

# Healthcare Beyond Reform

Doing It Right  
for Half the Cost

Joe Flower



CRC Press

Taylor & Francis Group

Boca Raton London New York

---

CRC Press is an imprint of the  
Taylor & Francis Group, an **informa** business

A PRODUCTIVITY PRESS BOOK

CRC Press  
Taylor & Francis Group  
6000 Broken Sound Parkway NW, Suite 300  
Boca Raton, FL 33487-2742

© 2013 by Taylor & Francis Group, LLC  
CRC Press is an imprint of Taylor & Francis Group, an Informa business

No claim to original U.S. Government works

Printed in the United States of America on acid-free paper  
Version Date: 20120126

International Standard Book Number: 978-1-4665-1121-7 (Hardback)

This book contains information obtained from authentic and highly regarded sources. Reasonable efforts have been made to publish reliable data and information, but the author and publisher cannot assume responsibility for the validity of all materials or the consequences of their use. The authors and publishers have attempted to trace the copyright holders of all material reproduced in this publication and apologize to copyright holders if permission to publish in this form has not been obtained. If any copyright material has not been acknowledged please write and let us know so we may rectify in any future reprint.

Except as permitted under U.S. Copyright Law, no part of this book may be reprinted, reproduced, transmitted, or utilized in any form by any electronic, mechanical, or other means, now known or hereafter invented, including photocopying, microfilming, and recording, or in any information storage or retrieval system, without written permission from the publishers.

For permission to photocopy or use material electronically from this work, please access [www.copyright.com](http://www.copyright.com) (<http://www.copyright.com/>) or contact the Copyright Clearance Center, Inc. (CCC), 222 Rosewood Drive, Danvers, MA 01923, 978-750-8400. CCC is a not-for-profit organization that provides licenses and registration for a variety of users. For organizations that have been granted a photocopy license by the CCC, a separate system of payment has been arranged.

**Trademark Notice:** Product or corporate names may be trademarks or registered trademarks, and are used only for identification and explanation without intent to infringe.

---

**Library of Congress Cataloging-in-Publication Data**

---

Flower, Joe.  
Healthcare beyond reform : doing it right for half the cost / Joe Flower.  
p. ; cm.  
Includes bibliographical references and index.  
ISBN 978-1-4665-1121-7 (hardback : alk. paper)  
I. Title.  
[DNLM: 1. Health Care Reform--United States. 2. Costs and Cost Analysis--United States. 3. Delivery of Health Care--economics--United States. 4. Forecasting--United States. 5. Health Expenditures--United States. 6. Health Policy--United States. WA 540 AA1]

362.10973--dc23

2012002158

---

Visit the Taylor & Francis Web site at  
<http://www.taylorandfrancis.com>

and the CRC Press Web site at  
<http://www.crcpress.com>

Embargoed  
for promotional purposes only

International Copyright 2012  
Joe Flower

We are called to be the architects of our future, not its victims.

—**Buckminster Fuller**

---

# Contents

---

<b>Acknowledgments</b> .....	<b>xiii</b>
<b>About the Author</b> .....	<b>xvii</b>
<b>The Facts</b> .....	<b>xix</b>
<b>First, a Story: Tom Johnson’s Belly Encounters Healthcare as It Has Been</b> .....	<b>xxi</b>
<b>Introduction</b> .....	<b>xxxiii</b>

## SECTION 1 HOW WE GOT HERE

<b>1 Half Off?</b> .....	<b>3</b>
Looking at Normal Countries.....	3
Economists Behaving Badly with Smoke and Mirrors .....	6
The Fairness Factor .....	7
The American Ways of Healthcare.....	9
Possible Savings: Getting to Half.....	10
<b>2 Waste</b> .....	<b>13</b>
Level 1: Doing the Right Things the Wrong Way .....	13
Level 2: Doing the Right Things in the Wrong Place.....	14
Level 3: Doing the Wrong Things—and Not Doing the Right Things...	14
How Much? .....	14
Where Are the Biggest Savings? .....	16
Inappropriate Therapies .....	16
How Big Is This Waste? .....	22
Heroic End-of-Life Treatment.....	23
Insurance Waste.....	25
Pharmaceutical Waste.....	26
Chronic Disease.....	26

<b>3</b>	<b>Trends: Opportunities.....</b>	<b>31</b>
	The Economy.....	31
	Rampaging Geezers.....	32
	Aging Clinical Workforce.....	34
	Chronic Disease.....	35
	Computerization and Automation.....	37
	Reform and Insurance.....	38
	Brute Force Cost Reductions.....	39
<b>4</b>	<b>Healthcare Economics 101.....</b>	<b>41</b>
	Ahmed Buys a Rug.....	42
	The Convoluted Economics of Healthcare.....	43
	Competing Influences.....	46
	No Cost Accounting.....	48
	Split Buyers, Split Sellers.....	49
	Why the Ever-Popular “Cost Controls” Do Not Control Costs.....	52
	Health Systems: More Complex.....	54
	No More Cost Decanting.....	55
	It’s About to Get Really Complicated.....	56
	Inflexible Systems.....	57
	Unit Costs vs. System Costs.....	58
	The Two Core Rules of Economics.....	59

## SECTION 2 WHAT MUST BE DONE

<b>5</b>	<b>The Five Strategies.....</b>	<b>63</b>
<b>6</b>	<b>1. Explode the Business Model.....</b>	<b>67</b>
	The End of Fee-for-Service Healthcare?.....	68
	What Are We Buying?.....	69
	What’s Wrong with Competition?.....	69
	Emerging Business Models.....	72
	The Safeway Experience.....	72
	CIGNA’s Choice Fund.....	74
	Formula One.....	75
	The Boeing Experience.....	76
	On-Site Clinics.....	77
	On-Site Clinics without Employers?.....	79
	Medicaid-Based Business Models.....	79
	Disease Management Programs That Fail.....	80

	Disease Management Programs That Work .....	81
	Direct Primary Care .....	82
	Direct Primary Care—Online.....	83
	Structure Matters.....	84
	Share the Risk.....	85
	A Brief History of Risk in Healthcare.....	86
	Putting the Customer at Financial Risk.....	87
	“But Capitation Doesn’t Work” .....	89
	Putting the Provider At Risk.....	90
	Providers At Risk Behave Differently .....	91
	Putting Providers Systemically At Risk .....	92
	Shopping.....	94
	Virtuous Deflationary Spiral.....	95
	Redesigning Markets .....	96
	Explode the Business Model .....	98
<b>7</b>	<b>2. Build on Smart Primary Care .....</b>	<b>99</b>
	The Medical Home .....	100
	How a Medical Home Actually Works .....	102
	Making More Money by Being a Better Doctor .....	103
	Taking on Risk .....	103
	Integration: It’s Not Just “Kumbaya” .....	104
	From Evidence-Based Medicine to Evidence-Based Health .....	105
	Explode the Business Model and Build on Smart Primary Care .....	106
<b>8</b>	<b>3. Put a Crew on It.....</b>	<b>107</b>
	A Team Care Example: Diabetes .....	108
	Teamwork at All Levels.....	109
	Getting on the Same Team with the Docs.....	110
	Alaska Native Healthcare.....	111
	What Makes a Team? A Scoreboard .....	113
	Explode the Business Model, Build on Smart Primary Care, and Put a Crew on It.....	114
<b>9</b>	<b>4. Swarm the Customer .....</b>	<b>115</b>
	The Magic of Mr. Moon .....	116
	The Pareto Principle in Healthcare.....	118
	Hotspotting.....	121
	The 5% That Does the 50%.....	124
	More Help, Smarter, Earlier.....	125

**10 5. Rebuild Every Process ..... 127**

- The Tough Business of Caring ..... 127
- Time to Get Fierce..... 128
- Perfecting Clinical Processes..... 129
  - Evidence or Intuition?..... 130
  - Measure It—and Get It Right ..... 132
  - Check It Out, Dude!..... 133
- Other Industries: “Quality Is Job One” ..... 135
- The Institute for Healthcare Improvement ..... 136
- Comparative Effectiveness Research ..... 138
- Evidence-Based Design..... 140
- The Lean Medical Practice..... 143
  - Doing It Cheaper..... 144
  - Raise a Glass to Carlos..... 146
- Big Data..... 147
  - Analytics for the Country..... 148
  - Analytics for Systems..... 150
  - Analytics for You ..... 151
    - With the Doctor..... 153
    - Taking It Home..... 153
- Apps..... 154
- Extending the Clinic into the Home..... 156
- India and China: Globalization Cuts Both Ways..... 157
  - India ..... 158
  - China ..... 159
  - Cheap Biologicals and Biosimilars ..... 159
  - Reverse Innovation ..... 160

**SECTION 3 MAKING IT ALL WORK**

**11 Beyond Healthcare ..... 165**

- Len Duhl, the Father of Healthy Communities ..... 167
- Involve Everyone..... 169

**12 The Evil Profit Motive and the Virtues of Competition ..... 173**

- Arguments for a Single-Payer System ..... 174
  - Insurance Companies Are Evil ..... 174
  - Extra Transaction Costs..... 174
  - Extra Fundamental Costs ..... 175
- For Profit? Or Not? ..... 176

Is Healthcare a Right?.....	180
It's Not That Simple.....	182
<b>13 There Ought to Be a Law .....</b>	<b>187</b>
Introduction .....	187
Scope of Practice.....	187
Corporate Practice of Medicine .....	188
Certificate of Need .....	189
Anti-Kickback Legislation .....	190
Transparency .....	190
Fraud .....	192
Insurance Regulation.....	193
ERISA Immunity .....	193
End Fraudulent Rescissions and Claim Denials.....	194
Swiss Rule.....	197
Direct Primary Care .....	198
Transparency .....	199
Competition .....	200
Operating across State Lines?.....	200
Malpractice.....	201
It's Not Greedy Patients .....	204
Fixing Malpractice.....	205
Systemic Effects .....	208
Fixing the Pharmaceutical Industry.....	209
Pharma Runs into a Wall.....	210
Burying Germany in Jeeps.....	212
Why We Don't Get Legislation That Works .....	214
<b>14 The X Questions .....</b>	<b>215</b>
A New Mind-Set.....	215
The X Questions .....	216
Confronting Your Risk .....	220
<b>15 It's the System.....</b>	<b>221</b>
Wait. Half? .....	222
Our Shaky Equilibrium.....	222
Beyond the Tipping Point: Rapid System Change .....	223
True Shoppers.....	226
Automatic Cost Reductions .....	227

<b>16</b>	<b>Beyond Reform—The Next Healthcare</b> .....	<b>229</b>
	Employers .....	230
	The Poor .....	230
	Medicare.....	231
	States .....	231
	How Fast? .....	232
	<b>Appendix A: Stupid Computer Tricks: How Not to Digitize Healthcare...</b>	<b>239</b>
	<b>Index</b> .....	<b>245</b>

---

# The Facts

---

In 1980, healthcare took no more of a bite in the U.S. than it did in other developed countries like Canada, Sweden, Denmark, and Germany—about 8% of the whole economy.

In 1983 the U.S. instituted the first cost controls. Did they work?

By 2000, healthcare cost the U.S. 50% more than its closest rivals, and twice as much as most other developed countries. Today it takes up 18% of all the resources in our struggling economy, even while many hospitals and clinics and doctors are struggling to stay in business.

There is something deeply wrong with this picture—and it's something we can fix. By 2020, we can be back to costing the same as any other country—half the current bite out of the economy. Here's why, and here's how we'll get there.

---

# First, a Story: Tom Johnson's Belly Encounters Healthcare as It Has Been

---

---

Tom Johnson's belly hurt. He sat on the edge of the bed and rocked, gripping his aching belly with both hands, grunting with the pain. This was getting worse. But there was nothing more he could do about it, unless it was bad enough to go to the hospital. He had insurance for the hospital.

Tom had never felt comfortable with health insurance companies. He remembered, and would recount with some vehemence whenever people argued about healthcare, an incident from the time when his wife was alive. When she got sick, she needed a particular type of respirator at home, so that she could sleep. The insurance company, the one that billed them \$1,017 every month for the two of them, would not pay for it. A long call to the company finally got him to a supervisor who said that they only paid for things that Medicare would pay for. He went online and found a Medicare list—and the respirator was on it. Another long trek through telephone trees, and he finally talked to another supervisor. Oh no, he was assured, it wasn't the Medicare list that counted, it was the Medicaid list. He found that list online, and it too listed the respirator. A third long call, and this time the supervisor said the other supervisors were mistaken, they just don't cover that respirator. They cover a

different kind of respirator, but the doctor hadn't prescribed that one, so they couldn't pay for that one either. In the end Tom just paid for it himself. Tom didn't like insurance companies one bit.

The pain in his belly was getting worse.

A month after his wife had finally died, a new monthly bill arrived from the health plan, listing him as the sole beneficiary, and increasing his monthly payment to \$1,247. The bill did not explain why insuring one person in his 50s should cost even more than insuring two people in their 50s.

Tom had called his insurance agent, Bill Hackford. "Why, that's outrageous!" Bill said. "Listen, I'll get right on this. I'll find out what's going on. I'll call you back."

And he did. "Well, I talked to your health plan."

"Yeah, what did they say?"

"They said they were canceling your insurance."

"Why?"

"Didn't say why, really. I think they canceled you because you complained."

Tom sighed and sat shaking his head. He felt like he had been punched in the stomach. He had to have some insurance, but he couldn't afford much. He was a structural engineer, and his employer had cut back his hours in the building slump. So he told Bill to find him a policy that just covered hospitalizations, nothing else. It cost far less, but anything less than a hospitalization would come out of his own pocket.

The pain was getting very bad. Earlier in the evening, when his belly first started hurting, Tom had gone to see a doctor at a local clinic. The place was really for Medicaid patients and people like that, but he had heard that they would take cash, so he went. The place seemed well organized and welcoming. For his \$50 he got a few minutes with a doctor who prodded, poked, asked a few questions, and told him to go buy some Pepto-Bismol at the drug store down the block.

The Pepto-Bismol had not helped.

Suddenly Tom bolted for the bathroom. The pink Pepto-Bismol and everything else came up. *All right*, he thought. *This is serious. It's a good thing I had Bill get me that hospital plan, because that's where I'm going.*

He felt light-headed, a little dizzy, it was hard to walk, and the pain in his gut was doubling him over. *I'll just call 911*, he thought. But does the insurance cover an ambulance ride? He wasn't sure.

So he drove himself to the hospital, Tradition Memorial.

He staggered into the busy emergency department and presented himself at the desk. He tried to explain what was going on to the woman at the desk, but he had a little difficulty talking. The woman waved at a section of hard plastic chairs in the corner and said, "Sit over there."

He did. He sat clutching his belly and moaning. A TV blared in the corner. He watched as a cop brought in a drunk, and the nurse waved to the same section of seats. He realized, *They think I'm just drunk*. He didn't know if he could talk any better now, but he pushed himself to standing, and started toward the desk when another wave of nausea hit him. He saw a rest room sign and headed for it.

He woke up on a gurney. He was in an ER room. He was still in serious pain. People were swarming around him. A nurse was pushing a needle in his left arm. Above him to his right was another woman. "Hi, I'm Dr. Hedley. I'm glad you woke up. But we're going to sedate you in a moment, and give you some morphine for the pain. You appear to have acute appendicitis. It may have ruptured already. We're going to operate as soon as we can get you in."

The nurse started undressing him. He could barely move to help her. Everything he did hurt. Someone was starting to shave his belly. The woman from the front desk appeared near his feet. "Mr. Johnson," she said, "I have your wallet here. May I look in it for your insurance card?" Tom nodded. The sedation was coming on, and he was feeling sleepy.

In the end, Tom Johnson would spend 12 days in Traditional Memorial Hospital recovering from the burst appendix and the six-hour open abdominal surgery to clean it up, and fighting the infections it brought on.

Recovery was tough, it was a hard fight, but in many ways his time in the hospital was tougher.

The first day he was heavily sedated and under strong pain medication. He drifted in and out of awareness. But that night the pain seemed to return. He pressed his call button. When a nurse finally appeared, he asked why it hurt so much.

"They are titrating your pain medication. They switched you from morphine to hydrocodone. You shouldn't need such a strong one now."

"But it really hurts. Can you put me back on the stronger stuff?"

"You'll have to wait until the doctor sees you in the morning. I can't just change the orders."

So he writhed in pain. *At least he might be able to sleep until morning*, he thought. But as soon as blessed unconsciousness came, it seemed, the nurse was shaking him awake. "Mr. Johnson, sorry I had to wake you up, but you were moaning and disturbing the other patient."

He looked over at the other bed, where a much older man lay on his back, eyes closed, not moving.

"Okay."

The pattern repeated all night long.

By the time morning came, Tom was exhausted. But finally the doctor bustled in. "How are we doing?" he asked briskly, lifting the sheet and probing at Tom's wound.

"We're hurting a lot. Ow! Could I go back on the strong stuff again for a while at least?"

"A lot of pain? Keeping you up?" He considered, made a note on the chart, and replaced it in the rack at the foot of the bed. "Okay, we'll do that."

After he was gone, a nurse he had not met before came in with a small paper cup with a syrupy dose in it. "Here you are, drink this down."

He took the cup, drank the syrup down, and said, "I'm glad to finally be getting something stronger for the pain."

"Stronger?" She looked at him quizzically. She pulled the chart out of its rack. "Oh. I see. Well, I can't give you morphine on top of the oral hydrocodone I just gave you. You'll have to wait another four hours."

After he got the morphine at noon, Tom once again drifted in and out of awareness. There was a TV screen near his bed. He watched old movies, but he could barely focus on them. The machines over his bed and his roommate's bed beeped softly.

That evening, the beeping from his roommate's bed was suddenly replaced by a steady electronic alarm that startled Tom awake. After some minutes a nurse poked her head in the door, glanced at the monitors, then left again. The alarm

went on and on. The same nurse came back, peered at the monitors, and left again. In a while she returned with an older nurse, who glanced at the monitors, felt the man's neck, and said, "He's coding. Call a code blue." The younger nurse hurried out. There was an announcement on the PA system out in the hall. In what seemed only moments the room was bustling with doctors and nurses, barked orders, a rolling cart with equipment, but Tom was drifting back to sleep. He heard the young nurse say, "I thought the alarm was malfunctioning. Like it does, you know?"

When he woke the old man was gone. Tom never saw him again.

The next day Tom spent more time awake. Now he had a new roommate, a man about his age who seemed to be in pain a lot, like him.

Once, when the man seemed awake, Tom said, "So what are you in for?"

The man sighed heavily. "Brain tumor."

"Oh, wow. That's tough. They going to operate? They think they can help you?"

"Yeah, yeah. The doc says if they go after it right away, I have a good chance of making it. Bring in all the big guns, you know. Right now, real quick." After a long pause, he continued, "And I've got good insurance. I'm a professor over at the college. So at least I don't have to worry about that."

"Well, good luck, man."

Late in the afternoon, two women in business suits arrived in the room. They drew the privacy curtain around the professor's bed. But Tom could hear.

"Mr. Brennan, I'm Shelly, and this is Barbara. We're from the hospital finance office. I'm really sorry to tell you this. I have bad news for you. Your health plan has cut you loose."

"What?"

"They refuse to pay for your operation, and have rescinded your plan entirely. You are uninsured."

"Did they say why?"

"They said that you left some things off of your medical history the last time you re-upped—a possible aneurysm and being monitored for possible gallstones."

"My doc never told me either of those things."

"But apparently he made some notes in your medical record."

“Oh wow. Wow. Wow. So, wait, you’re going to do the operation and I’ll figure out how to pay for it, right?”

There was an uncomfortable silence. The other woman spoke. “Mr. Brennan, you are not at the moment in a life-threatening condition. The hospital has no obligation to treat you without knowing how it will be paid.”

“But ...”

“There are charity options we can explore, foundations, veterans groups, and such. But that will take some time to line up. For now, we are sending you home.”

“But the doctor said ...”

“I’m sorry, Mr. Brennan.”

He was gone within the hour.

Two days later, Tom had another roommate. In the evening the man suddenly said, “I’m having trouble breathing. I think I’m having an allergic reaction to something they gave me. It feels like my throat’s closing up.”

“Well, hit your button.”

He did. No one came. He hit it again. He whispered, “I can’t breathe!”

Tom started hitting his own call button repeatedly.

His roommate staggered out of bed and toward the door. He managed to get his hand on the door handle and jerk the door open before he collapsed into the hall. There were cries in the hall. Two nurses came. Help arrived. Someone gave him a shot. They took the man away on a gurney. The next day he was back, breathing but shaken.

Tom was an engineer, with an engineer’s interest in processes, in how things work together. As the pain medications were ratcheted down, and he began to think more clearly, he began to notice things and wonder. He didn’t know much about medicine, but some things struck him as odd. Such as: The people treating him rarely read his chart. Those who did only glanced at the top page. And why was it a chart at all, in the twenty-first century? And: There was a washstand in the room. One nurse washed her hands every single time she came into the room, or even between dealing with his roommate and coming to deal with him. Others scrubbed now and then. Most doctors and nurses and orderlies seemed never to use the sink at all. It bothered him that the nurses could not see him from the nurse station. They couldn’t see him at all unless they came into the room.

What was it about their work situation that made it so hard to get their attention?

After 12 days, Tom was discharged. He could walk, the pain was manageable with some vicodin every 4 hours. He even drove himself home. There was no one to care for him there. He didn't have a doctor to call his own. There was no home health nurse ringing his doorbell.

Two weeks later, two letters arrived on the same day, shoved through the door slot and landing on the beige carpet with all the drug store circulars and catalogs. Tom was still recovering, but he shoved himself out of his easy chair and walked slowly to the door to look at the letters. One was from the hospital. It included a bill for \$47,378.24. The other was from the health plan. It informed him that his policy was rescinded, and that the health plan would not pay for his surgery and hospital stay. There was a box on the form giving a reason. The reason was an "undisclosed prior condition."

Under that was a box listing what the prior condition was. The box said "acute appendicitis."

Is this over the top? Is this fictional scenario a bit extreme, too absurd? Things like that don't really happen, do they? Or at least not often enough to worry about, right?

It certainly does not represent the average experience. It is a catalog of mistakes and problems. If most experiences in healthcare were that bad, we would all be dead or broke by now. But extreme? Over the top? Unfortunately, no. Unfortunately, these experiences have been far too common in healthcare the way we have traditionally run it in America.

This scenario is a fictional amalgam, but each separate element happened to me, or was reported to me by the person it happened to, or was pulled from testimony in lawsuits or before Congress. Each of them I recognized, from my 30 years of observing and analyzing the industry, as "business as usual."

Think about this: "Medical misadventure" is one of the leading causes of death in America. You won't often see it listed that way in "cause of death" tables. The victims of surgery accidents, drug dosing problems, hospital-acquired infections, and other medical "adverse events" tend to show up in some other column naming the syndrome they actually died from, such as "infectious disease" or "stroke," rather than how that happened. About 600,000 people die each year from heart disease in the United States, and close to 560,000 from

cancer.\* “Medical misadventure” or “adverse events” probably comes third, at between 100,000 and 200,000 premature deaths per year, according to the most thorough studies. These are followed by chronic lower respiratory diseases like emphysema and bronchitis at about 137,000, stroke at 128,000, and accidents at 117,000.

Stories like Tom’s make me very angry. They are partly why I have chosen to come out of the relative privacy of my work consulting and speaking to groups inside the healthcare industry to make a more public statement about healthcare and how it can and must change.

I have been a healthcare analyst, a futurist, for over 30 years. It has been a long-term project in adult education—my education. I have consulted with governments and health systems in North America, Europe, and China; with the World Health Organization and the Department of Defense; with pharmaceutical companies, device manufacturers, health plans, and employers; with associations of doctors, nurses, physical therapists, psychologists, insurance brokers, healthcare architects—everyone involved in this sprawling industry. I work with organizations and leaders to work through the demographics, the economics, the technologies, and the systems dynamics of change, how they will affect their part of healthcare, their sector, their profession, and what they need to do tactically and strategically to survive and thrive and make healthcare better. I work with boards, sometimes for days at a time, working through the deep implications of these changes. I have helped train whole departments of large companies like Airbus, American Express, and GE Healthcare to think differently about what they’re doing and to approach their customers in new ways. Over the years I have toured hundreds of hospitals, clinics, and laboratories; interviewed thousands of healthcare executives, board members, patients and family members, entrepreneurs, doctors and nurses; and interviewed and compiled the thoughts and approaches of 60 of the top thought leaders of our time on change and organizations, from Peter Drucker to Jim Collins. It’s been a long search.

One of the things I learned over that time is the absolute necessity of listening to everyone, from the janitor in a hospital subbasement to the CEOs astride Fortune 100 corporations. The VP of quality can give you a whole PowerPoint stack about his or her “Lean manufacturing” principals and initiatives, but if the guy running the laundry can show you what he is doing to use less water and get better infection control at the same time, you know the company has something. The architect can talk about work flow patterns and walking distances and sight lines in the new wing; then ask the nurse executive whether nurses are vying to

---

\* Kochanek, D., et al., “Deaths: Preliminary Data for 2009,” *National Vital Statistics Reports*, Vol. 59, No. 4, March 16, 2011, Division of Vital Statistics, [http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59\\_04.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_04.pdf).

work in the new wing or avoid it, and why. To understand a system this complex and complexly enmeshed, you have to see it through all eyes.

Borrow my eyes for a while, ask with me for a while the core questions that have informed all of this searching. I want to understand how we got here. How have we transformed the process of healthcare into a monstrous twin personality, one a remarkable world of thoughtful people in innovative organizations delivering miracles of healing, and the other a brutal machine for random cruelty, visiting massive unnecessary suffering, premature death, bankruptcy, and incurable poverty on millions of Americans, while imposing on the whole country an ever-growing burden of unnecessary cost?

I had to go through many phases—of fury, of study, of hope, of disappointment—until I arrived at the right level of analysis, the one from 30,000 feet. I had to abandon concern for my own career, for smoothing it over with the people who hire me to consult and speak. I had to confront the fact that publishing this book may mean that I retreat to that little place in Baja California Sur my wife and I bought years ago, because the smart money is not on speaking common sense about what works for the good of everyone.

The first point to understand is this: Despite its chaotic appearance and wanton destruction, healthcare is a system, a dysfunctional, chaotic, adaptive system. There are patterns at work that no one designed and no one would have designed if given the opportunity. We must deal with these patterns, and the institutions trapped in them.

## Not an Easy Book

You may get angry reading this book. And I am going to ask you to bear with me. You may feel upset by my arguments, even dismissive. I'm going to ask you to stick around and think it through with me before you come to a conclusion.

Let me tell you why.

It has been a singular experience to write this book. People ask me what I'm working on—strangers, friends, people in the next seat on the plane. I say, "I am writing a book about how to make healthcare better and cheaper for everyone." Everyone, every single person that I have said this to, says encouraging things. They wish me well, they want to read it when it comes out, they hope it makes a difference. I have never encountered a single person who says, "Why? Healthcare is fine the way it is." No one. Everyone feels that healthcare is broken, and feels strongly that we need to fix it.

You probably have the same feeling. That's why you picked up the book in the first place.

The second singular thing is that almost everyone believes strongly not only that healthcare needs to be fixed, but that they know how to fix it. That opinion is almost always based on blaming one party or another—the greedy doctors or health plans, heartless behemoth hospital systems or overreaching pharmaceutical companies, overcharging device manufacturers or other healthcare vendors, vulturous malpractice lawyers or red-tape-happy regulators.

Everybody across healthcare has come in for their share of criticism, and a good case can be made in almost any direction. People’s opinions usually revolve around removing the offending party from the equation, or strapping them down so tight that they can’t make mischief anymore.

You probably hold some similar opinion. And you may well be right. I am not asking you to give up your opinion. I am asking you to hold it lightly while we think this through. Because blame is not enough. It will not fix healthcare. Removing any one group from the equation, or restricting them tightly, will not fix healthcare. Fixing healthcare means fixing the system.

The reality is that we have a system that rewards people all across healthcare for doing shoddy work at high prices, for ignoring what must be done and doing only what is profitable, for sloughing off the hard, years-long work of getting it right and instead concentrating on getting paid. We pay them to do this, and people will do what they are paid to do.

Most doctors and nurses are highly trained professionals who want to do nothing more than care for their patients in the best possible way—but they are caught in a system that rewards volume over quality, doing more things instead of doing the right thing, a system that overworks and distracts them while it squanders their time and skills. The incentives driving the decision makers of hospitals and health systems, of health plans, of pharmaceutical companies, and of medical suppliers have been similarly skewed. When they can see a better way to do things, they can usually also see that they would be penalized for even trying. Employers, who pay for much of the private side of healthcare, have not yet found a way to demand of healthcare providers the same constraints of cost and quality they would demand of any other suppliers to their businesses. And over the decades, the different segments of the industry have learned to protect themselves by skewing legislation, regulations, and payment systems even more in the direction of these perverse incentives, building up their sense of their own safety and stability rather than seeking solutions that are better for the whole system and for the hundreds of millions of Americans that they serve.

This \$2.6 trillion industry is made of people—talented, good hearted, hard working, at desks, at bedsides, in laboratories, on the graveyard shift. They have spent much of their lives training and apprenticing for the work they do now. Some are in it for service, some are in it for money, but almost everyone I talk to feels the same way: trapped in their role, frustrated by knowing that the good

they could do is in spite of the system, not because of it, that they are perpetually swimming upstream. It's a tragic waste of talent and hard work and treasure to have so many good people so hobbled by circumstances that no one intended.

After 30 years of working in the heart of healthcare, I believe that now is the best and only foreseeable moment when we can fix healthcare because healthcare as a system is more destabilized now than it has been in any of our lifetimes. It is at a tipping point. We are very close to being able to free the healing process and the people who are trapped inside this two-headed monster.

But here is the key: We now have the knowledge we need to make the change, to tip healthcare in the right direction. We have the evidence. We have done the pilots. We can see what works in real systems, with real clinicians and real patients in real lives. We can demonstrate the hard-won knowledge and experience that we will need in order to change healthcare. A clear framework for action has emerged, which I will outline in later chapters. And now, finally, we may have the momentum to make it happen. This is the moment.

---

# Introduction

---

We could do healthcare better, for everyone, for half of what it costs today.

We in the United States, as a society, can provide better healthcare for all Americans for half the percentage of the economy (the gross domestic product (GDP)) that it costs today.

We can do this in more or less the system that exists today, without putting the whole healthcare system on the government payroll, or shifting Medicare and Medicaid into a private voucher system, or necessarily moving the entire system to a single-payer model, or implementing any other grand legislative scheme.

In fact, most of the changes we need are not political or legislative at all; much of the legal and regulatory support we need to make those changes is already there in the law as it exists now, or in the healthcare reform law now being implemented, or in the healthcare experiments happening in various states.

We can do this without rationing healthcare or restricting anyone's choice. In fact, the only way to make it work is by giving people more resources and options, smarter and sooner.

We know we can do this because it is already happening in places.

We know we can do this because across the landscape of health and health-care we can easily see huge areas for improvement, vast opportunities disguised as intractable problems.

We know we can do this because we can see why we got into this mess of paying too much without getting what we want. We can see the mechanisms that drive down costs, and see examples where these mechanisms are already working.

We know we can do this because we have the technical tools that we never had before to track what works and what doesn't. We have done the pilot programs, the experiments, and the analyses. We have tested many new business models.

We know we can do this because if we look in the right places, it is obvious that we have learned an enormous amount over the last two decades about how to manage and pay for healthcare to get the best result. We can ignore all that we have learned, and end up with a system that is worse, more expensive, and less effective as every year goes by. Or we can notice what actually works, and

shift our policies and business models to imitate what works. We can build a smarter healthcare.

## It's the System

To make a whole system work better, you have to change how the system works, not just the people in the system.

Let me give you an example from outside of healthcare. Imagine that you were a young traffic engineer in, say, 1949. Imagine that you dreamed of making driving safer. What would you want to change to make driving safer?

The fact is, driving is much safer now than it was in 1949. In 2009, about 30,000 Americans died as a result of traffic accidents. This was the lowest figure since 1949. A nice outcome, but think of this.

Americans drove seven times as many vehicle miles in 2009 as they did in 1949. In 1949, 7.13 Americans died for every 100 million vehicle miles; in 2009, the figure was 1.09. So for every mile you drive, you are only one-seventh as likely to be killed in traffic as your grandfather was 60 years ago.\*

Why? Are Americans more skilled behind the wheel today? Not particularly. Experts credit the mandated use of seatbelts and airbags; breathalyzers and tougher laws against driving under the influence of alcohol or drugs; graduated licensing for teenagers; antilock braking systems; crash barriers, rumble strips, median barriers, and other improvements in road and highway design; steel-belted radial tires that don't blow out; and crumple zones and better bumpers on cars. These are all system tweaks that actually work, that make it 10 times as hard for even a terrible driver to kill himself or you.

It's the system, not the individual actors within the system. We have only started on the thinnest little wedge of that kind of thinking about healthcare.

To understand how to make the system work better, we have to understand how it works now. We have to understand how we have ended up paying people vastly more than any other society and getting mediocre results. Once we understand that, it becomes easy to see why some system changes would give us much better results at much lower prices.

If we make some key system changes, just as traffic engineers managed to get seatbelts and airbags in cars and crash barriers on the highways, we can expect not just to "bend the curve" of healthcare inflation by a few percentage points, but to actually drive the cost of healthcare down in a virtuous deflationary spiral.

---

\* Eisenstein, P., "U.S. Highway Deaths Plunge to Lowest Level Since 1949," Detroit Bureau, April 1, 2011, <http://www.thedetroitbureau.com/2011/04/u-s-highway-deaths-plunge-to-lowest-level-since-1949/>.

This will take many years and hard work at key leverage points in the system, but it absolutely can be done.

Most of that work will not be political. What is needed is mostly not grand new legislative schemes. Most of that work will be the efforts of people in health-care, and people working for health plans, employers, and government agencies paying for healthcare, working together to build new business models and payment structures within the existing system—as many already are.

## Systems Economics: Who Gets Paid? For What?

The core of the argument is about healthcare as an economic system. Understanding how systems work, and how the economics of healthcare drive the choices made by all the actors in the system, takes us a long way toward being able to see how health-care got in this mess, and to find the points of leverage that will get us out of it.

Most of the focus of the vast ongoing discussion about how to reform health-care has been on who pays for it: Should the government become the “single payer” for all healthcare, extending Medicare to all? Should employers continue to provide healthcare coverage for their employees? Does using private health plans bring the advantages of competition to the marketplace? Or does it simply put the consumer at the mercy of a faceless bureaucracy bent on its own survival?

These are valid questions. But they are obscured by the fact that the other side of the equation, who gets paid and what they get paid for, actually has a much greater influence on the dynamics of the system than who does the paying. Medicare, for instance, seems to be more efficient at allocating resources, requiring less overhead than private insurance companies, and less overhead by the clinicians making claims, and it usually reimburses the clinicians less than private health plans do. But this efficiency does not drive the system to be massively less expensive. Healthcare delivered under Medicare does not cost half as much as health-care paid for by private health plans. There is no reason to imagine that extending Medicare to all would cause a massive drop in costs or increase in quality.

For that, we have to look to: Who gets paid? For what? Almost all of health-care in the United States is paid for under one model: the commoditized, insurance-supported, fee-for-service model. That is:

**Commoditized:** The system pays as if every cardiac stress test is the same as any other, every replaced hip is the same as any other, which is clearly not true. There are wide variations on prices, but the variations have no relationship whatsoever to value. When the price has nothing to do with the value of what you are offering, the irresistible incentive is to offer the least value for the price.

**Insurance supported:** The person choosing to incur costs is separated from the entity paying for it. So at the moment of decision, cost has no influence. The incentive for the provider is always to use more, and for the patient is to demand more, since there is no other marker for value.

**Fee-for-service:** What is paid for is different from what we want. What we want might be a new hip, or treatment to heal us from an infection. What is paid for is a long list of items: therapies, tests, drugs. If you pay for items, you will get more items, whether or not the items move you toward what you really want.

This is why we don't get what we want and need out of healthcare: it's not just that there are for-profit health plans and pharmaceutical companies. Everybody works for a living, but no one is getting paid to deliver us what we need. Unlike any other industry, in healthcare nobody is making a market by delivering what we need, whether for profit or not, government paid or privately paid. If we don't pay for it, we will never get it.

Wherever we undermine, route around, subvert, or supplant this business model, suddenly we find all kinds of different opportunities to pay for what we want. That's what we will explore in this book.

## The Reform Is Not the Change

It may be startling for many readers to delve into a book about reforming healthcare, and discover that there is very little in it about the federal healthcare reform law, the Patient Protection and Affordable Care Act (PPACA). This is by design. PPACA, passed in spring 2010 and still a major political hot button two years later, is a catalyst, a facilitator, and an accelerator of the change we are going through. It is not the change itself. It is not even the cause of the change, because the change is driven by much larger economic and demographic factors, especially by the sheer crushing cost of healthcare.

The PPACA reform law can help accelerate change in some ways, but it will not cause the change we seek—because it does not change the fundamental economics of healthcare. Repeal or defunding of PPACA would not make healthcare better and cheaper for the same reason: it will not change the fundamental economics. Even the more drastic government payment reform of a national single-payer system would not change the underlying economics, and would not by itself bring us better, cheaper healthcare for everyone.

How can this be? It seems counterintuitive, it seems wrong: How can the PPACA reform act be of so little importance to the real reform of healthcare, when the political sphere has been frothing at the mouth about it for 3 years

already, and show all signs of continuing for years more? Surely it is of vast importance? Yes, it is. Healthcare is an incredibly large business, made up of enormous economic forces. Healthcare businesses are among the most profitable enterprises in the history of the human species. Why would they fight for more? In confronting such a question, it is well to remember a saying I made up: any population considering whether to have a third drink consists of people who have already had two drinks. You can lay good money on it: whenever any attempt is made to change the rules, those forces will bring out the long knives and fight in the political arena for their third drink. They are very good at it. That's what the fight is about. It is about economic forces trying to preserve their ability to make money the way they are used to, so every detail of the reform law is of vast importance to them. It is not of vast importance to us.

On balance the new law brings some good things, especially coverage of many who are now uninsured, and it catalyzes more good things. But it is not of epochal, life-changing importance to us, the consumers, the patients, the citizens, because it will not bring us better, cheaper healthcare for everyone. Nothing will do that until we change the fundamental economics.

Amazingly, that is what is beginning to happen right now. That's the good news. Actually, that is the incredible news. Despite these huge economic forces arrayed against common sense and doing the right thing, there is cause for optimism. Despite 30-odd years in these trenches, I am an optimist. Here's why:

As all these factors have come together, everybody in healthcare has come to believe that their usual way of doing business is crumbling under them. Doctors, hospitals, home health agencies, insurers, employers—everyone is desperate to find a new footing. And no one has found a certain footing yet.

That's why today, right now, we are at a tipping point in healthcare. Things are already changing, at every level and in every direction. Now, in this brief period before everything gels into its new shape, we have a window of opportunity to push the system in directions that will mean seriously better and cheaper healthcare.

From whatever place you have in the system, whatever influence you have over your part of it, whether as a citizen, a clinician, an executive in a healthcare system or a health plan or a supplier to healthcare (yes, I am talking to you), the time has come to do the right thing, to stand and deliver for the thousands and millions who depend on us. You: Make a difference. Now. Push it.

## In This Book

In the first section of the book we will take a clear, unencumbered, serious look at the exact nature of the mess we are in and its underlying systemic causes.

In the second section we will go over the Healthcare Beyond Reform framework, the five major strategies that will change the dynamics of the system for everyone involved in it. In this section, I guarantee, there is something that can change the direction of your life and career, if you let it.

In the third section we will look at several other ideas that may make a huge difference in our health, our healthcare system, and its costs—an even bigger difference than everything we have talked about before. In the final section, I'll set out the clear actionable steps on the paths forward and offer materials for healthcare leaders, employers, voters, and people with bodies. We will see how the change will affect different parts of healthcare, what legislative changes are needed, and what the next healthcare might look and feel like.

We can do this. We can end the suffering.

## The Goal

**Healthcare:** The best, highest-quality healthcare available.

**For everyone:** Because we are a compassionate people. Because it is necessary for life. Because we actually can afford it. And because it turns out that the only way to bring healthcare to most Americans cost-effectively is to bring it to everyone.

**For less:** Not just for a lower rate of inflation. For less.

**For a lot less:** For half the percentage of the economy it takes today (from 17% of GDP to 8.5%).

## We Can Do This

This is possible. People are already doing pieces of it, or doing all of it for particular groups of people. It doesn't take caped crusaders or alien powers. It takes ordinary people looking at the problem a little differently and being willing to try new ways of doing things. We can do it. We must do it.