Value-Based Competition in Health Care

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Proposals for Reforms

• Single Payer System
• Consumer-Driven Health Care
• Pay for Performance
• Electronic Medical Records
• Integrated Payer-Provider Systems
Issues in Health Care Reform

- Health Insurance and Access
- Standards for Coverage
- Structure of Health Care Delivery
Creating a Value-Based Health Care System

• Universal insurance is not enough

• The core issue in health care is the value of health care delivered

Value: Patient outcomes per dollar spent

- How to design a health care system that dramatically improves value
- How to design a dynamic system that keeps rapidly improving

• Significant improvement in value will require fundamental restructuring of health care delivery, not incremental improvements

Today, 21st century medical technology is delivered with 19th century organization structures, management practices, and pricing models

- TQM, process improvements, and safety initiatives are beneficial but not sufficient
The Paradox of U.S. Health Care

The United States has a **private system** with **intense competition**

But

- Costs are **high** and **rising**
- Services are **restricted** and often **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?
Competition in U.S. Health Care

Bad Competition

• Competition to **shift costs** or capture a bigger share of revenue
• Competition to **increase bargaining power**
• Competition to **capture patients** and restrict choice
• Competition to **restrict services** in order to maximize revenue per visit or reduce costs

Zero or Negative Sum

Good Competition

• Competition to **increase value for patients**

Positive Sum
Creating a Value-Based Health Care System

• Today’s **competition** in health care is often **not aligned with value**

| Financial success of system participants | ≠ | Patient success |

• Creating **competition around value** is the central challenge in health care reform
Principles of Value-Based Competition

1. The goal should be **value for patients**, not just lowering costs
   - This will require going **beyond cost containment** and **administrative savings**
Principles of Value-Based Competition

1. The goal should be **value for patients**, not just lowering costs

2. The best way to contain costs is to drive improvement in **quality**
   - Prevention
   - Early detection
   - Right diagnosis
   - Early treatment
   - Right treatment to the right patients
   - Treatment earlier in the causal chain of disease
   - Fewer mistakes and repeats in treatment
   - Fewer delays in the care delivery process
   - Less invasive treatment methods
   - Faster recovery
   - More complete recovery
   - Less disability
   - Fewer relapses or acute episodes
   - Slower disease progression
   - Less need for long term care

   • **Better health is inherently less expensive** than poor health
Principles of Value-Based Competition

1. The goal should be **value for patients**, not just lowering costs

2. The best way to contain costs is to drive improvement in **quality**

3. There must be **unrestricted competition** based on **results**
   - Results vs. supply control or process compliance
   - Get patients to excellent providers vs. “lift all boats”
Principles of Value-Based Competition

1. The goal should be **value for patients**, not just lowering costs
2. The best way to contain costs is to drive improvement in **quality**
3. There must be **unrestricted competition** based on **results**
4. Competition should center on **medical conditions** over the **full cycle of care**
Restructuring Health Care Delivery: Medical Conditions
Migraine Care in Germany

Old Model: Organize by Specialty and Discrete Services

- Imaging Centers
- Outpatient Physical Therapists
- Inpatient Treatment and Detox Units
- Outpatient Neurologists
- Primary Care Physicians
- Outpatient Psychologists

New Model: Integrated Practice Units

- Imaging Unit
- West German Headache Center
  - Neurologists
  - Psychologists
  - Physical Therapists
  - Day Hospital
- Primary Care Physicians
- Network Neurologists
- Essen Univ. Hospital Inpatient Unit

Source: KKH, Westdeutsches Kopfschmerzzentrum
What is a Medical Condition?

• A medical condition is an interrelated set of patient medical circumstances best addressed in an integrated way
  – From the patient’s perspective

• Includes the most common co-occurrences

• Examples
  – Diabetes (including vascular disease, hypertension)
  – Breast Cancer
  – Stroke
  – Migraine
  – Asthma
  – Congestive Heart Failure
  – HIV/AIDS
The Care Delivery Value Chain
Breast Cancer

INFORMING & ENGAGING
- Advice on self screening
- Consultation on risk factors
- Self exams
- Mammograms
- Office visits
- Mammography lab visits

MEASURING
- Counseling patient and family on the diagnostic process and the diagnosis
- Mammograms
- Ultrasound
- MRI
- Biopsy
- BRAC 1, 2...

ACCESSING
- Hospital stay
- Visits to outpatient or radiation chemotherapy units
- Office visits
- Lab visits
- Mammographic labs and imaging center 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)

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, lymphodema 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

Primary care providers are often the beginning and end of care cycles
Cycles of Care vs. Discrete Services

• Value is created by the **cycle of care**, not individual interventions

• Health care is **co-produced** between the patient and the medical team
  – The patient and his/her family must be **actively involved** in their health and their health care

• Excellent providers make patient engagement and compliance monitoring an **integral part of care delivery**

• **Prevention, screening, and ongoing disease management** are integral to the care cycle of every medical condition
  – Disease management must be **integral to the provision of care delivery**, not an overlay
HIV/AIDS Care Delivery Value Chain: Resource Poor Settings

- **Informing & Engaging**
- **Measuring**
- **Accessing**

<table>
<thead>
<tr>
<th>Prevention &amp; Screening</th>
<th>Diagnosing &amp; Staging</th>
<th>Delaying Progression</th>
<th>Initiating ARV Therapy</th>
<th>Ongoing Disease Management</th>
<th>Management of Clinical Deterioration</th>
</tr>
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(Patient Value
(Health outcomes per unit of cost)
Integrating Care Delivery: Patients With Multiple Medical Conditions

Integrated Practice Unit
Diabetes

Integrated Practice Unit
Congestive Heart Failure

Integrated Practice Unit
Migraine

Integrated Practice Unit
Osteoarthritis of the Hips
Principles of Value-Based Competition

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5. Value is driven by provider **experience, scale, and learning** at the medical condition level
The Virtuous Circle in a Medical Condition

- The virtuous cycle extends across geography
- Fragmentation of provider services works against patient value
Principles of Value-Based Competition

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

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
   - Manage care cycles across geography
   - Utilize partnerships and inter-organizational integration among separate institutions
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6. Competition should be **regional** and **national**, not just local
7. **Results** must be universally measured and reported

Results: Patient health outcomes over the care cycle

Total cost of achieving those outcomes
Measuring Results
The Information Hierarchy

Patient Results
(Outcomes, prices and costs)

Experience

Methods/Processes
(Primarily for internal improvement)

Patient Attributes
(For risk adjustment and clinical insight)
Measuring Results

Principles

- Measure outcomes versus processes of care
  - Process control is the wrong model

- Outcome measurement should take place:
  - At the medical condition level
  - Over the cycle of care

- There are multiple outcomes for every medical condition

- Outcomes must be adjusted for risk

- Outcomes are as important for physicians as for consumers and health plans

- The feasibility of universal outcome measurement at the medical condition level has been conclusively demonstrated
Measuring Results

The Outcome Measures Hierarchy

- Survival
- Degree of recovery / health
- Time to recovery or return to normal activities
- Disutility of care or treatment process (e.g., treatment-related discomfort, complications, or adverse effects, diagnostic errors, treatment errors)
- Sustainability of recovery or health over time
- Long-term consequences of therapy (e.g., care-induced illnesses)
Principles of Value-Based Competition

1. The goal should be *value for patients*, not just lowering costs

2. The best way to contain costs is to drive improvement in *quality*

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

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

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. *Results* must be universally measured and reported

8. Reimbursement should be aligned with *value* and reward *innovation*
   - Reimbursement for care cycles, not discrete treatments or services
Organ Transplantation Care Cycle

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

Alternative therapies to transplantation

Addressing organ rejection
Fine-tuning the drug regimen
Adjustment and monitoring
Principles of Value-Based Competition

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8. Reimbursement should be aligned with **value** and reward **innovation**
9. **Information technology** is an **enabler** of restructuring care delivery and measuring results, **not a solution itself**
   - Common data definitions
   - Interoperability standards
   - Patient-centered database
Moving to Value-Based Competition
Implications for Providers

- Organize around integrated practice units (IPU) for each medical condition
- Choose the appropriate scope of services in each facility based on patient value
- Integrate services for each medical condition across geographic locations
- Employ formal partnerships and alliances with other entities involved in the care cycle to integrate care and improve capabilities
- Measure results by medical condition
- Expand in high-performance medical conditions across geographic areas using an integrated model, versus aggregating broad line, stand-alone facilities
- Lead new contracting models with health plans based on care cycle reimbursement
The Care Delivery Value Chain

Chronic Kidney Disease

INFORMING
- Lifestyle counseling
  - Diet counseling
- Explanation of the diagnosis and implications

MEASURING
- Serum creatinine
  - Glomerular filtration rate (GFR)
  - Proteinuria
- Special urine tests
  - Renal ultrasound
  - Serological testing
  - Renal artery angiography
  - Kidney biopsy
  - Nuclear medicine scans
- Procedure-specific pre-testing
- Procedure-specific measurements

ACCESSING
- Office visits
  - Lab visits
- Various
  - Office visits
  - Hospital visits
- Office/lab visits
  - Telephone/Internet interaction

MONITORING/ PREVENTING
- Monitoring renal function (at least annually)
- Monitoring and addressing risk factors (e.g. blood pressure)
- Early nephrologist referral for abnormal kidney function

DIAGNOSING
- Medical and family history
- Directed advanced testing
  - Consultation with other specialists
  - Data integration
- Formal diagnosis

PREPARING
- Formulate a treatment plan
- Procedure-specific preparation (e.g. diet, medication)
- Tight blood pressure control
  - Tight diabetes control

INTERVENING
- Pharmaceutical interventions
  - Kidney function (ACE Inhibitors, ARBs)
  - Procedures
  - Renal artery angioplasty
  - Urological
  - Endocrinological
  - Vascular access graft at stage 4

RECOVERING/ REHABING
- Fine-tuning drug regimen
- Determining supporting nutritional modifications

MONITORING/ MANAGING
- Managing renal function
- Managing kidney side effects of other treatments (e.g. cardiac catheterization)
- Managing the effects of associated diseases (e.g. diabetes, hypertension, uremia)
- Referral for renal replacement therapy (RRT)

Feedback Loops

Nephrology Practice
Other Provider Entities
Analyzing the Care Delivery Value Chain

1. Are the set of activities and the 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 (optimize overall allocation of effort) 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?
Integrating Services Across Geography

Current Model: Each Unit is Stand Alone and Offers Most Services

- PCP
- Community Hospital A
- Academic Medical Center
- Specialist Practice
- Community Hospital B
- Specialist Practice

New Model: Care is Specialized and Integrated Across Geographic Units By Medical Conditions

- Regional Outpatient Hub
- Satellite Hospital Unit
- Referral / Disease Management
- Referral / Disease Management
- Referral / Disease Management
- Inpatient Unit
- Referral / Disease Management
- Referral / Disease Management
Moving to Value-Based Competition

Health Plans

“Payor”

Value-Added Health Organization
Moving to Value-Based Competition
Roles of a Health Plan

- Monitor and compare provider results by medical condition
- Provide advice to patients (and referring physicians) in selecting excellent providers
- Assist in coordinating patient care across the full care cycle and across medical conditions
- Provide for comprehensive prevention and chronic disease management services to all members
- Design new reimbursement models for care cycles
- Assemble and manage the total medical records of members
- Measure and report overall health results for members
Creating a High-Value Health Care System: Roles and Responsibilities

**Employers**

- Set the goal of **employee health**
- Assist employees in **healthy living** and **active participation in their own care**
- Set new expectations for health plans, including **self-insured** plans
  - Assist subscribers in **accessing excellent providers** for their medical conditions
  - Contract for **care cycles** rather than discrete services
  - Provide for convenient access to **prevention, screening, and disease management** services
- Provide for health plan **continuity** for employees, rather than plan churning
- 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

Government

• Measure and report health results

• Create IT standard data definitions and interoperability standards to enable the collection and exchange of medical information for every patient

• Enable the restructuring of health care delivery around the integrated care of medical conditions across the full care cycle

• Shift reimbursement to bundled prices for cycles of care instead of payments for discrete treatments or services

• End provider price discrimination across patients

• Remove artificial restraints to competition among providers and across geography
Moving to Value-Based Competition

**Government – cont’d.**

- Encourage the **responsibility of individuals** for their health and their health care
- Require health plans to measure and report **health outcomes** for members
- Enable **universal insurance** consistent with value-based principles
  - Create **neutrality** between employer-provided and individually-purchased health insurance
  - Establish **risk pooling adjustment vehicles** that eliminate incentives for cherry picking healthier patients
  - Move towards an **individual mandate** to purchase health insurance
  - All health insurance plans should include **screening and preventive care** in addition to **disease management** for chronic conditions
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

• Providers can and should take the lead