PUSHING HEALTHCARE TO THE TIPPING POINT

THE MANIFESTO
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The Manifesto

BY

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Healthcare is still broken.

Healthcare in the U.S. costs us twice as much as healthcare in other developed countries, but it still doesn’t take care of everybody, it still bankrupts people, it still does not give the best care for the least money of any healthcare system in the world — and this will still be true next year and the next. Unless we change it.

We can change it. We can change it fast. We are already changing it now. This is the moment. The healthcare world is in chaos. Everyone is trying to figure out the new game. The best way to figure out the new game is to build it.

This Book
Healthcare is big, it’s complex, it’s contradictory. But there is a big picture that has emerged, that shows us how we got here — and the way forward. That is the subject here.

In this book I will lay out the core ideas:

- A picture of what the future of healthcare might look like
- How we got where we are — how exactly healthcare in the U.S. came to cost so much and serve us as poorly as it does
- How to make sense of what we’re seeing and therefore how to recognize
- the tools we now have to hand, the Seven Levers that now exist that give each of us the ability to help push healthcare to the tipping point — and in the process get better healthcare for less for ourselves, our families, and our communities.

How to use these levers of change, how to turn this framework into action, is the subject of How to Get What We Pay For: A Handbook for Healthcare Revolutionaries - Doctors, Nurses, Healthcare Leaders, Inventors, Investors, Employers, Insurers, Governments, Consumers, You.

Healthcare the Day After Tomorrow
Healthcare tomorrow will look little like healthcare today. The hospital as we know it will deconstruct into something far more varied, personal, and smaller. Prices for many parts of healthcare may drop by 50 percent, even 75 percent, or more. A lot of medical care will happen where you are, not where the doctor is. Many
healthcare organizations that miss the twists and turns of adaptation will fail, their ruins absorbed by others.

- Carlton runs his EKG, and talks to his cardiologist about it — on his cell phone, while sitting on a bench at the park.

- Alicia checks on her sleeping mother recovering from surgery in her own bedroom — and on the cell-phone-sized ICU-style monitor strapped to her wrist, continually monitored by the hospital 3 miles away.

- Dexter calls his own personal doctor, whom he has on retainer, for an appointment that afternoon. Dexter is on Medicaid.

- Eva needs a new hip. She’s covered under her employer’s health plan, but her co-pay will be pretty big. Her employer’s HR department offers her a deal: They will fly her to California; put her up in a hotel; have the hip re-done at a top-flight facility; pay her co-pay, her drugs, her rehab, everything; and throw in a $5,000 bonus — all because the California facility will do it better and at one-quarter the price of the local facility.

- Gareth picks up his cane and hobbles to answer the door. Gareth is obese, his joints are inflamed, his lungs seem to be going. His diabetes is out of control, and he still hasn’t signed up for insurance. The woman at the door introduces herself: his own personal nurse case manager, sent over by the hospital after his third appearance at the emergency department in the last month.

These are vignettes of a real future, some are reality now. They are already happening in parts of healthcare. But we will only get to this much better place for all of us by understanding how we got here — how healthcare in the U.S. came to cost insanely more without producing better healthcare for everyone. Let’s take a look.

**How U.S. Healthcare Came to Cost Insanely More**

Cost is the big factor. Cost is why we can’t have nice things. The overwhelmingly vast pile of money we siphon into healthcare in the United States every year is the driver of almost every other problem with healthcare in the United States from lack of access to waste to fragmentation to poor quality. We can’t afford to fix the problems, cover everyone, do real outreach, build IT systems that are interoperable and transparent and doc-friendly — or so it seems, because at least on weak examination every fix seems to add even more cost. And in the old ways of doing things in healthcare, the way we have been used to doing business, the conclusion of the weak examination has been correct: Despite the tsunami of money, there is never enough to do it right.
Healthcare that costs more than it needs to is not just an annoyance; it’s a big factor in income inequality in the United States. The financial, physical and emotional burdens of disease are major drivers of poverty. At the same time, the high cost of healthcare, even after the Affordable Care Act, means that many people don’t access it when they need it, and this in turn deprives large swaths of the population of their true economic potential as entrepreneurs, workers and consumers. People who are burdened by disease and mental illness don’t start businesses; don’t show up for work; and don’t spend as much money on cars, smartphones and cool apartments. Unnecessary sickness is a burden to the whole economy.

How did we get this way? What was the mechanism that differentiated U.S. healthcare from all other advanced countries? The usual suspects (such as “We have the most sophisticated research and teaching hospitals,” or “It’s the for-profit health insurers” or “Doctors make too much”) all fail when we compare the United States with other sophisticated national systems such as those in Germany and France. Other countries have all of these factors in varying amounts — private health insurers, world-class research, well-paid physicians — and cost a lot, but still spend a far smaller chunk of their economy on healthcare. Blame has been leveled in every direction, but in reality no single part of healthcare has been the driver. The whole system has become drastically more expensive over the last three decades.

**What’s the Mechanism?**

Since the difference between the United States and other countries is so large and obvious, there should be some way we can look at healthcare spending that would make that mechanism jump out at us. And there is a way.

The Organization for Economic Cooperation and Development (OECD) gathers and publishes huge amounts of information about the top 40 or so national economies in the world. Go online and search for its database on national health expenditures as a percentage of each country’s economy. Don’t just look for recent data. We already know what that says: The United States throws twice as large a chunk of its economy into healthcare as most other countries; 50 percent more than the most expensive other countries. No, take the search back to the middle of the last century. Pull the data into a spreadsheet. Make the spreadsheet into a graph. Here’s what you get:
Wow. Suddenly a rather startling pattern emerges. Right side: Yes, the United States costs twice as much. Left side: Didn’t use to.

As economies grow in absolute size, they tend to dedicate a greater percentage to healthcare. After a certain point, somewhere around 9 percent, the cost continues to increase, but the rate of increase tends to flatten somewhat. Through the ’60s and ’70s we can see that happening. The United States, as the largest economy, is one of the most expensive, but it’s just there at the top of the pack. In the mid-1960s Medicare is implemented — the first big infusion of federal money into the healthcare economy — and does the U.S. line jump up? Not really. It flatlines for a year, then continues its moderate climb.

**Something Wicked This Way Comes**
Then something happens which is stark, sudden, and large. Healthcare economies tend to lag national economies by a year or two; in bad economic times governments and private purchasers can’t cut healthcare expenditures immediately, but they do tighten their belts for the future. At a moment when the other most expensive healthcare economies (Germany, Sweden, Denmark) are flatlining or
drifting lower in response to the global economic malaise of the early 1980s, the U.S. line goes nearly vertical, flatlines for a year or so, then leaps ever higher in a series of startling S-curves.

That first big leap is between 1982 and 1983. What was different in 1983 that was not there in 1982? DRGs, diagnosis-related groups — the first attempt by the government to control healthcare costs by attaching a code to each item, each type of case, each test or procedure, and assigning a price it would pay in each of the hundreds of markets across the country. The rises continue across subsequent years as versions of this code-based reimbursement system expand it from Medicare and Medicaid to private payers, from inpatient to ambulatory care, from hospitals to physician groups and clinics, to devices and supplies, eventually becoming the default system for paying for nearly all of U.S. healthcare: code-driven, fee-for-service reimbursements.

**Cost Control Drives Costs Up?**

How can a cost control scheme drive costs up? In a number of ways: In an attempt to control the costs of the system, the DRG rubric controlled the costs of units, from individual items like an aspirin or an arm sling to the most comprehensive items such as an operation or procedure. The system did not pay for an entire clinical case across the continuum of care from diagnosis through rehab; or for an entire patient per year on a capitated basis, which would capture the economic advantages of prevention; or for an entire population. While it is more cost-effective (as well as better medicine) to provide a diabetes patient with medical management, in-home nursing visits and nutritional counseling rather than, say, waiting until the patient needs an amputation, the coding system actually punished that efficiency and effectiveness. Under this system, we got paid for our inefficiencies, and even for our mistakes: Do-overs would often add far more to the bottom line than the original procedure did.

The system punished, rather than rewarded, spending more time with patients, trying to help patients before their problems became acute, or maintaining a long-term, trusted relationship with patients. Under a code-driven, fee-for-service system, getting serious about prevention and population-health management would be a broad road to bankruptcy for a healthcare institution.

If extra items were deemed necessary (an extra test or scan, say), there were codes for that, and reimbursements awaiting. So the system rewarded doing more (“volume”) rather than whatever would be the best, most appropriate, most efficient treatment path (“value”). At the same time, the reimbursements were constantly open to pressure from the industry. Each part of the industry, each region, each specialty, each part of the device industry, became fiercely focused on keeping those reimbursements up, and getting new codes for more costly procedures.
The business and strategic side of healthcare became a matter of making money by farming the coding system. Do more of what gets better reimbursement, less of what does not. Make sure every item gets a code and a price. The codes became a manual for success, a handbook for empire.

**The Smoking Gun**
The smoking gun is right there in the chart, at the big split between the trajectories of the United States and other countries. And today, at this moment, the code-based, fee-for-service payment system is still how most of healthcare does business.

There is no perfect way to pay for healthcare. All payment methods have their drawbacks and unintended consequences. But the code-based, fee-for-service system got us here, and any path out of the cost mess we are in has to get us off that escalator one way or another.

**Waste**
So institutions and doctors got used to being rewarded for doing more, rather than doing what was best and leanest. Which makes you wonder: How much of everything we do in healthcare is just plain waste, that is, stuff we really don’t need to do at all?

According to a variety of studies that have looked at the question in different ways, about one third. That’s about $900 billion.

How big is this? It is 50 percent greater than the entire US military budget. The federal part alone through Medicare and other medical spending is greater than the entire federal budget deficit.

Getting rid of this waste is the largest single opportunity of any kind in our entire economy.

We do this waste because we get paid to do it. If healthcare were paid differently, it would not do wasteful things.

What do I mean by “wasteful things”? Here are some examples — and all these clinical judgments are not mine, they are from studies in the peer-reviewed medical literature and from my interviews with specialists in those fields:

- **Complex back fusion surgery for simple back pain**, one of our most common major operations? Not only is it not medically indicated, we endanger patients in doing the procedure. We spend $2 billion per year on this one practice.
- **Computer aided mammography** adds $500 million per year to the cost. Recent studies have shown the number of extra tumors found by the
computer – as against by a human screener – for this half billion dollars? Zero. No help at all.

• Or even mammography for mass screening for cancer. Useful? Important? Not so much. The Canadian National Breast Screening Study, looked at 89,000 women over 25 years, and found the difference in cancers, and in deaths from cancers, between women who had annual breast exams by an M.D., and those who had the same breast exams plus mammograms to be zero. No help at all. Proper breast exams do the job.

• Implanted defibrillators are valuable devices, but twenty-two percent are implanted in people who do not have the medical indications that show they are needed. This costs some $880 million per year and endangers patients.

• Unnecessary cardiovascular stents cost us another $2.4 billion per year.

• Colonoscopies don’t require general anesthesia, so nurse anesthetists are widely employed for the conduct of colonoscopie, yet M.D. anesthesiologists are often used instead, typically adding $2,000 or more to the bill. Ending this practice would save an estimated $1.1 billion per year.

• Furthermore, most of the $10 billion in colonoscopies done in the United States every year are unnecessary. Screening for colon cancer is very important, but there are several less-invasive tests that could substitute for most colonoscopies at a tiny fraction of the price.

It adds up. We in healthcare are used to getting paid for waste. It’s a third of our business model.

Prices
What about the prices we pay for healthcare? When we look at prices actually paid, not just the phantom “chargemaster” list prices, they are way out of line. They are not just a little higher than other advanced countries but many times other countries’ prices — for no discernible reason. Prices vary randomly across healthcare with little relation to quality.

The most expensive place in America for your final illness is Cedars Sinai in L.A., followed by UCLA Medical Center, right next to Beverly Hills, and NYU Langone in Manhattan.

The least expensive place for that final illness? Mayo Clinic in Rochester Minnesota, second least expensive is Cleveland Clinic.

How can the best healthcare on earth cost half as much as the best healthcare on earth?
These price variations have little to do with geography or even with the wealth of the populations in a region. Prices can vary by five times virtually across the street from each other. They have little relation even to the actual costs of doing any particular procedure. By and large across medicine we do not know our actual costs of production.

**We Don’t Have to do This Anymore**
We could do it for half. Or less.

We could have healthcare — higher quality healthcare, for everyone — for half or less of what we pay today. We now have the tools to do this. It’s time to use them.

If we change the way we pay for healthcare so that we pay only for what is necessary and helpful, we will have eliminated over $900 billion in costs per year. If we change the way we pay for healthcare so that providers compete for our business on price and quality like other businesses do, prices will drop to well below today’s median price. If we do these things, healthcare will cost less than half what it does today, healthcare premiums will drop, Medicare will be safe forever, and the federal deficit will disappear. And the only way to do it, really, seriously, is to do it for everyone.

So how do we fix it? What are the tools?

**The Seven Levers**
We have seven tools that can make this work, seven levers of change:

1. Shopping
2. Transparency
3. Results
4. Prevention
5. Targeting
6. Trust
7. Tech

**Shopping:**
More healthcare consumers, including everyone who has come in under the Affordable Care Act, now pay part of the cost.

People who pay part of the cost are much more cost-conscious — especially as they learn how wildly costs vary, and how paying more does not necessarily get you more or better healthcare.
Savvy employers are rapidly deploying a number of new strategies to keep healthcare costs down. Many are self-funding, meaning they pay the actual costs directly, giving them more control over them.

They are offering their employees lower-cost, high-deductible health plans, along with health savings accounts, both of which turn the employees into more savvy shoppers.

Some of these health plans give the employees direct incentives for smart shopping, by paying all co-pays, for instance, for using the lower-priced high-quality providers.

Some companies are building their own Accountable Care Organizations (ACOs) which skip the insurance companies altogether and contract directly with hospital systems and large physician groups.

Some are hiring healthcare billing companies to audit the bills.

Some are offering healthcare providers cost-plus contracts.

Some are using “reference pricing:” For any given procedure or test, they establish a price below which one can find many high-quality providers. If you want to get your procedure or test at some place that charges more, the difference is your co-pay.

Some employers are striking "medical tourism” deals with some of healthcare’s biggest names, such as Mayo, Johns Hopkins, or the Cleveland Clinic. For certain conditions, your employer will pay your way and your co-pays to go to this high quality provider.

Many smaller employers are banding together to do these things in buying groups.

Many employers are building on-site clinics in their work-places, full primary care providers with no co-pay for the employees, and often no appointments needed and no cost for pharmaceuticals — because again the total cost to the employer is lower.

To become any kind of smart shopper, the customer has to find the answers to the usual questions any customer asks, such as how good is this thing that is on offer? How does its quality compare with its rivals? How much will it actually cost me? What kind of warranties and guarantees will I be given? Is this really necessary or even useful? What are alternative ways of solving this problem?

Answer those questions, and you begin to have true consumer-directed health care.
Transparency
You can't be a shopper if there are no price tags. Until just recently the idea of price tags in healthcare sounded just weird, like camels in a hockey tournament. There was no way to know how much any given procedure or test would actually cost, or how well it would turn out, or whether you really need it. If transparency still seems weird to you, now would be a good time to get over it. There are multiple new sources of information arising, not only about price but about quality and alternatives. Some are crowd-sourced through the Internet, some provided by employers or health plans based on actual payments. And increasingly, both employers and health plans are demanding “bundled” prices for an entire procedure from prep through rehab with no hidden or surprise costs, and backed by quality information and even warranties.

The key thing that customers of any kind want to know — and pay for — is not process or statistical averages. They want results.

Results
At a restaurant, you don't pay if the steak is burnt or never shows up.

In healthcare we traditionally pay for individual services (hence the term, "fee-for-service") whether or not it turns out they helped or were even necessary. Though it is obviously more complex in healthcare than in a restaurant, employers and health plans are increasingly finding ways to pay more for higher quality, to steer patients and employees away from institutions that make more mistakes, and to directly pay providers to improve your health, giving the providers more money if their panels of patients achieve higher health-quality markers and have less cause to use emergency services, surgery, and other expensive acute procedures and tests.

Beyond that, how can we reward the medical best result we can hope for, which is to never need expensive acute services at all?

Prevention
The #1 way to lower costs in healthcare is to stop paying for things that don't help, to end waste (1/3 of all healthcare) by shifting away from a code-based, fee-for-service system that rewards inappropriate and wasteful overtreatment.

The #2 way is to prevent chronic disease, and to manage it so that it does not become acute. For prevention, people need real help to connect with a patient-centered medical home, a primary care practice that has a direct financial incentive to help them stay well. They need real support and incentives for outreach efforts, workplace health, and home health. And they need real support for building healthier communities — and there are proven, tested, way beyond shovel-ready programs available to do just that.
Targeting
Some people use way more healthcare than other people. Over any given time span, for any given population, about 5 percent of the people use half of all the healthcare resources. Some of those folks just got hit by a bus, some have pancreatic cancer. But many others have poorly treated chronic disease and stay in the same high spending category month after month, even year after year.

Many programs have shown that if you find those of the 5 percent who have multiple chronic problems and give them extra attention and care you can reduce their costs by as much as 20 to 25 percent. So just by giving this small group special attention, you can drive down the costs of the whole population by 10 to 12.5 percent.

But to do this, to do any of this, you have to build trust with your customers. Not image management. Trust.

Trust
What do people most need from healthcare? A trusted partner.

Without trust, none of these strategies work. Building person-to-person trusted relationships between doctors, nurses and individual patients seems like an expensive proposition on the front end, but over time it is the single most productive efficiency engine in healthcare, simply because it works.

This is a tough strategic problem for healthcare, because it is structural. The modern version of the code-driven fee-for-service piecework medical system his built on “narrow networks” — your doctor is in the network if she accepts the discount the insurance company is giving for exactly your type of insurance. I call this the Default Model. With its complexity, its opacity, its random and arbitrary micro-management of coverage, and its adversarial “gotcha”-style risk mitigation, the Default Model drives all trust out of the system. Your image just doesn’t matter when your customers cannot trust you, and you cannot be their trusted partner.

We will see more and more healthcare providers seeking other business models that allow them to build true trusted relationships with their customers.

Today’s healthcare customers — patients, their families, their caregivers — have questions to which few organizations in the healthcare or health insurance world seem able to give reliable answers.

They are basic customer questions such as:

- Do you actually cover the places you say you cover?
- Will you cover them next year?
• Will my specialist, whom I have relied on for years, and whom you have covered for years, suddenly be out of your network?
• When I choose an institution and physicians who are in-network, will someone sneak in an out-of-network doc with a huge fee?
• Will you raise my premiums unreasonably?
• Will you be raising my premiums forever?
• Will you find some fine print reason not to cover something you said you would?
• If I have a problem, if I get surprised by huge medical bills, by fraudulent inclusion of out-of-network docs, or by balance bills, will you go to bat for me? Or will you make it my problem?
• Can you guarantee through my arrangement with you that I will not be bankrupted by disease?

The distrust is profound because these things hit people at the moments they are most vulnerable and frightened, battling serious disease. The amounts involved can be so large that any health insurer denying a claim or dropping coverage on a specialist can change the customer’s life status, moving them into bankruptcy and permanent poverty, or forcing them to choose between their cancer drugs and a roof over their children’s heads.

Anyone in the healthcare or health insurance industries who can find new business models that can answer even some of these questions with clarity and reliability will have an enormous strategic foundation.

As more of healthcare achieves this, trust will become a major catalyst for change across the system.

Tech
Tech is a major facilitator of change. Tech has the still mostly latent capability of driving rapid change:

• **medically**, through new processes that obviate the need for expensive and dangerous surgeries and procedures
• **clinically**, by enabling new efficiencies in documentation and workflow, and managing seamless dataflow across the continuum of care, and
• **analytically**, allowing enterprise leaders can use Big Data to see into these complex economic/clinical systems in real time

Tech will shift the relationship of the customer to the system, through mobile devices, apps, dongles, wearables, and the “Internet of Things,” creating a web of
constant or on-demand connection for those trusted relationships that must form the substrate of any new system.

All Seven
These seven levers work together. Of course, any one of them by itself can be powerfully effective in reducing the costs of healthcare, making it work better, and bringing it to more people, but working together they multiply their power systemically. The ability to shop is fueled by real transparency and supercharged by a transparency of results. Targeting high-cost individuals for extra help can be an able tool in bringing down costs, but much of its effectiveness derives from establishing real trust. Each of the seven builds on and feeds the others, as I show in greater detail in How to Get What We Pay For: A Handbook for Healthcare Revolutionaries — Doctors, Nurses, Healthcare Leaders, Inventors, Investors, Employers, Insurers, Governments, Consumers, YOU.

If we imagine consumers, employers, clinicians, healthcare organizations, inventors and investors and insurers all pushing on these same levers, we will be seeing a time when this vast disjointed system of healthcare crosses its tipping point and snaps into a better, cheaper, warmer, more helpful future.

Because there is a tipping point. Healthcare is a complex adaptive system, which means that when enough of the inputs change, the whole system adapts to the new demands of those inputs. New financial structures and organizations arise to serve customers at lower cost by serving them better, as we are seeing already in some parts of healthcare. Customers big and small learn to seek them out. Payers like health plans and the federal government find ways to reward the lower-cost providers — we are already seeing this in many areas. As lower-cost markets develop, suppliers learn how to supply better devices, tech, and services at lower cost to serve those markets. When high-cost hospitals and medical organizations find their market share draining away, they find ways to lower their cost structure enough to stay in the running. Each part of the system responds to all the other parts.

And here’s the key point: We don’t have to change all of healthcare for the whole system to shift. We don’t even have to change most of it. We have to leverage just enough change in the system that most of the big players cannot afford to lose that part of their market. Once that happens, the whole thing begins to tumble and re-link up in newer, cheaper, stronger shapes. There is a tipping point, and we are a lot closer than you might think.
The Call

Where did you come from? Who are your people?

There is a grave in Calvary Cemetery in Los Angeles with my name on it, a tiny grave, the grave of an infant. Nearly my name: Joseph Edgar Flower. I am Joseph Edward. He was born to my mother in 1949 with, we are told, “a hole in his heart,” lived 24 hours and died and broke my mother’s heart. The condition today is fixable with delicate prenatal cardiac surgery. In 1949, there was nothing one could do.

We are in this together. Compassion is not a hobby.

My dad was the son of a miner in the copper pits of Arizona — a violent man, a drunk. My father was determined not to be his father. While stationed at Pearl Harbor during World War II, he discovered peace in a garden kept by contemplative nuns in Honolulu, learned the Peace Prayer of St. Francis, was baptized and came home to marry a Catholic girl, daughter of Irish immigrants.

I was one of 10 children, not counting Joseph Edgar. I remember very few arguments between my parents, but one — loud, passionate — was when my brother lay dying. Jim was very sick. My mother would not call the ambulance because hospitals and doctors were expensive and we had little money, despite my father’s job as a salaried oval badge at Lockheed. My father said, “We will pay the price. Call the hospital. He’s my son.” When they carried him out (half a century later the memory sticks), I wondered. I had never known that humans could be blue. He had, it turned out, spinal meningitis and pneumonia. He lived.

People die. People suffer.

My friend Tom’s mother disappeared. She had, we were told, a “breakdown.” We were not told what that meant, or if she would be back. One did not speak of those things.

Dad did things. As Los Angeles expanded he founded parishes, founded councils of the Knights of Columbus, gathered funds to build hospitals. In those segregated days he would regularly go to the other end of the San Fernando Valley to where the Mexicans lived to build houses and bring help to families who were down on their luck.

We are a society. We are who we are because of each other.

When my own first child was born in San Francisco, my wife nearly died when, in the handoffs between shifts, the nurses lost track of the fact that she had been in
hard labor for over 24 hours and was fading in exhaustion. I was so exhausted just from tending her that I could barely speak, but I pointed out their mistake, and they rushed her into surgery. #LivesMatter. Yours, mine. Our children.

Dad died on the table in the surgical suite at 86 when a surgeon had convinced him that putting in a mitral valve at his age would be fine. It wasn’t.

I am not special. Everyone has these stories. Where do you come from? Who are your people?

Life, liberty, and the pursuit of happiness. Is “life” some abstraction? Or does it mean, actually, your life, the lives of your children, your parents, your best friend? Actual lives? Does that mean that if we have here in our hands the magic elixir that will save you, the procedure, the real help, that we will give it to you, help you have it — or withhold it from you because you had not managed to put together the right combination of job and insurance this particular year?

There is nothing abstract about this. Healthcare, how we manage it, how we pay for it, is about life and death, your life and death, your children, your suffering, their very real suffering. It’s about whether you have the power to do anything about it. I believe we do.

* * * * *

I think that’s your phone ringing. I recognize that special ring tone. That’s not your organization calling. That’s not even healthcare calling. That’s life calling.

You’re a VP of development at a hospital system, you’re a resident at a teaching hospital; you’re an employer, a Fortune 500 CEO, or a partner in a brew pub with a dozen employees; you’re an HR director; you’re an entrepreneur, an investor looking for the next big thing; you’re in the Senate or the House or a state legislature; you’re a citizen, a patient, a parent, a child of aging parents. And you may never have thought that life would come calling, come knocking on your door, come saying this is the time, this is the moment that you were made for, this is why you are here. No, we don’t know why, you and I, but it’s here.

There will be times when the fight to revolutionize healthcare will not seem worth it. Some of the time it will seem like there is no movement, or like things are getting worse. That is the nature of struggle, that it seems impossible until the moment when it seems inevitable.

It may seem often that you have no allies. But you will find them. We are here, and we are in your organization, your community, your profession, your part of the market.
There are already victories to celebrate and congratulations to share and there will be more. The victories will often seem partial. But victories there will be. We will make this better.

We are engaged one way or another with a mighty industry that has us in its hands, all of us, our life and death and our suffering. We have our hand on this magic thing, this marvelous magic thing that can relieve the suffering, that can help us to an easy birth, a whole and powerful life, a good death. We have our hands on that, and we have a chance to bring it, we have a chance to make it work, we have this one chance. You have this one chance to do a great and mighty thing. What will you do?

**What You Can Do**

This book is the gateway book to:


It’s a comprehensive guide, with checklists and resources. At the site you’ll also find other guides and resources specialized for your situation, whether you’re a healthcare leader making big expensive decisions that will change the paths of your organizations, or you’re an employer looking for new ways to cover your people, or you’re an investor or inventor tracking the next big opportunities, or you’re a consumer who just wants a square deal. You may be any of the other readers in the book’s title.

If you’re interested in learning how to help spur change and shape the Next Healthcare to make it far better and cheaper for everyone, while helping yourself, your family, your organization to finally get what we’re all paying for, read the book, or come to [http://www.ImagineWhatIf.com/want-help](http://www.ImagineWhatIf.com/want-help) to find out more.