CHAPTER 1

THE FUTURE OF HEALTH WILL BE LOCAL, OPEN, AND INDEPENDENT

It should come as no surprise that the most successful solutions to society's most challenging problems do not now and will not in the future arrive with the cavalry from Washington, D.C. After all, the great societal challenges that America has been tackling over the last several decades – civil rights, energy independence, climate change, better food – all have been fueled from the bottom up.

This is certainly true when it comes to health care: an industry that spends more on lobbying than oil and gas, defense, and financial services *combined* is going to have its way with Congress.[8] I've taken to calling most D.C. politicos "preservatives" rather than progressives or conservatives, as they get paid to preserve the status quo. The fact remains that over the last couple of decades neither Democrats nor Republicans have accomplished much to address the two biggest failings of the U.S. health care system: pricing failure and overtreatment. At the same time, government's failed approaches created collateral damage including under-resourced public health infrastructure.

Health care is particularly suited to a bottom-up approach because it begins at home. The fundamental value creation in

health care is the relationship between an individual and his or her care team. The more intermediaries and bureaucrats that get inserted into that relationship, the greater the chance for value to be extracted rather than added.

Chris Brookfield has close to 20 years' experience designing networks and services that empower people in emerging markets both in the U.S and abroad. In 2004, he left mainstream venture capital to focus on investments with broader and more beneficial human impact. He and his team played an instrumental role in lifting tens of millions of people out of poverty through micro-finance, small business loans, rural hospital development, and slum improvement finance in India. He is now applying his systems change model to remaking the U.S. food system as well as new services for the next era of capitalism.

Tired political labels get swept aside when people come together to solve their issues. Brookfield's work in food has revealed a natural collaboration between farmers and those in the local food movement, even though farmers tend to be more politically conservative and local food people tend to be more politically progressive. We find the same thing in health care, where free market-oriented, conservative physicians are pursuing the same objectives and using similar tactics as progressive union leaders.

Models that deliver systemic change, says Brookfield, have three big themes in common: They're local, open, and independent. In this chapter, I'm going to show how health care can capitalize on these same themes using excerpts from Brookfield's paper on system change (shown in italics).

Local

Focusing on local [reveals] a number of intrinsic advantages [that] are often overlooked [in the larger picture]. First, by decreasing scale, solutions can appear to problems that seem too complicated to solve at the global scale. For instance, re-engineering the food

system or decreasing poverty really are intractable when viewed at the global scale. Even the basic atoms of these systems – people – are invisible. By dialing into local, new features and relationships emerge.

In their new book *The New Localism*, urban experts Bruce Katz and Jeremy Nowak describe a diversity of needs at the local level. They compare cities such as Detroit, which may need to demolish blighted housing to boost value, to hot-market cities such as Boston, which may need to build and preserve more housing to meet demand. State and federal legislatures tend to enact one-size-fits-all solutions and, often for political reasons, prefer spreading public resources evenly, despite widely varying needs. New localism allows communities to focus on the challenges they actually have rather than on the national issue "du jour."

Localism realigns entrenched politics. It's striking how new alliances are formed at the local level that are impossible at the national level – where conservatives see new federalism, independence, entrepreneurism, and local business, and progressives see community building, health, nutrition, education, and nurturing. In health care, individuals receive care from local clinicians, yet only $0.27 of every dollar spent goes to these locally based, value-creating clinicians. Between $0.50 and $0.75 of every dollar goes to the drug supply chain, health systems, and health plans that are usually headquartered elsewhere. This is at the heart of how the "sick care" industry has extracted resources that would otherwise go to social determinants of health that are fundamentally local (e.g., schools and social services). The table below shows where the health care dollar goes.

~$0.45	Fraud Misdiagnosis & overtreatment (High-cost, massive overtreatment: spinal & stent procedures; high misdiagnosis areas: oncology, musculoskeletal, etc., ranging from 25%-67%) Abusive & arbitrarily high prices (Massive pricing failure: prices for similar quality often vary 2-10x)	Extractive or no value
~$0.30	Insurer or health system administration & overhead	Often extractive
~$0.25	Paying high-value care providers	Generally not extractive

Table 1: The Distribution of a Health Care Dollar

Note: These are very high-level approximations for illustrative purposes. They're based on multiple, widely recognized sources and generally accepted data, including PwC's "The price of excess– identifying waste in health care spending" and the Institute of Medicine's[9] estimate of waste at 30%-50% of spending. Other data points are outlined elsewhere in the book, including rates of misdiagnosis and pricing failure.

One of the key architects of the Patient Protection and Affordable Care Act (ACA), Bob Kocher, MD, echoes this reality in a *Wall Street Journal* op-ed entitled "How I Was Wrong about Obamacare,"[10] in which he outlines the importance of independent, locally controlled medical practices:

> *Personal relationships of the kind found in smaller practices are the key to the practice of medicine. Small, independent practices know their patients better than any large health system ever can ... [They] are able to change their care models in weeks and rapidly learn how to use data to drive savings and quality ... [I]t does not take [them] years to root out waste, rewire referrals to providers who charge less but deliver more, and redesign schedules so patients can see their doctors more often to avert emergency-room visits and readmissions.*
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> *I believed then that the consolidation of doctors into larger physician groups was inevitable and desirable under the ACA. What I know now, though, is that having every provider in health care 'owned' by a single organization is more likely to be a barrier to better care.*

Open

Openness is an advantage, largely because information networks have coalesced over the past 15 years and have exponentially increased the flow of information to local communities. There is no way to transmit proprietary ideas at anywhere near the speed and coverage that open-sourced ideas move.

Openness is proving itself in an array of settings. The beer market is mature and has been dominated in the U.S. by a couple of behemoths, yet craft brewers recently have grabbed 24%[11] of beer spending. How? Craft brewers are radically open with each other regarding how to succeed, recognizing that their real competition is the mega brewers, not each other.

One of the failings of the wildly underperforming status quo health care system is how poorly insights and breakthroughs get disseminated. Research shows that it takes 17 years for effective breakthroughs to become mainstream.[12] Therefore, a central tenet of the Health Rosetta is to create an open, Wikipedia-like "hive mind," which makes it much easier to understand and deploy approaches that sustainably outperform traditional approaches to Quadruple Aim objectives.

Near the conclusion of a great new book, *Our Towns*, James Fallows echoes the theme of taking what's already working and sharing it much more broadly. He quotes Philip Zelikow, a professor at the University of Virginia who said to Fallows:

"In scores of ways, Americans are figuring out how to take advantage of the opportunities of this era, often through bypassing or ignoring the dismal national conversation. There are a lot of more positive narratives out there – but they're lonely, and disconnected. It would make a difference to join them together, as a chorus that has a melody."

Katz and Nowak describe a new circuitry of civic innovation in which innovative practices are adapted from one city to another – cities in radically different circumstances that are simultaneously

trying to solve similar challenges. The adaptation of solutions is accelerated by new city-related associations that share innovation, industry-specific organizations such as the Health Rosetta, or major foundations such as the Rockefeller Foundation.

Independent

As with scale, we are hybridizing our approach to system design [of next-generation wheat mills] to incorporate the best of both local and conglomerated infrastructure. By integrating business models with existing social movements, we achieve network connectivity beyond the local watershed, allowing the sharing of resources, information, and values. By allowing each of these businesses to function autonomously within this fabric and grow to their fullest individual potential, an individual mill can utilize the control and hierarchical scalability typified by corporation[s] ... [A]t the same time, the fabric as a whole achieves quick responses, flexibility, and adaptability – responses [that] are inhibited by corporate concentration.

The first broad application of the local, open, and independent model is the vanguard benefits advisors, who are the torchbearers of the next health era. Perhaps no job is more underestimated in all of health care in terms of its potential to help (or hurt) the working and middle class of America. Our experience has been that the vast majority of employers defer most of their health benefits decision-making to their benefits broker, a different animal altogether. As outlined elsewhere in the book, this is often to the detriment of employers and their stakeholders, whether they be employees, shareholders, taxpayers, or otherwise.

The Health Rosetta benefits advisors are building the next generation health economy by replicating what is proving successful in a wide array of settings: public and private employers, rural and urban areas, large and small employers. Again, replication is the key word.

Given that the primary value creation in health care is fundamentally a local endeavor tuned to local dynamics, we believe replication is the way change will happen. This is a fundamental contrast to massive top-down, large-scale programs. Replication varies from application to application; scalability seeks to apply the same things everywhere. This distinction is subtle but absolutely critical to achieving success.

Post-Political

> *One indicator that a movement is ready for development in the commercial sphere is … when [it] ceases to be perceived as political within the relevant communities. While movements remain politicized, there is insufficient agreement; when the community itself is split in its support, this method of commercial development is doomed at the outset. On the other hand, it was obvious in the case of both microcredit and local food that virtually everyone in the local communities agreed with the underlying premise. When community business models and commercial values align, they were able to attract nearly unanimous support.*

As Katz and Nowak point out, new localism is also nonpartisan and powerful.

"The regular engagement of business, civic, and academic leaders elevates pragmatic thinking and commonsense discourse and crowds out the inflammatory rhetoric associated with partisanship and ideology. New localism is intensely focused on maximizing value for long-term prosperity rather than short-term private profit or political gain. Cities' main message to the federal government today is 'first, do no harm.'

"Millions of decisions are made by subnational leaders and ordinary citizens, and these decisions build communities, drive economies, educate children, catalyze innovation, and change lives. New localism is both representative of and restorative of the democratic ideals and principles on which

the republic was founded and which sustain Americans in good and bad times."

Perhaps it is time to dust off the public referenda process to garner support for transformative investments in the future. A great example of this is how the Austin electorate voted to tax itself during an economic downturn in order to fund the Dell Medical School. Central to the mission of the new medical school is serving as the community health care provider. Even in the short time since they opened, they've tackled previously resistant problems. For example, the working poor in Austin had an 18-month wait to be seen for orthopedic issues. Today, it's down to about a week, thanks to on-the-ground problem-solving versus simply pouring more resources into a clearly flawed approach.

The Original Sin

In *An American Sickness*, Elisabeth Rosenthal explained how the way we structured health insurance was in some ways the original sin that catalyzed the evolution of today's medical-industrial complex. This doesn't mean health insurance is a bad thing. It means health insurance as we have known it is a bad thing. We need to re-do health insurance to support the health care system we want, not the one we've got. Brookfield believes that huge risk pools are the heart of the problem.

When local networks are scaled up, you add hierarchy, says Brookfield, and this creates an opportunity for theft and redirection. Brookfield's genius has been understanding how social missions can be nested within free markets and how local control is a path to broad, positive change. This has been applied to microcredit, rural hospital development, and more. He has a proven track record of bipartisan approaches to tackling extremely difficult problems such as systemic poverty, lack of access to health care, and a food production system that has harmed local economies while producing subpar food. The following is Brookfield's reaction to Rosenthal's comment:

All group risk pools – health insurance, life insurance, credit insurance, disaster/property insurance – have a long social history. They all evolved out of village/community mutual aid groupings. So, for instance, along with microcredit (which has analogs that go back thousands of years) there were all kinds of group risk insurance. The community would pay if one member had an unanticipated tragedy.

These semiautonomous systems work very well at the community level. They are efficient and well supervised by their own participants. In this kind of network – some call it a fabric – there is much mutual overlap: walls are thin, and gossip travels fast, which drives the [development of] community governance. This kind of signaling among community participants is really highly effective at reining in [systemic] abuses, as well as bureaucracy, lag times, and translation errors. This is the essence of Elinor Ostrom's insight that won her the Nobel Prize for economics. But these systems go completely haywire when 'scaled up,' which creates opportunity for theft and redirection.

Persuading individuals to buy insurance is kind of backwards. I saw this in India all the time. Individuals do not value their own risks – their relatives and neighbors do. We could not get individuals to buy insurance. We made buying life insurance compulsory to receiving a much bigger benefit – personal loans. Then we quickly sold 10 million policies. It would be good for American policy makers to be reminded that insurance is not an attractive sale to an individual; the beneficiaries of insurance, fundamentally, are the family, community members, and invested financial institutions, not the insured.

Most modern insurance vastly scales up the number of people who bear the burden and, in the process, adds enormous cost while losing effective oversight. Pools of more than 1,000 people are redundant and may reduce resilience, as the ballooning overheads outweigh the marginal benefit from wider risk sharing. Pools of hundreds of thousands or more people simply mean more power and money

for the administrators, plus hugely expanded costs for end-of-life interventions that are a huge burden for smaller pools. Bigger scale + more cost = additional costs from providers … and on we turn.

For nearly all people nearly all of the time, says Brookfield, we would be better off with community risk pools, self-governed, for nearly all our risks, using traditional pools only as reinsurance.

The primary issue of outlier claims is easily addressed. Over 100 million Americans are in self-insured plans. All but the largest have stop-loss policies for outlier claims. This allows companies as small as 20 people to self-insure without risk of financial ruin if they have an unfortunate medical incident.

'Buy Local' Programs Will Reinvigorate Communities

Increasingly, communities realize the value of "buy local" programs that increase community resilience and economic opportunity. Today, the vast majority of communities send a large amount of money to out-of-town bureaucracies to pay for services that are mostly delivered locally. It's quite odd if you pause and think about it. In contrast, the Rosen Hotels case study is a microcosm of how a community can be literally transformed (crime down, high school graduations up, etc.) by reinvesting money that would otherwise have been squandered on giant out-of-town bureaucracies. Likewise, Pittsburgh has shown how a local insurance pool can ensure that education budgets no longer get eviscerated by a wasteful health care system.

Even in countries perceived to have centralized health care systems, ownership and administration is pushed down to much more local levels. Communities like Jönköping, Sweden have been internationally recognized for how they innovate and "real-locate" monies to fit the needs of community members. Jönköping leaders are aware that clinical health care drives less than 20% of health outcomes, so balancing that spending with investments in clean

air and water, better schools, job training, and other opportunity creation maximizes community well-being.[13]

In many ways, we already have this today in a variety of communities, from employers (self-insured and captive) to unions to health-sharing ministries. Health Rosetta co-founder Sean Schantzen tells me all the time about ways organizations hedge their bets against risks of all kinds, many of which are extraordinarily complex and unpredictable. For example, the wide range of reinsurance products, commodities options, currency hedging, etc. are all forms of insurance that enable organizations to tailor their protection to their comfort level with risk.

We know that our current approach to health insurance isn't well-received. Customer satisfaction with status quo health insurance is lower than virtually any other sector of the economy. The beauty of the approach Brookfield articulates is the blend of local control and accountability with the scale advantage from appropriate use of technology and modern business tools. Without local accountability, distant bureaucracies are vulnerable to abuse. Consequently, a cascade of stifling bureaucracy gets layered on to the point we've reached today, where an alphabet soup of MACRA, MIP, MU, PCMH, HCAHPS and more crushes our nurses and doctors. People sometimes conflate re-localizing health care and health insurance with past clumsy efforts to pool risk, many of which haven't worked.

They didn't work for the following reasons:

- They brought organizations together that had no connection or local accountability and were driven by distant state bureaucracies.
- They were predicated on buying from out-of-area intermediaries and insurance or provider companies versus locally controlled provider organizations. With that came all the baggage outlined in other parts of this book, such as PPO networks that once made sense but have become value-extractors from local families and economies. Case studies throughout this book of unions, employers, and

municipalities demonstrate how they are more effective than insurance companies at slashing health costs by managing things at an appropriate scale. Why? They have aligned interests absent from most intermediary arrangements in health care.

- They used the same old health payment approaches that have proven to deliver mediocre health outcomes, eat up extraordinary sums of money, and make clinicians' lives miserable. Hardly a recipe for success. When social missions are nested within free markets and local control, there is a path to broad, positive change that is embraced by people who put their humanity before tired political labels.

In the hopes of ensuring that you and your organization don't likewise experience failure, the next chapter digs into how to produce high-quality, low-cost, and even parent-approved health plans.

Key Takeaways and Things to Think About:

- By decreasing scale to a local level, solutions can appear to problems that seem too complicated to solve at the global scale.
- Roughly half of every dollar spent on health care adds no value; much of it is extracted out of local economies to out-of-town health plans, health systems, and investors, even though health care is fundamentally local. The value-creating nurses and doctors receive only $0.27 of every dollar ostensibly spent on health care.
- There is no way to transmit proprietary ideas at anywhere near the speed and coverage that open-sourced ideas move. The arc of health bends toward openness.
- Transforming health care requires re-doing health insurance to support the health care system we want, not the one we've got. This doesn't mean health insurance is a

bad thing. It means health insurance as we have known it has created a multitude of perverse incentives that harm both patients and clinicians.

- Combining the best of local autonomy with the benefits of modern financial and technology infrastructure can be achieved in post-political movements.