

Knowledge Review: Does Health Care Have a Future? by Joe Flower and David Knott

from **strategy+business** issue 46, Spring 2007

reprint number 07110



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It is no secret that health care in the U.S. is in crisis. Americans share a sense of impending catastrophe, and for good reason. Health care in the United States consumes some \$2 trillion per year — 16 percent of the GDP, and four times the expenditure for national defense. Yet U.S. health care's performance is ranked 15th globally by the World Health Organization; American life expectancy ranks 22nd in the world, and infant mortality ranks 39th. The U.S. spends more on health-care insurance than any other nation, yet 46 million Americans do without — a number that increases every year. The out-of-pocket costs of those who have insurance have nearly tripled in the last six years, as health-care premiums continue to rise at nearly three times the general inflation rate. Unpaid and unpayable health-care bills account for the majority of all personal bankruptcies in the country.

This can't go on. We cannot continue to have rising costs, uneven quality, and shrinking access to care. The appalling realities of the chaos we call health care (don't bother calling it a system) have

Photograph by Opto

Does Health Care Have a Future?

Eight books about the health-care system diagnose its problems and offer solutions.

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spawned a cottage industry of pundits, consultants, critics, and professional headaches. And this industry has spawned an ever-growing library of books hawking solutions, ranging roughly from the “manna from heaven” vision to the “let them eat Vioxx” point of view. But has anyone come up with a real solution?

To know a real answer when we see it, we must define the question clearly. On the basis of our research, our experience, and a broad review of the literature, we believe that a true health-care solution would meet eight criteria.

1. Consistent High Quality. A large and growing body of evidence suggests that health care in the United States could be far more effective than it is now. One data point to consider: In December 2004, the not-for-profit Institute for Healthcare Improvement, based in Cambridge, Mass., launched the “100,000 Lives Campaign”; its goal was to save those lives in U.S. hospitals through improved care. By June 2006 it had already exceeded that goal by 20 percent. That this campaign succeeded so quickly is impressive, but the very swiftness of that achievement also shows how

pervasive care of uneven quality is, and how little attention it has received until recently.

2. Lower Cost. In many cases, this point follows from the first. Higher-quality care is often inherently less expensive; providers improve their quality by honing their organizational processes to become more efficient and effective, to avoid error, and to do things right the first time. We’ve seen this happen in branches of the health industry that compete directly for the consumer dollar, such as plastic surgery and laser vision correction, where a proliferation of products and providers over the past 15 years has been accompanied by provably higher quality and dropping prices. Such examples make it clear that health care could not only slow its inflation rate but actually drop its costs substantially.

3. Available to All. For ethical, political, systemic, and business reasons, health care must be universal: available to everyone. There are many ways to enable this — for example, by extending Medicare universally, establishing government-funded medical savings accounts and catastrophic health plans for the working uninsured,

creating combinations of tax credits and vouchers, or some other approach. And universal coverage need not mean a single-payer system or more government control.

4. Single Model. For many of the same reasons, it will not work to have one system for the well-off while everyone else gets what health-care futurist Ian Morrison calls “the Department of Motor Vehicles with stethoscopes.” The market can be segmented, as most markets are, but one way or another, every provider in the system must compete to offer the best product at the best price.

5. Shaped by Market Forces. The experiences of the past 30 years make it clear that the market has the sustained systemic power to bring consumers more for less. We’ve already seen this phenomenon in other industries, as well as in the portions of health care that compete directly for the consumer dollar. (See number 2.)

6. Practical. Politically, economically, and systemically, the solution must arise from present realities. We cannot take seriously any proposal that wipes out the existing health plans, for example, for the simple reason that health

plans alone represent 5 percent of the U.S. economy.

7. Progressive. The solution must recognize that dramatic change cannot happen all at once. It has to be possible for any sector of health care, or even individual organizations, to move toward the new way of operating and be rewarded for it.

8. Self-Reinforcing. As any one part of the system moves toward the new reality, that movement must allow and encourage other parts of the system to move forward as well.

Taken together, these make for a very tall order. But if a proposed solution does not satisfy all of these criteria, it is either incomplete or impossible. The experience of reading through the reform literature, however, is an exercise in frustration. Author after author describes a piece of the problem and solution perfectly, each feeling a different part of the proverbial elephant, but no one author has addressed the whole problem.

Achieving Universal Care

Few books do a better job of describing the ills afflicting the U.S. health-care system than Donald L. Barlett and James B. Steele's *Critical*

Condition: How Health Care in America Became Big Business and Bad Medicine. This book is both true and infuriating. It shows vividly why almost everyone is deeply outraged about health care, and how a complex, dysfunctional system can look like a conspiracy to outsiders.

Most importantly, this book focuses on the problem of universal care. The Pulitzer Prize-winning investigative team documents the plight of the tens of millions of uninsured or underinsured Americans who can't easily get access to treatment, and the horrors of a system that forces doctors and nurses to cut corners with patients in order to save money while companies notch ever-higher profits.

If you wish to put shape and detail to your outrage, read the work of Barlett and Steele. But their prescription for reform, a single-payer system, suffers from the problems common to all such arguments: Eliminating the entire health insurance industry with a stroke of a legislative pen is politically and economically impractical. And although such schemes eliminate the huge cost of private insurance, they do nothing to drive down the root costs of medical care or to improve its quality.

Alternatively, to compare a variety of proposed payment mechanisms that would cover all Americans in the name of universal care, you could look into a number of recent titles, including *Uninsured in America: Life and Death in the Land of Opportunity*, by Susan Starr Sered and Rushika Fernandopulle; the Institute of Medicine's *Insuring America's Health: Principles and Recommendations*; Charles R. Morris's *Apart at the Seams: The Collapse of Private Pension and Health Care*

Protections; and Jill S. Quadagno's *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*. Each of these books argues compellingly for its own set of schemes, including among them total government control and direct payment, mandated employer insurance, government-subsidized insurance for the near-poor, vouchers, and tax credits. Some propose funding such an expansion by ending the tax deductibility of health insurance.

Unfortunately, none of the books engages the full scope of the problem. Although any number of these schemes might effectively give all Americans access to the existing health-care system, none addresses the fundamental systemic drivers that have caused health-care costs to increase while those of other industries have moderated or dropped. And none addresses the demonstrated unevenness of current medical care. If health care continues to eat up more and more of the national economy, no scheme to cover every American can work. However you slice and dice the economy, there simply will never be enough resources to pay for a perpetually expanding health-care system. Anyone who wants to argue a social agenda for insuring all citizens must show how we can change the current system to make health care less expensive and more effective, so that we can afford universal coverage.

We get closer to the nub with a pair of books about how society can fund health-care coverage: Arnold S. Kling's slim *Crisis of Abundance: Rethinking How We Pay for Health Care*, and a massive tome edited by Regina E. Herzlinger, *Consumer-Driven Healthcare: Implications for Providers, Payers, and Policymakers*.

Kling's book advocates greater government involvement in the care of the very sick, the chronically ill, and the very poor — those who really need it. His principal argument is that governments waste their tax dollars with a number of policies: by paying for the care of all people over 65, including those who are not poor or sick; by making health insurance tax deductible for everyone, whether they need it or not; and by stinting on services for the very poor and uninsured, who end up spending more than they would otherwise need to because they tend to wait to seek care until the last minute, when their condition has become acute. Kling offers a number of specific insurance mechanisms for shifting tax-supported health care to those who really need it, and away from those who need it less, such as healthy, childless adults. Yet none of his solutions are self-generating or self-sustaining. All require major legislation and central direction. And oddly, considering the libertarian bent of the publisher, the Cato Institute, he does not focus on the capacity of competition to shape the health-care market.

By contrast, Regina Herzlinger, a professor at Harvard Business School, does focus on competition. *Consumer-Driven Healthcare* examines the power of the new “consumer-directed health plans” (CDHPs), which combine high-deductible catastrophic insurance with health savings accounts to remold health care around consumers' needs and desires. CDHPs, she argues, will open health care to new levels and types of competition, bringing us savings and higher quality — the usual products of market competition. You can gather the core of her argument in the first sec-

tion of the book, a cogent and knowledgeable 202 pages written by Herzlinger herself, leaving aside the subsequent hundreds of pages by 92 other authors. She gets the key points right: What is missing in health care is true competition, driven by information and the power of the consumer to choose. For the first time, CDHPs allow for that possibility. If even a significant fraction of health-care consumers begin operating like true retail buyers, then the market as a whole will begin to act like a true retail market.

Redefining Competition

But Michael E. Porter and Elizabeth Olmsted Teisberg carry the argument a crucial step further in *Redefining Health Care: Creating Value-Based Competition on Results*. Porter and Teisberg — he is a professor at Harvard Business School and she at the Darden School of Business at the University of Virginia — ask the key question: Why has competition failed to work the same wonders in health care that it has in so many other industries? Their answer: because competition has taken place at the wrong level and over the wrong goals. Further exacerbating the problem is the complete absence of feedback loops (information channels that help a system govern itself). Very little in health care has a real price or a real, measurable result. This book comes closest of all to getting at the core problem of the U.S. health-care system and, for that reason, is the single indispensable work in the current field.

Competition in health care has consisted, in the main, of health plans' and providers' attempts to push cost and risk off themselves and onto each other or onto em-

ployers — and now, in some cases with CDHPs, onto the consumer. To the extent that providers have competed against one another, it has been as massive institutions that claim to do everything well. The first key insight of Porter and Teisberg is that, as health-care consumers, we are not looking to embrace an institution, but for a solution to a particular medical condition. We want the baby successfully delivered, the knee fixed, the diabetes managed. It is at this level, the level of the medical condition, that any true competition must occur.

Their second key insight is that when we turn to health care for a solution to our medical condition, we do not typically find any products designed to solve our problems. We find a vast array of specialists, technologies, devices, drugs, and therapies. Unlike other service industries, health care does not usually offer discrete, comprehensive “packages,” such as a “birthing program” that carries the mother and child from the earliest prenatal care through the birth, dealing with any complications, until mother and child are comfortably home. Or a “knee service” that includes diagno-

“Universal coverage provides a payment mechanism that covers everyone but does not guarantee good-quality care.”

sis, an array of offerings ranked by severity and type of problem, treatment, rehabilitation, physical therapy, and follow-up condition management, all in one package. Or a comprehensive “diabetes product” to help people manage the disease, including a dedicated insurance (or prepay) program.

The third key insight proceeds directly from the other two: When we turn to health care with our medical condition, there is no value proposition even if we are paying part of the cost through our CDHPs. That’s why the lack of real prices and measurable results matters so much in health care. If you are considering buying a Toyota Prius, you know the value proposition: It costs about \$24,000, it gets about 50 miles per gallon, and it carries Toyota’s reputation for quality. If you are getting knee surgery because you want increased range of motion and decreased pain and swelling, you don’t know the true price of the whole experience, whether your surgeon and the rest of the team are better or worse than average, or whether you can rely on getting what you (and your employer or insurer) are paying for.

You can’t know, your referring

physician can’t know, even the surgeon can’t know, because the actual quality is never measured in any standard way. In those parts of health care in which actual results are measured, the data is typically either kept secret or not broken out in a way that would help the consumer make a choice (such as by institution, team, or individual practitioner). As a consumer or referring physician, your most appropriate question is not, “Which is the most impressive institution?” or even, “Which institution or surgical practice has the best overall reputation for quality?” Your question is, “By measurable, risk-adjusted results and published prices, who can do the best job on this knee for the lowest price?”

Porter and Teisberg offer a vision in which health care is organized mainly around products tailored to particular medical conditions. These products are delivered by medically integrated practice units made up of teams that work together on the same medical condition over long periods of time, continually learning from their experience with the condition and from each other. These teams are comprehensive and seamless. A dia-

betes management team might include an endocrinologist, a behavioral therapist, a nurse educator, a dietitian, an exercise physiologist, a podiatrist, a dentist, and even a computer technician to help patients set up their home health monitoring devices. These products are clearly delineated, with real prices and a single bill, and the teams compete directly against other teams that work on the same medical condition, on the basis of value: measurable results at a published price.

In this vision, transparency drives quality. Health plans steer patients toward the providers who offer the best results for the least money. Referring physicians refuse to recommend any specialist or package with quality scores in the lower quintiles, for fear of being sued for malpractice themselves.

When health-care providers compete at the level of the medical condition, on real prices and real results, the feedback loops will become extremely compelling. Offering the highest possible quality at the lowest possible price will no longer be voluntary. Health plans will also be forced to compete on the basis of real results and genuine

With transparent information, it is hard to imagine health-care consumers choosing low quality at high prices, as they do today.

customer service at the lowest price, rather than their current modus operandi — which can include denying coverage and shifting cost and risk to employers, consumers, and providers.

Porter and Teisberg argue strongly that such a model would actually work better under a universal, single-tier payment system. “Universal coverage provides a payment mechanism that covers everyone but does not guarantee good-quality care,” they write. “Changing the structure of health care delivery is fundamental to improving care for the poor. Value-based competition on results will be necessary to ensure that excellent care is received by all patients.” Reducing the cost of care through competition makes it possible to treat those who cannot afford it. A single-tier system eliminates the perverse incentives to shave coverage and quality for those in the lower tier.

Delivering Value

Put together any of the schemes for introducing universal coverage with Regina Herzlinger’s vision of consumer-driven health care and Porter and Teisberg’s vision of value-

based competition on results, and you get a system that meets all eight of the criteria above.

The most compelling part of this “health-care delivery value chain” model is that it is possible: It can arise from current realities, piecemeal, in a self-reinforcing fashion. In fact, it already is doing so. New structures for public reporting of medical results are popping up on federal, state, and regional levels. Weak, voluntary, and secret reporting systems are being superseded by mandatory public systems tied to reimbursement, such as the U.S. Health and Human Services Department’s “Hospital Compare” initiative (www.hospitalcompare.hhs.gov). In many of these initiatives, process measures (such as use of thrombolytics in heart attack patients) are starting to give way to results measures (such as risk-adjusted mortality rates for patients undergoing bypass grafts).

In a number of regions, new tiered payment models use co-payments and other means to encourage patients to use the providers with the lowest cost and highest quality scores. Such models also reward more efficient systems, those that beat their risk-adjusted cost tar-

gets, with higher reimbursements, and punish less efficient providers with lower reimbursements. New insurance companies like HealthMarkets of North Richland Hills, Tex., provide customers with cost and quality scores by procedure, physician, and facility for all providers in their area; other companies, such as Boston-based Best Doctors, offer the information independent of insurance products. A number of major providers, such as Intermountain Healthcare of Salt Lake City, the Cleveland Clinic, the Boston Spine Group, M.D. Anderson Cancer Center of Houston, the Texas Back Institute, the Texas Heart Institute, and Wisconsin’s ThedaCare, have moved increasingly toward organizing their care into the kinds of medically integrated practice units that Porter and Teisberg describe.

Each of these pieces — transparency, integrated products, and true measurement — is coming into play in the health-care marketplace, and as they do, those who use them are being rewarded. The result is likely to leave health care looking dramatically different in as little as five years. As Porter and Teisberg express it: “If competition on results

Health-Care Resources

Works mentioned in this review.

Donald L. Barlett and James B. Steele, *Critical Condition: How Health Care in America Became Big Business and Bad Medicine* (2004; Broadway, 2005), 286 pages, \$14.95

Susan Starr Sered and Rushika Fernandopulle, *Uninsured in America: Life and Death in the Land of Opportunity* (University of California Press, 2005), 272 pages, \$15.95

The Institute of Medicine, *Insuring America's Health: Principles and Recommendations* (National Academies Press, 2004), 222 pages, \$26.10, or download PDF for \$22.50 at <http://newton.nap.edu/catalog/10874.html>

Charles R. Morris, *Apart at the Seams: The Collapse of Private Pension and Health Care Protections* (Century Foundation Press, 2006), 86 pages, \$14.95

Jill S. Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance* (Oxford University Press, 2005), 286 pages, \$28

Arnold S. Kling, *Crisis of Abundance: Rethinking How We Pay for Health Care* (Cato Institute, 2006), 120 pages, \$16.95

Regina E. Herzlinger, editor, *Consumer-Driven Healthcare: Implications for Providers, Payers, and Policymakers* (Jossey-Bass, 2004), 926 pages, \$55

Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Harvard Business School Press, 2006), 524 pages, \$35

drove the pursuit of health care value for patients, the gains would be enormous. Huge gains are possible by reducing the variations in the value of care across geography and providers, reinforcing and rewarding excellent providers, and encouraging physician and consumer choices based on information and results. It is within the nation's capability to increase health-care quality and lower cost dramatically,

even using today's technologies and methods. The enormous savings that could be achieved would help pay for improved care for every American, especially those who lack access in the current system."

A health-care system arising from true value-based competition is not inevitable. To reach that goal, we need a wholesale reorganization of health care. And although it does not require government to pass any

mind-numbingly vast scheme that changes everything all at once (as the U.S. Congress is sometimes tempted to do), it does require legislators and regulators (including state and local officials in the U.S.) to understand the goal well enough to get out of its way — by changing the numerous laws and regulations that impede transparency and consumer choice. And this plan requires both providers and payers to see and seize the opportunities it affords. Based on Booz Allen Hamilton's experience with clients, we believe this will require a fundamental transformation of health care from a wholesale to a retail industry. (See "Making Health Care Work," by David Knott, Gary Ahlquist, and Rick Edmunds, *s+b*, Spring 2007.)

Yet the version of reform presented by Porter and Teisberg remains the most hopeful of all possibilities. Much depends on how far providers allow transparency to go, and that may depend on how emphatically consumers demand it. Once it becomes common for health-care providers to post actual prices and actual results in standardized ways that produce comparable data, it is hard to see how consumers, insurance companies, and referring physicians would ever choose low quality at high prices, as they do today. Real transparency will mean real competition, and real competition, in every other industry, has benefited the consumer. One does not have to be an oblivious optimist to imagine health care 10 to 15 years from now being available to all and offering substantially higher quality at significantly lower cost than it does today. This is the magic, and even the inevitable result, of competing on value. +

Reprint No. 07110

strategy+business magazine
is published by Booz Allen Hamilton.
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