The model is still built on the old idea of fee-for-service and segregates providers through differing reimbursement methods rather than creating a new model where all providers are at risk together.

So we have a governor who wants to transform health care, but it doesn’t play out well at a local level. The community is still embedded in the old models and in the traditional way of delivering health care.

You have been working on helping the care unfold in a high quality, lean, and efficient way throughout your operations.

On the purely clinical side with physicians, we have 8 or 10 groups — for example, there is a group of obstetricians working on using Lean (Lean Six Sigma) to address C-sections, how to standardize them and getting rid of variation.

I am convinced that it is a significant part of the solution, but it will take time to reengineer the mental models that people have been using.

It requires more than a mild level of investment behind that to get it to work; it’s not easily within the wherewithal of many systems.

Part of the problem is a cultural one. We still have our committees that see independence and autonomy as an important aspect of what they do. Independence and autonomy are in many ways contradictory to the concept of standardized work.

Hospitals have overcapacity – the average occupancy in America is about 57 percent.

This is a part of the culture that has resulted from how we have developed health care in America. You have to get past that – there is value in standardization. Every human is different, but there is more that is similar than different and the value comes from applying the best protocols. Then you apply the human element, i.e. the physician, to deal with the variations that come up.

Let’s move to the patient side. Some leaders within the industry are latching onto patient decision-making as the next trend. How important will that become?

There is nothing I would argue with about making major medical decisions – I still see people defer to the decisions the physician or another health care professional makes. From concept, it absolutely makes sense; in practice, we probably have a long way to go.

Alluding to the issue of culture: the younger generation is far more oriented to ask questions and debate than the older generation.

I have had a chance to do global research on shared decision-making. When people are informed, they will more often than not take the less intensive care path. The data that I found the most compelling is when physicians themselves have a cancer diagnosis, their course of care is much different than the rest of the population.

When you discuss this as a part of the model of the medical home (and integrated approach among physicians) where you have a team to address it (the medical condition), this could work. Until you get to that model, I’m not sure how far you’ll get, because the current model doesn’t lend itself to that.

We’re probably not going to shut down hospitals but the rate of growth of new beds will probably slow down. How are you thinking about other parts of the care continuum such as hospice, palliative care, and home health? Will you partner?

We’re very much in our infancy with these areas. We’re still trying to focus on creating some methodologies. For example, we’re going to be liable for readmissions within 30 days. How do we do that with a conventional medical staff where our responsibility typically ended at the door when the patient went home?

We’re nowhere near figuring out how to create structures with others in a way that allows for us to manage patients and be aware of them once they leave the hospital, so we have a long way to go.

I have heard some industry luminaries project that there are going to be 15 mega health systems in the U.S. in the future. What are your views on industry aggregation and pursuit of scale?

I see the health systems of America paralleling what we have seen in the airline industry. If you look at the airline industry, historically, they have dealt with overcapacity and huge fixed costs. Hospitals have overcapacity — the average occupancy in America is about 57 percent. Kaiser, for example, doesn’t build a hospital until Kaiser can fill it up in most cases, based on the health plan they have and the number of subscribers.

I see more closings and consolidation of services in geographic areas — where there were three hospitals, now there may be two or one. You move your three heart programs that are all marginal to one place that does a lot of hearts and do them more efficiently at lower cost and higher quality.

We’re going to parallel the airline industry. People think of scale too often as access to capital. I think scale is much more about streamlining operations, eliminating some overhead, and filling up hospitals, similar to the airlines industry shutting down airlines and getting rid of airplanes. They have taken assets offline.