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
- What Care Should Be Covered?
- Structure of Competition in Health Care Delivery

Issues in Health Care Reform
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 inappropriate **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 prices and results
- **Wrong patient attitudes and incentives**: little responsibility
- **Wrong health plan strategies and incentives**: the culture of denial
- **Wrong incentives for providers**: get big, pay to treat, reward invasive care
- **Employers went along**: discounts, minimize annual costs, 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
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
- Rising Efficiency
- Better Information/Clinical Data
- More Fully Dedicated Teams
- More Tailored Facilities
- Rapidly Accumulating Experience
## Transforming the Roles of Health Plans

<table>
<thead>
<tr>
<th>Old Role</th>
<th>New Role</th>
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<tbody>
<tr>
<td>• Restrict patient choice of providers and treatment</td>
<td>• Enable informed <strong>patient</strong> and <strong>physician choice</strong> and patient management of their health</td>
</tr>
<tr>
<td>• Micromanage provider processes and choices</td>
<td>• Measure and reward providers based on <strong>results</strong></td>
</tr>
<tr>
<td>• Minimize the cost of each service or treatment</td>
<td>• Maximize the value of care over the <strong>full care cycle</strong></td>
</tr>
<tr>
<td>• Engage in complex paperwork and administrative transactions with providers and subscribers to control costs and settle bills</td>
<td>• <strong>Simplify</strong> payments dramatically, and minimize the need for administrative transactions in the first place</td>
</tr>
<tr>
<td>• Compete on minimizing premium increases</td>
<td>• Compete on subscriber <strong>health results</strong></td>
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</table>
Moving to Value-Based Competition

Health Plans

Health Information and Patient Support
1. Organize around medical conditions, not administrative functions
2. Develop and assemble information on providers and treatments
3. Actively support patient choice with information and unbiased counseling. Reward excellent providers with patients.
4. Organize patient information and interaction around full cycles of care
5. Provide disease management and prevention services to all subscribers, even healthy ones

Restructure the Health Plan-Provider Relationship
6. Shift the nature of information sharing
7. Negotiate prices that reward provider excellence and value-enhancing innovation for patients

Redefine Contracting, Transactions, Billing, and Pricing
8. Move to expect single bills for episodes and cycles of care, and single prices
9. Simplify, standardize, and eliminate paperwork and transactions
10. Move to multi-year subscriber contracts with gainsharing, and assist subscribers in plan contracting
11. End cost shifting practices, such as re-underwriting of ill subscribers, that erode trust in health plans and breed cynicism
Patient Medical Records

12. Provide the service (or access to an independent service) of aggregating, updating and verifying **patients’ complete medical records** under strict standards of privacy and patient control.
Moving to Value-Based Competition

Employers

Enhance provider competition
• Expect providers to provide information about their results, experience, and practice standards at the condition level
• Require a single transparent fee for each service bundle
• Require one bill per hospitalization or treatment cycle
• Eliminate billing of employees by health plans or providers for any service covered by the plan, except for co-pays or deductibles
• Collaborate with other employers in advancing these aims

Set new expectations for health plans, including self-insured plans
• Select or specify plans that help subscribers obtain and understand results information on specific conditions
• Select or specify plans that ensure that patients are diagnosed and treated by experienced and excellent providers
• Select or specify plans that provide access to excellent out-of-network providers, including non-local ones, at reasonable cost
• Select or specify plans that provide comprehensive disease and risk management services
• One-stop shopping for health plans is usually inadvisable

Provide for health plan continuity for employees, not plan churning
Moving to Value-Based Competition
Employers (Continued)

Support employees as consumers and in managing their health
• Offer encouragement and support for employees in managing their health
• Provide independent information and advising services to employees to supplement other sources
• Enable cost-effective health plan structures and Health Savings Accounts

Find ways to expand insurance coverage and advocate reform of the insurance system
• Create vehicles to offer lower cost insurance to employees not currently part of the system
• Support reform that levels the playing field among employers

Measure the company’s health value received and make benefit managers accountable
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.
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 Evolution of Reform Models

**Past**
- Focus on Cost Control, Bargaining, and Rationing
  - Limiting provider compensation
  - Managing care

**Present**
- Focus on Recourse/Regulation
  - “Patients’ rights”
  - “Consumer-driven health care”

**Future**
- Focus on the Nature of Competition
  - “Value-based competition”
  - Specific medical conditions
  - Patient-centric
  - Information on results

- Focus on Provider / Hospital Practices
  - “Quality” and “Pay for performance”
  - IT as the silver bullet (EMR, CPOE, genetics, decision support)

- Focus on Health Plan Choice
  - “Patients’ rights”
  - “Quality” and “Pay for performance”
  - IT as the silver bullet (EMR, CPOE, genetics, decision support)
What Business Are We In?

Nephrology practice →

• Chronic Kidney Disease
• End-Stage Renal Disease
• Transplants
• Hypertension Management
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
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)
Boston Spine Group
Clinical and Outcome Information Collected and Analyzed

<table>
<thead>
<tr>
<th>RESULTS</th>
<th>METHODS</th>
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<tbody>
<tr>
<td><strong>Patient Outcomes</strong> <em>(before and after treatment, multiple times)</em></td>
<td><strong>Medical Complications</strong></td>
</tr>
<tr>
<td>Visual Analog Scale (pain)</td>
<td>Cardiac</td>
</tr>
<tr>
<td>Oswestry Disability Index, 10 questions (functional ability)</td>
<td>Myocardial infarction</td>
</tr>
<tr>
<td>SF-36 Questionnaire, 36 questions (burden of disease)</td>
<td>Arrhythmias</td>
</tr>
<tr>
<td>Length of hospital stay</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>Time to return to work or normal activity</td>
<td>Vascular deep venous thrombosis</td>
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</tbody>
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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 Process Metrics**
Operative time
Blood loss
Devices or products used
Length of hospital stay

**Surgery Complications**
Patient returns to the operating room
Infection
Nerve injury
Sentinel events (wrong site surgeries)
Hardware failure
Overcoming Barriers to Value-Based Competition

Providers

External
• Health plan practices
• Supplier mindsets
• Medicare practices
• Regulations
• Limited information

Internal
• Assumptions, mindsets, and attitudes
• Governance structures
• Management expertise
• Medical education
• The structure of physician practice

• Providers who have made progress towards value-based competition have often been ones who face fewer barriers and have avoided the dysfunctional aspects of the current system
  – e.g. Cleveland clinic (all physicians are salaried), Intermountain, the Veterans Administration Hospitals (integrated with a health plan).
Moving to Value-Based Competition

Suppliers

Offer unique **value over the full cycle of care**
- Compete through offering unique **value** in supporting health care delivery
- Focus on **cycles of care** rather than narrow product usage
- Sell not just products, but provider and patient **support**

**Demonstrate value** based on careful study of long term costs and results
- Use evidence on **long-term** clinical outcomes and cost to demonstrate value
- Develop new metrics to measure long-term **results and costs**, in cooperation with providers, health plans, and medical researchers

Ensure that the products are used by the **right patients**
- Increase the clinical value
- Avoid wasteful marketing to overly broad base

Ensure that drugs/devices are embedded in the **right care delivery processes**
- Use knowledge of product to help provider increase the value of its use

Build marketing campaigns based on **value, information, and customer support**
- Concentrate marketing efforts on value, not just volume and discounts
- Improve value by providing **continuing information** that supports consumers, providers, health plans, and employers

Offer services that **contribute to value** rather than reinforce cost shifting
- Develop expertise around diseases and across the care cycle to identify opportunities to add value
- Serve providers with knowledge of best practices and possible innovations in organization and delivery of care
Overcoming Barriers to Health Plan Transformation

Health Plans

External

• Medicare practices
• Provider resistance
• Lack of information on results and costs

Internal

• Information technology
• Medical expertise
• Trust
• Mindsets
• Culture and values

• Health plans that are integrated with a provider network have had advantages in moving in these directions in the current system, but independent health plans offer greater potential to support value-based competition
Moving to Value-Based Competition
Consumers

Participate Actively in Managing Personal Health
• Take responsibility for health care *choices* and health care
• Manage health through lifestyle choices, obtaining *routine* care and testing, *compliance* with treatment protocols, and active *participation* in disease management

Expect Relevant Information and Seek Help
• Expect transparent information on provider medical results, *experience*, and *cost* from any provider that is considered
• Seek help, if necessary, to *interpret* information
• Utilize *independent* medical information companies if information and support are not offered by the health plan

Make Provider Choices Based on Excellent Results in Addressing the Patient’s Medical Condition, Not Overall Reputation, Convenience, or Amenities
• Choose *excellent* providers, not just local providers or past providers
• Pay attention to *costs* as part of the value equation

Choose a Health Plan Based on Value Added
• Choose health plans based on their excellence in *information*, *assistance in securing the best care*, and comprehensiveness of *disease management* and *prevention programs*
• Consider *alternate health plan structures* such as high-deductibles and HSAs to improve value in health care choices and save for future health care needs

Build a Long-term Relationship with an Excellent Health Plan

Act Responsibly
• Provide for one’s own health care
• Litigate only for *truly bad* medical practice
Issues in Health Care Reform

- Health Insurance and Access
- What Care Should Be Covered?
- Structure of Competition in Health Care Delivery
What Government Can Do: Policies to Improve Health Insurance, Access, and Coverage

Insurance and Access
- Enable value based competition among health plans, rather than move to a single payer system
- Ban re-underwriting where it remains legal
- Assign full legal responsibility for medical bills to health plans – except in cases of fraud or breaches of important plan conditions
- Prohibit balance billing
- Mandate universal health coverage
  - Assigned risk pools
- Make HSAs available to all Americans
- Move to equalize taxation of individual and employer purchased health coverage
- Level the playing field among employers in terms of the burden of health coverage

Coverage
- Establish a national standard for minimum required coverage
- The Federal Employees Health Benefit Plan (FEHBP) as a starting point
What Government Can Do: Policies to Improve the Structure of Health Care Delivery

Open Up Competition at the Right Level

• Enforce antitrust laws
• Eliminate network restrictions
• Prohibit conflicts of interest such as self referrals or referrals to an affiliated organization without a results justification
• End restrictions on specialty hospitals
• Establish reciprocal state licensing
• Require periodic renewal of licenses based on results
• Revise tax treatment for medical travel expenses
• Curtail anticompetitive buying group practices

Promote the Right Information

• Establish common national standards and metrics for reporting on results, processes, and experience at the medical condition level
• Require mandatory reporting of results information as a condition to practice
• Designate a quasi-public entity to oversee information collection and dissemination
• Encourage private efforts to analyze and build upon mandatory data
What Government Can Do: Policies to Improve the Structure of Health Care Delivery (Continued)

Require Better Pricing Practices
• Require transparent prices for health care services
• Over time, require bundled prices that aggregate charges for episodes of care
• Limit or eliminate price discrimination based solely on plan or group membership

Reform the Malpractice System
• Allow lawsuits only for truly negligent medical practice

Redesign Medicare Policies and Practices
• Medicare should act like a health plan, not just a payer
• Medicare should set pricing, information, and other practices to enable value-based competition at the condition level
• Medicare should outsource health plan roles it is not equipped to play itself
• Recent promising Medicare experiments need to be improved and rolled-out

Redesign Medicaid Policies and Practices
• Medicaid policy should move from state-federal cost shifting to supporting value-based competition
• Medicaid should provide for the value-adding roles of health plans

Invest in Technology and Innovation
• Continue support for basic life science and medical research
• Create an adoption of innovation fund