Part One

Can We Get Better?

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Framing the Forces of Change

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EDITOR'S INTRODUCTION

Many people outside the US health care industry focus their attention on national reform efforts, the most recent being the Patient Protection and Affordable Care Act passed by Congress in 2010. Because the course of reform is hard to predict, the real challenge for industry leaders is to improve their own organizations—to make them better today.

Doing so will not be easy, as this chapter explains. Leaders face a series of potential pitfalls, any one of which can derail change efforts. The chapter also describes a way forward. By discarding old assumptions and mapping out a path to change, leaders can avoid the obstacles and bring about real improvement in their organizations.

The poet Edna St. Vincent Millay wrote, "It's not true that life is one damn thing after another. It's one damn thing over and over."[1] That is certainly true of the attempt to reform health care in the United States. Theodore Roosevelt called for reform nearly a century ago. Harry Truman, in his 1949 State of the Union address, said, "Our health is far behind the progress of medical science. Proper medical care is so expensive that it is out of reach of the great majority of our citizens."[2] Nearly every president since Truman has at least given lip service to the need for

reform. Some have done considerably more, such as Lyndon Johnson, who signed Medicare into law in 1965, and Bill Clinton, whose effort to transform the entire system crashed and burned in the early 1990s. Most recently we have the Patient Protection and Affordable Care Act of 2010, derided as "Obamacare" by its critics. The new law is complex, ambitious, and controversial. Its ultimate effects will not be known for years, and it will be determined not only by continuing wrangling in Congress but also by the writing of thousands of administrative rules and regulations.

One thing we can be sure of, however, is that the push for reform will not go away. Even those who most strenuously oppose the latest reform know that the status quo in health care is unacceptable to many Americans and likely to be unaffordable as well. Another thing we can be sure of is that the most recent law will not accomplish everything its supporters hope for. (It probably will not do all that its critics fear, either.) So there will be many more attempts at reform in the future. Aside from letting their opinions be known, health care leaders cannot do much to affect the outcome. As Doris Day once sang, "Que Sera, Sera"—whatever will be, will be. If we wait for Washington to create a great health system, chances are we will be waiting a long, long time.

Nevertheless, health care leaders can do a lot in the meantime. They can make their own organizations better.

"Better" is a useful term in this context, because it cuts through the tired debate about how good American health care really is. Everybody agrees on the positive aspects of the US system—leading-edge diagnostic and therapeutic technologies; safe, effective drugs and medical procedures; many world-class clinicians and institutions; and nearly unlimited health care information (80% of Internet users have searched for health care information online)[3]. Many wealthy people from all over the world come to the United States for certain kinds of treatments and procedures. Conversely, nearly everyone also agrees on the negative aspects of the system. The number of medical errors is appallingly high. The variability in care from one region to another—even from one organization to another within the same region—is substantial. Many people have no insurance coverage and do not have regular, easy access to care. Overall, health care costs far more per person in the United States than in other countries, yet it produces

results that are often no better and in some cases worse. Even tiny Cuba has a lower infant mortality rate than the United States. Cuba spends roughly $900 per person per year on health care, compared with more than $7,000 in the United States.[4] Perhaps the most troubling of all is that our "system" is far from systematic.

Rather than debating which list of factors, the positive or the negative, outweighs the other, as so many people do, let us pose a deeper question: *If we are so good, why aren't we better?* And how can we get better? How can we create more effective and more efficient health care from the ground up? Health care leaders cannot solve all of the system's problems, to be sure. But they can certainly help their own organizations improve. In this chapter, we look at the many factors and obstacles they must contend with, and we consider the essential elements of plotting a way forward.

The Context of Change

Most of the factors I describe here will be familiar—they are forces that every health care leader deals with all the time. But only when we add them up and consider them as a whole can we begin to see where progress might be made.

Multiple Stakeholders

What is the mission of a health care organization? This is a profound question, and a difficult one to answer. Some people believe it is to heal the sick. That is right, of course, as far as it goes. Still, the mission could be developed in other ways. Why are there so many sick people? What is the best way to realize the mission of healing the sick? And is "heal the sick" sufficient? Let us not forget—we have to heal the sick in a manner that costs less than the reimbursement we will receive from the government or the insurance company, or else make up the difference between costs and income some other way. Alternatively, perhaps the mission is to prevent illness. But now we are really on shaky ground. The last I checked, there was no reimbursement code for that.

It is not uncommon to hear people in health care say, "No margin, no mission." One might conclude that their primary goal

is to make money, like any other business. That, too, is fine. Everybody has to earn a living, and every organization has to produce a surplus over and above its costs. Would anybody really want to tell patients that the primary goal of the organization that is about to care for them is to make money? What about saying that to the companies and agencies that pay patients' bills? Or to regulators? In one discussion at a world-class medical center, a senior physician I spoke with scorned the idea that the hospital should make money. He had a different view. The purpose of this hospital, he said, was to provide a place for physicians to practice. An unusual mission! I do not know of another industry on earth in which more than 80% of all revenue is generated by nonemployees—in most cases, by physicians.

The fact that "Americans pay more when they get sick than people in other Western nations—and get more confused, error-prone treatment,"[5] is to a great degree an issue of stakeholder conflict, of differing views as to the mission of health care. Patients want the best possible care. Payers want the most cost-effective care. Clinicians want the freedom to do their work as they see fit. Regulators want to enforce standards. Boards of trustees and senior executive teams want to create notable and prosperous organizations. How on earth do we define *better* in this context? Everyone has an interest—a stake—and views of their own as to what would *be* better. In health care, where you stand depends greatly on where you sit.

Variability of Outcomes

Most stakeholders, we might assume, prize consistency—consistency of procedures, consistency of treatment, consistency of outcomes. After all, consistency is the hallmark of most industries. Air passengers virtually always get where they are going because the airlines have developed rigorously consistent methods of operation. Restaurant patrons eat billions of meals and very rarely get sick because restaurants follow prescribed food preparation and sanitation procedures. The movement for evidence-based medicine is essentially a push for consistency. Treat the same condition in the same manner—in whatever manner has been

shown to bring about the best outcomes. Yet, studies have shown that patients receive only 55% of recommended, evidence-based care.[6] They do not consistently adopt the treatment plans and procedures that their peers have judged most effective. This kind of inconsistency permeates health care. Operating room procedures have been at least partly standardized, but they still vary from one hospital to another. Some hospitals and medical centers have mounted effective programs to ensure regular hand washing among doctors and other clinicians. Others have not. Some have developed effective programs to ensure that every staff member gets a flu shot. Others have not.

The result of all this variability is a dramatic *in*consistency of outcomes. Elsewhere in this book, you will read about the Dartmouth studies that found startling variations in treatment protocols, medical results, and costs from one part of the country to another. State rankings exhibit similar variation. According to the most recent United Health Foundation study, published in late 2010, Minnesota ranked as the healthiest state in terms of outcomes, whereas Vermont was number one on the factors likely to determine future health, such as rates of cancer, smoking, car accidents, and high school graduation. Mississippi ranked as the unhealthiest state overall, as it had for the previous nine years. It had high rates of obesity, children living in poverty, and preventable hospitalizations, along with a relatively low high school graduation rate.[7] The disparity between top-ranked states and those at the bottom was wide.

The performance of individual health care organizations varies widely as well. In 2011, for example, the ratings organization HealthGrades analyzed thirteen different kinds of "patient safety events," such as postoperative respiratory failure and catheter-related bloodstream infections, among Medicare patients at every hospital in the United States, nearly 5,000 in all. The organization found that the top 5% of hospitals significantly outperformed the others. In fact, if all hospitals provided the same quality of care as that provided by the top 5%, nearly 175,000 patient safety events could have been avoided, more than 20,000 seniors might have survived their hospitalizations, and the federal government could have saved nearly $1.8 billion in health care costs.[8]

Unrealistic Expectations and Poor Behaviors

People have huge and often unrealistic expectations for health care. Because doctors can now do so much compared with what they were able to do in the past, patients expect to walk into a physician's office or a hospital and walk out cured. (The story is told of the orthopedic patient who told his surgeon that he wanted to be back on the tennis court a day or two after his knee operation—and he hoped his game would be improved as well.) The trouble is, many patients fail to do their part. They do not eat well or get regular exercise. They fail to take their medicine as prescribed, follow their therapeutic regimens, or return for follow-up appointments. Some 70% of Americans with high blood pressure do not have it under control. Approximately 70% of asthma patients do not know how to use their inhalers. Low health literacy and a lack of education can contribute to counterproductive behavior. A study of inner-city adults with severe asthma found that more than half believed that they had the disease *only* when they had symptoms. Many of these people did not believe their disease was chronic.[9] Unrealistically high expectations of medicine combined with poor lifestyle choices and noncompliance combine to create poor patient outcomes and dissatisfaction.

Low Satisfaction and Trust Levels

For the three stakeholder groups for which we have national data—physicians, patients, and other health care workers—all groups show declining satisfaction with the health care system. They are dissatisfied not just with the system but also with their own organizations. More than 40% of nurses, for example, say that if someone close to them were sick, they would not recommend sending that person to the hospital where they work.[10] This is a rather stunning indictment. The widely noticed decline in satisfaction on the part of physicians is equally noteworthy. Many are retiring earlier than they had hoped or planned to. Some report feelings of depression. Many perceive that they have an inadequate amount of time to provide the kind of patient care they were trained to offer.[11] One doctor I spoke with quipped, "I

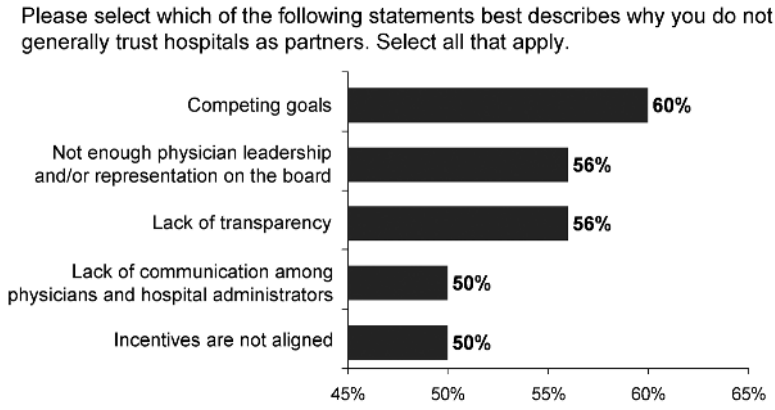
like to get to work an hour before all the other physicians. That way I'm the first one who's an hour behind schedule."

One reason for the low levels of satisfaction is the lack of trust among stakeholders. In my own research in physician group practices, the number one source of dissatisfaction among physicians is what they sometimes call the "Mother, may I?" syndrome—the requirement imposed by some health insurers that physicians obtain preauthorization or precertification for many treatments or procedures. The insurers sometimes retort in private that as many as 50% of physicians admit that they lie, cheat, and steal on behalf of their patients to get them the treatment that the physicians believe they need. The insurers, of course, regard such behavior simply as lying, cheating, and stealing. Doctors show a similar lack of trust in hospitals. A study in 2010 found that approximately 20% of physicians say they do not trust hospitals, whereas another 57% said they trust them only "sometimes." The reasons included lack of transparency, competing goals, and misaligned incentives (Figure 1.1). For their part, 60% of the hospitals believed it would be "difficult to obtain information from community physicians to improve patient care."[12]

Cure, Not Prevention

The vast improvement in health and life expectancy during the latter half of the nineteenth century and the first half of the twentieth was due not so much to better medical care as to better public health. Clean water supplies, public sewer systems, and the like drastically reduced the spread of communicable diseases. Today we seem to have forgotten the importance of prevention. According to a study by the Milken Institute, the growing rates of seven chronic diseases, including cancer, diabetes, hypertension, and stroke, threaten to cancel out improvements in treatment for these diseases. Yet preventive measures such as weight control, improved nutrition and exercise, and more aggressive early disease detection could substantially lower the incidence and effects of all of these diseases. The study estimated that "reasonable improvements in health-related behavior and treatments" would reduce the costs of these diseases by $1.6 trillion over the fifteen-year period from 2008 to 2023.[13] However, most health care

Figure 1.1. Top five reasons physicians do not trust hospitals as partners.



Source: PWC Health Research Institute. Figure 1. in "From Courtship to Marriage: Why Health Reform Is Driving Physicians and Hospitals Closer Together," 7. http://www.pwc.com/us/en/health-industries/publications/from-courtship-to-marriage.jhtml. Accessed January 15, 2012. Reprinted with permission from PricewaterhouseCoopers LLP.

organizations are like police: They clean up after the fact. They have little impact on the incidence of illness and injuries.

Slow Rates of Change

Over the last decade or two, Americans and many other people worldwide have grown accustomed to "Internet time"—the notion that things are changing incredibly quickly, that what we experienced only two or three years ago was quite different from what we are experiencing today, and the world a few years hence will be equally as different. The breathtaking rise of young companies such as Google and Facebook feeds this feeling that the world is changing at a rapid pace. Health care seems to work on a different time frame altogether. In a later chapter you will read that US physicians and health organizations have been exceptionally slow to adopt electronic health records (EHRs). Forget EHRs; 33% of medical practices in the United States do not even take credit cards.[14]

Therapeutic progress proceeds glacially. On average, it takes four to six years for a landmark study on clinical innovations to achieve just twenty-five citations in the medical literature. These innovations take six to ten years to appear in standard medical textbooks and review papers. And once an innovation appears regularly in textbooks and reviews, it *still takes another nine to ten years* before it is used by 50% of the relevant clinicians.[15] One reason, of course, is that new knowledge is arriving much faster than human beings can assimilate it. With two million new articles appearing in the literature each year, a physician would have to vet six thousand a day just to keep up with the new evidence. But the slow pace of change goes deeper than that. Medical culture and tradition encourage health care providers and organizations to do what they did yesterday until an alternative course of action is *very* well established. Indeed, physicians tend to mistrust any innovations not born from lengthy clinical experience. Doctors also may have difficulty understanding or interpreting new studies, and they may resist new ideas out of insecurity. In addition, some therapeutic innovations may require systemwide changes in the day-to-day practices of health care organizations—changes that, for whatever reason, are difficult to implement.

New pharmaceuticals are equally slow to appear, though for very different reasons. It takes an average of 97.7 months—more than eight years—and $1.2 billion to bring a new biotech drug to market. Traditional pharmaceuticals take only a little less time: an average of 90.3 months.[16] There have been astronomical increases in research and development (R&D) expenditures on the part of the pharmaceutical industry over the past two decades, but the number of successful "blockbuster" drugs has not increased.

All in all, this collection of factors creates a rather dismal picture. Why, then, are there grounds for hope that individual health care leaders can improve things and make their organizations better?

The Way Forward

One source of hope is the proposition that the industry you are in does not determine your destiny.

Many leaders believe that it does. Health care is a terrible industry, they say, a terrible system. Reimbursement rates are too low. The insurance companies are impossible. We cannot get good people. The regulations are too costly. And now, well, the reform, however it turns out, will just make things worse. The writer, surgeon, and Harvard faculty member Atul Gawande addressed the 2005 graduating classes of Harvard Medical School and Harvard School of Dental Medicine. He came up with five rules for these newly minted professionals to follow in their careers. Rule number 2 was simple: Don't whine. "To be sure," he said, "doctors have plenty to complain about: computer system crashes, 2 AM pages, insurance companies, work getting dumped on you at 6 o'clock on a Friday night. We all know what it is to be tired and beaten down. Yet nothing in medicine is more dispiriting than to hear doctors whine."[17] The same might be said of anyone in health care, or indeed anyone in any other industry. No one likes a whiner.

And besides: Health care surely is the most difficult industry, except for all the other industries. Autos? Detroit's Big Three do not think this is an easy business. Neither does industry leader Toyota, which was suffering from serious quality problems even before the troubles caused by Japan's 2011 earthquakes. Computers? IBM found itself in deep trouble in the 1990s and returned to prosperity only by redefining its entire business. Hewlett-Packard continues to struggle; so does Dell. Or look at the airline industry in the United States. In the past three decades they have had to cope with deregulation, a strike of air traffic controllers, skyrocketing fuel prices, huge debt levels, the collapse of their business following 9/11, a spate of mergers, and heaven knows what else. Several have been through bankruptcy. Most continue to find sustained profitability elusive.

I will say it again: Industry is not destiny. Do you know what the single best-performing stock was in the thirty-year period from 1972 to 2002? It was not General Electric, not Intel, not Pfizer, not Wal-Mart. It was Southwest Airlines.[18] Since 2002, Southwest has continued to grow and has continued to earn money. So, for the most part, has JetBlue Airways. Nearly every industry has at least one company that hugely outperforms the rest. One study found that these high performers consistently grew both revenue

and profits faster than industry competitors and the S&P 500 average.[19] And guess what: There are outperformers even in health care. Earlier in this chapter I mentioned the difference in patient safety outcomes between the top 5% of hospitals and the rest. Now look at examples of the difference in financial outcomes. As I write, twenty-four hospitals in the United States today—hospitals with two hundred or more beds—have operating margins of 25% or more in a sector where the average operating margin is –0.7%.[20] Fifteen of these twenty-four are for-profit, and nine are not-for-profit. The group is geographically dispersed. Some of the top performers are rural, some urban. And yet all outperform their immediate competitors by an order of magnitude, even though they draw on the same workforce and serve similar populations of patients.

So do we really want to foist all of our troubles on the assumption that health care is such a terrible industry? "As soon as we blame another for our predicament, we give up responsibility, and we give up our power, because we have identified the cause of the situation as something outside ourselves." This quotation appears in the afterword of a classic education book from the 1970s called *No Particular Place to Go: The Making of a Free High School.* But it applies equally to health care in the first decades of the twenty-first century. The real issue is not how bad health care is; the real issue is how to move forward. I break the task down into five steps.

1. Discard old assumptions.

   It is hard to remember now, but General Motors once utterly dominated the US auto business, with a market share of close to 50%. Not surprisingly, its management assumptions and philosophies were carefully studied. They have often been summarized as follows:[21]

GM is in the business of making money, not cars.

Success comes not from technological leadership but from being able to quickly adopt innovations successfully introduced by others.

Cars are basically status symbols. Styling is therefore more important than quality to buyers—who will trade up every other year anyway.

The US car market is isolated from the rest of the world. Foreign competitors will never gain more than 15% of our domestic market.
Energy will always be abundant and cheap.
Workers have no important impact on production or product quality.
Managers should be developed only from the inside.
The consumer movement does not represent the concerns of any significant portion of the US public.
Government is the enemy. It must be fought tooth and nail every inch of the way.
Strict, centralized financial controls are the secret to good administration.

Assumptions such as these served GM well during the period of its dominance. Then the world began to change, and the assumptions no longer held true. Not surprisingly, GM executives took many years to realize that fact. Eventually, their company reached the brink of collapse, along with the assumptions on which it was based.

Health care organizations should not fall into the same trap. If we learn one thing from the current context, it is that the industry is in flux. The political context is changing. Stakeholders have different interests. The system may change slowly, but change it will, and no one can afford to rely on the same set of unquestioned assumptions. To take just one rather obvious example: Physicians' offices and clinics have long assumed that they will continue to be reimbursed on a fee-for-service basis and that their job is to work within that context. This assumption may no longer hold true.

2. Distinguish between market threats and market drivers.

The famous Alcoholics Anonymous serenity prayer—often attributed to the theologian Reinhold Niebuhr—reads as follows:

> God grant us the serenity to accept the things we cannot change, courage to change the things we can, and wisdom to know the difference.[22]

Knowing the difference between things you cannot change and those you can also underlies a great deal of good

medicine. If I have hypertension, my physician and I are not going to talk about my age, my sex, or my race, even though these all might be risk factors. The reason is that none of these are changeable. Rather, the focus would be on my eating habits, my exercise levels, my degree of stress, my potential need for medication, and so on—the things we can change.

So it is with good leadership. Every health care leader faces a series of *market drivers*. These are the things that cannot be changed, at least in the short run: an individual patient's age, sex, and genetics, and the commensurate statistics for a patient population. Market drivers reflect immutable demographic and sociocultural factors that would exist even if the framework of the market changed. Leaders also face *market threats*, which are factors that can be changed because they are produced by the market itself. Market threats are generated by organizations, systems, or government and include insurance companies' reimbursement policies, government regulations, and people's health habits. A great deal of confusion—and a great deal of passivity—result from mixing up the two categories. Take the nursing shortage. It is typical for health care leaders to say, well, that is a market driver, it is cyclical, we have a nursing shortage every so often, nothing you can do about it. The awkward truth, however, is that not all health care organizations do face nursing shortages. Some decided that the shortage was a factor they could do something about—a market threat rather than a market driver. They did that something, and presto: no more shortage. (You will read in Chapter Three about how North Shore/Long Island Jewish Medical Health System is managing this challenge.)

3. Create a burning platform for change.

   On a July evening in 1988, at 9:30 PM, there was a huge explosion on an oil drilling platform in the North Sea, off the coast of Scotland. More than 160 crew members and two rescuers were to lose their lives in the catastrophe. A superintendent named Andy Mochan was awakened by the explosion and made his way to the edge of the platform. As a plume of fire billowed behind him, Andy decided to jump. Jumping was a risky option. It was a 150-foot drop from the platform to the water. The surface of the water was covered with debris and

burning oil. And if the jump into the 40-degree water did not kill him, he would die of exposure within fifteen minutes. Andy was rescued. When asked why he jumped, he replied, "Better probable death than certain death. It was either jump or fry."[23]

Note a few points about Andy's situation. He did not jump because he felt confident he would survive. He did not jump because it seemed like a good idea. He did not jump because he thought it would be intellectually intriguing. He did not jump because it would be a personal growth experience. He jumped because he had no choice. The drawbacks of staying on the platform—of maintaining the status quo—were just too high. Similarly, businesspeople use the phrase "burning platform" to describe a situation that must change because the cost of maintaining the status quo is too high. Identifying the "burning issues" encourages change in stakeholder behavior.

There is no shortage of burning platforms—real and potential threats—in health care. The list includes unjustifiable practice variations, a disconnect between quality outcomes and intensity of care, spiraling costs, stakeholder dissatisfaction, quality and safety gaps, inequity of care, poorly aligned incentives, antiquated billing and payment systems, significant levels of fraud and abuse—though the list could go on, perhaps that is enough for the moment. Which ones would you emphasize, and why? Which are the real threats to your organization?

4. Map out a vision of the future.

The burning platforms in health care, unlike Andy Mochan's, are metaphorical. People *can* stay put, doing exactly what they did yesterday, at least for a while. And the pressures to do so are strong, as we have seen. So the sense of a burning platform needs to be coupled with a vision of an alternative. People need to see the benefits of change as well as the costs of staying put. In short, leaders need to define what it would mean to be better.

Defining *better* begins with what I refer to as "MV^2"—the organization's mission, vision, and values. *Mission* is the purpose, the organization's raison d'être. *Vision* is the direction it needs to go to achieve the mission. *Values* are the

nonnegotiable principles that guide it along the way. Spelling out MV^2 is essential because no one wants to act inconsistently with what the organization stands for. To be sure, making these goals and principles explicit means confronting the different missions and interests of each stakeholder. But health care organizations have ignored that misalignment for too long; it is time to get important stakeholders on the same page. An organization that cannot finally bring its stakeholders together to agree on a mission, a vision, and values is an organization that will not survive change.

Later in this book, in Chapter Eleven, you will read about how to take that vision and make a *promise* to the marketplace. The promise is what differentiates you from everybody else. It is what your brand stands for. It is the position you will occupy in the minds of your customers and patients. You will need to answer the question: What is the single most important thing you want your organization to be known for in the minds of your key stakeholders? If you can identify that, you will be well on your way to defining *better*.

5. Launch the exploration-and-execution process.

However, MV^2 and the promise to the marketplace only begin the process of defining *better*. Ultimately, *better* depends not just on a grand and probably somewhat abstract MV^2 and promise but on specific, tangible improvements on the ground. The vision and the promise have to become reality. The organization has to actually provide better care at the bedside, commit fewer errors, implement superior human resources practices, create quick and cost-effective systems for scheduling and billing, whatever the priorities may be. At most health care organizations, the list of possible improvements is long. A *gap analysis*, a description of the difference between where we are and where want to be, can help leaders pinpoint the key areas needing change. It should help create strategic alignment among stakeholders, leading to action: Here is what we have to do.

But then it all gets down to specifics. Organizations do not change through wishing and hoping. They change through projects—through practical, team-based efforts that research, design, and implement specific changes. Later in this book,

in Chapter Twelve, I examine the process of creating project teams and implementing projects. For the moment, let us look at the basics of how projects come about.

Exploration is the process of generating ideas for change. Every innovation comes originally from an idea, whether it is an idea generated in-house or an idea imported from somebody else (or, as often is the case, a hybrid of the two). The best ideas need not come from the top of an organization; often, they emerge from people who are trying to cope with an unsatisfactory situation and see a way to improve things. Leaders need to encourage the process of ideation throughout the organization, and they need to have a way of sifting through the ideas to determine which ones have the best chance of helping them realize the vision and the promise they have agreed on.

Ideas, of course, are nothing without *execution*. And it is through projects that ideas are developed, tested, and eventually executed. This is how organizations create new value; it is how they create competitive advantage. A project team needs to be able to describe very concretely what it hopes to bring about at the end of six or twelve months or however long the project may last. Its members should be able to say exactly what people will be doing differently, and where the benefits will come from. The ubiquitous Plan-Do-Study-Act cycle describes in a nutshell how many projects go about their business: They make a plan, try it out, see how it worked, and eventually implement whatever works best. This is how *better* gets defined in practice. Of course, it is rarely such a linear process. Just like the plays a coach draws on a blackboard, real-world projects seldom work out exactly as planned. That is why every project entails some risk.

Conclusion

This synopsis of the way forward is necessarily brief. My own articles and those of my colleagues in this volume will further develop these ideas. These chapters analyze the issues in greater depth and show the possibilities for change more clearly than I can here.

What they have in common is a new approach, an approach that does not wait for a magic wand from Washington or anywhere else to create the Promised Land of Health Care.

Everybody in health care seems to believe that there *is* a way forward—that things can be better. However, too many people seem to wait for somebody else to lead the change or find somebody else to blame for why the change is not happening now. The Forces of Change analytic model and program, on which this book is based, takes a different and more fruitful perspective. Health care is simply a marketplace, a human endeavor much like many other human endeavors. It has its own set of opportunities and constraints, to be sure. It is remarkably complex, and many of those opportunities and constraints can seem daunting. Although an organization's performance is influenced by outside forces, in the end, strong leadership can guide an organization to success despite these challenges. Leaders who set out to create a true high-performing health care organization can do so, as we have seen. The Forces of Change model seeks to offer leaders a roadmap of how to navigate the marketplace and gain a competitive advantage.

EDITOR'S SUMMARY

Attempts to change health care organizations encounter many potential obstacles. The obstacles include multiple stakeholders, variability of outcomes, unrealistic expectations and poor behaviors on the part of the public, low satisfaction and trust levels, an emphasis on cure rather than prevention, and the slow pace of progress in medicine generally. But industry is not destiny; some health care organizations significantly outperform their competitors. Leaders of organizations that want to join the ranks of outperformers must discard old assumptions. They must see clearly the difference between market drivers (which they cannot affect) and market threats (which they can). They must create a burning platform for change, map out a vision of the future, and then launch a process of exploration and execution.