



THE RIPPEL FOUNDATION AND RETHINK HEALTH: NEW THINKING ABOUT HEALTH AND CARE

“The betterment of humankind depends on the ability of fallible human beings to make decisions, manage resources, and govern themselves. This is the basis of democracy, and of civilization itself.”

Workshop in Political Theory and Policy Analysis
Indiana University in Bloomington

Background

In October of 1976, a young scientist named Amory Lovins, now Chief Scientist of the Rocky Mountain Institute, wrote an article that appeared in “Foreign Affairs.” It challenged the nation to think about America's formal and de facto energy policies and where they were leading us. He drew on the words of poet Robert Frost as he raised questions and presented options of where we might choose to go instead.

*Two roads diverged in a wood, and I –
I took the one less traveled by,
And that has made all the difference.*

Lovins’ first path was essentially an extrapolation of the recent past, relying on rapid expansion of centralized high technologies to increase supplies of energy. The second path combined a commitment to efficient use of energy and renewable energy sources matched in scale and in quality to end-use needs. The second path, which offered a whole greater than the sum of its parts, diverged radically from the incremental past practices and instead pursued long-term sustainable goals. Both paths presented difficult, but very different, problems. The first path was convincingly familiar, but the economic and sociopolitical problems lying ahead loomed large, and were eventually, perhaps, insuperable. The second path, though it represented a shift in direction, offered many social, economic and geopolitical advantages. In the article, Lovins reminded us that the two paths are likely mutually exclusive. Because commitments to the first may foreclose the second, we must soon choose one or the other before our failure to stop the current trajectory has foreclosed both as options.

Thirty-four years later, we can look back on Lovins’ important work. While we have progressed, the energy challenges before us loom ever large. Our incremental strategy – our lack of choice – has left us no farther along than we were so long ago.

As we look at health and healthcare in America, we face the same crossroad that Lovins saw in energy in 1976. We can continue on a path of incremental change based on a system which, while good in many ways, fails to meet global standards on significant measures of quality and outcomes and which we know is unsustainable over time. The choices we are being given, as Dr. Don Berwick, the Administrator of Center for Medicare and Medicaid Services and former head of the Institute for Healthcare Improvement tells us, are to “spend more or do less.” But Berwick offers us a third choice – another path: “redesign.” Our challenge is to define the path and create the leadership that will result in the shared creation and ownership of a sustainable system that will have every American simultaneously realize better health, better care and lower costs.

Lovins provided two ideas for how we might think about this redesigned system. The first is the principle of “end use/least cost.” This important concept considers what quantity, quality, scale, and source of resources will achieve the desired goal or task in the least expensive way. The system design starts with what people really want. In energy, Lovins speaks of hot showers and cold beer. In health, what we really want is to be as healthy as possible for as long as possible — and to be treated respectfully, quickly, compassionately, safely, effectively and affordably when sick. We want the focus to be on us... not on a system.

The second concept Lovins offers distinguishes the “hard path” from the “soft path.” It demands that we consider the alternatives to our current high technology, highly invasive, costly structures and approaches to health and care that may in fact be equally or more effective. It requires that we consider the consumer’s desires and informed choices as key and respects the body’s inclination to heal itself in many cases if given the right support. It respects the value of time, attention, and conversation. It gives us a mandate to be truly present and patient-centered.

Data Driven Approach

More than 20 years of data collected and analyzed by the Dartmouth Atlas of Health Care, now under the direction of Dr. Elliott Fisher, presents glaring variations in how medical resources are distributed and used in the United States. The project relies on Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. While private payer rates may not always parallel the Atlas data, this data set also shows wide regional differences in costs even as utilization patterns are similar to those in the Atlas. The bottom line... in this country, the same or better health outcomes are achieved with widely differing approaches to care and with widely differing costs as a result.

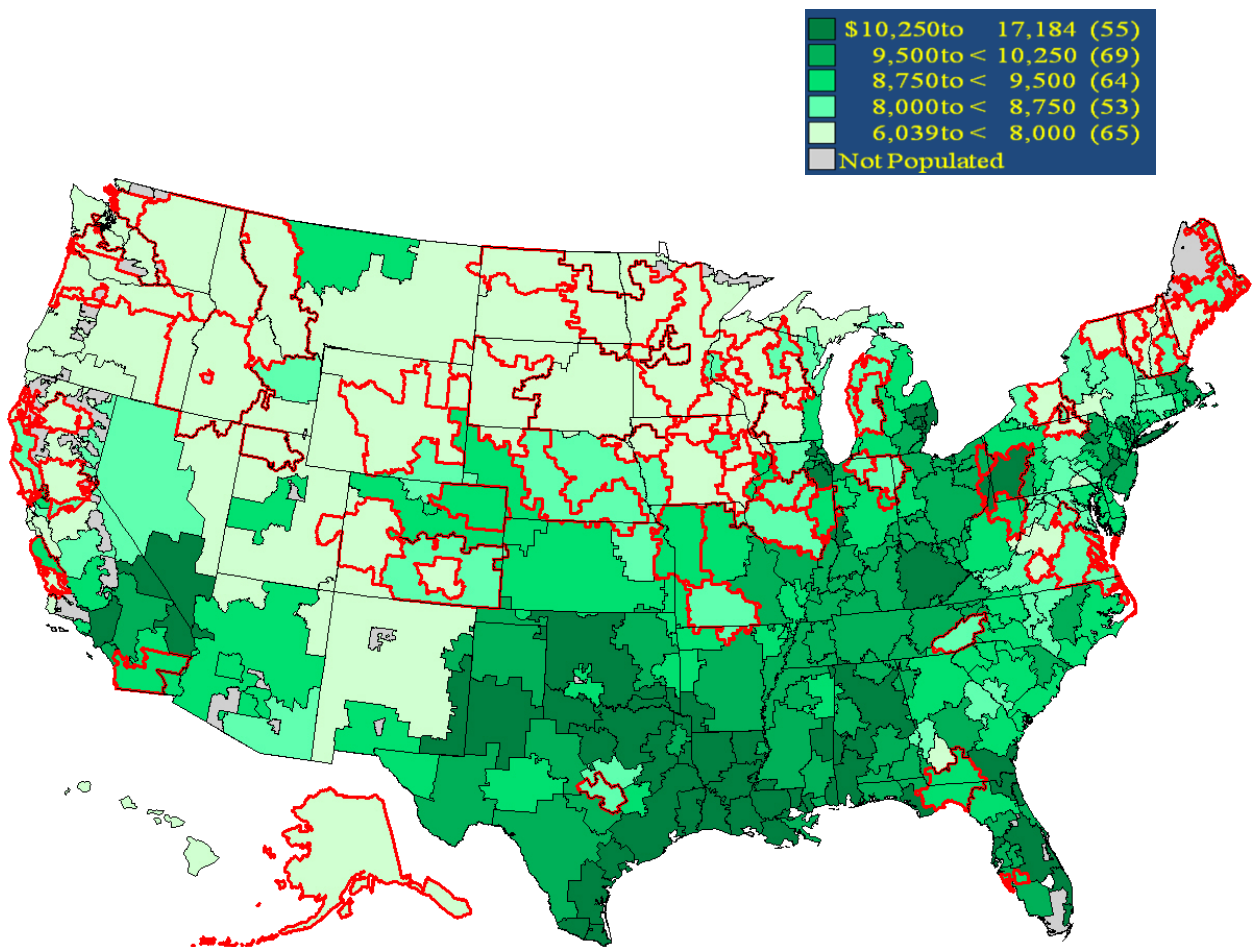
In June, 2009, ten of 74 health systems with above average overall quality and lower than average Medicare costs were brought together to ask “How Did They Do That?, how did they achieve “Low Cost, High Quality Care in America?” Many of the answers pointed to the importance and impact of local culture and local leadership. Leadership from a major regional

corporation, a health system CEO or a community payer, a provider culture created by the regional medical school, a system culture grown from the values of the founders such as the Mayo brothers or a denomination of nuns, the behavior patterns of the local community, the cost structure established by state government, the existence of a certificate of need program and more. Other common themes included:

- Shared aims and accountability to the community
- A strong foundation of primary care
- Physician engagement as leaders
- Savings through reduced use of the hospital
- The use of data to drive change

Not only was the impact of local culture and behavior considered critical, it was clearly evident that regions or communities made up distinct health systems – influenced by but not controlled by national policy. Communities were a clear target for change – as significant as health reform.

74 High Quality, Low Medicare Cost Health Referral Regions



The Atlas has also helped identify where the majority of difference in spending between high and low cost regions occur in our system. Medicare costs and system utilization seem to be fairly consistent for conditions or treatments where the benefits are clear for all and effective standards for care have been set. Examples include reperfusion or aspirin after a heart attack or pap smears for women over 65. Utilization also is quite similar across regions where clearly value based and preference sensitive decisions are required – hip or knee replacement, back surgery, coronary bypass surgery. Importantly, the majority of the differences between high and low spending regions by a factor of almost two are the supply sensitive, often unnecessary and avoidable provisions of care. These reflect the decisions made primarily by physicians at the moment of the patient encounter and are highly influenced by the prevailing regional culture. Examples include total inpatient days, impatient days in the ICU or CCU, evaluation and management visits, imaging, and diagnostic tests.

The over provision of services is also reinforced by a prevailing patient attitude that “more is always better” even as evidence shows that more may sometimes be worse. Studies show that higher spending regions have no better health outcomes (no gain in survival or better functioning), worse perceptions by physicians of the ability to communicate and coordinate, and greater physician perception of scarcity, as well as lower patient satisfaction with hospital care, worse access to primary care, and no less sense that care is rationed.¹

Additional drivers of care and costs that are often cited in reality have little impact. Patient demand makes little difference and malpractice accounts for less than 10% of the increased costs. Supply, the availability of services including specialists, test facilities, hospital and ICU beds, etc., emerges as perhaps the most powerful driver explaining something approaching 50% of the difference between the high and low spending regions – with little impact on overall population health or health outcomes.

Within this context, evidence is important but seems to have a limited influence on clinical decision-making where physicians rarely get feedback on judgment calls and where they practice within a local culture and context that profoundly, but invisibly, influences their decision making. Hospitals, challenged to maintain their bottom line, are forced to increase supply and recruit accordingly. Specialist availability then increases referral. And local social norms drive the public to welcome more care. Supply then drives demand – not medical necessity.

¹ (1) Fisher et al. *Ann Intern Med*: 2003; 138: 273-298

(2) Baicker et al. *Health Affairs* web exclusives, October 7, 2004

(3) Fisher et al. *Health Affairs*, web exclusives, Nov 16, 2005

(4) Skinner et al. *Health Affairs* web exclusives, Feb 7, 2006

(5) Sirovich et al *Ann Intern Med*: 2006; 144: 641-649

(6) Fowler et al. *JAMA*: 299: 2406-2412

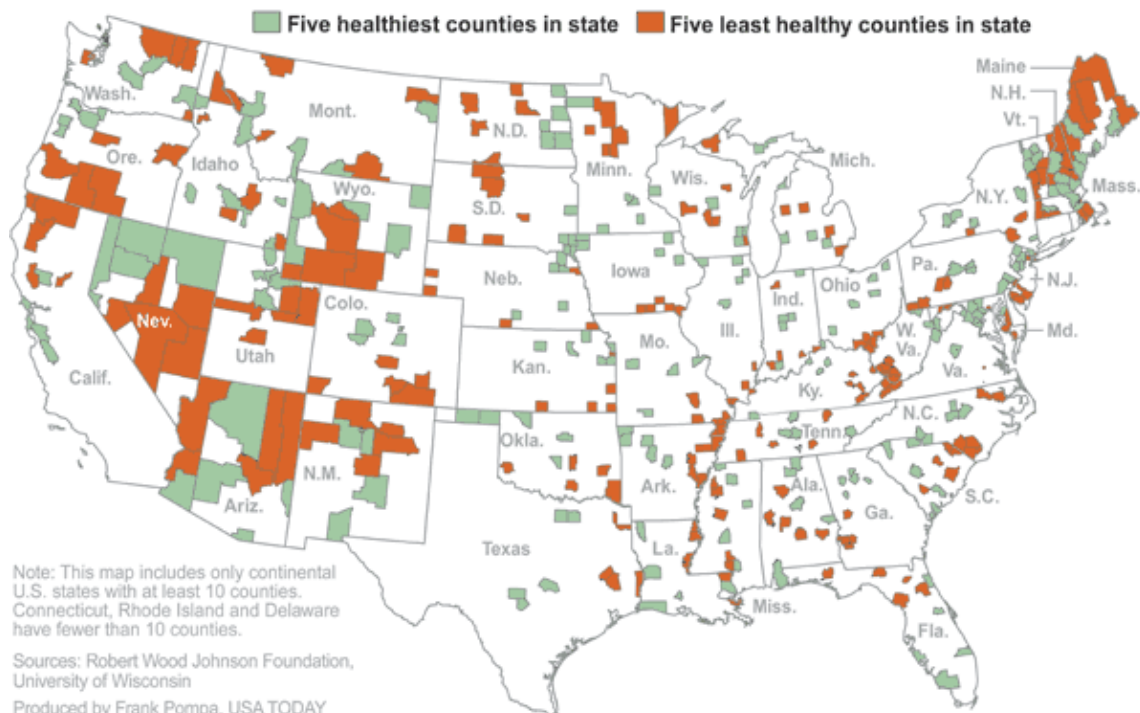
As Atul Gawande’s important and influential *New Yorker* article, “The Cost Conundrum,” so dramatically showed, regional differences in care and costs can be profound. His examination of McAllen and El Paso, Texas, dramatize the important impact of local culture and leadership of how we shape the approaches to health and care in the future.

Population Health

Certainly, supply, reimbursement, and the structure of the health care industry are major factors driving the future of our health care system. Yet our nation’s future will ultimately be determined by the health of the population and the culture and environment in which we live. These are the underlying problems that will ultimately be the source and solution to our nation’s health and healthcare challenges. The recent Robert Wood Johnson Foundation funded project to develop county by county maps of health indicators and outcomes for every state in the nation has begun to provide a database on which local communities and states can build. By understanding their relative and absolute standing on a variety of issues, interventions can be crafted and impact measured over time. While difficult, solutions – particularly the ones that address the drivers of chronic diseases like heart disease and diabetes – must consider the cross-boundary rolls and impact on the health system of the environment, economics, the food chain, obesity, exercise, stress, community violence and more. These will ultimately make a greater impact on the creation of a sustainable health system than many of the health reform efforts now in place.

State-by-state: Counties rated highest and lowest in health

Researchers ranked counties by “health outcomes” and “health factors.” This map represents “health outcomes,” based on disease and death rates in each county.



Context for Change

The quality movement in American healthcare is more than 20 years old. While America still lags behind other developed countries on key indicators of health and care, aspects of our acute and high-tech care system remain among the impressive results of industrialization. With increasing data and a growing focus on quality, we are now able to point to examples of significant improvements in hospital mortality rates, line infections, ventilator related pneumonia, patient suicides, and more. We are also able to point to examples of regions that have realized lower costs through reductions in specialty visits as a result of integrated care teams and expanded access to primary care, as well as reduced medical errors and readmissions. Chronic diseases, once considered acute, are now more successfully managed over longer periods of time.

But even as aspects of the system improve, access, cost and overall population health continue to move in the wrong direction. According to Peter G. Peterson, former Secretary of Commerce and founder of the Blackstone Group, without fundamental reforms, within 12 years total US revenues will only cover Social Security, Medicare, Medicaid and interest on the debt assuming the baseline interest rate of 5.0%. There will be no money for anything else. Further, our success in addressing the low hanging fruit of our health system only strengthens our realization that these solutions alone will not fix our health and care problems. The requirement that we get to the tougher systemic problems such as the underlying determinants of health only increases. And with the anticipated limit in the growth of available healthcare dollars, we must begin to look outside of the traditional boundaries and approaches of the past. As Dr. Barry Coller, a leading scientist at Rockefeller University, observed, our medical advances have led people to believe that they can live forever and that doctors can fix anything. We have abdicated our bodies and our lives to science and the medical community without admitting that their power is limited – and solutions might lie elsewhere.

Clearly the solutions cannot rely on the technical fixes that have brought us to where we are today. They can only be addressed in a system and culture that encourages trust, embraces new relationships and emphasizes personal responsibility. Finding solutions, as Rosebeth Moss Kanter of Harvard has said, will require that “we don’t just need to think out of the box, we need to think out of the building.” According to Kanter, existing corporate structures, controls, and incentives work against out-of-the-box thinking. To foster innovation, we should

1. **Look for small innovations, not just blockbusters.** Truly new concepts often spring from smaller beginnings.
2. **Create processes and controls.** The innovation process is inherently uncertain and requires new ways of tracking progress.
3. **Select the right leadership.** Isolated ideas will never catch on. Leaders are needed who can communicate and foster a collaborative culture.

4. **Create a culture of innovation.** Companies need a culture and way of working that emphasizes flexibility and attention to relationships across traditional boundaries.

Solutions

As the nation begins to accept the nature and importance of the challenge before us, there will be a growing effort to address those things we know can make a difference to the quality and cost of care. Some of these include strengthening primary care networks and medical homes, emphasizing chronic disease management, identifying and targeting high utilizing patients, expanding meaningful use of health information technology, experimenting with new insurance models, and heightening awareness about prevention. While important, many of these represent what Peter Senge calls symptomatic solutions. They address the symptoms, not the lasting root causes of the problems.

Fundamental solutions, those that over time will lead to an appropriate and necessary redesign of the system and truly sustainable change, will come from new thinking about the entire system of health and care, as well as innovative efforts – often small or regional to begin with – that show that change is possible. Drawing in part from Lovins models in energy, we must begin to consider innovations in when and where care is delivered, and in what quantity for optimal health. We must consider the structure of the health labor force and the new jobs and opportunities that could be created from down-sizing hospitals and specialist practices where over-supply exists. We must begin to look at new partnerships that cross traditional industry boundaries and engage community, consumers, employers, policy-makers and health providers in accomplishing a shared vision. We must provide access to care for everyone when needed since health affects us all. The payment system – for consumers and providers – should reward the behavior we want, not what we don't want. And medical or health provider education should encourage new models of care, not perpetuate a system that has been shown not to work. Palliative care and hospice should be better integrated into our health options. And ultimately, we must focus on how to keep people well and help them make truly informed decisions, including those at the end of life, based on their own priorities and values and those of their families, not the priorities of a doctor or a system.

The goal is a system that truly works for people....

Getting There

“Each man is locked into a system that compels him to increase his herd without limit – in a world that is limited. Ruin is the destination toward which all men rush...”

Garrett Hardin, “The Tragedy of the Commons” Science 1968; 162:1243-8

“When all is said and done, the only change that will make a difference is the transformation of the human heart.”

Peter Senge, Presence: Human Purpose and the Field of the Future, Page 26

There are models across the country of communities that are closer to an optimal vision of better health than others... and hospitals and health systems that truly deliver better healthcare at lower costs. While the solutions may differ depending on local culture and circumstances, many elements are transferable and can inform and stimulate new approaches to health and care. With all of this, we are left with a fundamental question of what health and healthcare in America should look like. And how do we foster the new thinking and new behaviors that will get us there from where we are today? These are the questions being addressed by ReThink Health.

An effort co-founded in 2007 and convened by the Rippel Foundation, ReThink Health brings together a highly diverse, dedicated and growing group of experienced leaders, thinkers and doers in an on-going dialogue and learning process. Having worked together to develop shared vision and values, the members have committed to a multi-year action-research agenda to change our nation's behaviors and systems around health and care. The Foundation-led effort began with an initial exploration of the relationship between health and energy with Don Berwick and Amory Lovins. The group now involves nearly 30 leading experts from across the country from a variety of fields.

Projects are designed to foster the thinking, understanding, leadership, tools and models that will lead to a sustainable health system for all Americans. Partnerships and action-research projects have been developed with some of our country's notable change agents whose expertise in sectors outside of healthcare is being innovatively applied to the work of ReThink Health. Examples of these leaders include:

- **Peter Senge, PhD**, founding chairperson of the Society for Organizational Learning, a senior lecturer at the Massachusetts Institute of Technology and the author of [The Fifth Discipline: the Art and Practice of the Learning Organization](#). Senge is known for translating the abstract ideas of systems theory into tools for better understanding of economic and organizational change.
- **Marshall Ganz, PhD**, a lecturer in public policy at the Kennedy School of Government at Harvard University. Ganz worked on the staff of the United Farm Workers for sixteen years before becoming a trainer and organizer for political campaigns, unions and nonprofit groups. He is credited with devising the successful grassroots organizing model and training for Barack Obama's winning 2008 presidential campaign.
- **Elinor Ostrom, PhD**, a professor at Indiana University - Bloomington, awarded the 2009 Nobel Memorial Prize in Economic Sciences for her analysis of economic governance, especially management of the commons, resources shared between or among populations. Ostrom's core efforts, many of which have focused on the management of natural resources, include the development of a more general theory of individual choice, as well as an institutional approach to public policy, known as the *institutional*

analysis and development (IAD) framework, that recognizes the central role of collective action, trust, and cooperation in coping with complex social dilemmas.

These are only a few examples of ReThink Health’s many efforts to identify and seed the creation of new approaches to health and care. By providing fresh and realistic approaches, we believe it is possible to give Americans what they really want and need: to be as healthy as possible for as long as possible — and to be treated respectfully, quickly, compassionately, safely, effectively and affordably when sick.

Principles

There are important common threads and key principles that guide our collaborative approach to change. All embrace the power and importance of leadership and the critical elements of collective actions, trust, cooperation and shared responsibility. They also bring a profound sense of optimism that positive change can be achieved – driven from the heart and informed by a capacity to be present, to listen, to trust, and to work together toward a shared vision. Rippel and ReThink Health’s goal is to better understanding what works and what does not, as well as how success can be measured. Our goal is to provide new models and tools for change so that people can jointly design and adapt their institutions to generate better and more desirable outcomes.

“We’ve come to believe that the core capacity needed for accessing the field of the future is presence. We first thought of presence as being fully conscious and aware in the present moment. Then we began to appreciate presence as deep listening, of being open beyond one’s preconceptions and historical ways of making sense. We came to see the importance of letting go of old identities and the need to control and, as Salk said, making choices to serve the evolution of life. Ultimately, we came to see all these aspects of presence as leading to a state of “letting come” of consciously participating in a larger field for change. When this happens, the field shifts, and the forces shaping a situation can shift from re-creating the past to manifesting or realizing an emerging future. “

Peter Senge, Presence: Human Purpose and the Field of the Future, Pages 11-12

Rather than succumbing to the “tragedy of the commons,” an inevitable trap from which we cannot escape, we believe in the capacity of individuals to develop optimal solutions to the challenges they face when they work together. Yet the capacity to do so seems to vary from situation to situation. As Ostrom says in Governing the Commons, “Why have some efforts to solve commons problems failed, while others have succeeded?”

To help guide our efforts, Rippel and ReThink Health rely on the following principles:

- **Better Health, Better Care and Lower Costs**
 - A sustainable health system can only be achieved by simultaneously addressing America’s needs for better individual and population health, better health care, and lower overall costs. A focus on any single aim will almost certainly compromise the others over time.
- **Systems Thinking by Leaders Working Together Across Boundaries**
 - The complex challenges before us can only be solved by developing sustained relationships among leaders from multiple organizations at the local, regional, state, national or international level who can work together across traditional boundaries to bring systems thinking to develop new structures, practices and policies.
- **Redesign to Meet Fundamental Health Needs at the Lowest Possible Cost**
 - A sustainable health care system must satisfy individuals’ needs – what they really want – at an affordable cost and can only be achieved through rethinking and redesigning systems.
- **National Purpose, Local Action**
 - Because health is supported and occurs within communities and most care is now and will almost certainly be delivered regionally, change must be driven at the local and community level with different places having different solutions yet unified by a shared purpose and supportive policy environment.

Approaches That Will Make a Difference

As we better understand and learn to take a systems approach to change, we know that our focus must be on long term, fundamental change, not short term fixes that may create even worse problems down the road. We must understand that investments in the short run can lead to longer term gains. Additionally, to acknowledge that there may be several opportunities for effective interventions – some of them not obvious. We must also be free to examine and experiment and to learn incrementally from structures and approaches that do not now exist.

To realize these changes, we need leaders capable of leading from a core set of values and beliefs that can engage others in true dialogue based on trust and mutual respect. Their capacity to be present and to share their stories will help garner the support and commitment of others who are also willing to take the risks associated with change. We must support that change with data, models, learning, and policies that take us where we want to go. In short, “we must have substantially new manners of thinking to enable mankind to bridge the gap between the things that have been and the things which will be.” (Julius A. Rippel, 1969)

While most of the technical solutions now being pursued as a result of the recent health reform legislation and by health systems are critically important to improving the quality of and access to care, they remain, as Lovins said of energy policy, “essentially an extrapolation of the recent past, relying on rapid expansion of centralized high technologies to increase supplies.” By seeking out new and untapped opportunities, and trying to continuously ask the questions that others have not, cannot or will not ask, we believe there are things that, over time, will make a difference – either in a region, a state or the nation as a whole. This second path combines a commitment to efficiency and sustainability matched in scale and in quality to end-use needs – the health our population really, really wants. As we work together to pursue this path, our approaches include:

- Helping providers and consumers better understand the roles each plays in the healthcare system and how they can be catalysts and co-producers of better health, better care and lower costs
- Changing how we think and talk about health, care and particularly end of life to create opportunities for families to make decisions about what they really, really want
- Creating models and tools to introduce true system thinking to health, community, business, and policy leaders of today and tomorrow
- Fostering leadership and organizing skills that can bring new vision and energy to the challenges before us
- Bringing successful approaches to change from other industries to our approaches to health and care
- Understanding the health industry’s assumptions, models and structures that work and those that don’t to help inform policy, reform and redesign
- Developing new data sets that help inform and document change
- Convening leaders across sectors to engage in new thinking about the future of health and care in our country and the drivers of change
- Developing a new generation of researchers and change agents who can take the learning of the past and the present into the future
- Supporting efforts that recognize and reinforce the central role of collective action, trust, and cooperation in coping with complex social dilemmas
- Sharing the stories for greater impact and change

Projects and Partners

To help achieve the goals of better health, better care and lower costs for all Americans, the Rippel Foundation, through its partnerships with the members of ReThink Health and others, has seeded a number of substantive projects designed to bring new tools, new thinking, and

new leaders to the redesign of our health system and to the challenge of keeping our populations well. Visit <http://rippelfoundation.org/category/initiatives/> for in-depth descriptions of our initiatives.

Conclusion

The Rippel Foundation and ReThink Health are engage in an important journey to transform our system in a way that truly helps victims of diseases like heart disease and cancer and key populations like women and the elderly get what they really want related to their health and what they need from their healthcare system. This encompasses creating a sustainable health system where hospitals play an appropriate role in a larger system of care. The path we have chosen is significantly different from other Foundations, and engages a growing group of amazing and engaged partners who share our passion and commitment to constructive change. The Board and the staff of the Foundation play a critical role identifying, developing, nurturing and growing the people and projects that can help make a difference in this highly complex system. Our work will continue to evolve and to change as we continue our efforts to “seed innovations in health.” We are at a crossroads and have chosen our path...

*Two roads diverged in a wood, and I –
I took the one less traveled by,
And that has made all the difference.*

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