Chapter Four

Care Delivery Is a Business

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Cash flow has an incredibly powerful impact on the delivery of care. The specific ways that we channel the flow of cash to caregivers in this country dictates almost all of the care that is delivered by those caregivers. If we want to change the care that is being delivered in this country, we will need to identify the care we want to buy, and then we need to change that flow of cash so that the money we spend to buy care will buy the care we want to buy.

Before we change the flow of cash in any meaningful way, we need to collectively recognize and address three very basic realities about health care in this country.

1) Care is a Business

Reality one is that care delivery is a business. We need to think of care delivery as a business and understand care delivery to be a business. It is a huge, well connected, cash-flow rich business that consumes roughly 18 percent of our total economy.[191] The people who deliver care are all paid money to deliver care -- and the care industry functions as a business in a very functional way -- with the care that is delivered to patients based very directly on the specific business model we use today to pay for that care.

2) Care is a Politically Powerful Business

Reality two is that health care is a politically powerful business. We will need to solve our massive cost problems and achieve both our cost reduction and our care improvement goals and targets in the political and economic context that is created by the massive and well-connected care delivery infrastructure of this country. That infrastructure of care delivery business units currently consumes nearly three trillion dollars a year in revenue.[192] The infrastructure has great collective political power. As one result of that power, that entire infrastructure has almost no quality or performance oversight. It has very effectively managed to put in place

and protect the highest prices for pieces of care that are paid to caregivers anywhere in the world. That massive and extremely well-financed infrastructure of care business units has -- for obvious reasons -- great political leverage and huge and very powerful regulatory influence.

So the truth is that any solutions that we would like to use for our cost and quality problems will have to be created, designed and implemented with that political reality in mind. The answers we will be able to use to address the cost of care crisis in this country will need to be acceptable to major elements of that very powerful infrastructure. As we design solutions to our cost challenges, we need to know that the answers we use will need to provide benefit to major portions of the infrastructure of care. We need to recognize that the proposed solutions to care cannot just somehow simply deprive that very powerful infrastructure of any significant amount of its revenue. Major portions of the care infrastructure of this country will need to receive positive financial benefits from any new business model. If that does not happen, well organized and very powerful provider resistance to any new approach will be fatal to just about any proposed new approach.

3) We Get What We Pay For

Reality three is that we get what we pay for. We get exactly what we pay for. This is also an important reality to understand. We need to recognize clearly that the massive infrastructure of care delivery that exists in this country today is based on and built very specifically around the exact business model we use now to buy care. We get exactly what we pay for and we will keep getting exactly what we get today from the American infrastructure of care until we change the way we currently buy care.

In order to get a better set of products and services from the infrastructure of care, we will need to first define those better products and services. Then we will need to put in place functioning cash flow mechanisms that will actually and explicitly buy those better products and services. Cash flow will continue to very clearly and directly both

determine and define care. To change care, we will need to rechannel some aspects of the flow of cash that actually buys care. That is a very simple but incredibly powerful truth.

We Now Sell, Produce And Buy Care By The Piece -- And Pieces Rule

So -- how do we buy care now?

The key point to understand about the way we buy care now is that we almost always buy care by the piece. We have a piecework business reality in this country for care. Because we buy care by the piece, we sell care by the piece, and we produce care by the piece. Pieces rule. We have almost a purely piecework based economy for most of the care that is delivered in this country. It is a very simple cash flow model. We buy care by the piece and cash flows are based on direct payment for each piece of care.

There are some very important restrictions in place that define which pieces of care we pay for. That set of restrictions is another very important fact about the business model we use to buy care that we need to recognize and understand. Restrictions exist. We need to understand what those restrictions are and we need to know why they exist. Those clearly defined restrictions on which specific pieces of care will trigger payment for our caregivers often create their own challenges to care flexibility and their own very powerful array of barriers to care improvement and care affordability.

Those restrictions on the pieces of care that will be paid for in this country have been created by the two major sources of cash for caregivers. Those restrictions on the reimbursable pieces of care have been defined and determined by the government and they have been defined and determined by the health insurers who pay for most care in this country. That is also an extremely important point to understand. The exact pieces of care that we buy and pay for today are not defined by the patient, or by the caregiver. They are not defined by the market. They are not created by any market process or by any care engineering approaches that continuously create a set of patient-focused care services. Cash flow for the pieces of care that are delivered by caregivers

is restricted to paying only for a defined set of services and our major payers have defined those "allowable" services based on their own determination of what pieces of care they want to buy.

Care That Isn't On The Approved List Generates No Revenue

Those lists are very powerful. People do not appreciate the power of those lists to both dictate care processes and restrict how we deliver care in this country. Care that is not on those lists generally generates no revenue for any caregivers from the major payers. Care is -- as this chapter pointed out at the very beginning -- a business. Businesses inherently pay attention to revenue. Caregivers usually do nothing that doesn't generate revenue. So any care item that is not listed on the approved insurer, Medicare or Medicaid payment list generally does not happen.

That payment process is clearly defined, and it is very tightly and skillfully administered by each payer. Claims examiners for each of the payers look carefully at every bill that is submitted by each caregiver to see if the bill represents a piece of care that is on the approved list.

Each business unit in this country that sells care by the piece understands that model well. Each business unit that sells care by the piece builds its operations, structure, work flow, functionality, service capability, and products around that specific piecework cash flow. Care is defined by those lists.

The Care Infrastructure Only Delivers Care Defined By the Fee Schedule

The power of that defined and approved procedure list to sculpt care should not be underestimated.

The care delivery infrastructure very rarely performs any services or does any pieces of work for patients that are not specifically listed on and included in the standard insurance-process blessed piecework fee schedule. Having a nurse call an asthma patient to make sure that the patient has refilled their prescription is a very good thing to do. Having

asthma patients refill their prescriptions helps reduce the number of asthma attacks. That particular service is not, however, usually included on any of the approved fee lists. So those very useful and high value calls from nurses to asthma patients rarely happen in most care settings. At the other extreme -- having an emergency room treating an asthma patient who is in crisis and is actually having an actual asthma attack triggers a set of services that are very much on the approved payer fee list. So treating an asthma patient who is horribly and painfully in crisis creates a flood of approved cash that flows freely to the various care sites that see and treat that patient in the context of that crisis.

Because that crisis care is paid for, the emergency rooms are set up to handle those patients and those crises. Because we do not pay for those nurse calls, most care sites have not been set up to have nurses do that array of work. The nurses, therefore, who work in the doctors' offices where the asthma patients get their primary care seldom make those unbillable phone calls to see if the asthma patient has had their prescription filled for use in an asthma crisis.

We get exactly what we pay for.

That process of defining functional care delivery for each patient through the approval process screen of an insurance company or a government program approved fee list creates a sometimes crippling and often highly dysfunctional rigidity in care delivery. Innovation is usually crippled and entirely legitimate care process enhancements are sometimes actually criminalized by the rigor of that piecework payment model. Criminalized is a relevant word to use to describe the enforcement power of those payment rules for government payers. Billing a government payer for a nurse making a phone call to check on an asthma patient can actually be considered billing fraud by the government because that is not an authorized bill for a nurse to send to Medicare or Medicaid. The bill for the nurse's service is considered fraudulent if it is sent in. Fraud is considered a category of criminal behavior. The payer defined lists tend to be very inflexible -- both for the sets of services that can be provided and for the type of caregiver who is allowed to perform them.

The list of approved services that exists today in the fee schedules reflects a rigid model of thinking about what constitutes reimbursable care. The lists of services that we use today to approve claims payments tend to be a snapshot of specific individual care services that have traditionally been done by particular subsets of licensed caregivers in the context of our historic, completely piecework approach to producing and buying care in this country.

That payment model and cash flow rigidity clearly creates some real problems if our goal is to continuously improve care.

Optimal Asthma Care Should Be A Package -- Not An Avalanche of Pieces

Asthma care is a very useful example of how the rules set by those approved billing lists can create inferior care.

Chapter two made this same point.

If we really wanted to provide optimal care for asthma patients, we would actually structure the care around each asthma patient. We would build a plan for each asthma patient to both prevent asthma crisis for that patient and to intervene quickly when crises do occur for that patient. An overall patient-focused model that looks at the full scope of asthma care, -- done well, -- can reduce asthma crises by half or more.[193] That would be the approach that providers would create if asthma care was sold as a package of care for asthma patients. That's not the approach we use. We just buy defined pieces of asthma care. When we buy asthma care only by the piece and use the approved procedure list to define the pieces -- there is no payment for that nurse doing that care delivery preventative patient-focused intervention work. There is not only a lack of payment for those proactive prevention services -- there is actually a lack of needed tools to perform those services. Chapter one talked about our data deficits and our tool deficits. There sadly are no tools today in most care settings to link multiple caregivers for an asthma patient because there is currently no fee that will be paid to any of the caregivers for using those tools or doing that linkage work when payment is determined by today's standard fee schedules. We waste a lot of money

on asthma patients and we get bad and unnecessary asthma care in the process because of that clearly inferior and entirely reactive way of dealing with asthma care that is dictated by that fee schedule.

The current piecework payment model we use to buy asthma care does create a lot of money for caregivers, however. It is not without irony that the piecework approach we use to pay for care actually generates huge revenue for caregivers when an actual, full blown asthma crisis happens for a patient. Hospitals, emergency rooms, and doctors' offices can each bill for a lot of pieces of care when asthma attacks happen. By contrast, those very same piecework reimbursed caregivers can completely lose their revenue when their well-done prevention efforts work well for a patient and when those horrendous asthma attacks do not happen for that patient. As this chapter clearly pointed out at the beginning, health care is a business, and we get what we pay for. So what do we get? We pay for crisis.

We get a lot of crises. We have twice as many asthma attacks as we would have and should have in this country if we were delivering optimal care and buying asthma care by the package and not by the piece.[194]

This isn't simple speculation or academic theory. There currently are a few prepaid health plans and care teams in some settings who now basically do sell care by the package instead of just selling care by the piece. Those plans that are paid for a full package of asthma care tend to look carefully at the whole patient relative to asthma care because they know that they reduce their expenses when they reduce asthma attacks. The care sites that sell a complete package of care can benefit financially when asthma attacks do not happen. By contrast, there is no reward or financial advantage given to any fee-based care site of any kind who might be equally successful in preventing an asthma attack.

We Have Twice as Many Asthma Crises As We Need to Have

The result of that perversely designed payment approach is that we have twice as many asthma crises as we need to have in this country and we spend a lot of money unnecessarily on overall asthma care.

One very inflexible piece of that typical payment rule set is that doctors must directly deliver all pieces of care in order for care to be paid for. The fee schedules usually mandate that only doctors can do the billable units of care.

The infrastructure that we have set up to provide the care pieces for asthma care are therefore usually organized so that each allowable and billable piece of care will be delivered by a physician rather than done by any other member of their care team. So we have physicians doing services that really do not need to be done by a fully trained physician. That exclusive mandate that physicians must deliver many services happens in this country today because the approved fee schedule that defines allowable care for a piece of care is usually only activated for payment if an actual physician provides those pieces of care to a patient. Having a nurse do some key points of that work may make great logistical, practical, operational, functional, programmatic, and medical sense -- but that level of nursing care usually doesn't happen in most care settings because the standard third-party payer fee schedule doesn't pay nurses when they do that work.

Asthma care is, of course, absolutely not alone in having the business model we use to buy care cause the current infrastructure of care delivery to perform in sometimes perverse and frequently suboptimal ways. This chapter describes asthma care as an easy illustration of the perversity and dysfunctional aspects care delivery that result from the way we buy care, but those same dysfunctionality issues extend across almost the entire spectrum of piecework-reimbursed care in this country.

The Cash Flow For Care Rewards Crisis And Bad Outcomes

The truth is, as chapter two pointed out, the current business model we use to buy care very directly rewards both medical crises and bad care outcomes for just about all medical conditions. The pattern is pretty clear. As noted earlier in this book, the current way we buy care richly rewards heart attacks and it very much underfunds heart attack prevention. The current way we buy care pays way too much money for

hospital infections and it does little or nothing to reward or even fund hospitals for preventing or minimizing those infections. The very best care sites have less than one percent of their patients who get pressure ulcers.[195] Average hospitals have five to ten percent of their patients with those ulcers.[196] How does our payment model deal with those very different consequences of care? The current fee schedule we use to buy care doesn't pay a dime to have all of the highly skilled patient- focused and extremely competent nurses in the best hospitals checking all of the high-risk patients in those hospitals hourly for those infections. Those hospitals get no fee schedule "credit," and they get no cash for the amazing amounts of work that are done in those hospitals by those nurses on behalf of those patients. But the fee schedule we use to buy care actually will easily pay each of those hospitals -- on average -- more than $40,000 per patient when those nasty and dangerous ulcers do happen. That is a lot of money paid for failure and no money paid to achieve success.

Buying Care By The Piece Discourages Care Reengineering

Those perverse payment approaches are actually not the absolute worst consequence of buying care entirely by the piece. An even more negative consequence for both care quality and care affordability is that the current piecework model of buying care also discourages and even penalizes many aspects of basic care process reengineering. That particular point was also made a couple of times earlier in this book. It is important to be understood. That piecework approach we use to buy care keeps continuous improvement approaches from becoming a major aspect of the way we deliver care in far too many care settings. The impact of cash flow considerations literally financially crippling and penalizing any significant reengineering efforts most of the time is a major flaw of that piecework payment approach.

Buying care by the piece usually financially penalizes clearer, simpler, and better processes that are designed by care sites. It financially penalizing the care sites if any of the process redesign work that is done by the care site eliminates a billable piece of the original care

process. Far too often, implementing very reengineered beneficial changes in care approaches will directly and immediately reduce the revenue flow for the care site that does the reengineering. The amazingly effective work process redesign work that was used to get pressure ulcers for hospitalized patients in the best hospitals to less than one percent of patients is not currently reimbursed by any fee schedule. The sad reality is that when fee-based hospitals actually do that wonderful prevention work, they lose an average of $40,000 in piecework revenue per patient when that work succeeds and the patients are not damaged.

That is obviously a very dysfunctional and perverse way to buy care. The financial consequences of reengineering key pieces of care are often fiscally dire for the hospital who reengineers. The medical consequences of not reengineering that care are, of course, dire for the patient. Cash flow wins. Very few hospitals do the work needed to achieve those highly improved levels of care.

There Are Many Opportunities For Care Process Redesign

There are actually a great many opportunities that result for care process redesign in the delivery of care in this country. Many of those opportunities are strongly obvious to just about everyone who delivers care. There is a lot of "low-hanging fruit" available and waiting for some basic care process redesign -- but that process redesign very rarely happens in real care settings because the piecework model of payment reduces cash flow to any fee-paid care sites that actually redesign and improve processes.

Remember the points that were made at the beginning of this chapter. Care delivery is a business. We get exactly what we pay for -- and we don't get what we don't pay for.

The perverse economic equation that exists can be hard for patients, the news media, and policy makers to believe, but every care site in this country that is paid by the piece knows it to be true.

That crippling of process redesign innovation work may be the single most damaging impact for this country that results from buying care by the piece. That piecework payment model literally cripples both

process improvement and reengineering processes for many important areas of care.

Process Reengineering That Improves Care Can Cut Revenue

People often ask why health care hasn't taken advantage of the process reengineering approaches that have transformed so many other industries. The answer to that question is actually pretty easy and very basic.

Process reengineering rarely happens in health care delivery settings in this country today simply because any care process engineering improvement approaches that actually streamline the processes of care tend to also reduce the number of currently billable care steps that now generate real cash for the care business unit that does that redesign. Reengineered processes and innovative new care approaches that deliberately eliminate redundant, unnecessary and duplicative tests for a hospital admission, for example, almost never happen in the real world of care delivery. Those obvious and easy to do reengineering steps to eliminate unnecessary pieces of care do not happen in the real world of health care very often because each of those care improvement changes will clearly cut off at least some of the existing revenue stream and reduce the current cash flow that has been created for that particular piece of the business infrastructure of care by running those unnecessary, duplicative -- but very billable and highly profitable -- tests.

No Industry Ever Reengineers Again Its Own Self Interest

We obviously need to improve those aspects of the business model of care if we want to get rid of even obviously unnecessary tests and procedures.

As this book points out in several places, no industry ever reengineers against its own self-interest. Wal-Mart has done some spectacular and brilliant work relative to the processes involved in distributing their products. They have done brilliant interactive work with

their vendors. Their just-in-time inventory control is legendary.[197] The truth is -- if the consequences to Wal-Mart of doing that wonderful just-in-time inventory reengineering would have been for Wal-Mart to lose twenty percent of their customers and to lose thirty percent of their net revenue for those specific products, then the likelihood of Wal-Mart going down that particular reengineering path would have obviously been significantly diminished. If the old way of getting supplies on the shelf in the Wal-Mart stores would have generated thirty percent higher profits, the old way would probably have prevailed. Wal-Mart brilliantly reengineered key processes. Why? Wal-Mart benefited directly from the redesigned process. Wal-Mart made more money as a result of that new process -- not less money. Any redesign work in any industry that impairs profits instead of improves profits is a lot less likely to happen in any business setting. That is true in any industry and it is very much true in health care.

That's another reason why we need to change the business model we use to buy care. We need to put a business model in place that rewards reengineering and rewards patient focused process improvement work. The current way we buy care badly flawed when it comes to incenting reengineering.

We also need a business model that rewards price competition. Every other industry tends to have some level of price competition. Health care has almost none.

Price Competition Is Not Rewarded By Market Forces In Care

The business model we use to buy care today clearly does not reward caregivers for making care more affordable. That is another question people often ask. Why don't caregivers figure out how to reduce prices? The odd but very real truth is that caregivers do not benefit in most settings as businesses by being able to reduce prices. That is sad but it is sadly very true. That economic reality usually isn't true in other industries. In other industries, price cuts can often improve profits because lower prices can very often increase the sales volume for whoever cuts their prices. Basic price cuts often don't damage businesses

in other industries because sales generally go up when prices go down for most products in most industries.

That specific cycle of achieving financial rewards as a business based on reducing costs and prices does not happen very often in health care. The price chapter of this book made that point clearly. Price competition is almost non-existent for caregiver business units in this country. In the business model we use today to buy care, cutting the prices for any piece of care usually just reduces the caregiver's total income without increasing the caregiver's volume or without improving the bottom-line of caregiver organizations.

Health care providers are all very intelligent people. Anyone smart enough to get into medical school or into a health care administration program is more than smart enough to understand that basic financial reality. Doing things that damage their own business interests isn't something that intelligent people who run businesses usually do.

We Will See A Golden Age of Care Process Redesign When Care Is Purchased By The Package

That means we need to change the way we buy care to make reengineering of key processes to reduce prices an approach that directly and clearly benefits caregiver business units rather than an approach that directly penalizes and economically damages caregiver business units. This is another very basic point to understand. We clearly need to make reengineering to create lower prices something that benefits care sites -- not damages them financially. When that happens, reengineering in health care will flourish.

Many Caregivers Are Ready For A New Market Model

When the business model changes, we will see an explosion of creativity -- a golden age of care process redesign.

Caregivers are -- in many settings -- ready for that change to happen. There are brilliant caregivers who will improve processes in

amazing ways once those process improvements create a financial reward for the care sites instead of creating a financial penalty.

So how can we create those rewards? A key next step will be to buy more care in packages in a way that changes the cash flow for caregivers and moves the flow of cash away from a total dependence on selling care entirely by the piece. The piecework approach to buying care incents volumes of inappropriate care and it clearly limits our ability to strategically and functionally reengineer care. We need a business model that allows us to buy packages of care -- not just pieces of care -- so we can liberate the care redesign thinking in health care and see care become more efficient, more effective, and more affordable.

Providers Can Do Wonderful Reengineering When Care Is Sold As A Package

Providers of care can and will do really smart things -- both alone and collectively -- when care is purchased in packages.

Buying packages of care empowers and enables caregivers to reengineer both the pieces and the processes of care in very positive ways that can meet both the business needs of the caregivers as well as the cost needs of the people paying for care.

There is ample evidence showing that to be true. Many people who do health care policy work know some of those examples. But a couple of those examples need to be described more heavily in this chapter of this book. The examples that are described below show significant successes for both care delivery costs and care quality that have actually resulted from buying packages of care -- instead of pieces of care -- in real world American health care settings. The first two examples listed below are two specific procedures -- eye surgery and heart transplant surgery. In both cases, care was reengineered and transformed when the business model moved away from buying that care by the piece to buying it as a package. The third example of positive care engineering described below came from a care site that actually guaranteed the success of their key surgeries and agreed not to charge for any needed “redos.” The care site that guaranteed their surgical results reengineered both their processes

and their services and their patients ended up with better care at less cost.

Perhaps the most powerful example described below shows the great care that can result from buying all care as a total package from a team of caregivers for an entire population of patients for a fixed monthly price. That particular example is one that the author is very familiar with, because it is an example from his own workplace. All four of those very real business model examples make the case that care can be reengineered in very effective ways when the cash flow model that is used to buy that care changes.

In each of those settings, real world caregivers in this country have used the cash available from a package payment to reengineer real care. Each example is worth understanding at a level that is less superficial than just describing the impact at a vague and macro level.

Eye Surgery Sold As A Package Worked Well

Let's start with eyes.

One very good example of real world experience and care delivery changes that can happen when we buy care by the package has been Lasik Eye Surgery. People who look at selling packages of care often use Lasik eye surgery as a really good example of what can happen when you start buying and selling care by the package instead of by the piece.

The basic elements that resulted from that change in the business model for that particular surgery are also pretty clear and worth understanding.

Lasik eye surgery improves people's vision. It is a very useful surgery.

When Lasik eye surgery was first introduced to the market, the total surgery cost over $3,000 per eye[198] and that fee didn't always involve all of the ancillary charges that are generally incurred for all of the related care sites and connected procedures. Three thousand dollars is a significant amount of money to spend for a procedure that basically functionally replaces eye-glasses.

That procedure and that price is relevant to this chapter of this book because the market model we used in this country to buy care for that surgery didn't simply follow our usual purchasing approach for basic surgeries. Instead of selling all of the individual service that related to that eye surgery as a pile of billable pieces, the economic model that is now used to pay for that surgery now includes all aspects of that surgery as a package of services -- with one price for the surgery and the entire set of related services.

Why did this country use a different business model to pay for those particular surgeries?

Insurance companies made a very important decision about that eye surgery very soon after it was made available.

They did not make it an insured benefit.

Insurance companies and health plans decided not to cover and pay for that specific procedure when it was invented. The insurers called that eye surgery "cosmetic" rather than therapeutic. Cosmetic procedures are usually not covered by insurance. Those particular surgical procedures for eyes did not, therefore, go on the approved payment list for insurance coverage. You may disagree with that definition and with that decision by the insurance companies relative to the approved benefit status for that particular eye surgery -- but the consequence of that payment exclusion decision by the health insurers was fascinating. The impact of that payment decision on provider behaviors and provider practices relative to that surgery is definitely worth understanding and discussing.

If the Services Had Been Insured, The Initial High Price Would Have Been Permanent

If the insurers had decided to simply include that new eye surgery procedure as another covered benefit in everyone's insurance plan, then the care improvement story and the affordability issues for that particularly surgery would both have been ended by that decision by insurers to simply pay for the procedure. If the insurers had routinely added that eye surgery benefit to their list of approved services as a

standard covered procedure, then insurance companies would have simply paid that initial designated price for each surgery. The future prices that would have been charged for that particular eye surgery would have stayed at the initial $3,000 per surgery price total cost level. That's how pricing usually works for pieces of insured care in this country.

Some insurers would inevitably have negotiated some volume discounts with various eye surgeons who did that service, but those price discounts would probably not have steered very many patients in any particular direction to any care site because -- as we know -- insured patients usually only pay the flat deductible amount for any service. That flat amount of deductible expense would have made any insurance plan negotiated discounts and price differences for that procedure invisible to the patient and therefore irrelevant for any actual patient decision making about that surgery.

That's how we buy most care in America. That point was discussed earlier in the chapter on prices. Our most current widely used insurance benefit plan design -- the deductible -- tends to hide both prices and price differences from consumers once the deductible is met. Deductibles tend to make prices invisible and irrelevant for every piece of care that costs more than the deductible. That would also have been true for that particular eye surgery if the surgery had been insured and then paid for by the deductible benefit package insurance plans.

Insured Premiums Are Based On The Average Cost Of Care

Insurance premiums are always based on the average cost of care for each population of people who are insured. So if the Lasik eye surgery had been a covered benefit, then each health insurer for each patient who had that surgery would have paid those full fees to each eye care surgery site on behalf of each patient. Those additional payments that were made by insurers to buy that new surgery would then have caused insurance premiums to go up. Each payment made by each insurer for each patient for that new benefit would have simply and directly increased the average cost of care for their entire set of insured people. That higher total care expense would have triggered higher premium levels -- and the insurers

would have used that premium money collected from all of their customers to pay for the Lasik surgery for the customers who choose to have the surgery done.

We Use Other People's Money To Pay For Our Care

That is actually a very important fourth financial reality we all should understand about the delivery and financing of care in this country.

In this country, we almost always use other people's money to pay for our care. If we are in a government program, we use taxpayer money to buy our care. If we have a private insurance plan, we use the actual money that comes from all of the other people who also pay premiums each month to our insurance plan to pay for our care.

Getting access to other people's money is the primary purpose and the function of insurance premiums. The next chapter of this book discusses that business model in more detail.

In the case of the eye surgery -- if the health insurance companies had simply decided immediately to make the Lasik surgery a covered benefit -- then the consumers who choose to have the surgery done would each have paid only the deductible amount, and the rest of the fee schedule for each surgery would have been paid by each insurer -- using other people's money collected in premium as the source of that cash.

Insurance Premiums Is A Good Way To Collect Other People's Money To Pay For Our Care

New benefits always have that impact on insurance premium. New benefits always increase the average cost of care. So new benefits always increase premium. The math is pretty simple and pretty direct.

In this case, however, that particular fundamental cycle of premium calculation mathematics -- with new benefits creating premium increases -- is entirely irrelevant. You don't need to raise the premiums if the insurers don't need money to pay for the care.

That decision by the insurers not to insure that service changed the business model for both caregivers and patients for that piece of care. Consumers who wanted that service now were forced to use their own money to buy that care instead of just paying a flat deductible and then using other people's money to pay for the care. That new financial reality and that new cash flow very directly changed the functional and economic model of care for those eye-surgery caregivers.

Direct Payment By Consumers Created A Different Business Model

Fees for that surgery were suddenly highly relevant to both the patients and the caregivers. Fees were actually highly visible to each customer instead of being quietly buried behind the obscuring financial fog of an insured deductible benefit plan.

So what happened next? Adam Smith would have recognized and probably saluted the process.

The market worked. Market forces became relevant for that surgery. Those market forces changed both the way that surgery was done and the way that surgery was priced.

Market Forces Became Relevant

What market forces were activated?

Price competition happened very quickly. That makes sense. When people had to pay for that surgery out of their own pocket, prices for that surgery become extremely relevant. Price competition very quickly developed and that competition structured the marketplace for that particular surgery. When the actual prices for the surgery became highly relevant to customers, care sites started competing for customers by both lowering prices for the surgery and by aggressively advertising their lower prices. Patients made their choices of caregivers and patients also made their personal care delivery purchase decisions based to a large degree on the highly visible price levels that were set by each competing care site. Competition worked. Sales volume followed prices. Lower prices created significant sales increases for the lower priced care sites. Prices

for the surgery dropped from that initial $3,000. The prices actually dropped incrementally for several years. Some surgery sites dropped their prices below $1,000, and a few sites ultimately sold the procedure for roughly $300 per eye.[199] A thriving market developed for that surgery. It is very important to note that doing the surgery was actually profitable the entire time for the care sites that were competing for that business even though their prices for doing that surgery had dropped significantly.

Reengineering Became A Relevant Skill Set

How did those care sites manage to make money and be profitable doing a highly skilled surgical procedure at those very low prices?

The answer is simple. Every other industry knows both the answer and the approach that was used by those surgeons. They reengineered. They very directly improved processes. Reengineering was suddenly relevant to the care teams who did the surgery.

The business units who did that surgery very skillfully reengineered care. When prices became relevant and when providers were rewarded financially for dropping prices, the care teams changed the operational processes that were needed to support the surgery in order to bring down the actual functional operating costs for doing the procedure.

Those eye surgery care sites created new work flow for their care teams. They did very smart things about functionality. Efficiency became relevant, so efficiency happened. They reengineered their surgical lasers to allow the machines to move easily from patient to patient. They changed the recovery space and they changed the recovery staffing and they changed the recovery process. They even changed the record keeping for the surgery. They changed the anesthetic to a simpler process. The eye surgery units and care teams took a hard and clear look at each piece of the care process for that surgery. Care actually got a lot better. They computerized and improved the pre-surgery exam process. They actually improved the outcomes for that surgery in the process and they reengineered almost all of the steps involved in doing the surgery. They did that work and they did it well because the provider business

units that were selling the surgery for a package price wanted to reduce the operating costs to each provider site that were being incurred for each patient by doing that surgery.

Health Care Is Not Immune To Reengineering

Reengineering works. It can be done. Health care is obviously not immune to reengineering. Providers of care just need to have a business reason to do that work. If the insurance companies had decided at the very beginning when the surgery was invented to simply cover that eye surgery -- and if the insurers had decided to simply charge each insured patient who received the surgery only their standard flat insurance benefit deductible -- there would have been absolutely no value to any provider to ever reengineer any part of that specific care process because there would have been no financial reason to do that reengineering work. That surgery had been profitable at the original price of $3,000. There would have been no reason for any surgery site to drop that price if the service had been insured and if the insurers were all paying that $3,000 price, no questions asked.

This point was made earlier.

No industry ever reengineers against its own self-interest. But when there is a business reason both to engineer and to reengineer, then very smart things can be done in health care to achieve really important process improvement goals and to bring down the cost of care.

Heart Transplant Surgery Followed A Similar Path

Eye surgery isn't the only example of the business model of care changing for some aspect of care and then having care delivery reengineer itself to respond to the new business reality. As noted in the chapter on prices, when Medicare stopped buying hospital care by the piece and instead decided to use a new Diagnosis Related Group (DRG) payment approach that used a partial package payment for most Medicare-funded hospital care, hospitals in this country reengineered care immediately and well. That reengineering was done so well as a

result of that change in the payment model that we Americans now have the shortest hospital stays in the industrialized world. Remember chart 3.13. The basic business model that was used by Medicare to buy hospital care changed. The care delivery infrastructure for hospital care followed that change in the cash flow so well that we are now the world leader in low levels of hospital care -- with the lowest number of hospital days used per patient and the shortest lengths of stay in the industrialized world.[200]

Heart Transplant Surgery Followed A Similar Path

Heart transplant surgery followed a path that was similar in several ways to the path that was followed for the Lasik surgery. The business model that was used to buy that care also changed for heart transplants a number of years ago.

How and why did the business model change for heart transplants? The approach that was used to change the business model to buy that particular transplant was elegantly simple. Major buyers who paid a lot of money for heart transplant simply put heart transplants out to bid and those payers asked the caregivers for a packaged price.

When several major players in this country started to use that very different business model to buy heart transplants a couple of decades ago, the care sites that did those complex heart surgeries went through a change in their care delivery approach. Those changes very much resembled the work that was done for the eye surgery. The transplant centers applied processes and skills sets that paralleled the steps used in the eye surgery reengineering successes. Focused reengineering that was done by several of our very best great care teams made heart transplants both less expensive and more successful in a relatively short time. Reengineering worked again. The new package price business model that was used for buying that care trigged a whole array of care delivery process enhancements. Reengineering happened for those transplants. Reengineering happened because the providers who sold the transplants at a package price benefited from doing that reengineering work rather than being penalized for doing that work.

The patterns of thinking and reengineering that happened for heart transplants strongly resembled the reengineering approaches that happened for the Lasik eye surgery. As with the eye surgery redesign, the new heart transplant process made those surgeries both better and a lot less expensive.

Initial heart transplants were highly expensive. Quality of care for the transplants was inconsistent and prices were very high and going up. Spending more than a quarter of a million dollars to do a single heart transplant was not rare roughly twenty years ago.[201] Costs of those surgeries were very high at that time and both the costs and the volumes of the surgery were increasing steadily. Heart transplants -- like the eye surgeries -- can be wonders of medical science. Patients benefit significantly from both procedures. So an increasing number of heart transplants were being done -- and all of the health insurers and the government programs who covered that procedure were simply paying the constantly increasing bundles of fees that were being charged by each care site to do those complex and expensive procedures.

As was noted earlier, we always use other people's money in this country to pay for our care -- so health insurance premiums were being increased for all insured people to give the insurers enough money to pay for those transplants.

All insured patients were paying through their increased premiums for the growing costs of doing those lovely, life-enhancing transplants for the people who clearly needed them.

At that point -- as was noted earlier -- a few key buyers decided to simply put those surgeries out to bid. Those high volume buyers asked the very best care sites to give them a package price for that procedure.

That request, of course, changed the market model for those transplants. The insurers didn't just ask for a percentage discount of some kind from the typical avalanche of transplant related fees. They asked for a single flat fee to do the entire procedure. The insurers who went down that path very wisely made the decision to only use the very best care sites with the best care outcomes and the best success levels to do the transplants and then they asked those best care sites to give them a package price for the whole procedure.

Packaged Prices Created The Opportunity To Reengineer

The buyers didn't simply try to negotiate steeper discounts. They also did not go to low quality vendors in order to get a low price. They very deliberately used the best care sites. The insurers knew that there were a number of great care sites around the country that did very good heart transplants. They believed that the best sites for that transplant were likely to get continuously better. Winners win. That's not always true, but it is generally a good way to bet. The insurers also knew that heart transplants were a medical procedure where the practical logistics of care for the procedure allowed a patient to travel safely to a care site -- so the care site for a heart transplant did not need to be in the same city or country as the patient's home. The willingness of patients to travel to get great transplant care was clearly enhanced by the fact that the care sites chosen by the insurers were care sites with great brands and wonderful reputations.

The insurers used several of the right "R" words in the process. The health insurers did not ration transplants. They repriced transplants. They also rewarded the reengineering of transplants. They repackaged transplants. Repricing, reengineering, repackaging and then rewarding caregivers are all good R's words to use.

The Surgery Care Teams Looked At Prices Improvement Opportunities

Some of the transplant centers were initially not happy with that change in the market model for heart transplants. But then the care teams and the leadership teams at the various transplant centers looked at the proposed package cash flow approach and at the reality of a package price, and they realized how liberating that cash flow approach can be relative to empowering care reengineering and directly rewarding creating process improvements for care. It was clearly very empowering for the care sites to be paid a package price for each heart instead of having to sell their transplant care services patient by patient and piece

by piece. The great heart care centers each took a careful look at their heart transplant process and then they simply reengineered multiple steps in the process to make the process both better and more affordable.

They often started by eliminating unnecessary duplication in the tests that were ordered for each patient.

They Reduced Test Duplications

Those unneeded and duplicative tests all used to be direct revenue for the care sites when they were paid entirely by the piece. When the new revenue stream became a single package-based fee, those unneeded tests stopped creating revenue and they simply became excess expense generators. Those tests were useless for care purposes so they become irrelevant to the revenue stream. So the people designing the flow of care inside those packaged price care teams usually very quickly reduced the number of duplicated and unneeded tests. They also changed some sites of care. Some transplant centers began to have some of their heart patients who were not at immediate medical risk sleep in hotel rooms next to the hospital for some days prior to surgery rather than having those same patients sleeping for those pre-surgery nights in very expensive -- and relatively uncomfortable -- hospital beds. Having a pre-surgery patient sleeping comfortably for a night or two in a very nice $200 to $300 per night hotel room rather than sleeping uncomfortably in a $3,000- $4,000 per night hospital bed makes a lot of sense when you are selling care by the package and not selling care by the piece.

When you are paid by the piece in a piecework cash flow model, however, having your pre-transplant patient stay in your $4,000 a night hospital bed to simply rest for a couple of days is very profitable for the care site. In a package price model, that use of an expensive hospital bed to be a pure resting site created an expense for each transplant patient that was clearly not a medical necessity. The actual medical needs of the patient were met as well or better by resting in a nearby hotel.

They Also Improved Recovery Time And Sites

The transplant centers also worked out better and faster post-surgery recovery agendas and sites. They did some serious process improvement work and the surgery centers created actual significant internal operating efficiencies around each piece of care.

That change in the business model for that element of care worked. The change was good for the patient and it was good for the caregivers. Outcomes were better. Processes were standardized. Survival rates went up. And the whole pile of pieces and procedures that had been billed under the old piecework payment model to add up to total fees in excess of $200,000 per heart were soon being done at some of the best hospitals in the world for roughly $100,000 to $150,000 per heart.[202] Two decades later, basic transplant prices are still below where they were when the business model for heart transplants changed. Costs are down, prices are down, and the success rates from that surgery are much higher. Care got better and costs went down when the cash flow and operational thinking was centered on a package of care and not on pieces of care.

Guaranteeing Successful Results Also Triggered Reengineering

Care teams can and will do very smart things when the business model rewards doing smart things.

As noted earlier, one famous East Coast care site changed its business model a couple of years ago to guarantee the results from several of their key surgeries.[203] Making those very clear guarantees of surgical success was a very different business model for that surgical care. That care site basically said to patients -- if this surgery fails, we will do the surgery again and we will fix it for nothing. There will be no charge for the redo.

That care site started as one of the best surgery sites in the U.S. They already had fewer surgical redos than other care sites in the area. When they guaranteed results, and changed their surgery business model to not charge patient or insurers for redos, they got even better. As a

business unit of care delivery that was now making actual guarantees of surgical success, they knew that a failed surgery would no longer simply result in them making twice as much money for that patient because they would simply be doing the surgery again and charging the patient double for the redo. That care team never ever did anything at any time in the old business model to cause any surgical redo to happen -- but that care team also was not as focused on making sure that the redos did not ever happen before they put their guarantees in place.

The People Who Guaranteed Success Studied Each Failed Surgery Very Closely

Again -- just like the heart transplant sites and the Lasik eye surgery sites -- the care sites that were involved in making that surgery outcome guarantee did careful process design and redesign work. Data became a key tool. They expanded their use of care related data. They studied each failed surgery --going back for multiple prior years to look at old failures. They carefully studied each current failure. They looked very closely and candidly to see what had caused each failure to happen. And then they made a few very well designed process reengineering changes to reduce the likelihood of those specific problems reoccurring for their patients.

What was the result of that work? It was exactly what you would expect.

Process Improved -- Care Got Even Better

Processes improved. Data gathering became increasingly sophisticated and effective. Surgeries got better. The numbers of surgical redos were very low for that particular surgical center to begin with and they went down even further. That care team started with really good care and the quality of care in those centers went up when the business model changed. The total cost of care went down because outcomes were better and redos dropped significantly. The operating costs of the care sites were also reduced when the processes were reengineered and improved.

So how was that particular decision to guarantee success for surgeries rewarded by our current business model for care? Not very well. That surgery unit initially lost some volume – because they had fewer redos -- and they, therefore, lost some revenue because their good care got even better. In this particular case, however, there was some offsetting volume-based market rewards for that care site because more people in the geographic area wanted to get their care from the surgery sites that guaranteed results.

At a macro level, that care site benefited economically from better care because their public aura and their credibility as a high quality care team that guaranteed results was good for their overall volume of patients and good for their brand. For obvious reasons, it was great for their local and their national reputation to be the care team that actually guaranteed their surgical results. That care organization made a gutsy call as a business to guarantee those surgical results, but the overall impact of making that guarantee turned out very well at several levels.

The caregivers on that care team took great pride in continuously improving their care. When care sites anywhere develop cultures of excellence and build cultures of continuous improvement, those cultures result in better care. Those cultures also tend to be good for the morale of the caregivers and those cultures of continuous improvement tend to be self-reinforcing at very useful and important levels.

The key point for us to learn about that surgery-results guarantee example is this -- care design and redesign can be done in almost any care setting -- and the results of the redesign can be excellent. Redesign work can actually be done in a very functional context for many key areas of care. Real opportunities to improve care processes do exist and those opportunities will only be very real and relevant in American care sites when the business model for our care sites makes those opportunities relevant and real.

Selling A Package Of Care Reduced Broken Bones By A Third

In each of the examples listed above -- selling eye surgery and heart surgery by the package, selling hospital care through DRG payment

model, and selling packages of surgery with a guarantee of success -- the business model for the caregivers involved changed and the caregivers responded by coming up with care process redesign efforts that created financial successes under the new model. Cash flow changed for care for those purchases. As a result, care changed to respond to the cash flow.

Buying All Care For A Package Price is Even More Liberating

We need to expand that purchasing model to make it more comprehensive to give caregivers even more flexibility in figuring out the right processes of care.

A number of health care policy experts are now recommending that we move as a country away from buying care by the piece and that we should begin buying care more by the package. The next chapter of this book deals with variations on that approach -- looking at how caregivers can create better team using new tools like patient centered medical home care settings and can create better coordinated care though the new Accountable Care Organizations -- or ACOs. The ACO proponents are advocating that physician and hospitals should come together to accept accountability for the total care of patients in settings where the cash flow can be blended in ways that create flexibility among the caregivers relative to use of the money. One major goal of the new ACO agenda is to have caregivers collectively accountable for the care of a population of people rather than just dealing with care for people one incident at a time. As the next chapter explains, that new ACO model isn't entirely defined or refined yet, but it obviously has a lot to offer in many respects. There is a very good reason to believe that the concept of accountable and the commitment to organized care is a good path for us to be on as a country. We know from real experience that the Accountable and Organized model can work.

There are some Accountable Care Organizations in existence and that have been in place for a relatively long time. Some care sites and some care teams actually sell all of the care needed by a population of patients for a fixed price as a total package today. There are existing

multispecialty care teams now who are paid a single monthly payment for all care and who actually have no fee-for-service billing now for major pieces of that care. That is a very different payment model than buying care entirely by the piece. The care priorities and the care delivery approaches that result from that flat payment approach for a package of care can be very different then the priorities that are a fact of life for a fee based piecework payment business unit.

Kaiser Permanente is one of those prepaid care teams that sells care by the package and not by the piece. With three dozen hospitals, 550 medical care sites, 180,000 caregivers, and 9 million members, Kaiser Permanente is paid a flat fee every month for each of the 9 million members, and uses that money to provide the care needed by the 9 million people.[204]

Less than 5 percent of the Kaiser Permanente revenue comes from fees. Internally, there is no mechanism to transfer money in any way based on fees. Like the care systems in Sweden and Norway, the care delivery is based on the needs of the patients and not on the need to code a bill for a service that will generate piecework cash payment for each piece of care.

Being freed from the tyranny and structure of a piecework cash model allows the care teams to focus on the patients.

One example of how care can be different on that approach relates to broken bones.

The Kaiser Permanente care team looked at broken bones very differently than the way that the standard piecework, payment-focused care sites looked at broken bones. Most piecework-paid care sites actually make a lot of money when bones break. By contrast, the Kaiser Permanente care team incurred only additional cost and generated absolutely no revenue when bones broke for their patients. Broken bones are an expense to that care team -- not a revenue source, so it made sense for those caregivers to figure out how to reduce the number of broken bones.

The care team worked systematically to prevent bones from breaking rather than just waiting for bones to break and then providing crisis care to those damaged patients. The number of broken bones for

the more senior patients in that care system was actually reduced by an amazing degree. The care teams reengineered their care with a particular focus on high-risk seniors. The care teams introduced individual care plans for their senior patients and they targeted effective preventative services for their patients who were at high risk of breaking bones. Prevention worked. The care team in that system actually reduced the number of broken bones for their senior patients by more than a third.[205]

The basic economic reality is that Kaiser Permanente does not make money when bones break. Kaiser Permanente also does not make revenue when strokes happen or when patients have heart attacks or when asthma crises happen. Kaiser Permanente also doesn't make money when patients have pressure ulcers or any other kinds of hospital infections. As this book has pointed out several times, other hospitals generally have 5 percent to 10 percent of their patients with pressure ulcers.

Kaiser Permanente has less than 1 percent, overall, of patients with those ulcers. And some hospitals have not had a single ulcer in over a year.[206]

KP revenue is not based on chasing down and billing separate fees for each piece of care as their foundational source of cash. Fees actually don't exist for internal cost factors inside of the Kaiser Permanente care infrastructure.

As the introduction to this book noted, the author of this book worked for Kaiser Permanente for 12 years. The author knows the business model of Kaiser Permanente very directly and fairly well. It is a very effective business model. Because Kaiser Permanente is prepaid and doesn't have to base its business model on protecting units of piecework cash flow, Kaiser Permanente actually has significant flexibility in figuring out the best ways of delivering care.

There are some benefit plans sold to members that require Kaiser Permanente patients to pay some fees, but the total cash flow from all of those fees is less than 5 percent of the total revenue of Kaiser Permanente.[207]

This book has stated several times that care design can be much more flexible when it is liberated from a piecework cash flow. That

statement about liberation from the fee schedule isn't based on guesses, theory, conception, or speculation. The author knows from direct experience that the prepaid cash flow approach can be very empowering and highly enabling relative to designing care delivery approaches and processes. Being prepaid -- and not having to collect piecework fees to generate basic revenue -- changes the economic incentive and business model entirely relative to both designing and delivering care.

Functional Preventive Interventions Are Needed

As noted above, selling care by the package gives the Kaiser Permanente care organization a strong and direct financial incentive not to incur the cost of repairing broken bones. Functional prevention interventions are an important focus for creative thinking about the tools needed for optimal patient care. Those exact same incentives to prevent problems rather than waiting for crises and then treating problems also apply to KP patients not having strokes, asthma crisis or heart attacks. Those same incentives encourage the care team at Kaiser Permanente to have cancer detected at very early stages, and to have many fewer patients damaged for life or killed by pressure ulcers or sepsis.

Kaiser Permanente has some of the highest levels of blood pressure control of any care system in America -- and that high level of control helps with multiple levels of chronic care improved care outcomes.[208]

Package Prices Can Reduce Overall Costs

That reduction in hospital use for all of those categories of patients has allowed overall Kaiser Permanente premiums to be lower because less hospital care was needed for these patients. Some insurance-linked processes that compare health plans with one another can become completely confused about how to evaluate those kinds of successful results.

Some process analysts know the piecework payment model well but they do not understand packages of care. These analysts sometimes weigh and compare health plans based on the relative discount levels that

plans have negotiated for their fees. The plans with the biggest discount levels get the highest ratings on some consultants' comparative measurement scales. Those approaches comparisons sometimes have trouble understanding or relating to Kaiser Permanente care performance levels. The analyst formulas can compare and weigh a discounted fee. They can't weigh the absence of a fee. Done well, the fee does not need to exist. Care improvement is the best measure of value in that setting.

Stroke Deaths Are Down 40 Percent -- Cancer Deaths Are Down 20 Percent

As noted earlier, Kaiser Permanente has also used team care and care reengineering processes to reduce stroke deaths by 40 percent.[209] Kaiser Permanente has colon cancer mortality rates that are about twenty percent lower than other care sites.[210] Kaiser Permanente also has used proactive and coordinated team care to achieve an HIV death rate that is half the national average.[211]

A major key to success for the Kaiser Permanente care team in those areas is simply to be liberated from the fee schedules that rigidly define the menu of care approaches that are used in other piecework-reimbursed care settings. To cut the HIV death rate to half of the national average – with some of the best care results in the world -- Kaiser Permanente does 14 things that do not show up on a Medicare or standard insurance company fee schedule.[212] Likewise, for the broken bones successes, Kaiser Permanente did six things that do not show up on a Medicare fee schedule.[213]

Care Processes Don't Need to Protect Billable Events

Those successes are relevant to the rest of American health care today, because both buyers and care organizations are trying to move away from fee-based payment models. The people who are proponents of the ACO model of providing packages of care to a population of people as a better way of buying care should be highly encouraged by the Kaiser Permanente examples and successes. Kaiser Permanente is functionally a

prototype full service ACO -- with all of the essential ACO component parts -- and the model works well.

Because Kaiser Permanente is paid by the package and not by the piece, care in the KP care settings can be designed around the patients. That is also the goal of the new ACO's. Process engineering thinking at Kaiser Permanente doesn't have to be focused on protecting piecework cash flow and maintaining high volumes of billable events from a fee schedule create by someone else. That is also a major goal for the new ACO'S. Care at Kaiser Permanente is not limited to delivering pieces of care that are included on a specific list of fees that function to define the cash flow and determine the economic survival for most fee-based care sites in this country.

A major goal of the ACO's is not to be limited by that schedule of fees. So the successes at Kaiser Permanente should be encouraging both to the medical homes and to the ACO's that are described on the next chapter in this book. Both the Kaiser Permanente approach and the KP tool kits and data sets are relevant to these effects.

Eye Surgery Packages or Total Prepaid Care

Kaiser Permanente also has created high levels of electronic connectivity between its caregivers and with the KP patients. Care information is sent directly to patients over the internet. Electronically reported lab results and even electronic doctor visits are popular with patients in those care settings.

Roughly, 15 million e-visits between doctors and patients happened electronically last year at Kaiser Permanente.[214] Patients loved them. Those e-visits don't happen in most piecework-based care settings in this country because the caregivers in those piecework settings need to see their patients face-to-face in order for the insurance companies or Medicare or Medicaid to pay them for their work. That is unfortunate. E-visits can transform some pieces of care. A prepaid system -- and a patient-centered medical home -- can do e-visits with no loss of revenue.

So millions of these visits happen now at Kaiser Permanente. Piecework care settings can't afford to do them. So very few of these visits happen in those other care settings.

Organizations that deliver packages of care for a fixed price have a much higher ability to bring the processes and skill sets of reengineering and all of the new connectivity tools and care support apps to bear in health care to improve outcomes and to reduce costs and prices.

Buying care by the package made a major difference for Lasik eye surgery and for heart transplants. It sets up an extremely new set up opportunities for caregivers who aspire to function in teams. The key will be to create cash flows that allow the caregivers to function in teams and thrive.

Someone Has to Change the Purchasing Model or It Will Not Change

How can care purchasing be done by the package far more often in our country than it is done today? And how can we create cash flow approaches that will encourage team care, care reengineering and patient focused care approaches?

The truth is that changing the way we buy care will not happen spontaneously or serendipitously. It has to be intentional. Someone needs to make that market reality happen. Buying care by the package cannot happen until someone with real money buys care by the package.

The truth is that someone embedded at the key points in the total cash flow of health care in this country need to set up the mechanisms that can create those kinds of purchasing arrangements and those kinds of care delivery approaches or those mechanisms and those approaches will not happen. The fee-based caregivers of this country clearly will not spontaneously reorganize into entities that will begin to sell care in packages.

The current infrastructure of care that is now absorbing all of that money will not spontaneously do a better job of integrating care at the levels that are so badly needed by the patients who need integrated and coordinated care. The rest of health care has had 50 years to spontaneously evolve into being Kaiser Permanente or into being the

functional equivalent at Kaiser Permanente. That evolution has not happened -- for a number of reasons. We can count the number of reasons. There are 2.8 trillion of them. The rest of health care generates $2.8 trillion in cash flow from the current way we buy care. The infrastructure of care that is absorbing all of that money and doing very well financially will not evolve on its own to deliver the kinds of care that were discussed in chapter two or even to creating care that is sold in packages rather than pieces.

A Spontaneous Integration Into Teams Will Not Happen

The cash flow model for care delivery in this country clearly can only be changed by one or more of the parties who are right now upstream in the actual flow of cash in this country. One or more of those parties needs to change the way they buy care. That is the topic and the agenda for the next chapter of this book. Who can actually change the cash flow for care? How should that cash flow be charged?