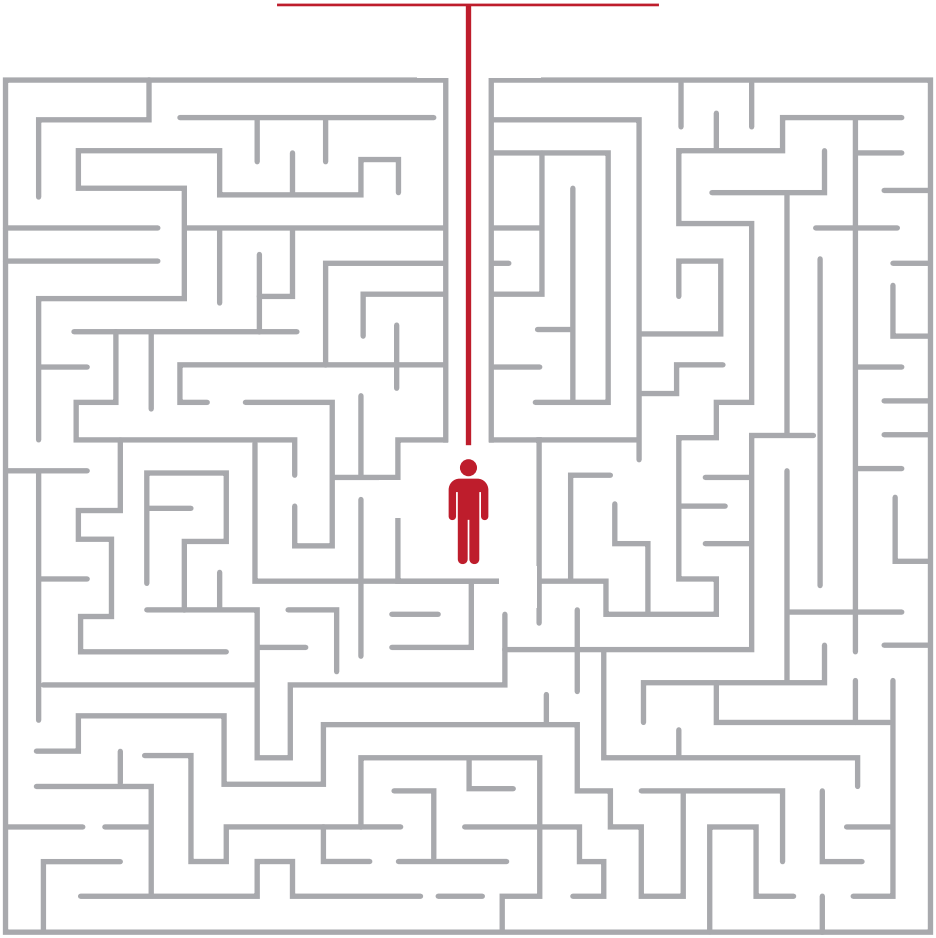
The Health Care Delivery System

A Blueprint for Reform



Center for American Progress and the Institute on Medicine as a Profession

CHAPTER 2

The Organization of Health Care Delivery

A Roadmap for Accelerated Improvement

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OVERVIEW

The problems facing the U.S. health care system are often portrayed as unique to this country. Indeed, our system has the most expensive price tag and the highest rate of cost-related barriers to health care of any comparable nation. Yet we may not be as different as we imagine. Costs in some other developed countries are rising at about the same rate, and concerns over gaps in quality and safety are widespread internationally.

The ubiquity of this trend indicates that policies for financing health care alone are unlikely to resolve cost challenges. Real progress will require a multipronged strategy that promotes greater organization and integration of health care—a goal that should be an explicit focus of the next administration's policies.

Organization of health care providers is itself a means to an end; it will establish and promote systems that improve efficiency, reliability, safety, and patient-centered care—goals detailed in the book's introduction. Greater organization of care has the potential to lead to important benefits such as better integrated and more efficient care, but it will also make difficult demands on health care providers.

KEY POLICY RECOMMENDATIONS

- Develop a federal commission with authority to offer a one-stop shop for would-be integrated organizations to obtain a facilitated review of proposals to develop new organizational models and payment approaches.
- Align payment approaches to hospitals with physician incentives, encouraging the development of hospital-physician organizations functioning as self-contained, integrated, delivery systems—beginning with Medicare.
- Support regionally based organizations to support data and public reporting on individual and organizational quality. Medicare should actively participate by contributing provider-specific data, consistent with privacy protections, to permit more robust measurement of provider performance.

Health care culture will have to move away from the current emphasis on physician autonomy over collaboration, which does not always promote the professionalism needed in an increasingly commercial health care environment. This more unified health system will require shifting away from the fee-for-service payment system that rewards volume of services, and therefore supports the current fragmentation among U.S. health care providers. An information systems infrastructure can facilitate collaboration among providers and with patients themselves, but the federal government will have to work to implement and promote use of these systems.

The relationship between providers and patients will also have to change. Providers will have to overcome public perceptions that organizations may prioritize financial considerations and compromise physicians' duty to act in their patients' best interests. Larger provider groups will also likely need to begin matching and even exceeding the personalized service offered by many small physician group practices in order to attract patients. And patients and providers will have to balance organized provider groups' potential to negotiate higher payments against their ability to provide improved care.

Daunting though it may be, the challenge of disorganized health care is worth confronting. The shared root cause behind rising costs and disappointing quality is the chaos resulting from medical progress in a fragmented and disorganized delivery system. Many providers still rely upon paper documentation and memory in treating patients, and they struggle to deal with a tidal wave of new information, tests, and treatments. Indi-

vidual physicians cannot know all they need to know, and do not have the time to do all that they should to stay on top of medical innovations.

Alternative forms of real-time communication have become standard in other sectors of the economy—phones, email, text messaging—yet they are underused in health care where the fee-for-service payment system stays rooted in face-to-face interactions between physicians and patients. Most clinicians do not even have the systems in place that could help them coordinate their efforts with their colleagues or patients themselves.

The most effective way to address our cost and quality challenges is to confront the root cause—the chaos in everyday health care. We should focus our efforts on accelerating the organization of health care providers so that they can adopt systems that are likely to reduce errors and improve the overall coordination of care. Health care spending will inevitably rise as people live longer and new tests and therapies become available. But clinicians can mitigate these cost increases if they have help identifying the best and most cost-effective management strategies and incentives to adopt these strategies, and if they work in teams that help patients stay as healthy as possible.

Organization of health care providers will not occur naturally or easily. Medicine relies on the high professional standards of individual physicians to ensure quality. Admirable though it may be, holding individual doctors accountable for excellence has led to a health care system in which most patient visits are to small (one to four physicians) practices.[1] These stand-alone small businesses treasure their autonomy, and are often unwilling and unable to adopt information systems that allow them to coordinate care with other providers.

Yet medicine today is so complex that patients with serious conditions virtually always need care from multiple clinicians and other health professionals, who should be working as a team, sharing information about their patients. Teams need structure, leadership, communication tools, and "playbooks." In short, they need to be organized so that they can create the context for systems that improve care, including information systems, team-based care, and disease management programs.

Information systems, such as computerized physician order entry and electronic medical records, help physicians make better decisions. They can provide information, such as the safest and most cost-effective drug, and facilitate collaboration with other members of care teams by allowing each medical professional to see what has been done for the patient.

Information systems can also facilitate care by permitting the care of populations of patients and of individuals throughout the year, not just when they have acute problems. An example is the use of registries to keep track of patients with diabetes, which enable providers to contact patients who may not have come in for recent office visits with reminders that they need preventive care.

Disease management programs can help improve coordination of care for the sickest and most complex patients by providing highly personalized evaluations of their needs, often via telephone call centers. Just 5 percent of patients account for about 50 percent of healthcare spending; frequent contact with health care professionals outside of physician office visits can reduce their rates of emergency department visits and hospitalizations. Vendors external to provider groups usually provide disease management services, but their functions can often be performed more effectively when they are integrated and coordinated with patients' physicians.

Most U.S. healthcare providers operate in an environment that is too fragmented to support development of such programs. Indeed, most providers are not part of organizations capable of negotiating contracts with the health plans that would reward them for adopting such systems and achieving economies of scale.

Provider organizations can help—and should be expected—to protect a commitment to highly valued professional standards, such as avoidance of conflicts of interest and a commitment to serving the whole community, not just those with preferred health insurance cards. Thus, there is a potential "goodness" to "groupness" that extends beyond the direct effects of better and more efficient care for individual patients.

THE FUTURE OF HEALTH CARE DELIVERY

Organized care is not an abstract concept or an unattainable ideal. Several organizations already use information systems and teams of clinicians to provide care efficiently, reliably, and safely. Some of these organizations are fully "integrated" delivery systems that own the hospitals, employ the physicians, use a single information system, and also play the role of health insurance plan. Examples include the Veterans Health Administration, Kaiser Permanente, Intermountain Healthcare, and Geisinger Health System.

Some of these tightly organized, fully integrated systems have patients who are "locked in"—that is, they pay a substantial financial penalty if they seek care outside of the organizations' physicians and facilities. When patients, physicians, and hospitals are all completely integrated into a single organization, it makes business sense to meet patients' needs as efficiently as possible. These fully integrated systems are therefore providing much of the leadership in the United States for the development of systems such as disease management and care coordination programs that prevent hospitalizations and promote "non-visit care," which allows patients to interact with clinicians without having to make an actual office visit.

Yet the painful reality is that the cost-savings potential of information systems, disease management, and other such systems is largely unproven in mainstream American medicine.[2] Some organizations have found that these systems can indeed help them provide accessible, efficient, reliable, and safer care, but the costs of the systems often offset savings from greater efficiency. And when systems are able to lower misuse and produce savings, these savings accrue to the payer, but not the provider organization, whose fee-for-service payments go down. This creates roadblocks for further evolution of cost-effective reorganization or health care delivery.

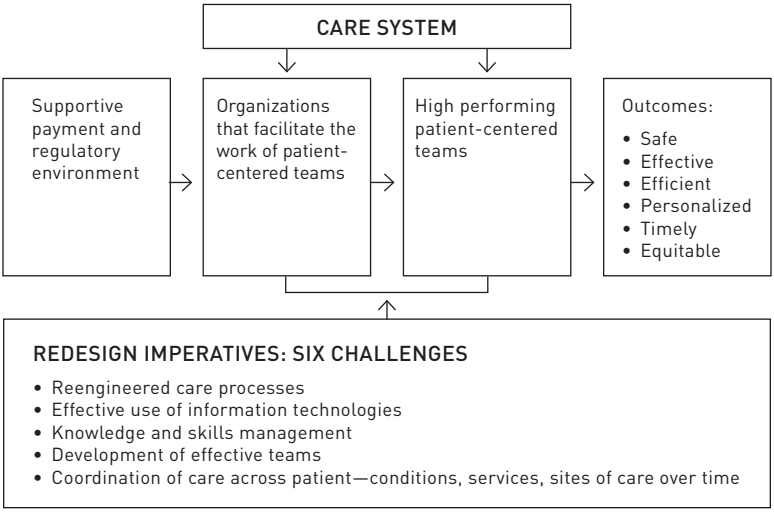
We will need to enhance organized care's ability to achieve cost savings. Organization of care does more than just save money, but it must do more than pay for itself to ensure widespread implementation. The federal government should provide compelling incentives to encourage providers to become part of organizations, and then achieve the efficiencies that will enable them to reduce costs. To achieve true cost savings, provider organizations must be able to set ambitious goals that transcend the abilities of individual physicians and individual hospitals, such as reducing preventable admissions of patients with chronic diseases, reducing readmissions for recently hospitalized patients, and providing care in the most efficient settings.

We also need to enhance the attractiveness of organized care to patients themselves. Organized care competes with the convenience and personalized service that many small physician practices provide. Organized care must maintain the aspects of service that come with the traditional doctor-patient relationship, as well as implement systems that will provide patients with enhanced services, such as access to information and the ability to schedule appointments and tests online. Organizations should also

encompass small practices dispersed throughout the community, where practical, by encouraging the adoption of information technology, especially fully interoperable electronic medical records. In this way, the small practices that often provide first contact care can retain their responsiveness to patient needs, while also taking advantage of the organized group capabilities for referrals, quality improvement, and systems' support. "Adoption" of small practices by organized groups might also help address the particular organizational isolation faced by small rural providers.

The Institute of Medicine, in its report, "Crossing the Quality Chasm,"[3] describes what health care delivery organizations need to redesign their systems (Figure 1). It asserts that effective provider organizations cannot exist without payment and regulatory environments that enable them to thrive. Supportive environments allow providers to organize teams that redesign and coordinate care, and use information systems and management tools to improve performance. These innovations enable providers to follow patients over time, meet their needs outside of hospital admissions and office visits, coordinate their care with other clinicians, and reduce waste. Creating the context for improved care will therefore require policies that spur change in the payment system, the culture of providers, and the market itself.

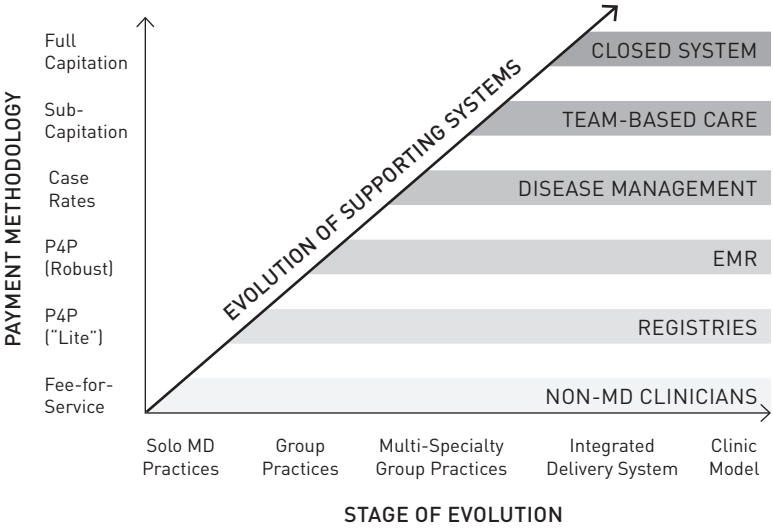
Figure 1.
The Institute of Medicine's requirements for making change possible[3]



Payment reform

Organization and improvement cannot proceed without change in how health care is financed. Payment systems interact with provider organizations, and there is a rough "fit" between the level of provider organization and the most appropriate and effective type of payment system (Figure 2).

Figure 2.
Evolving Reimbursement and Care Models



Provider organization evolves from solo physician practices to groups and multispecialty practices. These physician organizations can take on contracts with insurance plans that provide incentives for improving the reliability of care—bonuses for higher rates of eye examinations for diabetics, for example—what we label "Pay for Performance - Lite." Providers can achieve these relatively modest goals with correspondingly modest systems, such as file cards maintained in shoe boxes. Unfortunately, research shows that Pay for Performance - Lite does not effectively improve care. Testing diabetes control, for example, does not necessarily lead to lower

glucose levels or longer lives for diabetics. Nor does this form of pay-for-performance foster other types of improvement, such as greater efficiency or improved safety by decreasing overuse and misuse of care.

"Pay for Performance - Robust" performance systems include direct incentives for improving efficiency, such as increasing the rate of generic agent prescriptions or decreasing the rate of high-cost radiology tests and medical-surgical admissions per 1,000 members. To effectively take on such goals, providers generally need more advanced software systems such as electronic medical records with decision support, as well as more advanced human systems, such as heart failure disease management teams. The more robust pay-for-performance model would also include incentives for improved patient outcomes. But the challenges of measuring and rewarding true outcomes are formidable, and, for now, such measures should only be adopted for important conditions where there are readily implementable outcome measures.

Farther down the road of provider organization are integrated delivery systems that include hospitals and physicians, many of whom may be affiliated, but not actually under employment agreements with the organization. Examples include Advocate Health System in Chicago and Partners HealthCare System in Boston. Beyond these integrated delivery systems are "Clinic Model" organizations, where all of the providers are employed by a single organization, such as the Veterans Health Administration and the Mayo Clinic.

More organized provider groups have the ability to be more effective in developing and pursuing organizational goals, which can be focused on quality, efficiency, or both. Not all relatively well-organized groups are currently focused on controlling overall health care costs. Fully integrated clinics that derive most of their income from patients who are referred to their specialists tend to focus on providing excellent service and saving time for referring physicians and the patients themselves, regardless of the cost. No matter what goal is being pursued, more organized groups have greater potential to be more effective than less-organized groups.

Organizations that include hospitals as well as physicians can negotiate "case rates" or "bundled payments" that provide a fixed payment for an episode of care (see chapter 4 on payment reform for more information). An example that received considerable publicity in 2007 is Geisinger Health System's coronary artery bypass surgery program, which "guaranteed" that

40 key processes would occur for every elective bypass surgery patient. The program sought a case rate payment that would cover the inpatient procedure and 90 days of care for any complications that might occur afterward. This approach has attracted considerable attention for representing a "sweet spot" in which both quality and efficiency goals are aligned. The Geisinger providers have every incentive to be efficient so that they do not lose money under the case rate. Reducing complications by reliably providing evidence-based care is one of their key tactics for doing so.

Some might view the ideal end-state for health care as the upper right corner of Figure 2—a closed system in which patients receive all of their care from a tightly structured clinic-model organization that is being paid under full capitation—a fixed per member, per month payment. But this ideal model has been limited by the value that patients place upon the option to seek care from whomever they choose—even if it is outside their "network" of providers. Closed systems are especially difficult to develop in rural settings, where there are fewer providers separated by greater distances. And bringing all these providers into one organization can arouse antitrust concerns under current interpretations of the law.

Full capitation approaches have also been hampered by the lack of good risk adjustment, which alters payment amounts depending on the underlying health of the population served. Without payments that reflect enrollees' characteristics, groups spend inordinate time figuring out how to avoid having to care for patients with potentially high-cost health care needs rather than rolling up their sleeves to better care for them. Newer capitation methods are now available to reduce the perverse effect that capitation payments can have on provider group behavior.

The relationship between payment system and provider organizations illustrated in Figure 2 suggests a flexible approach to payment that would allow providers to choose the type of payment model that they prefer. Yet it also incentivizes more advanced payment systems by rewarding the improved quality and efficiency that those more advanced payment systems would enable. Under this approach, individual physicians in solo practices might opt for fee-for-service payments, but more organized groups could choose pay-for-performance, case-rate models, or even capitation. A hybrid payment model used in some marketplaces uses budget-based capitation with the potential for a 3 to 10 percent bonus if the providers achieve specific quality goals. The capitation component pro-

vides a direct incentive for efficiency, while the bonus program provides direct incentives for quality.

These choices should not all have equal value—and more advanced payment systems should carry greater potential rewards that correspond with their greater financial risk. Capitation-based contracts, for example, should be structured so that *most* of the providers enjoy a budget surplus as long as they achieve specified quality goals.

The explicit message for providers who are not part of any organization and are set up to accept only fee-for-service payment should be that annual increases in payments may not keep pace with inflation in their costs. This has essentially been the situation in Medicare in recent years. Indeed, payments for some services provided by specialists might be frozen, or actually reduced in real terms, to correct for current distortions in public and private insurance fee schedules that inappropriately reimburse procedural services more generously than evaluation and management services.

Further improvements to fee-for-service payment could include monthly care management supplements to primary care physicians in a "patient-centered medical home" so they can better support patients with chronic conditions. But while fee-for-service reforms need to occur as an interim step to help promote the conditions conducive to integrated organization development, pure, traditional fee-for-service is not a viable long-term business model, except in unusual circumstances, perhaps in health professional shortage areas.

Provider evolution

Providers need to move from a culture based on pride in individual excellence to one that, while not conceding this core value, adds to it pride in organizational effectiveness. This shift will help make the organizational changes needed to deliver higher quality and more efficient care. Health policies can reinforce two key aspects of this evolution: working in teams that focus on improving care over time, and using systems that improve care.

Payment systems should reward providers who are willing to do more than address the needs of the acutely ill patient. Physicians must work in collaboration with non-physicians to improve care for certain populations, and meet the needs of individuals in between office visits and hospitalizations. Commercial and government insurer payment policies

can promote such collaboration through, for example, contractual incentives to reduce rates of hospital admission for patients with heart failure or re-admission for patients with conditions such as asthma and chronic obstructive lung disease. Considerable evidence exists that close regular contact with such patients can reduce hospitalizations and improve outcomes. "Care coordination" and "disease management" are most efficient and effective when implemented by non-physicians, such as specially trained nurses, with support from others with unique clinical skills such as pharmacists and nutritionists.

Federal payment and regulatory policies can also hasten adoption of information systems such as electronic medical records and computerized physician order entry. The cost-savings potential of such information systems is difficult to isolate or prove, but there is broad consensus that major improvement in health care will be impossible if information systems are not widespread. Incentives could include higher payments for providers that are using such systems or requiring use of electronic records by a certain date.

But policy changes should do more than push cultural changes. Providers need capital in order to fund information systems and the organizational infrastructure to implement more coordinated care. Providers have only three ways to accumulate such capital: surpluses from operations, borrowing, and philanthropy. Borrowing and philanthropy are somewhat dependent on having a stable, profitable operation, and neither can be relied upon to entirely fund the re-engineering of a health care delivery organization.

Provider organizations face financial difficulties because of the varying payment rates paid by various public and private payers. Medicaid programs pay substantially below costs, and Medicare in recent years has not provided cost-based rates of increase in their payments, especially for Part B services. Providers end up shifting costs to private insurers, which diverts focus from efforts to improve quality and efficiency to reimbursement and cost-shifting strategies.

The federal government will have to make policy decisions regarding how active it wants to be in promoting the organization of providers. The Federal Trade Commission and Department of Justice have been generally wary out of concern that provider organization might decrease competition and therefore lead to higher prices without higher value for consumers.[4] A more neutral perspective may be evolving in which regulators rec-

ognize that provider organizations may be essential to improving health care. But there remain concerns about provider organizations obtaining "market power" that would prevent the efficiencies produced from being passed on to payers and consumers.

The current legal environment has created similar barriers to delivery system innovation, including the movement toward accountable care systems.[5] Joint ventures between physicians, hospitals, and other providers are all affected by antitrust laws, as well as state laws related to the corporate practice of medicine, scope of practice, and certificate of need. They are also affected by federal laws relating to prohibitions on kickbacks, limitations on self-referral, and private inurement, which occurs when tax-exempt healthcare organizations enter into financial relationships that result in impermissible benefits to other parties.

Many legal barriers have arisen reasonably to protect patients and payers functioning in a fee-for-service payment environment. Yet it should be possible to relax prohibitions that frustrate integration if higher levels of organizational integration are accompanied by higher levels of consolidated payments, with some amount of provider risk taking. Some state laws, such as those regarding corporate practice of medicine, could be eliminated altogether, especially if organizations themselves adopt ethical codes that encompass traditional and important professional duties to clients.

At the federal level, several federal agencies have independent jurisdiction over the interpretation and implementation of relevant laws, yet make little attempt to coordinate their actions with others, frustrating providers' integration efforts. Some health policy experts have called for a single governmental commission, which would include representatives from each agency and be responsible for offering a one-stop review to permit expansion of new forms of organization.[6] Successful arrangements could become models for new safe harbors under the tax, antitrust, antikickback, and self-referral laws, and provide information needed to modify existing prohibitions and limitations to promote organizational development.

Health care providers have much to learn from non-health care industries on how to use their manpower more efficiently. New management skills, many of which are lumped under the label "process improvement," but are also known by names such as Lean Management and Six Sigma, have not been prominent in training health care executives. Policies that promote dissemination of such expertise would help health care organizations control the rate of rising costs.

Market evolution

Policymakers should have realistic expectations for strategies that engage consumers in driving healthcare improvement through greater provider organization. Two key strategies are "transparency," which encourages the public to report on the efficiency and quality of health care providers, and insurance product design, which pushes patients to seek care from higher quality and more efficient providers.

Public reporting is increasingly widespread; data on the quality of care provided by hospitals and groups of physicians is more widely available than ever before. Yet currently available quality measures have been developed for the fragmented and disorganized U.S. health care system, and therefore may not capture the value created by effective provider organizations. For example, quality measures do not reflect the flow of information from hospital to non-acute facility to ambulatory care settings. Nor do they capture patients' ability to access care quickly or conveniently. Measures of efficiency for isolated components of the health care system are particularly limited in their usefulness.

Public reporting of organization performance, in contrast to reporting of disaggregated providers, should lead to greater interest in and public use of the information. When considering performance at the integrated organization level, measures of quality and cost on population-based measures—rather than just on particular episodes of illnesses—become possible. Integrated groups can be assessed not only of the quality and cost of an intervention, but also on whether the intervention was appropriately provided in the first place. Because organizational-level assessments permit the aggregation of individual instances into much larger numbers than is possible for individual clinicians, the data would be more valid and reliable for comparison purposes.

A background issue is whether the true targets of public reporting are consumers or providers. Available data suggest that few consumers currently use publicly reported data. On the other hand, providers give disproportionate attention to publicly reported data. This imbalance suggests that public reporting programs should either seek approaches that are more useful to consumers, or tailor their approaches to health care providers in ways that encourage them to pursue better outcomes, which may be facilitated through greater organization.

Another approach to activating consumers is to enroll them in health insurance products that give them a financial incentive to seek care from more efficient and higher-quality providers. However, individual physicians and hospitals rarely have complete control over the quality or efficiency of care, particularly for the most sick and complex patients. Market incentives for patients could therefore be better constructed by encouraging them to receive care from well-organized systems that can assume total responsibility for the costs and quality of their care. Private plans might, for example, develop differential cost-sharing products that provide incentives for patients to select care from organizations, rather than disaggregated providers.

POLICY RECOMMENDATIONS

Promote a flexible payment reform strategy in public programs

The federal government and commercial payers should support flexible payment strategies that reward providers for forming more organized groups and accepting payment systems such as robust pay for performance, case rates, and improved capitation. The federal government and commercial payers can improve fee-for-service payment approaches, not only to encourage a better mix of services, but also to promote conditions that are more conducive to the development of provider organizations. Certain conditions can give physicians increased reason to see participation in organized groups as the best approach to responding to the altered payment incentives, such as reducing the current distortions in public and private fee schedules that promote procedures and tests, rather than patient-centeredness and care management.

It is clear that a "one size fits all" payment strategy no longer serves the diverse types of provider organization. The current fee-for-service approach is the lowest common denominator and not appropriate to support the efforts of organized systems. The federal government will therefore need to make significant investments in moving providers toward more evolved payment systems.

Medicare is a good place to start because its fee schedule guides private payers and Medicaid programs, who would likely follow a major effort in

Medicare to alter the current basis for setting fee-for-service payments (see chapter 4 on payment reform for details).

The federal government should also set expenditure targets for fee-for-service payments that lack incentives for quality and efficiency, except in health professional shortage areas. Organized groups would be held accountable for group-specific performance on cost, quality, and patient experience and therefore should be exempted from the cruder expenditure controls that would apply to unaffiliated physicians. The federal government can also increase the potential financial reward to providers in proportion to their willingness to accept financial risk. For example, case rates or capitation-based contracts should offer providers the potential to achieve margins greater than inflation if these providers are creative and effective in improving quality and efficiency.

Payment approaches to hospitals should be modified to promote alignment with physician incentives, which would encourage the development of hospital-physician organizations functioning as self-contained integrated, delivery systems.[7] For example, bundling physician and hospital services—and perhaps post-acute care services, such as skilled nursing for discrete episodes of care—would reward efforts to develop integrated systems and lay the ground for movement to more fully developed case rates and, ultimately, capitation.

Encourage adoption of information technologies

The federal government should promote national initiatives to make information technologies more widespread, especially electronic medical records in physician offices (see chapter 2 on infrastructure for more detail on information technology recommendations). These initiatives should include financial support for providers combined with mandates for adoption.

The government might arrange for long-term loans to help finance infrastructure enhancements, especially the adoption of electronic medical records, and in some cases, short-term loans to manage cash flow during the often-difficult practice transformation. Enhanced information technologies will make it much easier for organized systems to incorporate geographically dispersed, but community-based, small practices into their groups, thereby combining organized systems' ability to manage cost and quality while supporting the patient-centered attitudes that community-based small practices often display.

Promote public reporting

Government programs should engage providers in the development of public reporting methods so that they are "customers" instead of merely critics. Efforts to improve public reporting need to be cognizant of the inherent limits of relying on objective quality measures in such a highly technical area as health care. Models of performance measurement development and implementation in health plans, organized provider groups, and consumer collaboration, such as the Integrated Health Care Association in California, offer the promise that information can enhance consumer choice while also giving providers the structured feedback needed for self-assessment and improvement. Government—at both state and federal levels—can play an important role in encouraging regional organizations to come together to support these efforts. Medicare should actively participate in these regional collaboratives, contributing provider-specific data, consistent with privacy protections, to permit more robust measurement of provider performance.

Develop a federal commission to oversee system innovations

The federal government should create a new commission that centralizes control over health care regulations and has the authority to permit delivery system innovations, including new forms of organization, that are time-limited and contingent on periodic evaluation demonstrating cost savings and improved quality. This new commission would be charged with modifying existing laws that were developed to protect the public from incentives inherent in fee-for-service reimbursement. The modernized laws would recognize and encourage the variations in payment approaches that provide inherent incentives to restrain cost increases. The proposed single government commission would also have the authority to offer one-stop shopping for would-be integrated organizations to obtain a facilitated review of proposals to develop new organizational models and payment approaches.

Provide government oversight of accountable care organizations

Provider organizations have the potential to lead a transformation in how care is provided, at the same time improving quality and patient experience and restraining health care spending. The federal government needs

to provide the public with basic protections that ensure that organizations receiving new forms of payment that incentivize efficiency are acting responsibly and not cutting corners. A basic regulatory oversight program needs to be developed that is specific to this unique provider type.

Fortuitously, because integrated provider organizations rely on advanced health information technology, including interoperable electronic health records, oversight can move away from the sometimes counterproductive emphasis on assuring the presence of specified structures and processes to oversight more oriented to outcomes. Regulatory oversight can also assure the public that organizations have adopted and implemented codes of ethics acknowledging the long-accepted professional duty to act in the best interest of clients and avoid conflicts of interest, while also addressing the new expectations that organizations need to prudently manage resources and be accountable for their performance. Regulatory oversight can make sure that the relationships organizations enter into with other components of the health care system are transparent to the public.

CONCLUSION

The next administration should develop and implement policies that address the health care system's underlying chaos by reinforcing the organization of health care and integration of health care providers. Incentives to promote and reward organizations will need to be carefully crafted so that their primary interest is improving quality and patient experience while conserving resources and not attempting to use market power to extract higher prices from payers. Given the correct incentives, new forms of organization will become indispensable to efforts to increase the value of health care that citizens deserve, altering the U.S. health care system's mediocre performance on objective measures of system performance.

The federal government needs to be much more assertive than it has been to promote integration of providers into a variety of potential organizational structures that would better support high quality and improved patient-centered care. It needs to do a better job restraining cost increases, while at the same time being vigilant about the potential for misuse of the approach. Not all physicians, health care professionals, and institutional providers are ready to participate in organized systems, and there will

need to be parallel work to improve quality and efficiency for those that initially choose to remain independent. Over time, with a supportive payment system, providers should migrate to this approach and be better able to take on the growing challenges of caring for an aging population.

ENDNOTES

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