A CROSS-INDUSTRY PERSPECTIVE:
The New Health Care Dynamic
This spring, the American Hospital Association, in collaboration with Health Forum, brought together a panel representative of the broader segments of health care for an important and timely strategic planning event in historic Williamsburg, Va. Hospitals, while central to the delivery system, must re-examine their scope of services and relationships with other parts of the health care continuum. Representatives from the provider segments, payers, retail, capital markets and employers participated in a panel discussion to assess where the industry is today and what can be done to accelerate the transformation of the care delivery system for the benefit of patients, communities and purchasers.

“A Cross-Industry Perspective: The New Health Care Dynamic” is a summary of that discussion held at the William & Mary Raymond A. Mason School of Business, facilitated by GEORGE LYNN (seated), president emeritus of AtlantiCare and past chair of the AHA, and ADRIAN SLywotzky, senior partner, Oliver Wyman.

The panel explored four key topics:

1. Evolving health care economics
2. Accelerating the pace of change
3. The emergence of the new consumer
4. The new business model
A CROSS-INDUSTRY PERSPECTIVE:
The New Health Care Dynamic

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Former President and CEO | HealthCare Partners | Phoenix

OUR EXPERTS:
(front row left to right) Agee, London, Graham, Warner, Samitt; (back row left to right) Hinton, Forsyth, Bernd, Wilkins
INTRO | The volume-to-value revolution
By Adrian Slywotzky

Value migration is the process in which market capitalization shifts from old business models to new designs that are better at doing three things: understanding how the priorities of the customer are changing; understanding how to create value in the new industry situation; and understanding the next-generation business model or design that the organization needs to create, capture and protect that value and profitability.

IBM has been surviving and thriving in this kind of world for a hundred years. And we have a half dozen other companies that are centuries-old that know when it’s time to change and that have the leadership to move pretty decisively to do it. IBM is being challenged to do that once again.

The process of value migration doesn’t happen randomly. It plays out in certain well-defined patterns. One pattern is the evolution of an industry, or part of an industry, to become a no-profit zone. Take Coca-Cola. What’s Coca-Cola’s largest single line of business? It’s selling carbonated beverages to grocery stores in the United States. How much does Coca-Cola make in this market? If you buy a Coke in a vending machine, you pay about 8 cents per ounce. If you buy a Coke in a restaurant, you pay about 10 cents an ounce. If you buy it from the grocery store, you pay about 1.5 cents per ounce. The

most powerful brand in the world is running a no-profit zone business. They can’t walk away from that. They did a brilliant business remodel in the ’80s and the ’90s, but have failed to do so since then. In that time, they lost one-third of their value. They are working hard on a comeback now and making tremendous progress.

The rules of value migration apply to every industry. When you think about your business model today, you need to think about it in terms of shelf life and the next generation. Are there any no-profit zones in health care? Are there any emerging? Can you walk away from them? Intel faced the decision with memory chips versus processor chips. It made the decision to walk away from memory chips and has been happy ever since.

Process and product innovation are very important. As we look across industries, from the airlines to computing, the winner — the value creator — is the company with great process, great product and the (best) business model or design. We all intuitively know what that means. But at the strategic level, it’s a devilishly difficult process to determine. These are some important questions to ask: Who is my customer and who is not? What’s the organization’s unique value proposition? Why do my customers buy from me than from someone else? What is our profit model? How do we protect our profitability?

In health care, the value proposition is a change from fee for service to fixed payment. People love value migration because it helps to define the winners and the losers. What’s important to know is that the leading incumbents in other value chains have missed it for a period of a dozen years. This matters because during that period, $1 trillion out of $2.5 trillion went from the incumbents to newcomers. To prevent that shift, organizations should look at two things. The first is the hassle map for the customer. The second is how to move the dots to radically improve that hassle map. All of us have experienced the hassle map of what Amazon has done to retail buying and what Netflix has done to video viewing.

Tech companies love hassle maps because they see an opportunity to change them, and that’s a tremendous opportunity for creating new value. On the tech side, serious financing in health care ventures has increased seven times in the last four to five years. That amounts to an annual rate of $2.2 billion, growing at 30–40 percent. They are looking at the gaps that consumers face in health care and they are inventing answers to fill those gaps. This is a huge understatement, by the way, because it doesn’t calculate the billions of dollars already invested by the likes of Apple, Google and IBM. I recommend that hospital and other health care executives spend one hour thinking about the hassle map for their most important customer segment.

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— Adrian Slywotzky

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We may be looking at a fundamentally changing market that has been focused on and designed for volume. We’ve had one competitive value chain in health care. Now we have more, to include retail and tech. It was a patient-centered business, which is potentially evolving to a consumer-centered business. The profit model was fee for service and volume, shifting to shared savings and fixed payment. And the focus must shift from competition to collaboration in the future, resulting in a more multidimensional, complex industry.

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The future of the health care delivery system remains in a state of flux as organizations balance between value-based care and fee for service. How well the industry is faring during this transition depends on whom you ask. What’s clear is that employers and consumers are demanding change, and health care organizations need to make their case to ensure long-term survivability.

How are the economics of health care changing? What will happen to pricing and volume for the key traditional business models — hospitals, payers and medical groups?

DAVID BERND: The economics of health care are varied. If you look at the provider side, we have a lot of winners and a lot of losers. On the payer side, some insurers are doing very well. Physicians, generally speaking, are struggling in some markets, particularly those in private practice.

NANCY AGEE: It’s going to be chaotic. It’s not going to be a pace of change that’s slow or fast. The variability is going to be very harmful to hospitals and to other providers.

CRAIG SAMITT, M.D.: The story I’m going to tell goes back to my Dean Clinic days. Fifty percent of our revenues were coming from our owned health plan. We obviously were offering value-based care delivery for half of our business. The problem was that the other half of our business was rewarded either through fee-for-service Medicare or another fee-for-service payer. We were at the point where we needed to decide what we were going to be. Are we going to be a volume player or a value player? What we are seeing is a shift of the burden, not only in lower prices to providers, but also in the increase of bad debt, because people can’t pay their deductibles or co-pays.

LORRIE WARNER: In general, the average operating margin for the health services provider segment is 2.5 percent. If you parse the different models, sizes and scales of organizations, two strategies have proven to be successful in nearly doubling the average, expected margin. One strategy is scale — go bigger! The other has been integration.

JIM HINTON: The way the business model is evolving is more toward risk and the value perspective versus the volume perspective. When you peel back the layers of the onion, you see that the government payers are actively trying to push risk onto the health care providers.

What happens when employers unleash the consumer? What effect will that have on the economics of the business?

HINTON: There are a number of large, sophisticated employers who are going to defined contribution plans and really trying to unleash the consumer purchasing instincts of their employees. But I don’t think there’s going to be a clean, subtle move toward risk. There’s going to continue to be a lot of messiness among large purchasers.

BERND: Consumer-based plans usually have very high deductibles. This drives a different kind of purchasing by consumers and much higher bad debt for providers. What we’re seeing is a shift of the burden, not only in lower prices to providers, but also in the increase of bad debt, because people can’t pay their deductibles or co-pays.

ALAN LONDON, M.D.: I’m seeing a change in pace like I’ve never seen in my career. One of the signs of that is the rate of merger and acquisition activity; there are strange bedfellows merging and acquiring today. Organizations are going to try to accelerate the change from within by acquiring the skill sets they need.

SAMITT: One thing that’s important for hospitals and health systems to understand is that focusing on unit price and lowering the cost per unit is not enough. It’s not going to be just about the lowest price for hospitalization, it’s going to be about a 50 percent reduction in hospitalizations and the use of specialty services. In other words, it’s not just about cost, it’s about use.

What do you anticipate in terms of revenue loss over the next four to five years if you consider the impact of the effects of volume and pricing?

JOE WILKINS: In the boardroom, we’ve been careful about projecting revenues because of the uncertainty. We are looking at different measures. In the next four years, we are committed to having a clear vision of producing a million lives at global risk. That’s our objective. We believe that if we do that, it will be through quality, and the dollars will follow. If you look at Amazon, its early innovation was about volume and quality, and the dollars came. That’s the model we’re trying to follow.
Accelerating the pace of change

The pace of transformation remains uncertain. Some markets are well into their transition to value-based care, while others remain grounded in the volume-based world. Accelerating the pace of change requires innovation, agility, the willingness to accept risk and strong leadership.

What can hospitals and health systems do to accelerate the pace of change? Will the industry achieve lasting transformation?

JOHN FORSYTH: We could have held this panel in 1992 and we’d probably be discussing the same things. We need some major transformational event. Otherwise, it will move slowly. One thing that is different now is technology. We have a greater ability to understand formational event. Otherwise, it will move slowly. One thing that is probably be discussing the same things. We need some major transformation.

DAVID BERND: Managing the transition is a huge challenge. We are in a unique position in that we have a large health plan, so it gives us the perspective of both payer and provider. We have patient-centered medical homes. We know how to do case management and we have managed groups of patients across the continuum of care. In one year, we reduced the cost of care for those patients by double digits. The current payment system doesn’t reward this kind of behavior and results.

JOE WILKINS: To drive change requires an enlightened board. It requires governance to help transform and support management in terms of the change that’s needed. Clearly, as we look toward the future, trustees need to be more engaged.

CRAIG SAMITT, M.D.: What hasn’t been done well, both on the governmental and commercial side, is creating an adequate bridge so that organizations can make the transition from volume to value knowing that it’s the right thing to do. My guess, this time, is that it will happen because there will be a methodology created to help span that bridge. That being said, the reality is that this change is hard. It’s a culture change and there isn’t a secret formula for how it’s done.

JOHN FORSYTH: Our strategy is about utilization relative to the health system and not counting on the health system to encourage change. It’s a shared-risk model.

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TAMI GRAHAM: We don’t have decades left to accelerate change. I come from an industry that can change overnight. Change is ever-present. It’s part of our DNA and I don’t think it’s in the DNA of the health care delivery system. Part of the DNA of health care is to be all things to all people. Health care organizations should focus on what they do well. The industry needs to be somewhat segmented, with organizations choosing the areas in which they excel.

JIM HINTON: If you consider the growth of Medicaid and the ultimate expansion of Medicaid throughout the United States, we’ll have the highest segment of health care consumers in managed care programs with capitation incentives. That’s the tipping point.

LORRIE WARNER: High-deductible plans change consumer behavior. It’s dramatic. If price were the only factor, Mercedes, BMW and Ritz-Carlton would be out of business. There needs to be a value equation. It’s a combination of price, service and ease of access.

Are employers different today? Or do we have just a subset of employers that are being proactive and innovative in trying to curb the rising cost of care?

GRAHAM: I believe we are different. In my industry, we watch for disrupters. If we watch them closely enough, we can get ahead of them. There are many disrupters in health care that are being ignored. I like to stir things up. We were the first to adopt consumer-driven health care and now we have 70 percent of our population under those types of plans. We were the first with on-site clinics. And we were one of the first with a biometric wellness plan. Are all big employers doing this? No. But the big employers are trying to push the health care industry to think differently.

FORSYTH: In an ideal state, all incentives would align. So this is not an ideal state. We do not have aligned incentives among the providers, payers and consumers.

What are short-term and long-term consequences on our organization if we continue to operate indefinitely under both fee-for-service and value-based business models?

AGEE: It’s not just about health care, it’s about the economy. We have eight hospitals and employ about 12,000 people across a wide geography. If we closed down services or closed a hospital, it would ruin the whole economy of the region.

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ALAN LONDON, M.D.: The appetite for change is greater than I’ve ever seen it before. I think it will stick this time. Previous attempts failed because we didn’t have the data and we didn’t have consumers engaged the way they are today.

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The emergence of the new consumer

The days of the passive health care consumer are long over. From the selection of health plans to the selection of providers, consumers have a greater say in their care. More importantly, they are demanding high-quality, high-value care. It’s clear that hospitals and health systems must shift from a provider-centric system to a consumer-centric system if they are to form lasting relationships with the consumers in their marketplace.

How is the emergence of the new consumer impacting strategy at your organizations? What can hospitals and health systems learn from other industries?

ALAN LONDON, M.D.: I worked on the health system side the majority of my career. During this time, we always felt we had a good view of our patients. When I joined Walgreens, however, knowing the customer reached an entirely different level. We have tremendous data on the shopping habits of our customers. We know that 25 million seniors come to our stores each week, for example. So we look for ways to meet their needs. We focus on how we can engage them across the different channels, whether in person, online or through mobile technology.

TAMI GRAHAM: For the longest time, we were the dominant player in the traditional PC scene. We thought we knew what the PC experience was about. And then there was the iPad. As a company, we had to switch our thinking about what the consumer needs and wants. We now have a whole segment of our business focused on the end-user experience. We have anthropologists and others who go out in the field to study and understand how people use technology in their lives, throughout the world. The health care industry really hasn’t done that, or done it well enough.

LONDON: Younger generations have different demands. They want access to care when, how and where they want it and at a price they can afford. So, part of our strategy is partnering with health systems to bring some of that advantage to our 8,500 locations. It’s essentially providing an extension of the health systems at our stores.

JOE WILKINS: Understanding the consumer is where we in health care need to do a great deal more work. We need a better understanding of what consumers want from our network. We know they want quality. We know they want continuity. They want to enter any of our facilities and have the same experience. We have to build that knowledge into our strategic plan so that we can improve our connection with our consumers.

CRAIG SAMITT, M.D.: The reality is that there isn’t just one type of health care consumer. There are dozens. We need to customize the care that we provide more effectively to meet each consumer segment. We have to recognize the complexities.

NANCY AGEE: I feel we should eliminate the term continuum of care from our vocabulary and replace it with constellation of services. Patients don’t come in and go through a care continuum. In my view, patients come in and experience a constellation of services that meet their needs, whether it is within our system or not. That makes partnerships all the more important.

SAMITT: An important question is: When will consumers recognize the need to focus on wellness and prevention? That’s going to be a much longer time horizon. Unless the incentives become very good, very fast, most systems will continue to have problems effectively engaging patients around wellness.

LORRIE WARNER: We talk a great deal about aligned incentives, but those conversations do not involve the consumer. The consumer has to be seen at the top of the system, and health care organizations need to figure out how to align the incentives and engage them around wellness. With our credit card customers, they get rewards points when they use their card. The incentives are directly aligned.

We have a pretty good picture of what value-based care may look like. How does your organization’s brand need to change to reflect that? What does the brand promise need to look like in the future?

SAMITT: In the past, we’ve hidden behind the lack of transparency. As the data improve, and as transparency is enforced, we’re going to have to prove that we are better from cost, service and quality standpoints.

JIM HINTON: Hospitals have taken looking in the rearview mirror to an art form. Many organizations have been around for more than 100 years. Well, most of the patients haven’t. We need to make sure that our brand promise expresses itself in a meaningful way for the people we serve. A brand means different things to different people; it’s not a one-size-fits-all. It needs to be forward-looking and agile; and it needs to be meaningful to the people we serve who haven’t been around for 100 years.

What changes are we seeing in our marketplace among the large employers’ benefit plans? Have you engaged employers to assess their needs and provide them with specific services to meet their needs?

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The new business model

The business model of health care continues to evolve, and no clear winners have emerged to guide health care organizations into the future. The transformation of the health care delivery system will require innovation and extensive collaboration to form effective integrated delivery systems.

What are the most interesting health care business model innovations you’ve seen emerging?

ALAN LONDON, M.D.: I’ve visited more than 100 health systems in the past couple of years. It’s clear that there’s a tremendous interest in access, primary care availability and the integration of pharmacy into clinically integrated networks. At Walgreens, all of our future plans are being built around these partnerships. There’s no cookbook, there’s not an easy way to do these things. We are partnering with health systems at different levels based on their degree of integration and their appetite for population health. We used to deal with health systems at different levels based on their degree of integration and their appetite for population health. We used to have pricing predictability over extended periods. We are looking at a long-term relationship in which we can get the medical trend consistent with the consumer price index and the table. We are looking at a long-term relationship in which we can get the medical trend consistent with the consumer price index and the table. We are looking at a long-term relationship in which we can get the medical trend consistent with the consumer price index and the table.

JOHN FORSYTH: We try to get the employers and providers around the table. We are looking at a long-term relationship in which we can get the medical trend consistent with the consumer price index and the table. We are looking at a long-term relationship in which we can get the medical trend consistent with the consumer price index and the table.

LORRIE WARNER: The biggest problem with health care has been the silos. True models of success are coming from organizations that lead in the path of integration.

JOE WILKINS: I would wager that most of our organizations, from a capital-investment perspective, spend more on information technology than anything else. It’s really a back-to-the-future solution to bring down silos, improve processes and engage the consumer. This is an investment we’re making in our system in terms of acquiring our own IT organization that’s focused on consumer connectivity through the Web and to other personal devices.

TAMI GRAHAM: One killer to collaboration and innovation is the status quo. The silos are very entrenched. “No” is a dirty word. When we partner with health care organizations, we don’t want to hear “no.” Even if it’s something that’s deeply entrenched within the organization, bring me solutions.

NANCY AGEE: This is a risky business. I don’t see a real accelerator coming in and changing things. We have to anticipate change and that’s perhaps the industry’s Achilles’ heel. We see things happening and we don’t react fast enough. Probably 80 percent of hospitals and health systems in this country are stand-alone or belong to small systems, trying hard to meet the needs of their community. That’s why, when we’re looking at change, it’s not going to happen quickly.

JOHN FORSYTH: What we’re really talking about is the intersection between how we get our money and how we deliver care. For us, two-thirds of our money comes in a budgeted or fixed payment and one-third is still fee for service. The question we need to ask ourselves as hospitals and health systems is: What are the implications of that for our hospitals? It turns out that the implications are not as dramatic as you’d think, because the incentive in the hospital is to manage the episode of hospitalization as efficiently as possible. We’re rewarded for that under fee for service and we’re rewarded for that under capitation.

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