

IF THE WORLD IS FLAT, WHAT ABOUT HEALTH CARE?

Thomas Friedman wrote his popular book, *The World Is Flat: A Brief History of the Twenty-First Century*, after a visit to India in which he saw a business environment radically transformed by global interconnectedness. The connections brought people, products and markets together in an entirely new way.



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He says the world began to flatten when the Berlin Wall came down in 1989. Then windows opened — not literal windows, but digital windows. Netscape Navigator — one of the first web browsers — and online collaboration, outsourcing and instant access to vast amounts of information broke down geographic and economic barriers like never before.

These developments flattened a world that had been separated into isolated communities by high mountains of inequality. The internet enabled the rapid spread of music, money, products and labor. It has enabled one government to attack another's electrical grid, it has spread ripples of scandal through a presidential campaign.

As Friedman says in the introduction to his book's paperback edition, "My use of the word 'flat' does not mean equal (as in 'equal incomes') and never did. It means equalizing, because the flattening forces are empowering more and more individuals today to reach farther, faster, deeper and cheaper than ever before, and that is equalizing power — and equalizing opportunity..."

Is health care getting flatter too? A blogger for a John Hopkins Medicine International website pointed out two years ago that an internet search for "health care" and "globalization" mostly turned up search results about medical tourism — and medical tourism isn't the big trend it once was expected to be.¹ The bigger trend is the collaboration and the flow of information and services that have begun to flatten health care so advances and technology available in one country might be available in many other countries. What's more, as the blogger said, "health care globalization at its best will be about bringing a vast range of in-

ternational resources to bear on comprehensive local solutions."

It is not hard to see that flattening effect in Catholic health care. Mercy in St. Louis and Avera Health in Sioux Falls, South Dakota, have both started innovative "e-hospitals" that use the internet to bolster the quality of health care in smaller communities that do not ordinarily have access to specialists. Mercy Virtual Care Center opened last year. It has 330 employees and a nighttime census of more than 500 patients, but none of them is in St. Louis. Rather, Mercy's staff takes over from local hospital staffs from 7 p.m. to 7 a.m., providing relief for on-site personnel and the services of specialists that small hospitals could not afford. It offers telestroke, virtual hospitalists and an electronic ICU called SafeWatch that provides a second set of eyes to 30 ICUs across five states, as well as home monitoring.

Avera's E-Helm began in 1993 by providing e-consults to rural, frontier and critical access hospitals in the Midwest. It now provides 24-hour coverage — including eEmergency, eICU and ePharmacy — to hospitals all across the country. Both systems have used their virtual capabilities to reduce waiting times for stroke patients. Quick-

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er contact with specialists and fewer ambulance transfers enable them to start treatment faster and significantly improve stroke outcomes.

Home health care is another example. Monitoring devices enable chronically ill patients to remain in their own homes longer and avoid office visits and hospital stays. Now they can stay home, yet be in almost instant contact with a health care provider. In fact, remote observation allows more consistent and thorough monitoring than even the most attentive hospital nurse could ever provide.

Supply chain, too, has been flattened. I remember a presentation by the supply chain executive at a large health system. He had three identical boxes of surgical gloves in front of him.

“We used to pay \$3 for this box, \$5 for this box and \$11 for this box,” he said. “In the future, we are going to pay one price — \$4 — for all of them, across the entire system.”

That economy, he explained, resulted from his system’s ability to track usage, negotiate better deals and take advantage of a global workforce.

Flattening means fewer acute-care hospitals and more ambulatory and home health care. Robert J. Henkel, CEO of Ascension Health, said recently that Ascension no longer considers itself primarily an acute care system because of the diverse delivery methods and sites it has developed. Most of them are dependent on technology.

Despite these significant developments, health care is not yet where we need it to be. There is growing awareness of disparities in both access to health care and health care outcomes. At the local level, social determinants lead to higher incidence of disease and poorer outcomes, even from neighborhood to neighborhood. Writer Atul Gawande, MD, noted this when he described medical “hot spots” — specific neighborhoods that have clusters of sicker and needier patients.²

It also is true globally, because most of the world’s population lacks access to the sophisticated care available in North America and Europe. This “geographic morality” allows first-world countries to lavish long-term care on permanently unconscious patients when such an accommodation would be unthinkable in underdeveloped

countries where even basic care is hard to come by.

Health information technology has enormous potential, not only for information portability, which will help lower costs by reducing redundant tests, but also for the amount of aggregate information that will be available to us. This information will give us a picture of population health and enable us to see correlations in a way never before possible.

Is health care ethics getting flatter too? I believe it is. Not that long ago, health care ethics barely existed. Physicians and nurses had professional codes of ethics, but the physician remained the primary repository of both clinical and ethical information. Today, we not only have health care ethicists, but the ethical task has flattened out so that other caregivers, patients and families all can be part of the deliberation about treatments and prognoses. In ethics, flattening means much wider participation.³

Sometimes flat is boring. But in the case of technology that links us together across geographic, economic and social borders, it is very exciting.

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NOTES

1. Johns Hopkins Medicine International Staff, “The Future of Health Care Globalization,” *Perspectives on Global Collaborative Healthcare* blog, July 18, 2014. Accessed at international.blogs.hopkinsmedicine.org/2014/07/18.
2. Atul Gawande, “The Hot Spotters: Can We Lower Medical Costs by Giving the Neediest Patients Better Care?” *The New Yorker* (Jan. 24, 2011). www.newyorker.com/magazine/2011/01/24/the-hot-spotters.
3. See John Paul Slosar, “Embedding Clinical Ethics Upstream: What Non-Ethicists Need to Know,” *Health Care Ethics USA* 24, no. 3 (Summer 2016), in which he describes Ascension Health’s model for “proactive ethics integration.”

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