CHAPTER 18

# ECONOMIC DEVELOPMENT 3.0: COMMUNITIES TAKE CENTER STAGE

*"We're paying more for the privilege of getting sick and dying early. Once again, it makes no sense. And once again, no one in Washington is talking about how to fix it." – Michael Bloomberg*

In his book *The Coming Jobs War*, Jim Clifton, Chairman of Gallup, makes a strong case that the United States is already in World War III. Unlike the previous wars, which dictated which countries would lead the world in prosperity as a function of property, the current war will dictate which communities will prosper by winning the lion's share of jobs. Civic leaders can and should seize this opportunity to reinvent their communities and build infrastructure.

The wisest leaders will shift how their communities think about economic development. It turns out that having a high-value health ecosystem is likely to be of greater benefit than a tax break. Conversely, communities with expensive health care have what amounts to a large health care tax that will push businesses away or, at a minimum, impair their bottom line and the well-being of their workforce.

## The Post-Copernican View

Economic Development 1.0 was largely a function of geography: successful towns emerged near ocean and river ports or along transportation routes and capitalized on the need to shift goods and people efficiently.

Economic Development 2.0 has been largely a function of marketing: communities throw tax breaks at corporations to attract or retain them, without always considering the long-term effects. For example, building hospitals was perceived as an economic driver despite considerable evidence that adding capacity is actually an economic drainer after the "caffeine hit" of initial construction. This pre-Copernican view of health care puts hospitals and medical technology at the center of the health universe. The post-Copernican view puts individual and community well-being at the center of a properly functioning health ecosystem.

Economic Development 3.0 recognizes that all the tax breaks in the world are dwarfed by whether a community has a high-value or low-value health ecosystem. In Chapter 3, we explored the devastating impact health care has had on individuals and local economies as working and middle-class disposable income has increasingly vanished.

After payroll, health benefits are often the largest cost for most employers in both the public and private sectors. Just as manufacturers shift production to low-cost manufacturing centers, employers will be attracted to high-value health communities. For instance, IBM is making decisions on where to locate new technology centers based on the health care value equation.[152] Such decisions represent thousands of jobs for communities vying for growth opportunities.

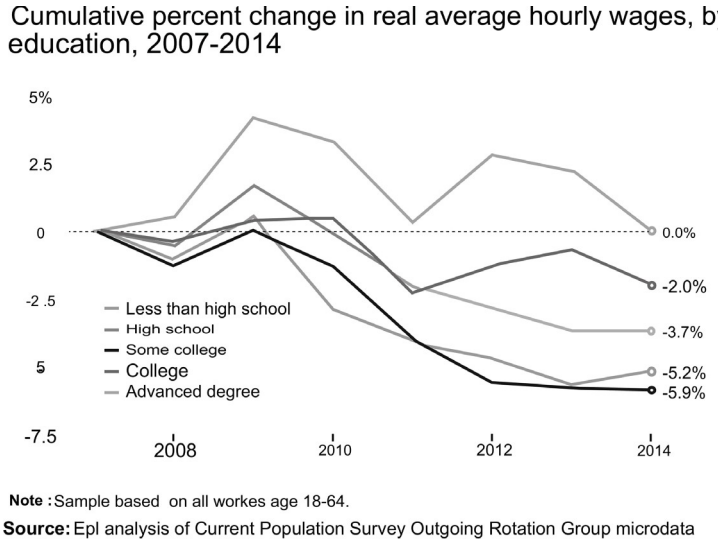


*Figure 11: 2014 Continues a 35-Year Trend of Broad-Based Wage Stagnation* [153]

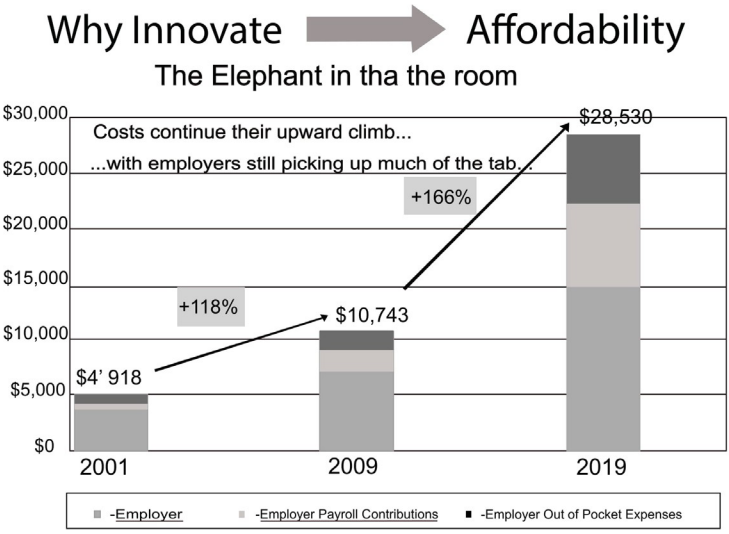


*Figure 12: Per capita spending for IBM employees 2001, 2009 with projection for 2019.*[154]

As we have seen, employers foot most of the health care tab[155] and are starting to flex their muscles. Thus, IBM shifted from thinking about health benefits as a soft benefit to seeing

them as a major supply chain input that will impact its profitability. The company decided where to locate 4,000 new hires based on their analysis of where they would receive the best value from their health care expenditure. After looking at the graph below it's easy to understand why they picked Dubuque, Iowa.

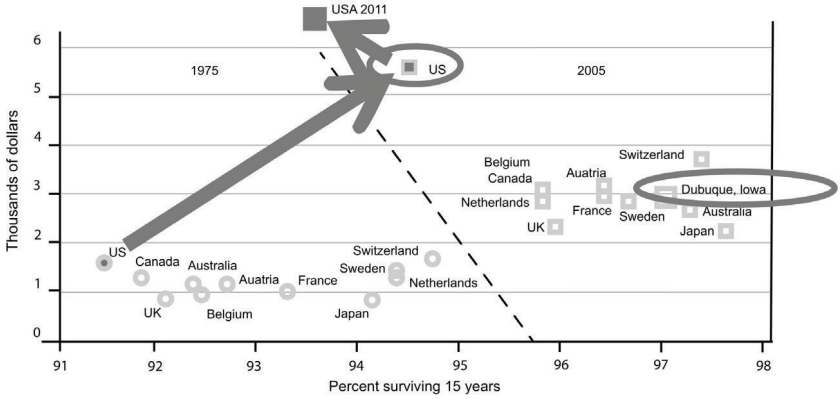


*Figure 13: Per capita spending and longevity by country, 1975 to 2005, by locale.*

Given the wide cost differentials, CFOs and CEOs are failing in their fiduciary responsibility if they do not move to modern health care delivery models that are proven to save money while maintaining or improving health outcomes and patient satisfaction. This is a scary prospect for communities that have high-cost health care with average outcomes.

Churchill was quoted as saying, "Healthy citizens are the greatest asset any country can have." It stands to reason that we should measure that asset. One could imagine a Community Well-being Balance Sheet as a leading economic indicator of prosperity. On the asset side of the ledger would be things like clean air, clean water, the number of high school/college graduates, community centers, and so on. On the liability side would be things like a Superfund site or outstanding hospital bonds.

We could also imagine something like a Gross Community Product: the collective revenues generated by local businesses subtracting out health care spending as a measure of people

who are not able to contribute to community well-being. Forward-looking economists are developing new economic indicators to better reflect the health of communities.

## Taxation Without Representation

Jeff Brenner, MD, founder and long-time executive director of the Camden Coalition of Healthcare Providers, currently senior vice president of Integrated Health and Social Services at UnitedHealthcare Community & State, and a 2013 MacArthur Genius Grant recipient, spoke about health care as a tax on a community[156] that the residents didn't get to vote on—a tax that negatively affects a community's competitiveness. He points to a "giant hospital bond market" that brought too many hospital beds online. An empty hospital bed, says Brenner, is the most dangerous thing in America.

> *"In the center of New Jersey… a couple years ago, they built two… $1 billion hospitals, 10 miles apart, very close to Princeton. One is called Capital Health, and the other is Princeton Medical Center. I don't remember anyone in New Jersey voting to build two brand-new hospitals. But we are all going to be paying for that the rest of our lives. We'll pay for it in increased rates for health insurance. And, boy, you better worry if you go to one of those emergency rooms, because the chances of being admitted to the hospital when there are empty beds upstairs… are… much, much higher than when all the beds are full – whether there's medical necessity or you need it or not. I'd be very worried if you live in Princeton that there are now two $1 billion hospitals waiting to be filled by you."*

Every health system CEO I've spoken with agrees with health policy expert Paul Keckley, PhD, that there is at least a 40 percent over-capacity of hospital beds,[157] and some communities are still building. A recent Harvard School of Public Health study of 195 hospital closings found that the closures had no discernible impact on outcomes.[158] In fact, in countries that have shifted

from a "sick care" model to a model that is focused on health and well-being, more than half of hospital beds were no longer needed. This is something to celebrate. While we have to be mindful of short-term impacts on individuals working in these facilities, there are higher and better uses for most of these people (e.g., health coaches and investments in health-enhancing infrastructure), especially at a time when there is full employment.

Even though many health systems are tax-exempt nonprofits, perverse incentives have created a dynamic where revenue growth has become a central objective. In reality, tax-exempt nonprofits make up 70 percent of the most profitable hospitals,[159] perhaps because their boards are typically made up of business leaders who reflexively view revenue growth as the goal when it should be community well-being and addressing major issues such as the opioid crisis. Hospital executives also realize it's easier to justify enormous compensation packages if their institution is generating massive revenue increases every year. As Axios reported, "Large not-for-profit hospital systems now resemble and act like Fortune 500 companies instead of the charities they were often built as. They consequently hold immense financial and political power."

In contrast, forward-looking nonprofits focus on long-term economic sustainability and their mission to serve as stewards of community health. With all of the changes in health care, it's just a matter of time before more enlightened boards fundamentally rethink their mission to emphasize the 80 percent of nonclinical factors that contribute to health and well-being.

## Closing a Hospital Opens Other Doors

One of the most respected health care leaders in the country, David Feinberg, MD, CEO of the renowned Geisinger Health System, believes his "job ultimately is to close every one of our hospitals," in order to take care of individuals at home, work, and school.

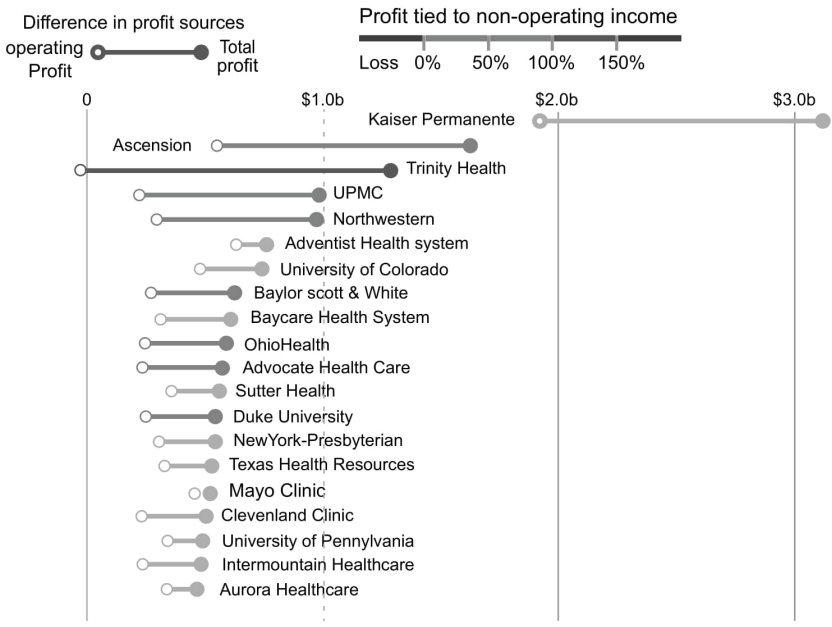


*Figure 14: Operating and total profit by health system*[160]

As overcapacity gives way to hospitals optimized for the health of communities, those communities will realize a bonus: hospitals are often in locations with high real estate values. According to David Friend, chief transformation officer at the consulting firm BDO in Boston, "a hospital could be worth more dead than alive."[161] Hospitals are often in city centers with great access to transit. Wide hallways, thick walls, and high ceilings make them easy to convert to housing. Communities have repurposed hospitals to a wide variety of uses, from low-income senior housing to health and wellness centers to office space.[162]

Being alarmed by a hospital closing is understandable. However, experience shows that this can open great opportunities while rarely affecting health outcomes. An analogy from military bases is enlightening: the closing of Philadelphia's naval shipyard was bitterly fought, yet now the repurposed naval yard is the most dynamic development in Philadelphia.[163]

## Rethinking Economic Development

Here are some examples of how forward-looking civic leaders are embracing Economic Development 3.0.

- Freeing up financial resources formerly dedicated to unnecessary and harmful clinical procedures allowed Rosen Hotels & Resorts to invest heavily in its community; the result was a reduction in crime of 67 percent and a doubling of high school graduation rates. The Rosen case study outlines how a single private employer pulled this off, but any employer—public or private, large or small, corporate or government—can do the same. In New Jersey, public and private unions joined with a Democratic Party-dominated legislature and then-Governor Christie to find common ground around improving health benefits to lower health care costs.
- Communities have found that "Shop Local" programs lead to more dollars circulating in the local economy. Health care is a fundamentally local interaction, yet the value creators (nurses and doctors) receive less than 25 percent of every dollar spent, with a much larger percentage going to bloated administration or overhead, fraud, waste, and abuse that robs communities. Municipalities as employers and trendsetters are increasingly contracting directly for health services in order to keep money in the community. For example, directly contracting with locally owned surgery and imaging centers[164] rather than with health chains owned by out-of-towners is increasingly common. The potential to recirculate dollars with locally-owned health care provider organizations is enormous.
- Mayors and economic development directors are catalyzing locally controlled health insurance pools referred to as "captives" where multiple organizations pool risk. Think of it as the health insurance equivalent of the Green Bay Packers where they are owned by a community with local control but have the ability to tap into national-scale contracts, reinsurance and technology.

- As large employers themselves, municipalities are getting much smarter about how they purchase health benefits, using the components outlined in the Health Rosetta blueprint. With respected organizations, such as PwC, acknowledging that more than half of health care spending is waste, it's logical that financially-strapped municipalities are rethinking their approach, as described in the Kirkland, Washington, and Milwaukee case studies.
- The historically adversarial relationship between school boards and teacher unions has hurt communities throughout the country. Proactive city leaders recognize healthy schools are one of the most important factors in attracting and retaining citizens. In an announcement about a new teachers' union agreement in a school district that covers one of the wealthiest areas of the country, one major accomplishment cited was that "teachers will see protection from rising health care costs," largely as a result of school district concessions. While this is laudable, the smartest districts and unions are realizing they're on the same side when it comes to health care costs and can collaborate to slay the health care cost beast, as they did in Pittsburgh. (See the Pittsburgh case study for more).

Sooner rather than later, we can expect other developments along the same 3.0 spectrum. Cities will incorporate true health needs into master planning and review building permit applications with a deep understanding that health care is a supply-driven market. The more supply there is, the more demand will increase, with little regard for value and community well-being. Approving more health care build-out virtually guarantees a massive burden on local citizens.

Forward-looking city attorneys and state attorneys general will challenge the non-compete agreements that doctors have signed as being against the public interest. In particular, primary care physicians (PCPs) are foundational to a more effective health system. Though they were ostensibly money losers in the waning fee-for-service industry, PCPs can refer more than $8 million per

year in revenue to the rest of a health care system. As a result, health systems have gobbled them up to protect their flank and create captive referral channels, insisting on anti-competitive deals that harm a well-functioning health ecosystem.

The #1 cause of personal bankruptcy is health care costs,[165] recently exacerbated by an opioid crisis largely inflicted on society by a failed health system. This has a profound impact on the economic vitality of neighborhoods and communities, dragging them into a downward spiral caused by overtreatment. Millennials will push back hard as they have in so many other sectors like banking and marriage. Indeed, we saw in Chapter 6 that staying on the current health care path will mean that millennials will spend over half their lifetime earnings on health care. There will be riots in the street before that happens.

I believe in the enormous potential of community-driven change from the bottom up. Central governments have largely reached the limits of what they can achieve. Increasingly, community-level change is where the action is.

## Key Take-aways

- Economic Development 3.0 recognizes that all the tax breaks in the world are dwarfed by whether a community has a high-value or low-value health ecosystem.
- Closing a hospital can open doors to myriad economic benefits to a community. Transforming hospitals and hospital beds to higher and better purposes is a sign of progress.
- "Shop Local" comes to health care providing an unprecedented economic stimulus opportunity.