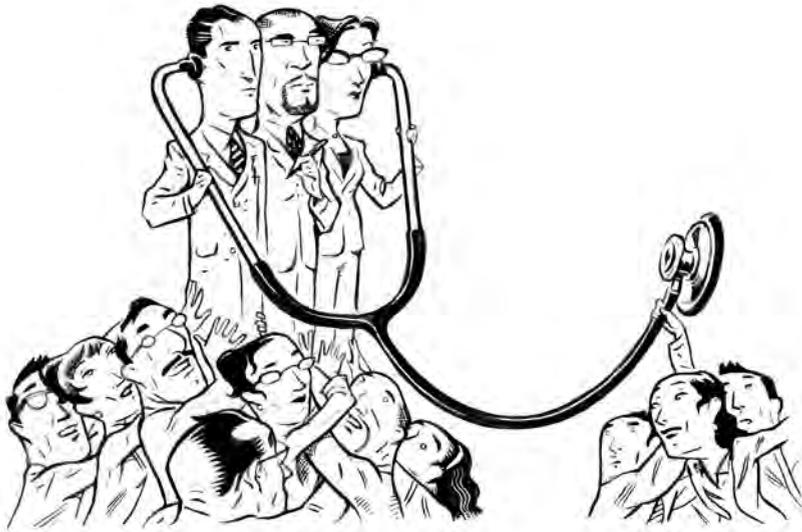


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# Transforming Healthcare Delivery

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the stakeholders who pay the bills must collaborate.

BY JOYJIT SAHA CHOUDHURY,  
AKSHAY KAPUR, AND SANJAY B. SAXENA



# Transforming Healthcare Delivery

As nations seek to expand services more cost-effectively, the stakeholders who pay the bills and provide the care must collaborate.

by Joyjit Saha Choudhury,  
Akshay Kapur, and Sanjay B. Saxena

**W**hen it comes to healthcare, many nations are not getting enough for their money. For example, in the U.S., an estimated 30 to 40 percent of total healthcare spending is wasted through systemic underuse, overuse, and misuse, even as costs climb at a rate that far exceeds overall inflation. Although medical costs in the U.S. are among the highest in the world, its healthcare system ranks only 37th in quality, according to the World Health Organization. A study by the Commonwealth Fund found that the U.S. spends twice as much per capita on medical care as do other industrialized nations, but is in last place in preventing deaths.

The United States is not alone in its healthcare conundrum. Statistics like these and the accompanying warnings about the unsustainable nature of healthcare systems around the world have been circulating for years, if not decades.

Many government leaders are heeding these warnings. Some are undertaking massive reform initiatives, including President Barack Obama's efforts in the U.S., which resulted in the Affordable Care Act, and Chancellor Angela Merkel's ongoing efforts to stem the escalating cost of healthcare in Germany. But these national efforts raise fundamental questions. To what ends should reform be directed? How will those ends be achieved?

The answer to the first question is simple: Reform should be directed

at bringing healthcare costs under control while improving the quality of care and patients' experience. In the U.S., this conclusion is often translated into an immediate goal of limiting healthcare cost increases to the growth rate of the consumer price index.

This goal is easy to set, but how is it to be achieved? Unlike a business, a healthcare system can't simply slash head count, operations, or overhead to bring costs under control. The impact on patients' access to medical services and the quality of care would be draconian.

Instead, most systems face the challenge of controlling costs while expanding patient access and improving care quality. The only way to meet this challenge is to focus on care delivery — the primary source of healthcare costs. In the U.S., care delivery, which includes physician and clinical services, hospital care, prescription drugs, tests, and procedures, accounted for approximately 85 percent of the US\$2.5 trillion spent on healthcare in 2009 (the remainder is investment and administrative expense). To achieve the quality improvement and cost reduction needed to ensure the long-term stability of the system and the success of the medical industry, healthcare systems need to transform the full spectrum of care delivery.

## Systemic Obstacles

The already considerable challenge of care-delivery transformation is magnified by inefficiencies that persist throughout healthcare systems and contribute to rising costs. These inefficiencies are often rooted in the structures of healthcare systems. In the U.S., for instance, four major structural flaws impede the efficient delivery of high-quality care.

First, healthcare providers, such as doctors and hospitals, get paid for the type, volume, and complexity of the care they deliver, not the quality of care. At best, this fee-for-service payment model creates a disturbing disconnect between providers and care quality. At worst, it gives rise to abusive practices, such as churning (the unnecessary scheduling of repeat visits by physicians to bolster revenue or productivity) and self-referral (the prescription of unneeded tests or services at facilities in which the referring provider has an ownership stake).

Second, many providers are needed to treat serious illnesses, and the lack of coordination among them adds complexity and cost to care, as well as myriad opportunities for medical error. For example, the Cleveland Clinic review of “sentinel events” — unanticipated events in a healthcare setting that result in death or serious physical or psychological injury to a patient, but that are not related to the natural course of the patient’s illness — and near misses in 2007 and 2008 found that 43 percent were related to suboptimal communication.

Third, the lack of adoption of proven, standardized approaches to care and evidence-based guidelines frequently results in expensive, flawed care. Intermountain Healthcare, which runs hospitals and clinics in Utah and Idaho, offers a good example of gains that can be captured. By implementing standardized care protocols, the company successfully halved both adverse drug events and the death rate for coronary bypass surgery.

Fourth, patients are largely disengaged from their own medical care. In the U.S., 81 percent of patients are insured through govern-

ment payors, such as Medicare, or through plans offered by their employers, and as a result do not need to consider the cost-benefit trade-offs inherent in care decisions or the overall cost of their care. Some patients may prefer to remain uninformed, but the system itself fails to reward informed decision making by other patients, even when it could lead to more effective prevention and treatment. Even consumers who would never buy a flat-screen television or a laptop without thoroughly researching their options are reluctant to question physicians about decisions that are often critical to their future well-being.

### **Bold Goals for Reform**

To overcome the structural barriers to systemic reform and transform care delivery, the three principal stakeholders in healthcare systems — providers, payors, and patients — have to work together toward common goals. This will demand some difficult adjustments in the traditional stances of these three stakeholder groups, but their closer alignment throughout care delivery is the best approach to achieving transformative change.

Other industries have been successful in finding new value by making similar adjustments. Automakers, for instance, have collaborated with their vendors throughout the design, production, and distribution processes to create value; ongoing innovation has led to vastly better quality at much lower cost. By building a system based on trust and well-aligned incentives, carmakers were able to draw on their suppliers’ knowledge as well as provide constructive feedback that helped the entire industry become much more productive. Consider

the returns that such a collaborative effort could yield in the untamed and bloated U.S. healthcare-delivery system alone: The elimination of the 30 to 40 percent of spending that is wasted would result in annual savings of \$750 billion or more at current expenditure levels.

To attain such savings, broad collaborations and bold goals are necessary. In the U.S., healthcare initiatives championed by a single stakeholder group have been unable to deliver better-quality care or lower costs. In the 1980s, for example, insurers attempted to push down the cost side of the medical value equation through managed care approaches, such as HMOs, but they were forced to back away when consumers and employers raised concerns about choice and quality. A decade later, providers failed to generate new value through major consolidations of hospitals and physician practices.

Incremental efforts involving multiple players have also proven unsustainable. For example, recent initiatives that attempted to create medical value by linking a small portion of provider pay to patient outcomes did not generate significant results because they were implemented on top of the traditional fee-for-service model that rewards complex and extensive care. Indeed, these well-intentioned measures can also create another layer of complexity — and cost — for providers and payors, because they need to add administrative processes to their operations to measure and manage the outcomes-based framework.

### **A Collaborative Vision**

What might the collaborative models necessary to transform care delivery look like? The recently enacted

healthcare reform legislation in the U.S. calls for some demonstration projects based on collaborative models, but before leaping into the adoption and implementation of these models, healthcare providers and other industry players need to step back and think hard about the vision and objectives of their collaborative efforts.

Transformation of the care-delivery system on a scale that will generate the cost savings necessary to revitalize the medical system will require myriad initiatives. In each one, the collaborating hospitals, physicians, and payors need to define and commit to an overarching vision and clear objectives. A vision defines what, in essence, the initiative is trying to achieve, whether that is cost reduction, improved quality, a better experience for patients, or some combination of those factors. Objectives define specific goals,

#### Joyjit Saha Choudhury

*joyjit.sahachoudhury@booz.com*

is a principal with Booz & Company in New York. He advises health-services clients on corporate and business unit strategies as well as strategy and capability building to drive medical value.

#### Akshay Kapur

*akshay.kapur@booz.com*

is a principal with Booz & Company in Chicago. He specializes in the development of corporate and business unit strategies for healthcare clients, with an emphasis on care-delivery innovation and transformation.

#### Sanjay B. Saxena

*sanjay.saxena@booz.com*

is an M.D. and a partner with Booz & Company in San Francisco, and leads the firm's West Coast health practice. He advises health-services clients on strategy development and capability building, specializing in payor-provider collaboration, next-generation payment approaches, and innovative care-delivery models.

Also contributing to this article were Booz & Company senior associate Scott Strand and partner Jack Topdjian.

such as targets for cost reduction or market share. Moreover, there must be overriding principles that stakeholders can use to resolve the conflicts that inevitably arise when trade-offs must be made. And all parties should understand what's in it for them — that is, what rewards they can expect to reap for meeting their targets. These elements are the foundation for mutual trust and genuine engagement on the part of all stakeholders.

Once the stakeholders in care-delivery transformations have a clear understanding of where they are headed, they can address the three major components of potential models: delivery, payment, and consumer engagement.

**Delivery.** Collaborative care-delivery approaches vary widely in both the level of integration and the degree of collaboration they require. Many other variables, such as provider mix and the underlying IT structure and capabilities needed to share information among all those involved in a patient's care, also play into the choice and development of a care-delivery approach.

One of the approaches generating the most interest among providers and payors in the U.S. is the accountable care organization (ACO), which is a coordinated network of provider partners, such as hospitals, primary care physicians, and specialists, who work together to improve care delivery and control costs, often in association with a healthcare insurer. Typically, ACO provider partners assume responsibility for meeting care quality and cost goals, and earn a share of the savings they produce. Another intriguing approach is the patient-centered medical home (PCMH), in which primary care physicians manage all aspects

of patient care, serving as team leaders and care coordinators when patients require specialist services, and seeking to involve patients as active participants in their own health and well-being.

**Payment.** Getting the payment scheme right is especially complex and is the most data-intensive part of the collaborative process. Because practice follows payment, however, it also holds the most potential for transforming healthcare systems.

In designing a payment scheme, participants must first decide how healthcare services will be priced. New, more collaborative models are often based on bundled case rates (fixed payments for a full episode of care, such as the aggregated set of procedures and services involved in a coronary artery bypass) or global payments (single, risk-adjusted payments coupled with quality metrics designed to discourage the withholding of care, encompassing all the care needed for a specific patient population, such as diabetics). Global payments offer the opportunity to cap the healthcare cost trend, but do not necessarily reduce absolute current spending.

All payment scheme designs come with implications regarding how cost increases will be controlled, quality will be managed, and patients will be engaged. In the U.S., the payment schemes of the future are likely to take cues from the consumer goods industry, adapting increasingly sophisticated pricing methodologies. For example, payors and providers may move toward tiered pricing based on controllable variables, such as length of stay or quality of service. Other future schemes may embrace more dynamic, varied pricing to improve care-delivery economics. For

instance, providers might charge less for using an MRI machine 30 miles from a patient's home where demand is lower than for using one that is closer but busier.

cardiac care services. To encourage its employees to take advantage of its terms, Lowe's waives deductible, out-of-pocket costs and pays travel and lodging expenses for employee

between insurer Humana and Metropolitan Health Networks Inc., which manages a network of physicians in South Florida, reported 33 percent lower hospital readmission rates compared with Medicare readmission rates in its first year.

Several Blue Cross and Blue Shield Association plans are experimenting with new payment schemes. Blue Cross Blue Shield of Massachusetts has implemented an "alternative quality contract" that is one of the largest global payment systems in operation in the United States. Blue Cross and Blue Shield of Minnesota (BCBS MN) has established a promising "shared incentive" partnership with major care-delivery systems that is designed to bring its costs in line with the consumer price index. Toward that end, BCBS MN and its provider partners are restructuring care delivery. For example, some provider systems have begun conducting e-consultations in place of traditional office visits, and BCBS MN is reimbursing them for this cost-saving service. Additionally, the payor is sending staff into hospitals to support case-management activities and help providers plan more seamless care for their patients.

These are all worthy experiments, and they suggest that the will to transform care delivery does indeed exist in many healthcare systems. But these efforts are still in their early stages, and if the U.S. and other nations are to create sustainable healthcare systems, all their stakeholders must continue to develop, test, and refine new collaborative approaches to medical value, seeking to increase care quality and manage costs. +

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## In the U.S., the payment schemes of the future are likely to take cues from the consumer goods industry.

**Consumer engagement.** Collaboration models need to determine the proper role of healthcare consumers in the overall integration. The objective of increased engagement is for consumers to take a greater degree of ownership in their health and make better, more informed lifestyle and healthcare consumption decisions. The level of consumer participation in collaborative models varies depending on their health status and medical conditions, as well as the level of care they require — for example, consumers can be assigned differing levels of responsibility in their own care by treatment type and level of risk.

The use of consumer engagement to transform care delivery and control costs is common in employer plans. These plans often include value-based benefit designs that motivate employees to make optimal choices in their consumption of care. Workplace incentives for programs such as smoking cessation and weight loss have existed for several years. Some large employers are expanding their efforts by assuming a more proactive role in steering employees toward better healthcare choices. For example, in 2010, home improvement giant Lowe's Companies Inc. struck a three-year deal with Cleveland Clinic for bundled

plan members who are willing to travel to the clinic for qualified cardiac surgery.

### Tomorrow's Healthcare Today

The Lowe's example is only one of many experiments in the transformation of care delivery under way in the United States. Geisinger Health Plan in Pennsylvania is conducting another: The company is developing disease- and procedure-based products — integrated, end-to-end care bundles that are designed especially for specific diseases, conditions, or procedures, and that span the entire episode of care — under the ProvenCare brand. ProvenCare products, which include packaged solutions for back pain, hip replacements, and cataracts, are supported by bundled payments that cover all professional and hospital services from pre-operative care through 90 days of post-operative care, as well as a "warranty" that covers post-operative complications. Early results are promising, demonstrating reduced lengths of stay and reduced readmissions.

A number of U.S. payors and providers are piloting PCMHs. By increasing provision of preventive care by primary care physicians, PCMHs can reduce the need for high-cost specialty and tertiary care. For example, a PCMH pilot

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