by the uncertainty of closure, and a community fearful of losing its safety net hospital.

However, I also sensed something even more powerful: hope. The people of Nashville still believed in this hospital. They wanted a champion, and I was certainly up for the challenge. Standing in the lobby, the dim sunlight struggling to penetrate the aged windows, I felt the convergence of past and present. Memphis had prepared me for this undertaking, and Nashville was calling me back to where I had grown into young adulthood after thirty-two years of being away. The years of study, the long days and nights of leadership, the successes and setbacks had all led me once again to Nashville. The stars had seemingly aligned.

This hospital, this city, this moment were all waiting for me. And even though leaving Memphis saddened me, I knew I was exactly where I was supposed to be at this time.

From the Brink to Renewal

When I arrived in January 2015 as the new CEO, the hospital was a shadow of its former self. The city had already decided to close it, and months of planning for the shutdown had depleted resources, staff, and morale. Departments were understaffed, equipment sat idle, and the community's trust in its safety net hospital had been severely shaken.

The only reason the doors were still open was that the community served by the hospital had fought and refused to let it be closed. Their voices had reversed the decision, but the hospital they'd saved was fragile and decimated.

I knew from the first time I walked through the hospital that this would not be a quick rescue but a journey.

You could cut the tension with a knife.

It would be a complete overhaul—operational, cultural, and strategic. The hospital would also require a completely new, innovative approach to delivering healthcare. Within the first few days of my employment, after an initial assessment of the hospital and its challenges, I began outlining and listing the evidence-based methods I would deploy to stabilize and improve the hospital's operations. In my office, there was a dry-erase board with hinged doors that allowed me to keep my notes out of public view. I began documenting on the board the evidence-based methodologies to be used to execute the turnaround. I was acutely aware that there was a small margin for error in this political environment.

Given the highly charged political and competitive environment, I knew I would need to apply proven concepts to this undertaking, and this would be an ideal opportunity to implement evidence-based approaches to fully achieve the desired outcomes. One of the very first evidence-based frameworks I decided to apply was Michael Porter's five competitive forces.[17] Porter's Five Forces theoretical framework is a model designed to help strategically analyze the competitive dynamics of any industry. Gaining insight into relevant market issues is exceptionally beneficial. Porter's model is a proven method for evaluating and analyzing the environment in which an organization operates; identifying its strengths, weaknesses, opportunities, and threats; and conducting strategic analysis of stakeholder relationships and collaborative opportunities.[18]

17 Michael E. Porter, "The Five Competitive Forces That Shape Strategy," *Harvard Business Review*, January 2008, https://hbr.org/2008/01/the-five-competitive-forces-that-shape-strategy.

18 Michael E. Porter, *Competitive Strategy: Techniques for Analyzing Industries and Competitors* (Free Press, 1980).

PORTER'S FIVE COMPETITIVE FORCES:

- Threat of new entrants: high regulatory and capital barriers
- Bargaining power of suppliers: relevant in healthcare when suppliers hold monopolistic control over specific patented pharmaceuticals, proprietary devices, and advanced technologies
- Bargaining power of buyers: patient, employer, and insurer demands regarding cost, value, and transparency
- Threat of substitutes: alternatives, such as freestanding wellness programs
- Existing competitors and industry rivalry: other hospitals and healthcare systems [19]

Stabilizing the Hospital

During the early months, I met with every department, listened to staff, and worked to restore essential services. We reopened some of the shuttered units, repaired relationships with vendors, and recruited physicians and leaders who shared our commitment to the mission of a safety net hospital. Even in those first days, I was thinking beyond just survival. I aimed to develop a system that not only responded to both acute and chronic illnesses but also promoted a sustainable organization focused on improving the community's health.

19 Ibid.

Building the Science of Healthcare Delivery

We began developing what I started to describe as the science of healthcare delivery, focusing on data-driven, evidence-based care. This approach later became the main guiding principle for all our decisions. I purchased a textbook on evidence-based decision-making and distributed copies to all leaders as required reading.

This approach resulted in adding staff and resources to the department of data analytics and in collecting and analyzing data on patient demographics, social determinants of health (SDOHs), and clinical outcomes. It also helped by identifying population health trends, including high rates of uncontrolled diabetes and hypertension, and gaps in preventive screenings.

The power of this approach enabled us to design evidence-based targeted interventions, measure results, and continually refine programs.

We began using risk stratification models to identify high-risk patients and to develop and analyze a community health needs assessment (CHNA).

So we diligently embedded this practice into our culture. Every leader, clinician, and care team member learned to view data not as a report to be filed away but as a tool to drive action and informed decision-making.

Meeting and Treating the Whole Person

The data confirmed what we intuitively knew: Our patients' health was shaped as much by their circumstances as by their symptoms. Therefore, we developed programs to address these realities:

- Food Pharmacy: providing fresh produce and staples to patients facing food insecurity

- Behavioral health services: integrating mental health care into primary care visits
- A faith-based initiative [501(c)(3)]: partnering with pastors and other faith leaders to support the health of their members (which grew to 108 congregations/churches)
- Community Care Team: establishing a team of nurses, social workers, and navigators who engaged patients in self-care

All of these were supported by evidence-based models—the Chronic Care Model (CCM), the Patient-Centered Medical Home (PCMH) and Patient-Centered Specialty Practice (PCSP) concepts, and the Triple Aim framework—which aimed to improve patient experiences, outcomes, and costs.

It is also worth mentioning that the patients in our cancer care program benefited from the Food Pharmacy in terms of longevity. Because of the program, none of them struggled with food insecurity, which could have potentially caused them to lose weight and body mass, leading to suspension from the treatment (chemotherapy) regimen, thereby decreasing their likelihood of survival. This was observed and recognized by the American College of Surgeons, the surveying body of the hospital's oncology program.

Turning Data into Action

An example of effectiveness was that our data showed that a small percentage of patients with uncontrolled diabetes, hypertension/congestive heart failure, and mental health issues accounted for a disproportionate share of ER visits, admissions, and costs. We created a targeted intervention—the Community Care Team—that addressed the needs of these patients by connecting them with community

resources, including a community care nurse, providing nutrition support through the Food Pharmacy, and offering behavioral health counseling to address mental illness and stress that interfered with their decision-making and self-care. Within a year, ER visits for this group dropped significantly, hemoglobin A1c and blood pressure levels improved, and patient satisfaction scores increased.

Cost Avoidance

Cost avoidance is a vital strategy, especially for hospitals that are not financially strong or do not have high levels of days cash on hand. Most safety net and rural hospitals operate with a very thin or negative operating margin. Not having to allocate resources to care for large volumes of patients, many of whom cannot afford to pay, is akin to creating an additional revenue stream. We emphasized this strategy because of the limited subsidies available to care for the indigent population, a common issue in public hospitals and health systems.

The strategy is implemented by establishing a structure and process, an evidence-based method outlined in the theoretical framework of the Donabedian model.[20]

A New Framework

The Donabedian model is a conceptual framework for examining health services and evaluating the quality of healthcare. According to the model, information about the quality of care can be drawn from three categories: structure, process, and outcomes.

20 Avedis Donabedian, *Explorations in Quality Assessment and Monitoring, Volume I: The Definition of Quality and Approaches to Its Assessment* (Health Administration Press, 1980).

Structure refers to the context in which care is delivered, encompassing hospital buildings, staff, financing, and equipment.

Process denotes the transactions between patients and providers throughout the delivery of healthcare.

Finally, *outcomes* refer to the effects of healthcare on patients' and populations' health status.

Avedis Donabedian, a physician and health services researcher at the University of Michigan, developed the original model in 1966.

Essentially, within the Donabedian model, structure and process are the two components necessary for an initiative or innovation to succeed and achieve the desired outcome, making it an evidence-based method. Perhaps the best example of applying cost avoidance using the Donabedian model is managing a high-risk patient population, where, statistically, 6 percent of patients can account for 50–70 percent of your costs.

This strategy was implemented for high-risk patients identified through a risk stratification model. Several risk stratification tools are available on the market. They rank your patient population by acuity, from one to three, with one being the lowest risk and three the highest.

High-risk patients often have multiple chronic conditions, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), and mental health issues. The opportunity for cost avoidance is clear in this scenario. The goal is to develop a solid structure and process that targets all three levels with appropriate resources and intensity.

You want to shift level three to level two or one, move level two to level one, and prevent level one from progressing to a higher level. Implementing this approach is straightforward; it requires discipline and adherence to a structure and process aimed at achieving the desired outcomes.

The mathematics makes perfect sense. It's important to note that this is one of the most effective ways to extend the sustainability of a hospital or system with limited resources, particularly when responsible for caring for a population with limited or no ability to pay.

The best way to address this financial challenge is to prevent illness and manage chronic conditions, which are the main drivers of healthcare costs, something the US healthcare system currently fails to do. This approach is crucial for maintaining financial viability and sustainability, particularly for hospitals that lack unlimited cash and resources.

Examples of resources and initiatives needed to implement cost avoidance successfully include

- utilizing community resources,
- educating and engaging the patient in their care,
- promoting regular and scheduled visits and follow-ups,
- enhancing clear communication among clinical staff, and
- addressing key determinants, such as access to nutritious foods, transportation, and access to behavioral health resources.

These elements are all incorporated into the execution of the CCM, another evidence-based resource that my hospital utilized to care for the patient population. By now, you can begin to see the overlap between these methodologies for caring for a patient population. This is the essence of what it looks like to engage in population health management (PHM).

This is the essence of what it looks like to engage in population health management (PHM).

A key point to remember about caring for a population's health is that research shows that healthcare accounts

for approximately 20 percent of a population's overall health outcomes. The remaining contributors to a population's health outcomes are:

- Socioeconomic factors: 40 percent
- Health and lifestyle behaviors: 30 percent
- Living conditions: 10 percent[21]

Innovation in Action: The No-Wait ER

One of our most transformative innovations happened when we targeted the emergency department. When I arrived, the ER often faced bottlenecks. Patients frequently waited hours before being seen, and the experience was frustrating for both patients and staff. We realized that, for many in our community, the ER was their primary access point to care, and long wait times could lead to poor outcomes.

We reimagined the entire process and subsequently converted the existing ER into a no-wait ER:

- Patients were assessed and clinically triaged upon arrival by the nurse.
- Instead of waiting in a crowded room, patients were taken directly to a treatment space.
- Lab and imaging orders were initiated at triage to reduce delays.
- Bed assignment was streamlined and efficient.
- The Community Care Team engaged patients before discharge to connect them with follow-up care, primary care providers, social services, and a prescription to visit the food pharmacy if appropriate.

21 Caron, *Population*.

The results were dramatic: Average door-to-doctor times dropped from hours to minutes, patient satisfaction soared, and unnecessary admissions decreased. With the addition of behavioral health, the number of psych patients on ER hold was basically eliminated.

All things considered, the results speak for themselves:

- We transitioned from chronic deficits to achieving a positive operating margin.
- Patient satisfaction scores improved substantially.
- Health outcomes improved, readmissions decreased, preventive care rates increased, and patient length of stay decreased.
- Staff morale improved.
- The no-wait ER became a model that was not replicated by other hospitals in the region.
- Food insecurity, a prevalent SDOH among patients, was successfully addressed with the introduction of the Food Pharmacy and other innovative initiatives.

A Hospital Reborn

By 2025, the transformation was undeniable. The same city that had once prepared to close the doors of its public safety net hospital was now receiving local, regional, national, and international attention for its innovative initiatives/interventions and outcomes. We were financially stable, clinically strong, and deeply rooted in the community.

Looking back, the turnaround was not just about saving a hospital; it was about building a system of care that treated people as whole human beings, used data to guide decisions, and embraced innovation to meet patients where they were.

We did much more than keep the lights on. We built a blueprint for how public hospitals can thrive, grounded in science, compassion, and the courage to innovate. The entire process can be summarized as an exemplary execution of PHM.

During a 2024 visit, Dr. Bruce Siegel, president and CEO of America's Essential Hospitals (AEH), told me that I had "cracked the code" for a public hospital. In a recent interview, I asked him to explain what he had meant by that statement.

His reply was, "By cracking the code, I refer to the fact that you and your team understand that you must fully grasp the nature of the challenge you face in that community. And I can tell you that does not come easy." He explained that many hospitals similar to ours would use a general playbook for care, "but that's a one-size-fits-all approach that may lead to a good financial outcome, at least in the short term. Still, it doesn't always consider the individual."

Dr. Siegel added that our basis must be what truly drives health, or the lack of it, in the community: "What policies in this community influence these factors, and how do we craft solutions for long-term change that alter the trajectory of patients and communities? And how can this organization do that sustainably?"

US Healthcare: A Severely Fragmented Experience

Our healthcare system operates within a framework that creates significant variation, leading to poor outcomes, negative patient experiences, and high costs. Although the US healthcare system is often recognized as one of the most advanced globally, known for significant advances in medical technology, research, and specialized expertise, it consistently falls short on key population health metrics compared to peer nations. This paradox arises from a system that operates in silos, with limited integration among its various components. Hospitals, primary care providers, public health organizations,

insurers, and specialty services primarily operate as separate entities, each with its own goals, electronic health records, data systems, and operational culture.

This fragmentation produces inefficiencies, duplication of effort, and, ultimately, significant variations in clinical outcomes. The absence of a unified, evidence-based approach to care delivery makes these disparities worse, leaving the system vulnerable to inequities and preventable poor outcomes. The rest of this chapter examines the nature of these independent activities, the consequences of outcome variation, and the systemic failure to utilize evidence-based methodologies.

The US healthcare system's siloed nature is not accidental; it results from historical policy decisions, economic incentives, and cultural norms within the medical profession. The divide between public health and clinical care, for example, can be traced back to mid-twentieth-century reforms, such as the creation of Medicare and Medicaid. These programs prioritized reimbursement for medical services over population-level health interventions, thereby reinforcing the separation between preventive and curative domains.[22]

This translates into practice as hospitals focus on acute care and episodic interventions. Primary care providers manage ongoing patient relationships but often lack access to comprehensive public health data. Public health agencies monitor population trends but have limited influence over clinical decision-making. Insurers design benefit structures that may incentivize short-term cost savings over long-term health outcomes.

The absence of robust data-sharing mechanisms between these entities results in missed opportunities for effective care coordination.

22 Mahshid Abir et al., "Breaking Down Health Care and Public Health Silos—Once and for All," RAND Corporation, February 17, 2025, https://www.rand.org/pubs/commentary/2025/02/breaking-down-health-care-and-public-health-silos-once.html.

For example, a patient discharged from a hospital after a cardiac-related event may not be seamlessly connected to community-based rehabilitation programs, resulting in poorer recovery and higher readmission rates.

OUTCOMES VARIATION: A CHRONIC PROBLEM

Outcome variation in US healthcare is widespread. Life expectancy, avoidable mortality, and chronic disease management rates vary significantly across states and even counties within the same state.[23] Even the top-performing US states fall behind similar high-income countries in metrics such as preventable deaths and access to timely care.

There are several causes of this variation: Unequal access to insurance coverage leads to disparities in preventive care utilization. Differences in provider adherence to clinical guidelines lead to inconsistent treatment protocols. In addition, regional resource allocation affects the availability of specialized services.

These disparities are not merely statistical curiosities; they result in genuine differences in patient experiences and survival rates. A cancer patient in one state might get guideline-based treatment within weeks of diagnosis, while a similar patient elsewhere could face delays, incomplete staging, or subpar therapy.

THE EVIDENCE CHASM

Evidence-based healthcare is defined as "the conscientious, explicit, and judicious use of the current best evidence" in making decisions

23 David Blumenthal, "Why the US Healthcare System Is So Much Worse than Its Peers," *Harvard Business Review*, November 13, 2024, https://hbr.org/2024/11/why-the-u-s-healthcare-system-is-so-much-worse-than-its-peers.

about individual patient care.[24] This concept has since been expanded to include health policy and system-level interventions, ensuring that population health strategies are grounded in the best available research.[25] Ideally, this should form the foundation of modern medical and healthcare practice. However, in practice, its implementation in the US varies widely, often being inconsistent at best and absent at worst.

According to research by Kennedy et al., several barriers exist to evidence-based practice in public health preparedness and response, including [26]

- lack of clarity on which interventions are truly evidence-based,
- limited sharing of research findings with frontline providers, and
- insufficient training in implementation science.

Lack of funding inflames the problem. The Milbank Memorial Fund reports that less than 1 percent of federal research dollars are allocated to studying primary care delivery models despite primary care's central role in improving population health.[27] Without investment, innovations in care coordination, chronic disease management, and preventive services remain underdeveloped and maldistributed.

24 David L. Sackett et al., "Evidence Based Medicine: What It Is and What It Isn't," *BMJ* (Clinical research ed.) 312, no. 7023 (1996): 71–72, https://doi.org/10.1136/bmj.312.7023.71.

25 J. A. Muir Gray, *Evidence-Based Healthcare: How to Make Health Policy and Management Decisions* (Churchill-Livingstone, 1997).

26 Mallory Kennedy et al., "Factors Affecting Implementation of Evidence-Based Practices in Public Health Preparedness and Response," *Journal of Public Health Management and Practice* 26, no. 5 (2020): 434–42, https://doi.org/10.1097/PHH.0000000000001178.

27 Jabbarpour et al., "V. Research."

Pathway to Reforming Our Healthcare System

Effectively addressing fragmentation and variation in outcomes requires a multifaceted strategy and the collaborative engagement of key stakeholders. This effort should focus on major reforms.

Of immense importance is the need to develop interoperable health information systems that connect public health surveillance with clinical care records and increase federal investment in primary care research and evidence-based program evaluation.

We must link reimbursement to adherence to evidence-based guidelines, rewarding quality over quantity.

Training healthcare professionals in evidence-based decision-making and implementation science is key to this transformation, and formalizing partnerships between public health agencies and healthcare providers will enable goal alignment and resource sharing.

These reforms would not only reduce variation in outcomes but also strengthen the system's resilience against public health crises.

The US healthcare system's siloed structure is a significant contributor to inefficiency and inequality. Without a unified focus on evidence-based approaches, the system will continue to deliver uneven outcomes despite its access to extensive resources. Connecting research and practice, as well as public health and clinical care, is essential for creating a more effective and equitable healthcare system.

Comparative View of Healthcare in the US and Other Industrialized Nations

The US stands at the forefront of medical innovation. Its hospitals are home to pioneering surgeons, its universities produce Nobel Prize–winning research, and its pharmaceutical industry develops drugs that transform global health. Despite this scientific leadership, the US

health system consistently underperforms its peers across numerous performance metrics. Americans live shorter lives, face higher maternal and infant mortality, and experience greater inequities in access to care, all while paying nearly twice as much per person as citizens of other wealthy nations.[28] This paradox of spending more and achieving less is not a recent development. It is the product of decades of policy choices, institutional structures, and cultural values that have shaped the US approach to healthcare.

Unlike many European nations, which established universal health systems in the aftermath of World War II, the US pursued a fragmented path. Employer-sponsored insurance expanded during the mid-twentieth century, while public programs, such as Medicare and Medicaid, were introduced in 1965 to provide coverage for elderly and low-income individuals. However, no universal system was created. In contrast to the US's position on healthcare:

- The United Kingdom founded the National Health Service in 1948, offering free care at the point of use.
- Germany built on Bismarck's nineteenth-century model of social insurance, later expanding it to cover nearly all citizens.
- Canada adopted a single-payer system at the provincial level during the 1960s and 1970s.
- Norway developed a tax-funded system emphasizing equity and access.

The US healthcare system has remained rooted in private insurance and market dynamics and continues to be an outlier.[29]

28 Emma Wagner et al., "How Does Health Spending in the US Compare to Other Countries?" Peterson-KFF Health System Tracker, April 9, 2025, https://www.healthsystemtracker.org/chart-collection/health spending-u-s-compare-countries/.

29 Blumenthal, "Why the US Healthcare System."

PAYING MORE FOR LESS

In 2023, the US spent $13,432 per person on healthcare, nearly double the Organisation for Economic Co-operation and Development (OECD) average of $7,393.[30]

Peer nations spent far less:

- Germany: $6,191
- Norway: $8,693
- Canada: $6,207
- United Kingdom: $5,139

Healthcare accounts for nearly 18 percent of the US gross domestic product, significantly higher than the OECD average of 9–12 percent.[31] Much of this cost difference results from higher prices for services, drugs, and administrative overhead.

THE COST OF INEFFICIENCY

Despite its high costs and spending, the US ranks last among high-income countries in overall health system performance. Life expectancy in the US is lower than in Canada, Germany, and the UK. Maternal mortality is three to four times higher than in peer nations. Infant mortality rates exceed the OECD average, and preventable deaths from chronic conditions, such as diabetes and heart disease, remain elevated. However, the US does perform well in certain areas, such as cancer survival rates and access to advanced technologies. But

30 Wagner et al., "How Does Health Spending."

31 Wagner et al., "How Does Health Spending."

these successes are overshadowed by systemic inequities and gaps in basic care.[32]

The lack of universal healthcare coverage is a key feature of the US system. Millions remain uninsured, and many more are underinsured, dealing with high deductibles and co-payments.

These issues create a two-tiered reality for the American public.

For the wealthy and well-insured: access to world-class hospitals and cutting-edge treatments

For the poor and uninsured: delayed care, financial hardship, and worse outcomes

By contrast, in Germany, Canada, Norway, and the UK, coverage is universal. Patients may face wait times or resource constraints, but they rarely face financial ruin due to illness.[33]

The US healthcare dilemma is not a situation that cannot be reversed or improved to a respectable level. Policy reforms, such as expanding insurance coverage, negotiating drug prices, and investing in primary care, could bring the country closer to its peers. The challenge lies not in technical feasibility or wealth but in political will. Other nations have continuously demonstrated that it is possible to spend less and achieve more. The US must decide whether to continue as an outlier or to embrace the reforms that align spending with outcomes and patient experience.

32 David Blumenthal et al., "Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System. Comparing Performance in 10 Nations," *The Commonwealth Fund*, September 19, 2024, https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024.

33 Blumenthal et al., "Mirror, Mirror."

The US healthcare system reflects a series of choices regarding markets, government, and the role of healthcare in society. These choices have produced a system that is technologically advanced but socially inequitable, financially burdensome, and comparatively ineffective.

Health Disparities

Health disparities across racial and ethnic groups in the US represent one of the most persistent and consequential public health challenges. These disparities—defined as systematic, avoidable, and unjust differences in health outcomes and access to care—are deeply rooted in historical and structural inequities. Despite decades of policy efforts and medical advances, Black, Hispanic, American Indian and Alaska Native (AIAN), and Native Hawaiian and Pacific Islander (NHPI) populations continue to experience disproportionate burdens of disease, disability, and premature death compared to White Americans.[34]

The origins of racial and ethnic health disparities stem from centuries of systemic racism, including slavery, segregation, discriminatory housing policies, and exclusion from economic opportunity. These injustices have shaped SDOHs, including housing, education, employment, and neighborhood conditions, which continue to impact outcomes today. The COVID-19 pandemic highlighted these inequities, with Black, Hispanic, and AIAN populations experiencing disproportionately higher rates of infection, hospitalization, and death.[35]

Life expectancy is a powerful indicator of population health. In 2022, White Americans had a life expectancy of 77.5 years, while Black Americans lived an average of 72.8 years, and AIAN populations had the lowest life expectancy at 67.9 years. Hispanic Americans, despite facing socioeconomic disadvantages, exhibited a higher life expectancy of 78.5 years, a phenomenon often referred to as the Hispanic paradox.[36]

Infant mortality rates further highlight these disparities. Black infants (10.9 per 1,000 live births) and AIAN infants (9.1 per 1,000) are more than twice as likely to die before their first birthday compared to White infants (4.5 per 1,000).[37] Chronic diseases disproportionately impact racial and ethnic minorities. For example, 42 percent of Black adults suffer from hypertension compared to 29 percent of White adults. Obesity rates are also higher among African American women (80 percent) than among White women (65 percent).[38] Diabetes prevalence is elevated among Hispanic (12.3 percent) and Black (11.7 percent) adults, compared to 7.5 percent among White adults.[39] Asthma affects 12.6 percent of Black children, nearly double the rate among White children (7.7 percent).[40]

Cancer outcomes reveal stark racial disparities. Black Americans have the highest overall cancer mortality, with Black men experiencing prostate cancer mortality rates nearly double those of White

34 Nambi Ndugga et al., "Key Data on Health and Health Care by Race and Ethnicity," Kaiser Family Foundation, December 16, 2025, https://www.kff.org/racial-equity-and-health-policy/key-data-on-health-and-health-care-by-race-and-ethnicity/.

35 Ndugga et al., "Key Data."

36 Ndugga et al., "Key Data."

37 Danielle M. Ely and Anne K. Driscoll, "Infant Mortality in the United States, 2023: Data from the Period Linked Birth/Infant Death File," *Centers for Disease Control and Prevention, National Vital Statistics Report* 74 no. 7 (2025): 1–20, https://www.cdc.gov/nchs/data/nvsr/nvsr74/nvsr74-07.pdf.

38 Sofia Carratala and Connor Maxwell, "Health Disparities by Race and Ethnicity," Center for American Progress, May 7, 2020, https://www.americanprogress.org/article/health-disparities-race-ethnicity/.

39 Ndugga et al., "Key Data"; Carratala and Maxwell, "Health Disparities."

40 Carratala and Maxwell, "Health Disparities."

men.[41] Breast cancer mortality is highest among Black women (27 per 100,000), despite similar incidence rates to White women.[42]

Asian Americans have elevated rates of liver and stomach cancers, often linked to environmental and genetic risk factors.[43]

Five-year relative survival rates are consistently lower for Black patients across multiple cancer types, even when controlling for stage at diagnosis. For example, breast cancer survival is approximately 82 percent for Black women compared to 91 percent for White women.[44]

Mental health disparities are pronounced. White adults are more likely to receive mental health services (56 percent) than Hispanic (40 percent), Black (38 percent), or Asian (36 percent) adults.[45]

Disparities extend beyond outcomes to the healthcare experience. Minority Medicaid beneficiaries are less likely to report satisfaction with care and more likely to report discrimination.[46] Provider–patient racial concordance (a state in which things agree and do not conflict with each other) improves trust and outcomes; however, minority patients are less likely to have access to racially concordant providers.[47]

41 American Cancer Society, "Cancer Facts & Figures 2024," accessed February 18, 2026, https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/2024-cancer-facts-figures.html.

42 "Social Determinants of Health (SDOH)," Centers for Disease Control and Prevention (CDC), January 17, 2024, https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html.

43 Michelle Tong et al., "Racial Disparities in Cancer Outcomes, Screening, and Treatment," KFF, February 3, 2022, https://www.kff.org/racial-equity-and-health-policy/racial-disparities-in-cancer-outcomes-screening-and-treatment/.

44 National Cancer Institute, "Surveillance, Epidemiology, and End Results Program," accessed February 18, 2026, seer.cancer.gov/statfacts/html/breast.html.

45 Ndugga et al., "Key Data."

46 *Report to Congress on Medicaid and CHIP* (Medicaid and CHIP Payment and Access Commission, 2023), https://www.macpac.gov/wp-content/uploads/2023/03/MACPAC_March-2023-Report-WEB-Full-Booklet_508.pdf.

47 Carratala and Maxwell, "Health Disparities."

A 2024 Commonwealth Fund report revealed that disparities persist across all states, even in those with high-performing health systems. Black and AIAN populations are consistently more likely to die from preventable and treatable conditions than White Americans, regardless of geographic location.[48]

This report offered several ways to address racial and ethnic health disparities through a multi-level approach:

- *Expand health coverage through Medicaid expansion and affordable insurance options.*
- *Invest in resources to address health literacy.*
- *Commit resources to social determinants of health, such as housing, education, and food security.*
- *Improve data collection to better capture disparities among smaller groups, such as NHPI populations.*
- *Confront systemic racism in healthcare delivery through implicit bias training and structural reforms.*

Health disparities by race and ethnicity in the US are not inevitable. They result from poor policies and structural inequities. Comparative data show persistent gaps in life expectancy, infant and maternal mortality, chronic disease, cancer outcomes, and access to care. Achieving health equity requires sustained commitment, systemic reform, and recognition that—according to research—health outcomes are determined by a combination of factors, with healthcare accounting for only 20 percent and socioeconomic factors, lifestyle behaviors, and living conditions accounting for the remaining 80 percent.[49]

48 Blumenthal et al., "Mirror, Mirror."

49 Caron, *Population*.

Social Determinants of Health

Everyone in this country deserves the opportunity to be healthy and reach their full potential, regardless of their background or location.[50]

Unfortunately, this is not the case in the US, and several factors contribute to this unfavorable outcome. According to John Rawls, the author of *A Theory of Justice*, the conditions that qualify an individual for equality are neither confining nor binding. When someone lacks the requisite potential for equality, either by birth or by accident, this is regarded as a defect or deprivation. There is no race or recognized group of human beings that lacks this potential for equality.[51] Unlike health equality, health equity requires not only equal access for all persons but also actions to address the additional obstacles faced by vulnerable groups.

The World Health Organization (WHO) defines SDOHs as the conditions in which people are born, grow, live, work, and age, as well as the broader set of forces and systems that shape daily life.[52] These forces include economic policies, social norms, political structures, and systemic racism. The US Centers for Disease Control and Prevention (CDC) identifies five broad domains:[53]

- Economic stability: income, employment, and financial security
- Education access and quality: literacy, educational attainment, and school quality

50 James R. Knickman and Brian Elbel, *Jonas and Kovner's Health Care Delivery in the United States*, 13th ed. (Springer Publishing Company, 2023).

51 Joseph Webb, "Effects of a Faith-Based Initiative on Hospital Readmissions" (DSc diss., The University of Alabama at Birmingham, 2013).

52 WHO, "Social Determinants."

53 CDC, "Social Determinants."

- Healthcare access and quality: availability of services, insurance coverage, and cultural competence
- Neighborhood and built environment: housing, transportation, environmental safety, and green spaces
- Social and community context: social cohesion, civic participation, discrimination, and incarceration rates

These domains interact dynamically, influencing health both directly and indirectly.

To reduce health disparities and promote health equity, healthcare delivery needs a significant shift in focus to the community, with SDOHs as a primary concern. The questions are: How should we prioritize addressing these issues? What are the costs involved in tackling social determinants, and conversely, what are the costs of not addressing them? Additionally, which SDOHs have the most significant impact on overall population health, healthcare costs, and health equity?[54]

SDOHs are widely recognized as fundamental causes of health disparities. The concept of fundamental causes in public health refers to factors that remain associated with disease across different locations, even as the mechanisms linking them to health evolve. The interrelated forces that drive the US healthcare delivery paradox of high costs and poor outcomes are (1) a fragmented and siloed healthcare system that limits coordination between hospitals, primary care, public health agencies, and specialty services,[55] and (2) deeply entrenched conditions that serve as fundamental causes of health disparities.[56] Frag-

54 David B. Nash et al., *Population Health: Creating a Culture of Wellness* (Jones & Bartlett Learning, 2024).

55 Abir et al., "Breaking Down Health Care."

56 Paula Braveman, *The Social Determinants of Health and Health Disparities* (Oxford University Press, 2023).

mentation in healthcare delivery worsens the impact of adverse social determinants, and inequities in these issues make it impossible for isolated systems to achieve equitable outcomes.

SDOHs are upstream drivers of health disparities. These determinants shape multiple disease outcomes, operate through numerous risk factors, and persist over time. They are considered hallmarks of causal factors in public health.[57]

When healthcare operates in silos, it struggles to address critical issues effectively.

Economic instability may lead to missed appointments due to transportation barriers, but siloed systems rarely coordinate with social services to address these needs.[58]

Educational disparities can limit health literacy, yet patient education programs are often isolated within individual institutions rather than integrated across communities.[59]

Resolving detrimental neighborhood conditions, such as exposure to environmental hazards, requires cross-sector collaboration between health agencies, housing authorities, and environmental regulators, which is rare in a fragmented system.[60]

The result is a compounding effect that leads to adverse SDOHs and increased health risks, while fragmentation prevents the system from effectively addressing those risks.

There is a significant gap in the use of evidence-based healthcare delivery. The process of systematically applying the best available research, knowledge, and data to clinical and public health decision-

57 Michael Marmot and Richard G. Wilkinson, eds., *Social Determinants of Health,* 2nd ed. (Oxford University Press, 2005).

58 Braveman, *The Social Determinants of Health*.

59 CDC, "Social Determinants."

60 Abir et al., "Breaking Down Health Care."

making should be the foundation of modern healthcare delivery. However, this application in the US is inconsistent at best.[61]

Some of the barriers include a lack of clarity about which interventions are evidence based, limited dissemination of research findings to frontline leaders and providers, insufficient training in implementation science, and underinvestment in primary care research, which receives less than 1 percent of federal funding.[62]

In the absence of evidence-based integration, both clinical care and public health interventions fail to address the root causes of disparities in health outcomes.

The persistence of health disparities in the US is not just about the quality of medical care; it is driven by a fragmented healthcare system interacting with deeply rooted SDOHs. Fragmentation hampers the system's ability to address root causes early on, while adverse societal issues magnify its effects. Achieving health equity will require breaking down silos, integrating evidence-based approaches, and addressing the social conditions that influence health from the outset.[63]

Healthcare as a Commodity

Healthcare holds a unique position in the US. Unlike most goods and services, it is essential for survival, well-being, and societal participation. However, as it currently stands, healthcare is treated as a commodity, a product to be bought and sold in the marketplace.

Market-based approaches can foster innovation and efficiency; however, they also risk undermining equity, continuity, and patient-

61 Mallory et al., "Factors Affecting Implementation."

62 Jabbarpour et al., "V. Research."

63 Blumenthal, "Why the US Healthcare System."

centered care.[64] While these issues are real, the core problem in healthcare is not competition itself but rather the wrong kind of competition, one that no longer focuses on delivering value to patients. It has become a zero-sum game, where system participants fight over sharing limited value instead of increasing it. This results in high costs, wide variation, low quality, unnecessary or missing treatments, numerous preventable diagnostic and treatment errors, limited choices, rationed services, restricted access, and a high incidence of lawsuits.

Zero-sum competition in healthcare manifests in several ways that do not create real value for patients:

- competition to shift costs
- competition to increase bargaining power
- competition to capture patients and restrict choice
- competition to reduce costs by limiting services

Each of these types of adverse competition produces negative consequences.[65]

Treating healthcare as a commodity means viewing it as a market good, subject to the same supply-and-demand dynamics and profit maximization as consumer products. This view highlights the significance of competition, consumer choice, and price signals in promoting efficiency. However, unlike other commodities, healthcare

64 Jad F. Zeitouni, "Is Pursuing Profit Commensurable with Providing Good Health Care?" *AMA Journal of Ethics* 27, no. 5 (2025): E305–07, https://doi.org/10.1001/amajethics.2025.305.

65 Michael E. Porter and Elizabeth Olmsted Tiesberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Harvard Business School Press, 2006).

involves information asymmetry, life-or-death stakes, and externalities that make pure market logic problematic.[66]

The commodification of healthcare raises fundamental ethical questions. Should access to lifesaving care depend on market forces? Can profit motives coexist with the principle of equity? There is an inherent tension between health equity and profit-driven care, as disparities in life expectancy between high- and low-income groups have widened, even as healthcare profits have continued to grow.[67]

I can quickly identify at least four significant policy responses we need to consider: Strengthen the regulation of for-profit providers, expand public insurance or universal coverage to reduce inequities, incentivize preventive and primary care rather than high-margin procedures, and promote value-based care models and reward outcomes rather than volume.

Treating healthcare as a commodity fundamentally changes how it is delivered and its quality. Market mechanisms can promote innovation; however, they also divide care, prioritize profit over prevention, and worsen inequities. The challenge for policymakers and health leaders is to strike a balance between efficiency and equity, ensuring that healthcare is not merely a commodity to be bought and sold but a public good essential to human life and dignity.

66 Sirous Bahmani, "The Economics of Health Care: Balancing Cost and Quality," *Journal of Research in International Business and Management* 11, no. 3 (2024): 1–2.

67 Bahmani, "The Economics of Health Care."

"We Have Met the Enemy, and They Are Us"[68]

In an issue of the American Psychological Association's publication *Monitor on Psychology*, Dr. Kurt Salzinger applies this twist on an 1812 wartime quotation to the problems besetting his field.

"I know you could still pose the question of why we did not ask more people, why we did not try harder to come by the critical information; you could even question why we did not already know the solution to that problem ourselves," he writes.[69]

That sounds so familiar.

Since this nation did not invent the healthcare delivery system in a single lucid moment, we have been patching up a quiltwork of initiatives for centuries. So, *we* are the problem. There is enough blame to go around. The main idea I hope you are hatching right now is that you are very involved in the solution.

We know that variation and fragmentation in healthcare delivery contribute to poor outcomes. Inconsistent practices across providers and regions lead to disparities in outcomes, patient experiences, and costs. Reducing the variation is essential to improving overall outcomes and advancing equity in healthcare delivery.

Transformation begins with understanding the reality of your system. Healthcare systems are complex and adaptive, and without a clear understanding of how local structures, incentives, and processes function, reform efforts will likely fail. Systems thinking and reality-based assessment provide the foundation for meaningful change.

Evidence-based management is crucial for sustainable progress. Just as evidence-based medicine revolutionized clinical practice, healthcare organizations must apply the same rigor to management

68 Kurt Salzinger, "Walt Kelly's Pogo Is Right: We Have Met the Enemy, and They Are Us," *Monitor on Psychology* 34, no. 7 (2003): 26, https://www.apa.org/monitor/jun03/sd.

69 Salzinger, "Walt Kelly's Pogo."

decisions. Basing leadership and operational decisions on data and proven strategies reduces inefficiencies, resulting in consistent, high-quality care and long-term sustainability.

The US healthcare system is challenged by numerous systemic problems that stem from policies and beliefs deeply ingrained in political leadership's thought process over decades. Challenges currently faced by the system extend far beyond policies associated with the distributive ethic of healthcare delivery in the US. It is a problem that results in health disparities, inequitable care, high costs, and poor outcomes. As this chapter has demonstrated, variation in care is a significant contributor to poor outcomes, disparities, and high costs.

Any reform must be centered around a clear understanding of the system's reality, its purpose, and its actual performance. The goal should be to create a fair and equitable healthcare system that functions efficiently, is patient-centered, and delivers high-quality, equitable, and sustainable healthcare to the entire US population.

The system should also focus on executing a model that uses evidence-based methodologies, applying the same level of rigor to organizational decisions as we do in clinical practice, thereby clearing the way for a system that is fair, efficient, and genuinely patient-centered.

The pathway forward is to first gain a thorough understanding of the current reality of the US healthcare system. Advancing progress will require leadership skills combined with discipline, courage, commitment, and the gravitas to assemble like-minded stakeholders willing to challenge the status quo in exchange for a US healthcare system that aligns with those of collegial nations, especially those within the OECD. Despite its overall performance and outcomes, the US has some redeeming features, such as innovation and technology, that are worthy of leveraging to advance national and international growth and development in the quality of healthcare delivery.