

A Better Model for Health Care

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An innovative experiment in Florida shows the potential for more systemic collaboration as the catalyst for lower costs and improved quality.

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In 2009, U.S. health-care reform moved rapidly to the front burner, and it will stay there. President Barack Obama and his advisors have made it clear that reducing health-care costs is a necessary prerequisite to achieving their broader economic goals.

The levers that the new administration plans to pull will address the obvious issues: treatment variability (standardized procedures tend to be more cost-effective), value-in-use analysis (evaluating costs and benefits), chronic disease management, enhanced information technology, and utilization rates. (Utilization rates measure the amount of health care delivered and received per capita. Preventive medicine and other means of reducing long-term utilization while maintaining overall public health thus represent a major cost-saving opportunity.) The reforms are all expected to involve both public and private initiatives, reassuring voters that “if you have insurance you like, you can keep it.”

But it isn't yet obvious how the government's changes will actually work in the current industry struc-

ture of health-care delivery and finance. Today's health-care system in the U.S. is set up to optimize everyone's interests except the consumer's. Unlike other industries, in which products and processes tend to be about 80 percent standardized, and a purchaser has a reasonable sense of what to expect, the U.S. health-care industry is full of fragmentation, friction, unnecessary customization, and excessive costs. Reducing those costs would require holistic change in the practices and structures of the industry. It would mean reshaping everything from the patient care experience to the methods of gathering and sharing data.

In short, even if the new government health-care policies are well designed and effective, the U.S. will still be a long way from having a health-care finance and delivery system that can offer the right combination of incentives and relationships among sponsors (such as employers and associations), payors (health-care insurance companies and reimbursement plans), providers (including hospitals and physicians), and consumers. The federal government alone has the scope and authority to mandate top-down



change across the United States, but only the industry can implement it. The challenge facing the U.S. health-care industry is thus significant: Its many varied components must cooperate to rebuild their programs and structures from the bottom up.

To use an analogy to American football, the government “kicking team” is getting ready for the game to begin. But will the “receiving team” of employers, plans, providers, and consumers be ready?

Fortunately, there are some models that the industry can draw on to answer that question. One of the most promising is an innovative experiment just getting under way in Florida. The model, dubbed Healthcare of the Future (HOF), addresses health-care reform from the ground up and engages plans, providers, and consumers. Although it has started modestly with three initial services (involving cardiac care, lung cancer treatment, and hip and knee surgery), the program is expected to expand to as many as 25 offerings, covering the great majority of services and costs.

Compared with other health-care reform efforts, HOF is distinctive because it is both comprehensive (involving multiple participants in potentially broad-scale reform) and organic (evolving from current efforts and priorities). That makes it a relevant model for any country or health-care system. Different countries have their own approaches to the way health care is funded, but they are all wrestling with the same cost and effectiveness issues, and they must all figure out how to embrace technological innovation and best-quality science. In addition, many nations face the challenge of an aging population

that will have an increasing need for care and thus raise utilization rates.

If the United States is fortunate, and if models like HOF prove influential, there is a genuine possibility that the receiving team members will not just accept the ball from the government; they will change the very nature of how the game is played.

Health Care’s Structural History

Structural change is especially difficult in health care — an industry representing nearly 18 percent of the GDP of the United States. Perhaps that’s why, since the creation of the modern U.S. health-care system in 1965 (when Medicare and Medicaid were introduced), only one major structural change has been heavily promoted as a cost-saving measure: the health maintenance organization (HMO). This was originally conceived as a set group of doctors, often directly employed by the HMO, who would reduce costs by limiting consumer choices to a restricted group (a “closed panel”) of providers. Despite a laudable emphasis on prevention and a structural shift of risk from payors to providers, the movement lost momentum for two major reasons. First, as the recession of the early 1990s gave way to a seller’s market for labor, employers could no longer push their workers into limited-choice plans they disliked. Second, after an initial downward shift in utilization rates, demand jumped back onto its old growth curve, robbing HMOs of much of their economic rationale.

Since HMOs failed to sweep the country, ambitious wholesale attempts at structural change have been nearly absent. But some important smaller changes have taken

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place. Hospitals and physician groups have consolidated, allowing them to dictate terms and resist cost pressures. And some structural innovations have been tried, most notably the creation and mainstreaming of consumer-directed health plans (CDHPs).

CDHPs, particularly those with portable health savings accounts (HSAs) owned by the consumer, shift risk, accountability, and power from employers and sponsors to individual consumers, who make more choices about their treatment options and costs. The CDHP rollover and lifetime portability features — allowing enrollees to carry savings balances from one year to the next and to stay enrolled in the plan even if they change employers — encourage them to take a longer-term view of their lifestyle choices and the associated risks and costs. The increased role of personal responsibility is a nontrivial change; for example, data published by Aetna Inc. shows that CDHPs are saving money for payors and consumers, without the feared reductions in the use of preventive services and disease management. The use of CDHPs is growing rapidly — estimates vary from 11 million to 18 million individual members, depending on how the programs are defined. Although they have not led to system-wide reform, these programs demonstrate beyond doubt the value of innovative, broad-based approaches that directly address some of the fundamental fragmentation and perverse incentives built into the current system.

Now, in 2009, the U.S. faces a deep economic recession and continued rising health-care costs. Most of these costs are driven by utilization, and demand is likely to esca-

late as obesity rates rise and baby boomers age. This will be exacerbated by the longer-term costs of caring for wounded veterans of the wars in Iraq and Afghanistan. The problems won't get smaller anytime soon. And waiting for the level of personal responsibility among U.S. citizens to rise or for altruism to prevail along the entire value chain of health care is not a strategy for success. New structures, relationships, and incentives are needed.

Options for Reform

A relatively small group of specific supply-side and demand-side challenges account for a sizable majority of total costs. Thus, there is a fairly short and noncontroversial list of changes that must take place before any new regime can be successful:

- Reduced fragmentation of care, through more effective integration of and collaboration among health-care providers
- Early identification and management of risk factors for disease
- Effective management of chronic and pre-chronic conditions
- A more standardized approach to interventions, such as acute treatment and rehabilitation, based on the best-quality science and delivered in the most cost-effective setting
- Emulation of best practices in management and IT to reduce cost and variation in treatment protocols as well as preventable medical errors

The following changes in incentives are also needed:

- Financial incentives for providers that encourage evidence-based care, prevention, and chronic condition management, which will orient them toward value rather than volume
- New incentives (and other

forms of support) for consumers that promote a greater sense of individual responsibility for their own health and medical decision making

- End-of-life education to decrease the costs associated with heroic but often futile interventions

None of these issues can be addressed successfully without the proper relationships and incentives among the key nongovernmental players: sponsors, payors, providers, consumers, researchers, and suppliers. Structures, relationships, and incentives are needed that build on the lessons of the recent past (particularly from the use of HMOs and CDHPs) and retain at least some skepticism about the perfectibility of human nature. The necessary changes are daunting because they require shifts in many ingrained habits and practices.

For example, risk (and, one hopes, responsibility) should continue to shift to consumers, reinforcing and rewarding intelligent lifestyle choices and rational treatment decisions. Consumers need to be educated effectively on the value and costs of their decisions, with information that goes beyond what is available to them today. The same is true for health-care institutions. In modifying the behavior of both individuals and institutions, carrots (incentives and transparent information) work better than sticks (restrictions and fines).

In addition, the reduction of health-care costs requires a great deal more collaboration. Payors and providers could work together far more effectively to bring best-science protocols to prevention, management, and treatment. Providers (hospitals, clinics, and physicians) will need to drive clinical and operational efficiency in exchange

for incremental volume. Plan sponsors (particularly employers) will have to adopt longer-term views about costs and risk, especially as the government's changes go into effect. Pharmaceutical, biotechnology, and high-end technology suppliers will profit from best-value-in-use economics combined with rigorous best-science protocols. All of these forms of collaboration will require the various participating sectors to understand one another's business models, and the ways they might fit together instead of competing for dollars.

Finally, the fragmentation, duplication, variability, and anecdotalism in health-care practices and processes, all of which drive waste and unnecessary costs, must be reduced. Some prominent commentators, including Michael Porter and Regina Herzlinger, have pointed this out, but most promoters of reform, including those in the Obama administration, have still not fully recognized the degree to which cost-effectiveness depends on standardization. The health-care industry — in the U.S. and around the world — is the only industry whose products and services are virtually always custom-built, that is, independently engineered for each customer. If reform efforts simply expand coverage and make the system work faster by installing electronic medical records, costs will only climb further.

Consider the US\$36 billion planned investment in HIT, a comprehensive system of interconnected electronic records. The backbone of this system will be the International Classification of Diseases (ICD) codes developed by the World Health Organization, with many countries adopting their own

variations. The current U.S. version (ICD-9) has more than 16,000 codes, covering individual diseases, diagnoses, and treatments. The newer version (ICD-10), already adopted by many countries, has more than 155,000 codes, including some 68,000 diagnosis codes.

ment, and rehabilitation, as well as follow-up care such as the monitoring of lifestyle and diet. Other products might include basic surgery for sports-related injuries, including all the potential procedures and physical therapy involved; annual preventive care for children ages 5 through

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These become the basis for pricing throughout the health-care system. It's as if when you went to buy a car, the salesperson pulled out a list of 155,000 components, asked which ones you wanted in the car, and then said, "We don't know what the car will cost, but after it has been assembled and delivered, we'll send you a bill."

The alternative would be to introduce strong-form products based on best scientific practices, providing prevention and disease management, not just big-ticket acute care or hospital procedures. Strong-form products are integrated, consumer-centric offerings bundling world-class care from diagnosis through rehabilitation, simplified billing and payment, and consumer choice. Insurance pricing and billing must be part of the design of any strong-form product. To ensure that standardization takes hold, the bill must be the same regardless of which payor — employer, association, or government-funded insurance — is covering the cost.

One such product might be a cardiac care package for outpatients that includes consultation, treat-

13; and cataract treatment. Each would present to the purchaser a consistent overall price tag reflecting the standardized practices that every hospital and doctor would be equipped to deliver. Price adjustments — for example, incentives for preventive care — would be like options on a car: easy to recognize in the context of the basic, universal service. Today's intricate pricing codes would apply only to the 20 percent of care for which complexities or uncertainties make customized procedures necessary.

In such a world, electronic records would not be such a critical issue for reducing costs. After all, no one needs intensive electronic documentation to keep track of payments for groceries, or even for a car. The financial clearing system through which transactions are processed among banks around the world could serve as a model. Any bank can participate for any type of transaction, because there are international standards and protocols.

The Florida Experiment

The Healthcare of the Future experiment has been under way now for

two years. It currently involves three of the system's major structural sectors — consumers, plans, and providers. It also has the potential to integrate high-tech suppliers and pharmaceutical companies. The project addresses some of the system's biggest cost components: current and downstream costs of complex conditions such as cancer, and big-ticket acute interventions. (In its initial stages, HOF does not address chronic disease or end-of-life costs.) Its leaders are moving deliberately, thoughtfully, and quietly to develop new programs, protocols, structures, and relationships that will fit into a reformed pluralistic system, or even into a more radical national system.

The cast of characters driving the HOF concept and initiative include Blue Cross and Blue Shield of Florida (the state's largest health plan provider), along with a not-for-profit regional medical center with a

is emerging about the characteristics that a transformed insurance and delivery system should have.

In this vision, the variability of both treatment decisions and the delivery of care would be dramatically reduced. In the selection of care, the best offerings would be given preference, regardless of a particular hospital's full-service line. Because strong-form products include prevention and disease management, not just big-ticket acute care, smaller hospitals and rural providers would have more opportunities to attract consumers. With more insurance plans involved, health care could become a true retail marketplace — and bundled payments for doctors and hospitals would mitigate the “do more, bill more” mentality of many providers. In short, health-care services would mimic other retail markets. Consumers would have a better idea of

focuses on outpatients, managing risk factors and undertaking interventions for diagnostic catheterization, angioplasty, and electrophysiology (for example, ablations). The goal is better outcomes at lower cost, primarily achieved by avoiding bypass surgery where possible, and the program builds on a large regional provider's strength in cardiac services.

A second program, designed for inpatients, involves surgery for hip and knee replacement — an area that would clearly benefit from greater standardization, continuity, and predictability of outcomes and costs. The product spans diagnosis through rehabilitation. Again, a strong regional provider team is the foundation of the clinical side.

The third pilot program is for lung cancer treatment, drawing on the clinical strengths of a world-class oncology brand name. Experience and efficacy are keys to this product, since the variability of treatments and outcomes for this disease is far greater than for many other major clinical interventions (such as cardiac bypass). Like the knee and hip replacement product, this program is aimed at inpatients; the scope of services begins immediately after diagnosis and continues through treatment and rehabilitation.

Carrots, Sticks, and Precedents

If producing standardized care from best-science protocols were all that these efforts hoped to achieve, the concept would be laudable, but the program would merely amount to an expanded version of “centers of excellence” (high-quality health-care facilities with little or no influence on the larger system). What sets HOF apart — and may provide a model for federal initiatives — are

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leading cancer treatment facility, a large community hospital and its doctors, a for-profit hospital system and its physicians, and a large group of consumers who have taken part in in-depth surveys and interviews. (During this early stage, the names of most of the participating institutions have not been made public.) To varying degrees, the participants share a set of beliefs and hypotheses about what ails the health-care system and what could be done to control costs and improve outcomes. Based on these foundations, a vision

the costs, timing, billing arrangements, and expected events and outcomes in advance. (Eighty percent of the surveyed consumers showed very high interest in this feature.)

After two years of analysis and consumer research, the HOF players are planning to move forward with three pilot programs, each representing a different but crucial product type to demonstrate efficacy.

One is, in fact, the example we gave earlier for a strong-form product: an ambulatory care program for managing cardiac risk. The program

the structural innovations and incentives that involve plans and patients in new relationships with health-care providers.

Products and services, for example, are priced to be all-inclusive. A single fee encompasses everything from diagnosis to rehabilitation to final disposition. Providers are paid a set amount to cover facility costs, devices, drugs, and professional fees. This not only makes large-scale costs more predictable for plans and sponsors, but gives consumers a clear picture of their obligations at the beginning of treatment, not after months of claims adjudication and confusion.

The best health-care services, based on the best available medical science, are not much use if they aren't embraced by large numbers of patients. Thus, HOF offers financial and service incentives to encourage consumer participation. Reduced or forgiven deductibles and co-pays, combined with added amenities, are used as carrots.

The Healthcare of the Future approach may ultimately incorporate some sticks as well, perhaps moving nonparticipants into a more generic major medical plan whose premium reflects the fact that they have moved themselves into a higher-risk group. This form of "prescriptive" insurance — allowing patients to opt out of best-science approaches for a cost — is akin to requiring motorcyclists to wear helmets and charging them more if they choose not to.

This undertaking is both more significant and more difficult than other reform efforts to date because it seeks to align incentives across the entire structure of health-care finance and delivery — far more than just encouraging the use of a

handful of high-profile, costly inpatient procedures. HMOs have done this as well, but they lack several key features that stand in the way of a truly consumer-centric marketplace: Relatively few consumers have access to a fully integrated HMO, and such programs are hard to start up; HMOs, no matter how good, will almost certainly not achieve best-of-breed status for all their clinical products; and consumers really make only one choice in an HMO system (whether or not to participate). HMOs will have a place in a post-reform health-care world, but HOF-like approaches could very likely achieve a higher level of consumer choice and satisfaction while lowering overall costs.

Detailed pilot design — including assessment metrics and consumer feedback mechanisms — began in June 2009, with implementation to begin within the next few months. Some initial findings, and fine-tunings, are expected by early 2010. And this integrated approach, involving leaders of government and the diverse sectors of the health-care industry, could be the missing link that allows structural reform on paper to fulfill its promises in the real world.

In the final analysis, the HOF project and similar experiments that emerge will rise or fall on their ability to deliver the right results. They must improve outcomes and service for consumers and reduce costs and improve predictability for sponsors, plans, and consumers. If they prove their value at that scale, then they will demonstrate their potential for leading us to a world that is compatible with the best science and best management of care. +

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