Value-Based Competition in Health Care:
Implications for Physician Practices

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This presentation draws on a forthcoming book with Elizabeth Olmsted Teisberg (Redefining Health Care: Creating Value-Based Competition on Results, Harvard Business School Press). Earlier publications about the work include the Harvard Business Review article “Redefining Competition in Health Care” and the associated Harvard Business Review Research Report “Fixing Competition in U.S. Health Care” (June 2004). No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means — electronic, mechanical, photocopying, recording, or otherwise — without the permission of Michael E. Porter and Elizabeth Olmsted Teisberg.
The Paradox of U.S. Health Care

• The United States has more competition than virtually any other health care system in the world

BUT

• Costs are high and rising
• Services are restricted and fall short of recommended care
• Standards of care often lag accepted benchmarks
• Preventable treatment errors are common
• In other services, there is overuse of care
• Huge quality and cost differences persist across providers
• Huge quality and cost differences persist across geographic areas
• Best practices are slow to spread
• Innovation is resisted

How is this state of affairs possible?
Issues in Health Care Reform

- Health Insurance and Access
- Structure of Competition in Health Care Delivery
- What Care Should Be Covered?
Zero-Sum Competition in Health Care

- Competition to **shift costs**
- Competition to **increase bargaining power**
- Competition to **capture patients** and **restrict choice**
- Competition to reduce costs by **restricting services**

- None of these forms of competition **increase value for patients**
  - Gains of one system participant come **at the expense** of others
  - These types of competition **reduce value** through added administrative costs
  - These types of competition result in major **cross subsidies** in the system
  - These types of competition **slow innovation**
  - Adversarial competition proliferates **lawsuits**, with huge direct and indirect costs
The Root Causes

- Competition in health care is not focused on **value for patients**
- Competition in the health care system takes place at the **wrong level** on the **wrong things**

Between health plans, networks, hospitals, and government payers

In the diagnosis, treatment and management of specific health conditions for patients

- Competition at the right level has been **reduced** or **eliminated** by health plans, by providers/provider groups, and by default
- Efforts to improve health care delivery have sought to **micromanage providers** and **level the playing field** rather than foster provider competition based on **results**
  - Recent quality and pay for performance initiatives do not address quality directly, but process compliance
Why Competition Went Wrong?

• **Wrong definition of the product**: health care as a commodity, health care as discrete interventions/treatments

• **Wrong objective**: reduce costs (vs. increase value)
  – Piecemeal view of costs

• **Wrong geographic market**: local

• **Wrong provider strategies**: breadth, convenience and forming large groups

• **Wrong industry structure**: mergers and regional consolidation; but highly fragmented at the service level

• **Wrong information**: patient satisfaction and (recently) process compliance, not results

• **Wrong patient attitudes and incentives**: little responsibility

• **Wrong health plan strategies and incentives**: the culture of denial

• **Wrong incentives for providers**: pay to treat, reward invasive care

• **Employers went along**: discounts and pushing costs to employees
Principles of Positive Sum Competition

• The focus should be on **value for patients**, not just lowering costs.
  – Improving quality in health care usually also lowers cost

• There must be **unrestricted competition** based on **results**.

• Competition should **center on medical conditions** over the **full cycle of care**.

• Value is driven by **provider experience, expertise, and uniqueness** at the disease or condition level.

• Competition should be **regional** and **national**, not just local.

• Results and price **information** to support value-based competition must be collected and made widely available.

• **Innovations** that increase value must be actively encouraged and strongly rewarded
Moving to Value-Based Competition

Providers

1. Redefine the business around **medical conditions**
2. Choose the **range and types of services provided** based on excellence in value, both within and across locations
   - Deliver care at the **right** place
   - **Separate** providers and health plans
3. Organize and manage around **medically integrated practice areas**
4. Create a **distinctive strategy** in each practice area
5. Design **care delivery value chains** that enable these strategies and continually improve them
6. Collect comprehensive **results, methods, experience, and patient attributes** for each practice area, covering the **complete care cycle**
7. **Accumulate costs** by practice area and value chain activity over the care cycle
8. Build the capability for **single billing for cycles of care, and bundled pricing**
9. **Market** services based on excellence, uniqueness, and results at the practice area level
10. Grow locally and geographically in **areas of strength**, using a medically integrated care delivery approach
What Business Are We In?

Nephrology practice

• Chronic Kidney Disease
• End-Stage Renal Disease
• Transplants
• Hypertension Management
Moving to Value-Based Competition

**Providers**

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   - Deliver care at the *right* place
   - *Separate* providers and health plans

3. Organize and manage around *medically integrated practice areas*
Organ Transplant Care Cycle

- Evaluation
- Waiting for a Donor
- Transplant Surgery
- Immediate Convalescence
- Long Term Convalescence

- Addressing organ rejection
- Fine tuning the drug regimen
- Adjustment and monitoring
Moving to Value-Based Competition

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The Care Delivery Value Chain for a Practice Area

**ADMINISTERING**
- (e.g.) General management, budgeting, procurement, facilities management

**INFORMING**
- (e.g.) Patient education, patient coaching, patient compliance

**PRESCRIBING**
- (e.g.) Drugs, supplies, devices

**MEASURING**
- (e.g.) Tests, patient data accumulation, imaging

**PATIENT ACCESSING**
- (e.g.) Hospital visits, office consultation, patient transport, remote consultation

**MONITORING/ PREVENTING**
- (e.g.) Medical history
- Risk identification
- Screening
- Prevention programs

**DIAGNOSING**
- (e.g.) Medical history
- Interpreting data
- Consultation with experts

**PREPARING**
- (e.g.) Determining an appropriate course of treatment
- Choosing the physician/team
- Pre-procedure preparations
- Tracking disease progression

**TREATING**
- (e.g.) Administering drug therapy
- Performing procedures
- Anesthesiology
- Physical therapy
- Psychiatric therapy

**REHABING/ RECOVERING**
- (e.g.) In-patient recovery
- Outpatient recovery
- In-patient and outpatient rehab
- Lifestyle modification
- Therapy fine-tuning

**SUPPORTING/ MONITORING**
- (e.g.) Therapy
- Lifestyle modification
- Long-term rehabilitation

**PATIENT VALUE**
(Health results per unit of cost)
Moving to Value-Based Competition

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Information Hierarchy

- **Patient Attributes**
- **Experience**
- **Methods & Costs**
- **Patient Results**
# Boston Spine Group

## Clinical and Outcome Information Collected and Analyzed

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<th>RESULTS</th>
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| **Patient Outcomes**  
  (before and after treatment, multiple times)  
  Visual Analog Scale (pain)  
  Owestry Disability Index, 10 questions (functional ability)  
  SF-36 Questionnaire, 36 questions (burden of disease)  
  Length of hospital stay  
  Time to return to work or normal activity |
| **Medical Complications**  
  Cardiac  
  Myocardial infarction  
  Arrhythmias  
  Congestive heart failure  
  Vascular deep venous thrombosis  
  Urinary infections  
  Pneumonia  
  Post-operative delirium  
  Drug interactions |
| **Surgery Process Metrics**  
  Operative time  
  Blood loss  
  Devices or products used  
  Length of hospital stay |

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<th>METHODS</th>
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| **Service Satisfaction**  
  (periodic)  
  Office visit satisfaction metrics (10 questions) |
| **Overall medical satisfaction**  
  ("Would you have surgery again for the same problem?") |
| **Surgery Complications**  
  Patient returns to the operating room  
  Infection  
  Nerve injury  
  Sentinel events (wrong site surgeries)  
  Hardware failure |
Moving to Value-Based Competition

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The Virtuous Circle in Health Care Delivery

- Deeper Penetration (and Geographic Expansion) in Areas of Excellence
- Improving Reputation
- Better Results, Adjusted for Risk
- Faster Innovation
- Rising Capacity for Sub-Specialization
- Greater Leverage in Purchasing
- More Fully Dedicated Teams
- More Tailored Facilities
- Rising Efficiency
- Better Information/ Clinical Data
- Rapidly Accumulating Experience
- FASTER INNOVATION
How Will Redefining Health Care Begin?

• It is already happening!

• Each system participant can take voluntary steps in these directions, and will benefit.

• The changes are mutually reinforcing.

• Once competition begins working, value improvement will no longer be discretionary or optional

• Those organizations that move early will gain major benefits.