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BY GIL IRWIN, ART KLEINER, AND JOYJIT SAHA CHOUDHURY

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When Disruptive Integration Comes to Health Care

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If one lesson can be drawn from the unresolved battles over health-care reform in the U.S. Congress in 2009, it is that government action by itself is insufficient. Sooner or later, no matter what the outcome in Washington, the problems of the health-care system — rising costs, limited access to services, and inconsistent quality of care — will fall, at least in part, to the private sector to solve. As Aetna Inc. CEO Ronald Williams mentioned recently, these underlying issues of quality, access, and affordability aren't going away. If health-care businesses don't find ways of addressing them, their own profitability will be at risk..

Yet few people are looking intently at the role that corporate leaders can play as primary movers in reducing costs and improving the system. In *The Innovator's Prescription: A Disruptive Solution for Health Care* (McGraw-Hill, 2009), Clayton M. Christensen, the late Jerome H. Grossman, and Jason Hwang have taken exactly that step. Their book argues that corporations in the health-care sector must rethink how they deliver their products and services, or they will lose their position to more innovative players in the marketplace. In other words, policy reform must go hand in hand with business reform, and only so much of that reform can be dictated from above.

Jason Hwang is a doctor of internal medicine and the executive director of health care at Innosight Institute, a nonprofit think tank focused on social-sector innovation. Innosight Institute's practice is based on disruptive innovation, an idea first put forward in Christensen's influential book *The Innovator's Dilemma: When New Technologies Cause Great Firms to Fail* (Harvard Business School Press, 1997) and only now applied to the health-care system. Disruptive innovators are low-margin, experimental upstart entrepreneurs in an established market, who take advantage of untapped and emergent customer groups and other unfilled opportunities to build new types of business and ultimately reshape the industry. Established incumbents, tied to their existing customers and practices, have a great built-in incentive to overlook the potential impact of these new competitors. Therefore, they ignore them until the upstarts grow large and powerful enough to displace them. It has happened in a variety of industries, including computer components, steel, and media. Now, the presence of disruptors — including new types of clinics, hospitals, and online services — is evident in health care as well.

This is not just an American dynamic; in every country, health-care businesses and regulators alike are trying to cope with rising costs and difficult trade-offs. In a recent interview with Hwang, we explored how disruptive innovation is unfolding in the health-care sector and discussed its critical relationship to the success of

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regulatory reform, both in the U.S. and around the world.

S+B: *The Innovator's Prescription* argues that legislative action is only a starting point for curing what ails health care. The more important challenge is disrupting the current business models, which are no longer working well. Why wouldn't this be a natural outgrowth of regulatory reform?

HWANG: Because the overall health-care system is already doing exactly what it was designed to do, and health-care reform, in itself, won't change that. The typical hospital and all of the institutions surrounding it make up a system that waits for you to get sick and then delivers complex, acute care at a very high cost. In the U.S., the business models in this "sick care" system were designed and perfected in the current regulatory environment. So when regulators say to health-care companies, "You need to change," they're asking them to do things that are antithetical to their nature — as it was shaped by regulation in the first place.

This current system is not designed to do the things that people increasingly want a health-care system to do: to deliver chronic disease management; to deliver wellness care; to counsel people when they're well; or to differentiate between serious problems and problems that need rapid, convenient solutions. When the established system does those things, it comes at a very high cost, but that's because it wasn't designed to manage these types of care.

As more people seek different kinds of care, the pressure on the current system grows stronger. And throughout our book we talk about niches where we think disruptive innovation is most likely to occur first. These niches can be fertile ground for entrepreneurs, but they are currently markets with low margins — at least compared to the traditional sick care setting. So they are typically unattractive to the incumbents in the industry: the big pharmaceutical companies, the established providers of service (like hospitals and related chains), and the major payors (largely insurance companies). Disruptive outside players could gain an early foothold in these niches, and then become dominant in the future, challenging and eventually replacing some of today's incumbents.

Disruptions of this sort happen despite the regulatory environment, which favors the well-heeled incumbents. Indeed, historically, regulations tend to relax only after disruptive players have established a niche and have proven themselves in the marketplace. In other words, regulatory reform is often the natural outgrowth of disruption, not vice versa.

S+B: When you talk about a "niche," it has a different meaning from what we would normally think of as a "niche market." Can you explain?

HWANG: For us a niche is a part of the market — a group of health-care consumers — with a distinctive set of needs. One niche, for example, might be working mothers with sick children. A typical mother of this sort, as we describe her in our book, has a specific "job" in mind, which she hires the health-care system to do. Whether or not she and her child have health insurance, there's a desire for convenience that the current system is not designed to deliver. Therefore, even though she could go to a pediatrician's office, she chooses instead to bring her child to a retail clinic. In this case the value proposition is convenience. It's an opportunity for inno-

vation, and the health-care system finds itself competing against any other product or service that attempts to deliver convenience to the mother.

The same concept applies to wellness and chronic disease care. These are areas of the marketplace that are not served well by the existing delivery system and where disruptive players could gain a very early foothold and become dominant in the future.

S+B: What are some of the new practices that might serve these niches?

HWANG: Some of them involve payors, such as health insurance companies. In *The Innovator's Prescription,* we describe the need for insurance that decentralizes decision making and the control of costs. In other words, insurance that puts more of the decision making into the hands of patients. The optimal vehicle that we've seen, although it's not perfect, is the health savings account. Combined with high-deductible insurance (for catastrophic expenses), this is a funded bank account that consumers have available for relatively predictable medical costs. The more judiciously they spend it on medical care, the more they have for retirement.

For hospital care, we need to differentiate the industry into separate types of hospitals, each with its own business model. Some would keep the currently prevalent "solution-shop" model, which is expertise-driven and focused on complex care. Others would need to specialize in specific conditions and procedures, like orthopedic hospitals or the Shouldice Hospital, which does nothing but hernia surgeries. The doctors get very good at that one procedure, and the whole business can be designed around it.

For primary care, the field is moving in two directions. With new technology, some primary care doctors ought to be doing more of what only specialists can do today. At the same time, a lot of people see primary care doctors as essential coordinators of care, focused on wellness, prevention, and the facilitation of quality medicine. Admittedly, this argument could have featured more strongly in our book, and it remains to be seen whether current proposals like the patient-centered medical home (a team-based approach guided by primary care providers) will do enough to preserve the wellness-oriented aspect of primary care medicine.

S+B: What interest do you see among industry leaders for moving in the direction of reform?

HWANG: The short answer is that there is interest, but putting disruption into action is quite difficult when you're already a successful health-care company. When we talk to incumbent hospitals and payors, for example, we try to point out niche areas we think are appropriate for investment. We also point out that by entering these disruptive areas, they may be creating new business models that could eventually put their existing approaches out of business.

Of course, that makes many incumbents uncomfortable. Hospitals and payors are very good at protecting their core markets in the existing system, and they constantly optimize their services to help those core patients. As Glenn Steele, the CEO of Geisinger Health System, once put it, there's almost a gravitational pull any time you introduce a new business or a new technology into the health-care system. It gets sucked into the orbit of the old hospital-centric approach, and all the care still gets delivered in ways that drive people toward more expensive hospital care.

One of the most telling cases is when CVS opened its first MinuteClinics in Massachusetts. It took a while for CVS to break into that market because the state wouldn't allow nurses to prescribe drugs. But when regulators finally acquiesced (only after the MinuteClinic concept had proven its worth in many other states), CVS moved in.

Then one of the largest hospital systems in the state decided to open its own retail clinic. When we tried to find out why they were doing this — because usually incumbents don't want to create new operations that would substitute for their established, higher-earning practices — it became clear that they didn't see it as a disruptive model at all. Instead, they saw it as a way to direct new patients into their core hospital business. In fact, that's how other ambulatory services, like primary care clinics, urgent care clinics, and emergency rooms, work: They are often money-losers in themselves, but they refer patients to the hospital, so that (with expenses covered by insurance) no beds go empty.

Meanwhile, in some other states, an independent retail clinic has proved to be a viable alternative business model to traditional clinic-based care, at least for basic needs. But the way the Massachusetts hospital system saw it, the only value of retail clinics was to serve as yet another entry point to drive patients into its hospitals.

S+B: Who are some of the new entrepreneurial players threatening today's incumbent players with disruptions?

HWANG: We've seen disruptive innovation happening

commonly among new companies that are targeting patient-centric care. For example, online communities such as PatientsLikeMe allow people with common problems and disparate experiences to share knowledge in ways that the health-care system normally doesn't enable.

S+B: For example, if you link 10 arthritic patients together, they know more about how to open a jar than the caregiver can teach them.

HWANG: That's right. Entrepreneurs are also finding ways to reach disenfranchised patients. These can be people who are in the "non-consumer" segment — essentially patients who may not have money, insurance, or the knowledge to access the services they need in the current health-care system. But new business models of care delivery have found novel ways to circumvent these barriers, much as retail clinics have managed to deliver convenience. Online communities are a direct assault on the traditional barriers to accessing health care.

Then there are the patients who want to have greater engagement with the health-care system. These are the "health-care participants"; they don't want to be silent, and they have significant knowledge to contribute. In fact, this is probably the one development no one could have imagined in the current health-care system, because all the expertise and services have always been controlled by physicians and the institutions of care delivery. By tying patients' collective knowledge into a coherent network, we can disrupt the expertise-dependent system and make health-care information far more accessible to everyone.

S+B: In the book, you also promote integration among providers and payors of health-care services. Why is this so important to improving the overall system?

HWANG: When a single company, or a closely knit partnership, can reach across the barrier between payors and providers, it's able to overcome a lot of hurdles that an independent payor or provider must otherwise face.

Organizations like Kaiser Permanente, Geisinger, and Intermountain are all integrated health systems, acting as both payor and provider. Therefore they have more flexibility and control over optimizing their systems. It's easier for them to take on some additional costs on the delivery side if they believe it will lead to savings on the payor side by reducing overall costs in the long run.

We often compare this to the computer industry, in which Microsoft designed your operating system, Intel designed your microprocessor, and Seagate your hard drive. Each one of them can, in principle, make its own product better and better, but none of them can really fundamentally redesign the computer. It requires total integration across each of these components to redesign how a system should be built. So either you need a single company, like Apple, overseeing everything, or you need a very well-established set of standards and a lot of communication among the players. In health care in the U.S., outside the 5 percent of Americans who get their care from integrated systems, we tend to have neither.

So we're going to need integrators. These could be large self-insured businesses, or they could be the government. But governments tend to be loath to change once they establish a new set of practices. A reform law could fix problems today, but make it even more difficult for the industry to adapt and change over time. That's why we favor replicating the model of the integrated health systems that have already demonstrated marked success without increasing government intervention.

S+B: The classic Clayton Christensen concept of disruptive innovation makes a very clear distinction between dinosaur incumbents and upstart entrepreneurs. In health care, the line between incumbent and entrepreneurs isn't quite so clear, because the system is so complex.

HWANG: To an extent you're right — health care has a more diverse set of players than most industries. But even in Clay's past cases of disruption, whenever new entrants dislodged old incumbents individually, other partners in the value chain, including suppliers and distributors, were being disrupted simultaneously. A favorite example is the introduction of solid-state electronics. Sony's transistor-based radios and television sets ultimately displaced vacuum-tube television sets and radios made by GE and Zenith and Westinghouse. But it wasn't just Sony that displaced these incumbent companies, it also happened because discount retailers were selling Sony's products, and they displaced the appliance stores that were selling the vacuum-tube television sets.

You're right that health care is a lot more complex than other industries we've studied. Sony's experience involved maybe four pieces of a value chain that moved together. In health care, where you see a lot of potential disruptions emerging at once across a large number of sectors, the result is a fragmentation of care. That's why

the system needs integrators that can pull all the strings and bring diverse elements together. In other words, to create the disruptions that get companies to change, it takes an innovator that is also an integrator.

S+B: If disruptive approaches are going to be so powerful, what do you advise the incumbents in the industry to do, especially if they want to see the system improve?

HWANG: Disruption is not the only way to improve the health-care system. Many sustaining strategies can make the existing system better without disrupting the current business model. For example, pharmaceutical companies can innovate and develop drugs faster. Payors can process their claims faster. Hospitals can deliver their acute care better and help more patients survive. These would all be great things.

But we just have to keep in mind that these sorts of innovations, which incrementally improve the existing way of doing things, tend to increase the cost of care, for less and less marginal return. In health care, competition does not necessarily lead to lower prices. For example, if a hospital buys a new surgical robot, it will advertise and say, "Look, we have the best technology. Come see us." When the word gets out, the hospital down the block will find a way to buy that same surgical robot so it doesn't lose patients. You're delivering marginal increases in improvements in care as a result, but often at an extraordinary cost to the system overall.

The system has the potential to provide better service, broader reach, and lower cost all at once. But to achieve that potential, we're going to need a different set of innovations — a kind of disruptive integration — that lowers the cost so everybody can afford to get the care they want. ✚

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