Redefining Health Care: Creating Value-Based Competition on Results

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Forces of Change
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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.
Comments on Other Speakers

David Cutler
- Value, not cost
- Research at medical condition level
- Universal coverage is efficient too

Regina Herzlinger
- Opened up application of business thinking to health care
- Patients as consumers
- Ideas around some time: why not catch on or solve the problem?

Arnold Epstein
- We need to focus on quality
- PFP puts providers at the center of the system
  But
  - Micromanagement won’t work
  - PFP is pay for compliance/often at the wrong level too
  - Builds in cost-escalation
    - Margin v. price
    - Patients much more of an incentive
  - Results info will work: previous lack of consumer response was because poor info, health plans not involved, no consequences.
Issues in Health Care Reform

Health Insurance and Access

Structure of Health Care Delivery

Standards for Coverage
The Paradox of Health Care

• Costs are **high** and **rising**
• Services are **restricted** and fall well short of recommended care
• In other services, there is **overuse** of care
• Standards of care often **lag** and fail to follow accepted benchmarks
• **Diagnosis errors** are common
• Preventable **treatment errors** are common
• 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**

• Competition is **not** working
• How is this state of affairs possible?
Zero-Sum Competition in Health Care

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

- None of these forms of competition **increases value for patients**
Root Causes

- Competition in the health care system takes place at the **wrong levels** on the **wrong things**

**Too Broad**
- Between broad line hospitals, networks, and health plans

**Too Narrow**
- Performing discrete services or interventions

**Too Local**
- Focused on the local community
Principles of Value-Based Competition

1. The focus should be on value for patients, not just lowering costs.
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2. There must be unrestricted competition based on results.

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

KNOWLEDGE MANAGEMENT

INFORMING

MEASURING

ACCESSING

MONITORING/PREVENTING  DIAGNOSING  PREPARING  INTERVENING  RECOVERING/REHABING  MONITORING/MANAGING
The Care Delivery Value Chain: Primary Activities

Breast Cancer Care

**KNOWLEDGE MANAGEMENT**
- Education and reminders about regular exams
- Lifestyle and diet counseling

**INFORMING**
- Self exams
- Mammograms

**MEASURING**
- Office visits
- Mammography lab visits
- Mammograms
- Ultrasound
- MRI
- Biopsy
- BRACA 1, 2...

**ACCESSING**
- Office visits
- Lab visits
- High-risk clinic visits

**MONITORING/PREVENTING**
- Medical history
- Monitoring for lumps
- Control of risk factors (obesity, high fat diet)
- Clinical exams
- Genetic screening

**DIAGNOSING**
- Medical history
- Determining the specific nature of the disease
- Genetic evaluation
- Choosing a treatment plan

**PREPARING**
- Medical counseling
- Surgery prep (anesthetic risk assessment, EKG)
- Patient and family psychological counseling
- Plastic or oncoplastic surgery evaluation

**INTERVENING**
- Surgery (breast preservation or mastectomy, oncoplastic alternative)
- Adjuvant therapies (hormonal medication, radiation, and/or chemotherapy)

**RECOVERING/REHABING**
- In-hospital and outpatient wound healing
- Psychological counseling
- Treatment of side effects (skin damage, neurotoxic, cardiac, nausea, lymphedema and chronic fatigue)
- Physical therapy

**MONITORING/MANAGING**
- Periodic mammography
- Other imaging
- Follow-up clinical exams for next 2 years
- Treatment for any continued side effects

Breast Cancer Specialist
Other Provider Entities
Principles of Value-Based Competition

1. The focus should be on **value for patients**, not just lowering costs.
2. There must be **unrestricted competition** based on **results**.
3. Competition should **center on medical conditions** over the **full cycle of care**.
4. High quality care should be **less** costly.
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4. High quality care should be less costly.
5. Value is driven by provider experience, scale, and learning at the medical condition level.
The Virtuous Circle in a Medical Condition

- Better Results, Adjusted for Risk
- Faster Innovation
- Spread IT, Measurement, and R&D Costs over More Patients
- Wider Capabilities over the Care Cycle
- Rising Capacity for Sub-Specialization
- Deeper Penetration (and Geographic Expansion) in a Medical Condition
- Improving Reputation
- Rapidly Accumulating Experience
- Rising Efficiency
- Better Information/Clinical Data
- More Fully Dedicated Teams
- More Tailored Facilities
- Greater Leverage in Purchasing
- More Patients
- Wider Capabilities over the Care Cycle
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6. Competition should be regional and national, not just local.
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5. Value is driven by **provider experience, scale, and learning** at the medical condition level.
6. Competition should be **regional** and **national**, not just local.
7. **Information** on results and prices needed for value-based competition must be widely available.
The Information Hierarchy

- Patient Results (Outcomes, costs and prices)
- Experience
- Methods
- Patient Attributes
### OUTCOMES

**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

**Service Satisfaction**
*periodic*
Office visit satisfaction metrics (10 questions)

**Overall medical satisfaction**
*“Would you have surgery again for the same problem?”*

### METHODS

**Medical Complications**
Cardiac
- Myocardial infarction
- Arrhythmias
- Congestive heart failure
Vascular deep venous thrombosis
Urinary infections
Pneumonia
Post-operative delirium
Drug interactions

**Surgery Complications**
Patient returns to the operating room
Infection
Nerve injury
Sentinel events (wrong site surgeries)
Hardware failure

**Surgery Process Metrics**
Operative time
Blood loss
Devices or products used
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6. Competition should be regional and national, not just local.
7. Information on results and prices needed for value-based competition must be widely available.
8. Innovations that increase value must be strongly rewarded.
Moving to Value-Based Competition

Providers

Defining the Right Goals

• Superior patient value

Strategic and Organizational Imperatives

• Redefine the business around medical conditions
What Businesses Are We In?

- Chronic Kidney Disease
- End-Stage Renal Disease
- Kidney Transplants
- Hypertension Management

Nephrology practice
Moving to Value-Based Competition

Defining the Right Goals

• Superior patient value

Strategic and Organizational Imperatives

• Redefine the business around medical conditions
• Choose the range and types of services provided
• Organize around medically integrated practice units
• Create a distinctive strategy in each practice unit
• Measure results, experience, methods, and patient attributes by practice unit
• Move to single bills and new approaches to pricing
• Market services based on excellence, uniqueness, and results
• Grow locally and geographically in areas of strength

Enabling Conditions

• Analyzing the care delivery value chain
• Harnessing the power of Information Technology
• Systematizing knowledge development
Implementing Value-Based Strategies
Stroke Care: Major Vessel

**KNOWLEDGE MANAGEMENT**
- Counseling prior stroke patients about future risk
- Counseling patient and family on the diagnostic process and the diagnosis
- Gaining informed patient consent to treatment
- Counseling patient and family on rehabilitation options and process
- Counseling patient and family on long term management

**INFORMING**
- Emergency non-contrast brain CT
- Emergency CTA (angiography CT)
- Emergency diffusion and perfusion MRIs
- Procedure-specific measurements (e.g. success of reperfusion therapy)
- Neurological/neuropsychological assessments
- Follow-up neuro-imaging
- Neurological assessment
- Neuropsychological/behavioral evaluations

**MEASURING**
- Transport to ER
- In-hospital transport
- In-hospital transport to the treatment site
- In-hospital transport
- Clinic and office visits

**ACCESSING**
- In-hospital transport
- Ambulance transport

**MONITORING/PREVENTING**
- Control of risk factors (e.g. Heart disease, peripheral vascular disease, and smoking)
- Observing patient symptoms (e.g. speech, paralysis)

**DIAGNOSING**
- EMT Assessment
- EMT communication w/ER physician
- Medical history (including from friends or relatives)
- Assessment of imaging
- Potential remote consultation with stroke experts
- Defining the treatment plan

**PREPARING**
- Assembling personnel, pharmaceuticals and materials

**INTERVENING**
- Administering TPA or other thrombolytic medication where indicated
- Emergency vessel re-canalization using endovascular methods

**RECOVERING/REHABING**
- Intensive Care Unit (ICU) or neurological ICU
- In-hospital observation and rehabilitation
- Inpatient rehabilitation hospital
- Out-patient rehabilitation
- Follow-up visits

**MONITORING/MANAGING**
- In-patient chronic care (nursing home)
- Out-patient (home) chronic care
- Follow-up visits
- Stroke prevention plan

**REQUIRED SKILLS**
- Primary or specialist physicians
- EMTs
- ER physician
- Neurology
- Radiology
- Internal Medicine
- ICU Staff
- Neurology
- Physical therapy
- Psychology
- Psychiatry
- Social Work

Non-Hospital Entities

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Analyzing the Care Delivery Value Chain

1. Is the **set and sequence** of activities in the CDVC aligned with value?
2. Is the appropriate **mix of skills** brought to bear on each activity and across activities, and do individuals work as a **team**?
3. Is there **appropriate coordination** across the discrete activities in the care cycle, and are handoffs seamless?
4. Is care structured to **harness linkages** across different parts of the care cycle?
5. Is the **right information** collected, integrated, and utilized across the care cycle?
6. Are the activities in the CDVC performed in **appropriate facilities and locations**?
7. What provider departments, units and groups are involved in the care cycle? Is the provider’s **organizational structure** aligned with value?
8. What are the independent entities involved in the care cycle, and what are the relationships among them? Should a provider’s **scope of services** in the care cycle be expanded or contracted?
Moving to Value-Based Competition

Suppliers

• Compete on delivering **unique value** over the **full care cycle**

• **Demonstrate value** based on careful study of long term costs and results versus alternative therapies

• Ensure that the products are **used by the right patients**

• Ensure that drugs/devices are embedded in the **right care delivery processes**

• Market based on **value, information, and customer support**

• Offer support services that **contribute to value** rather than reinforce cost shifting
Transforming the Roles of Health Plans

**Old Role**

- Restrict patient choice of providers and treatment
- Micromanage provider processes and choices
- Minimize the cost of each service or treatment
- Engage in complex paperwork and administrative transactions with providers and subscribers to control costs and settle bills
- Compete on minimizing premium increases

**New Role**

- Enable informed patient and physician choice and patient management of their health
- Measure and reward providers based on results
- Maximize the value of care over the full care cycle
- Minimize the need for administrative transactions and simplify billing
- Compete on subscriber health results
Moving to Value-Based Competition

Health Plans

Provide Health Information and Support to Patients and Physicians
1. Organize around medical conditions, not geography or administrative functions
2. Develop measures and assemble results information on providers and treatments
3. Actively support provider and treatment choice with information and unbiased counseling
4. Organize information and patient support around the full cycle of care
5. Provide comprehensive disease management and prevention services to all members, even healthy ones

Restructure the Health Plan-Provider Relationship
6. Shift the nature of information sharing with providers
7. Reward provider excellence and value-enhancing innovation for patients
8. Move to single bills for episodes and cycles of care, and single prices
9. Simplify, standardize, and eliminate paperwork and transactions

Redefine the Health Plan-Subscriber Relationship
10. Move to multi-year subscriber contracts and shift the nature of plan contracting
11. End cost shifting practices, such as re-underwriting, that erode trust in health plans and breed cynicism
12. Assist in managing members’ medical records
Moving to Value-Based Competition

**Employers**

- Set the goal of increasing *health value*, not minimizing health benefit costs

- Set new expectations for health plans, including *self-insured* plans

- Provide for health plan *continuity* for employees, rather than plan churning

- Enhance provider competition on *results*

- Support and motivate employees to *make good health care choices* and *manage their own health*

- Find ways to *expand insurance coverage* and advocate reform of the insurance system

- Measure and hold employee benefit staff accountable for the company’s *health value received*
Moving to Value-Based Competition

Consumers

• Participate actively in managing personal health

• Expect relevant information and seek advice

• Make treatment and provider choices based on excellent results and personal values, not convenience or amenities

• Choose a health plan based on value added

• Build a long-term relationship with an excellent health plan

• Act responsibly
Roles of Government in Value-Based Competition

• Require the collection and dissemination of the risk-adjusted outcome information

• Open up value-based competition at the right level

• Provide for price transparency

• Limit or eliminate price discrimination

• Develop information technology standards and rules to enable interoperability and information sharing

• Invest in medical and clinical research
What Government Can Do: Policies to Improve Health Insurance, Access, and Coverage

Insurance and Access

• Enact **mandatory health coverage**
• Provide **subsidies** or vouchers for **low-income** individuals and families
• Create **risk pools** for high-risk individuals
• Enable **affordable insurance plans**
• Eliminate **unproductive** insurance rules and billing practices
  – **Ban** re-underwriting
  – **Clarify legal responsibility** for medical bills
  – Eliminate **balance billing**

Coverage

• Establish a **national standard** for 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

• Enable universal results information
  – Establish a process of **defining outcome measures**
  – Enact **mandatory results reporting**
  – Establish information **collection** and **dissemination** infrastructure

• Improve **pricing** practices
  – Establish episode and **care cycle** pricing
  – Set limits on **price discrimination**

• Open up **competition** at the right level
  – Reduce **artificial barriers** to practice area integration
    • Modify Stark laws
    • Phase-out **corporate practice of medicine** laws
  – Require a value justification for captive referrals or treatment involving an economic interest
  – Eliminate artificial restrictions on **new entry**
  – Institute results-based **license renewal**
  – Strictly enforce **antitrust** policies
  – Curtail anticompetitive **buying group practices**
  – Eliminate barriers to competition **across geography**
    • Establish reciprocity in state-level licensing
    • Modify tax treatment of medical travel
What Government Can Do: Policies to Improve the Structure of Health Care Delivery (continued)

• Establish standards and rules that enable information technology and information sharing
  – Develop standards for interoperability of hardware and software
  – Develop standards for medical data
  – Enhance identification and security procedures
  – Provide incentives for IT adoption

• **Reform** the malpractice system

• **Redesign** Medicare policies and practices
  – Make Medicare a **health plan**, not a payer or a regulator

• Modify counterproductive **pricing practices**

• Improve Medicare **Pay-for-Performance**

• **Align** Medicaid with Medicare

• Invest in medical and clinical **research**
Health Care for Low Income Americans

• Mandatory, universal health coverage is essential, with subsidies for those who need – for reasons of economics as well as equity.

• Two class care works against the fundamental dynamic of using quality improvement to reduce costs

• Competition does not mean substandard care for low income Americans.

• Results reporting makes substandard care for any patient reflect poorly on the provider of that care, so quality and value will improve for all.
  – Results reporting will unmask disparities in care, making them intolerable.

• The price of a service should not depend on who is paying (as it does today), but on the care needed and on the provider.
How Will Redefining Health Care Begin?

- It is **already happening**!
- Each **system** participant can take **voluntary** steps in these directions, and will **benefit** irrespective of other changes.
- 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.