CHAPTER 7

Face the Business Realities

Healthcare has long prided itself on being mission driven. We see our purpose as healing, serving communities, advancing equity, and promoting the public good. It's a noble calling, and one that attracts people who care deeply about making a difference.

That mission-driven mindset is a good thing. But at the same time, it can create blind spots. Too often, leaders resist making financially driven decisions because they fear it indicates a shift away from patient care. The moment someone dares to mention money, the virtue signaling begins: "You don't care about patients!" That criticism doesn't always come from the public—it often comes from inside our profession.

MARGIN AND MISSION ARE NOT OPPOSITES

There's a reason for the adage "No margin, no mission." Financial health and community health are not competing priorities. It doesn't have to be an either/or. In fact, ignoring the business side doesn't protect the mission—it endangers it. When revenue declines and margins collapse, hospitals close. When that happens, communities lose access to care, and the very mission we sought to defend disappears with it.

The challenge for healthcare leaders today is not choosing between mission and margin—rather, it's learning how to protect both.

Financial sustainability matters. Everyone in healthcare is deeply committed to quality and outcomes, and rightly so. But we also have to be honest: When a hospital in your community closes, it's not because people stopped caring about patients. It's because the organization could no longer sustain itself financially. That is a reality we have to be willing to acknowledge openly.

We have to stop defaulting to easy villains or simple narratives. Hospitals don't close because of "faceless" businesspeople. Hospitals close because they are not able to generate enough revenue to sustain their operations. That's why maternity units disappear. That's why emergency departments close. And before we reduce every closure to under-reimbursement alone, we need to acknowledge that the reality is more complex than a single payment problem.

Our reality: In healthcare, we do what we are paid to do. We do more "sick care" because we get paid less for preventive care. For years, public health leaders have been asking why we haven't fixed this model, especially as disease rates and costs continue to climb. Changing payment models has a significant role here.

PREVENTION DOESN'T PAY—YET

How we treat obesity offers a clear example. We don't get paid for nutrition counseling, so we don't do it. That's a serious problem at a time when obesity rates in young people continue to rise, alongside diabetes. Nutrition isn't consistently taught in schools. Many experts believe that diets high in ultra-processed foods are contributing to the increase in chronic diseases—and even certain cancers—in younger populations. Rising obesity rates in children and teens mean earlier onset of diabetes, hypertension, and heart disease.[1] Even with the best technology and science, these trends threaten to erase our progress in lowering healthcare costs.

The old adage still applies: "An ounce of prevention is worth a pound of cure." Starting early to build healthy habits—nutrition, exercise, and good sleep—is important. No matter how advanced our diagnostics and treatments become, we continue to prove that "the basics" are the best way to improve whole health. The challenge is making prevention the first choice. We still have a lot to learn in this area, from self-management training for individuals to payment modeling. Some organizations are experimenting with new approaches, such as gamification and AI-driven personalization. Each represents an opportunity to reimagine how we engage people in their own health and make well-being the easy and first choice.

Even as we explore creative ways to make preventive care the optimal choice, healthcare continues to discover new treatment modalities. Enter GLP-1 drugs. These medications are a breakthrough for managing obesity and diabetes. They are transforming the prognosis for some of the costliest chronic conditions. But while GLP-1s are important, they're not the whole answer. We need to teach nutrition: what ultra-processed food looks like, how to cook healthy meals, and how to tailor advice to each person's culture, preferences, and budget. We can work to increase access to healthy foods and vegetables in communities, particularly food deserts. Building pathways for safe walking and exercise in communities may also have a positive impact. These should be foundational for good health, even if you do not have medical conditions such as hypertension, obesity, or diabetes.

When someone meets the evidence-based criteria for medical treatment, it should then be provided in addition to lifestyle management. Even with GLP-1 drugs, healthy behavioral changes are necessary for managing chronic conditions and for maintaining the benefits of a combined lifestyle and medication approach. We must continue exploring how to engage individuals in maintaining good health and habits. Helping them understand the options and removing barriers to treatment and adherence are critical. We must

also work with manufacturers, payers, and policymakers to ensure that the best treatments are offered.

Prioritizing prevention, nutrition, and wellness requires clear reimbursement pathways. Payments guide much of what we do in healthcare. We get paid to prescribe GLP-1s, so we do. Once we reimburse appropriately to teach nutrition and provide preventive care, I expect we'll see more services provided there. Holding ourselves accountable for bringing new payment models forward is a great opportunity for our industry today.

INNOVATION AND INCENTIVES

When the COVID-19 pandemic hit, healthcare moved very quickly. Almost overnight, we approved telehealth across state lines. But the real breakthrough wasn't the technology—it was reimbursement. Once telehealth visits were reimbursed, adoption skyrocketed. This is a vivid reminder that reimbursement drives behavior in healthcare faster than almost anything else.

Consider women with dense breast tissue. Traditional mammography can miss cancers in this population, even though advanced imaging technologies with greater sensitivity are widely available and clinically validated. Although these modalities are reimbursed in many cases, coverage is inconsistent, varying by payer, plan design, state mandate, and whether the imaging is coded as screening or diagnostic. As a result, access is uneven and adoption is slower than clinical evidence would support. Aligning reimbursement policies across stakeholders would accelerate earlier detection and improve outcomes.

We can and do care about revenue sustainability *and* patient well-being. It's not an either/or proposition. Healthcare is both a mission and a business. To sustain care in our communities and continue improving outcomes, we must ensure that both sides of that equation are strong.

This isn't only an industry or organizational issue; it's also a personal one. Every financial decision in healthcare is ultimately made by individuals—physicians, administrators, payers, and policymakers—each interpreting the same mission through a different lens. If we want to change how healthcare operates, the first step is changing how we *think* about financing healthcare. When we see financial strength as fuel for our mission rather than a threat to it, we open the door to smarter decisions, creative solutions, and sustainable innovation.

TIPS FOR SHIFTING YOUR MINDSET (AND THAT OF OTHERS) AROUND MARGIN AND MISSION

Smoothing the tension between mission and margin can be essential to sustaining care and expanding access. The following strategies enable leaders to build clarity around financial realties while aligning them with purpose.

Communicate continuously and transparently. Leadership requires constant communication that is factual, data-driven, and forward-looking. Link what's happening today to what may happen tomorrow—*before* negative outcomes affect people's livelihoods. Use clear, matter-of-fact language daily, and always tie it back to what's going on. The idea is to normalize financial language so it doesn't feel taboo.

Link mission to margin. When you talk about purpose, talk about revenue in the same breath. Say things such as, "We need to increase our margin so we can continue building essential programs. The community is counting on us." Making that connection clear helps staff understand that financial strength is what sustains patient care and community service.

Include physicians and clinical leaders in business conversations. Invite clinicians to join business discussions and contract negotiations. When they see the math—how reimbursements, costs, and margins actually work—they gain a clearer understanding of the "why" behind financial decisions. It transforms conversations from *us versus them* into *we're in this together.*

Make financial acumen a leadership requirement. Every leader in healthcare—clinical or administrative—should have a baseline understanding of financial principles. That doesn't mean everyone needs an MBA, but every decision-maker should know how to read a P&L statement, understand cost drivers, and evaluate ROI on new initiatives. Financial literacy empowers leaders to connect decisions to long-term mission sustainability.

Start financial education early. Incorporate basic financial and business training into physician onboarding and leadership development programs. Don't wait until someone is promoted to a leadership role to teach them about budgets and payer mix. The earlier people understand the business side of healthcare, the more naturally they'll integrate it into daily decisions.

Celebrate when mission and margin align. Recognize and share success stories where financial results and patient outcomes support each other. Call out teams or projects that achieved both. These stories reinforce the idea that financial health isn't separate from patient care—it's what makes it possible.

Caring about the business of healthcare doesn't make us less mission-driven. Rather, it makes the mission sustainable. Financial strength isn't separate from patient care; it's what allows care to continue. The most effective leaders talk openly about both, connecting the dollars to the difference they make.

Shifting our mindset starts with conversation, education, and shared accountability. When we link mission to margin, invite

clinicians into financial discussions, and celebrate wins where purpose and profit align, we create a culture that can serve both people and performance.

ENDNOTE

1. American College of Cardiology. 2025. "Eating Ultra-Processed Foods May Harm Your Health." Press release, May 8. https://www.acc.org/About-ACC/Press-Releases/2025/05/08/14/10/Eating-Ultra-Processed-Foods-May-Harm-Your-Health.