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Redefining Health Care

*Creating
Value-Based Competition
on Results*



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Creating a High-Value Health Care System

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This presentation draws on Michael E. Porter and Elizabeth Olmsted Teisberg: *Redefining Health Care: Creating Value-Based Competition on Results*, Harvard Business School Press, May 2006, and "How Physicians Can Change the Future of Health Care," *Journal of the American Medical Association*, 2007; 297:1103-1111. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means — electronic, mechanical, photocopying, recording, or otherwise — without the permission of Michael E. Porter and Elizabeth Olmsted Teisberg. Further information about these ideas, as well as case studies, can be found on the website of the Institute for Strategy & Competitiveness at <http://www.isc.hbs.edu>.

Redefining the goal:

The critical issue is the value of health care delivered.

Improving Value:

Better health outcomes relative to the cost of achieving them.

•E.g., Value of health care for people with diabetes clearly improves with effective early-stage care.

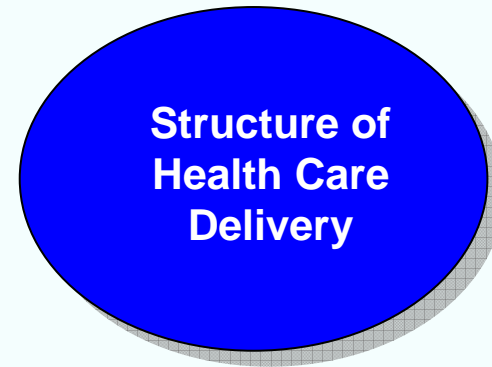
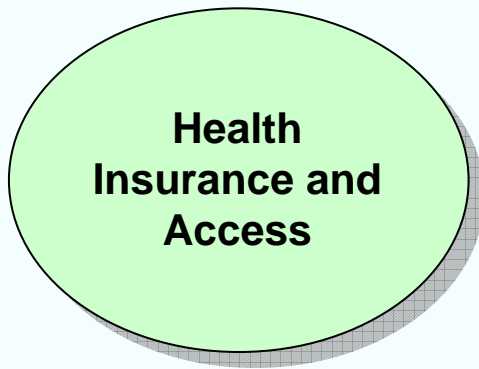
- Disease progression drives value DOWN with both worse outcomes and higher costs.
- Universal, early-stage care improves efficiency.

•If cost reduction were the real goal, we would need only pain killers and compassion.

•Ironically, the more we've focused on costs, the more we've driven them up. Cost shifting undermines efficiency and quality.

Universal coverage IS essential for equity and efficiency.

And, it is not enough.



**The key to success is improving the heart of the system:
delivery of care and enabling of health.**

When value increases significantly, it is possible to deliver far better health outcomes for the money spent. This enables more access and more coverage.

No matter who pays for health care, **increasing value is the critical issue.**

Creating a High-Value Health Care System

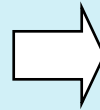
Framing the choice as between
a government run system and a consumer-driven system
misses a huge opportunity.

Government policy should **set the right rules and ensure results measurement**, but restructuring health care delivery must occur from the **bottom up**.

Consumers cannot fix the dysfunctional structure of the current system.

We offer a **different conception of market-based reform**.

→ Government-run
→ Consumer-driven
→ Payment-centric



→ **Results-driven**
→ **Patient-centric**
→ **Physician-led**

To achieve dramatic and ongoing improvements in value for patients, “set the compass” with 3 guideposts:

1. Patient-Centric Care

- Define the goal as increasing value for patients.

2. Results-Driven Improvement

- Measure results at the level at which value is created for patients.
- *Drive learning!*

3. Physician-Led Reorganization

- Redesign delivery around full care cycles for medical conditions.

A “medical condition” is a set of interrelated medical circumstances that are best treated in an integrated way.
(So, diabetes with hypertension IS a medical condition.)

1. Patient-Centric

Improving results for patients increases value rather than dividing value.

- **This is a win-win proposition.**
- Consider anesthesia improvements.
- Notice, the goal is improving value for patients, not creating consumer-driven care, which often means shifting costs.
- Swedish results improvements

What should it mean to COMPETE?

Sports and war are the wrong models.

Healthy competition is about INCREASING VALUE.

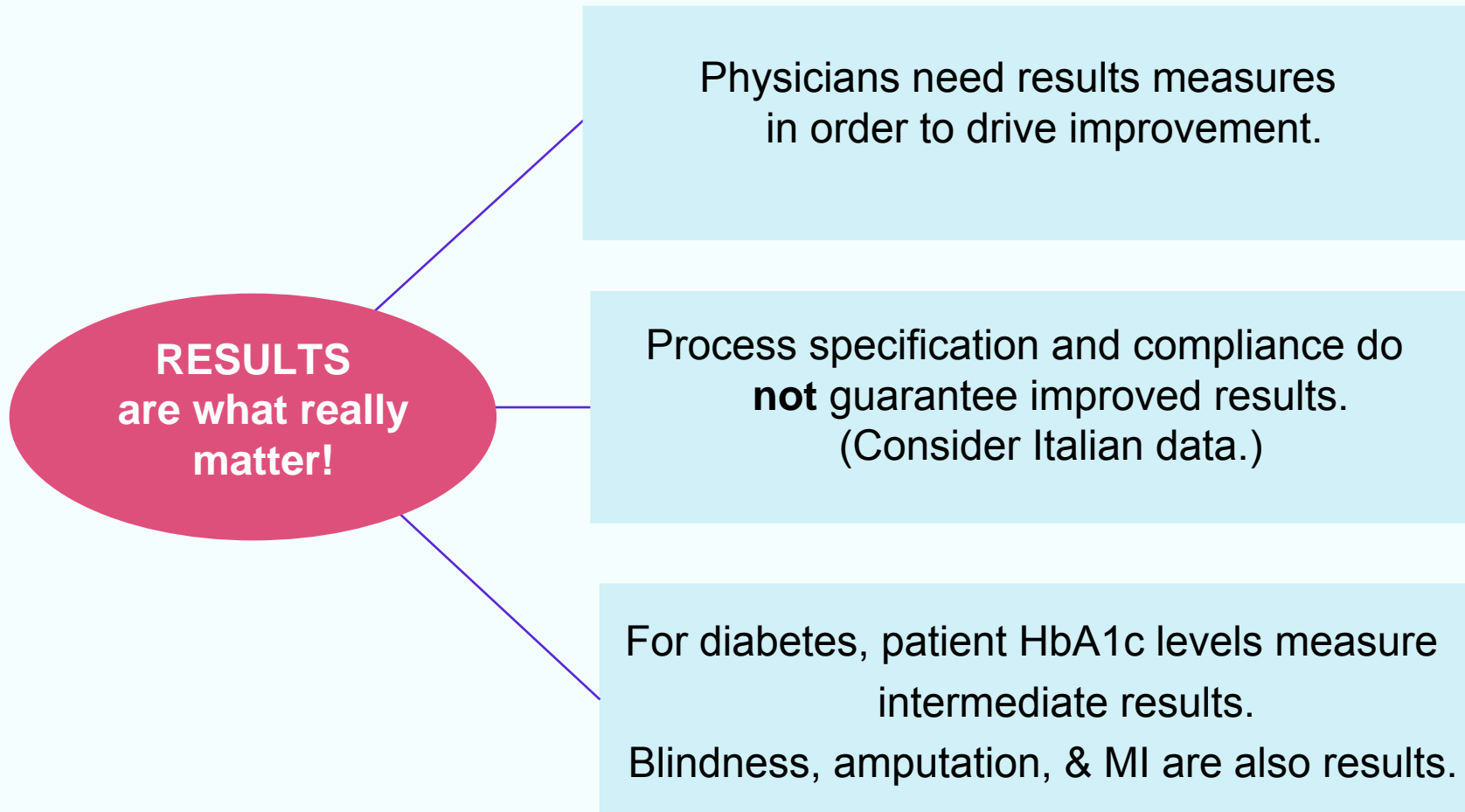
**This means improving results (outcomes and costs),
not shifting costs or winning at someone else's expense.**

**Improving results for patients *increases value*
rather than dividing value.**

**And improving value aligns interests, rather than
having participants pursuing different goals.**

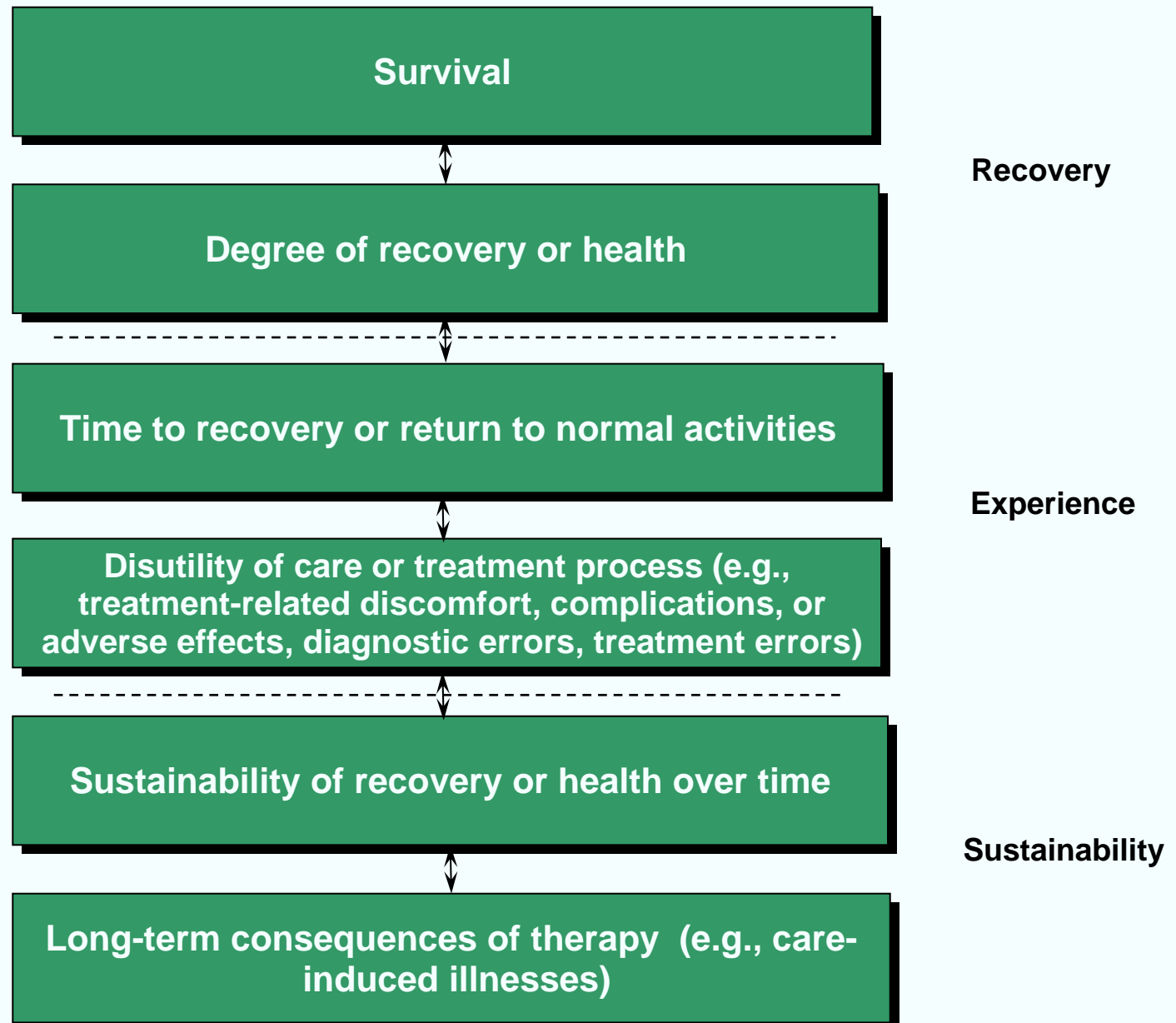
2. Results-driven.

Widely available information on results drives improvement in outcomes for patients.

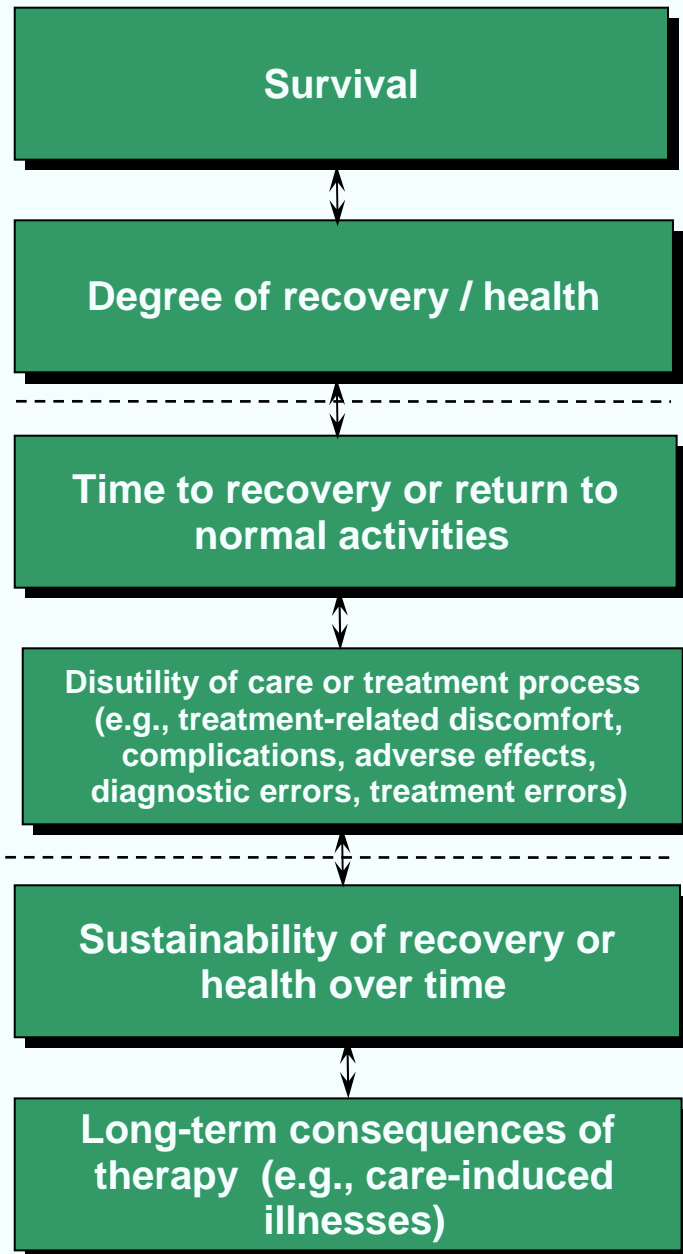


Measuring Results

Multiple Outcome Measures



Measuring Breast Cancer Outcomes



- **Survival rate**
(One year, three year, five year, longer)
- **Remission**
- **Functional status**
- **Breast conservation surgery outcome**
- **Time to remission**
- **Time to achieve functional status**
- **Nosocomial infection**
- **Nausea**
- **Vomiting**
- **Febrile neutropenia**
- **Limitation of motion**
- **Depression**
- **Cancer recurrence**
- **Sustainability of functional status**
- **Incidence of secondary cancers**
- **Brachial plexopathy**
- **Premature osteoporosis**

2. Results-driven

"But, patients don't use outcome information when it IS available!"

The point is ... doctors do!

- New York, CABG surgery
- Cystic fibrosis national comparisons
- Minnesota public outcome measures for diabetes

- And... truly informed, involved patients take more personal health responsibility and choose less invasive, less expensive care. (Throwing information on the web is not enough.)

But are results really all that different?

- Consider heart transplants.
- **Too often, physicians and patients lack data on RESULTS.**

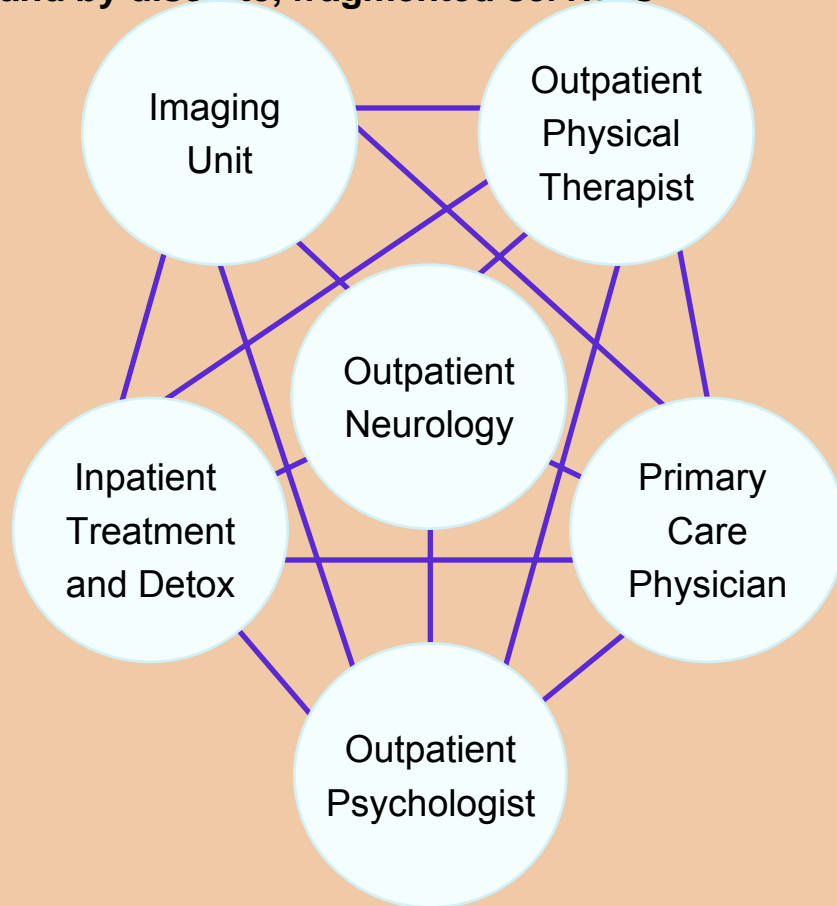
The feasibility of universal outcome measurement at the medical condition level has been **conclusively demonstrated.**

And *using* measures is the fastest way to ensure improvement -- not just in results, but in the measures themselves.

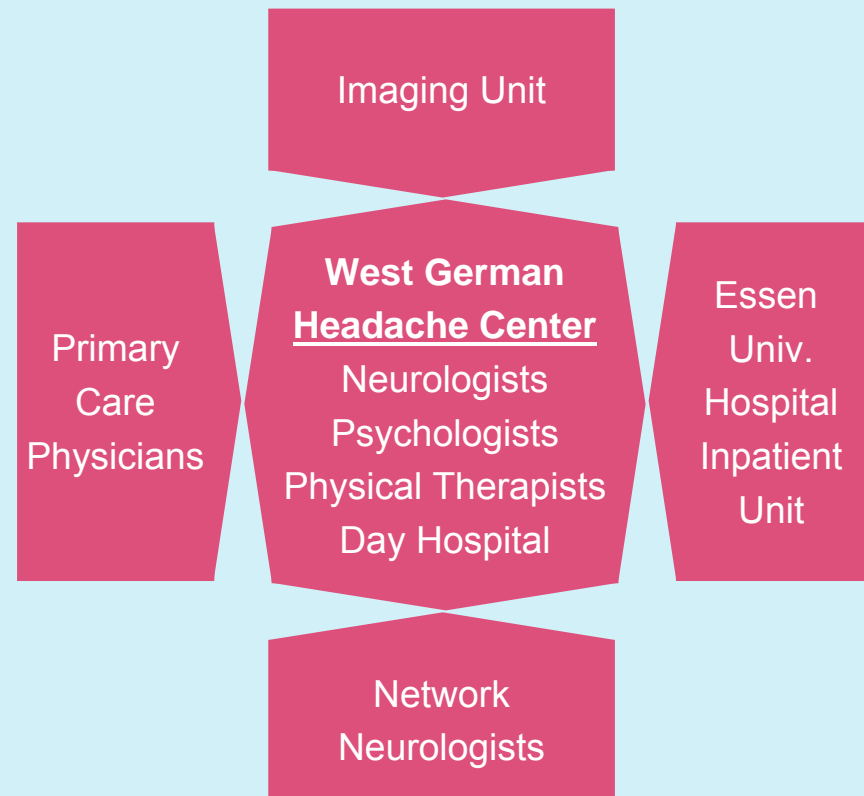
3. Physician-led service lines

Patient value needs to be the beacon of inspiration for organizational innovation.

Old model: Organized by specialty and by discrete, fragmented services



New model: integrated practice unit

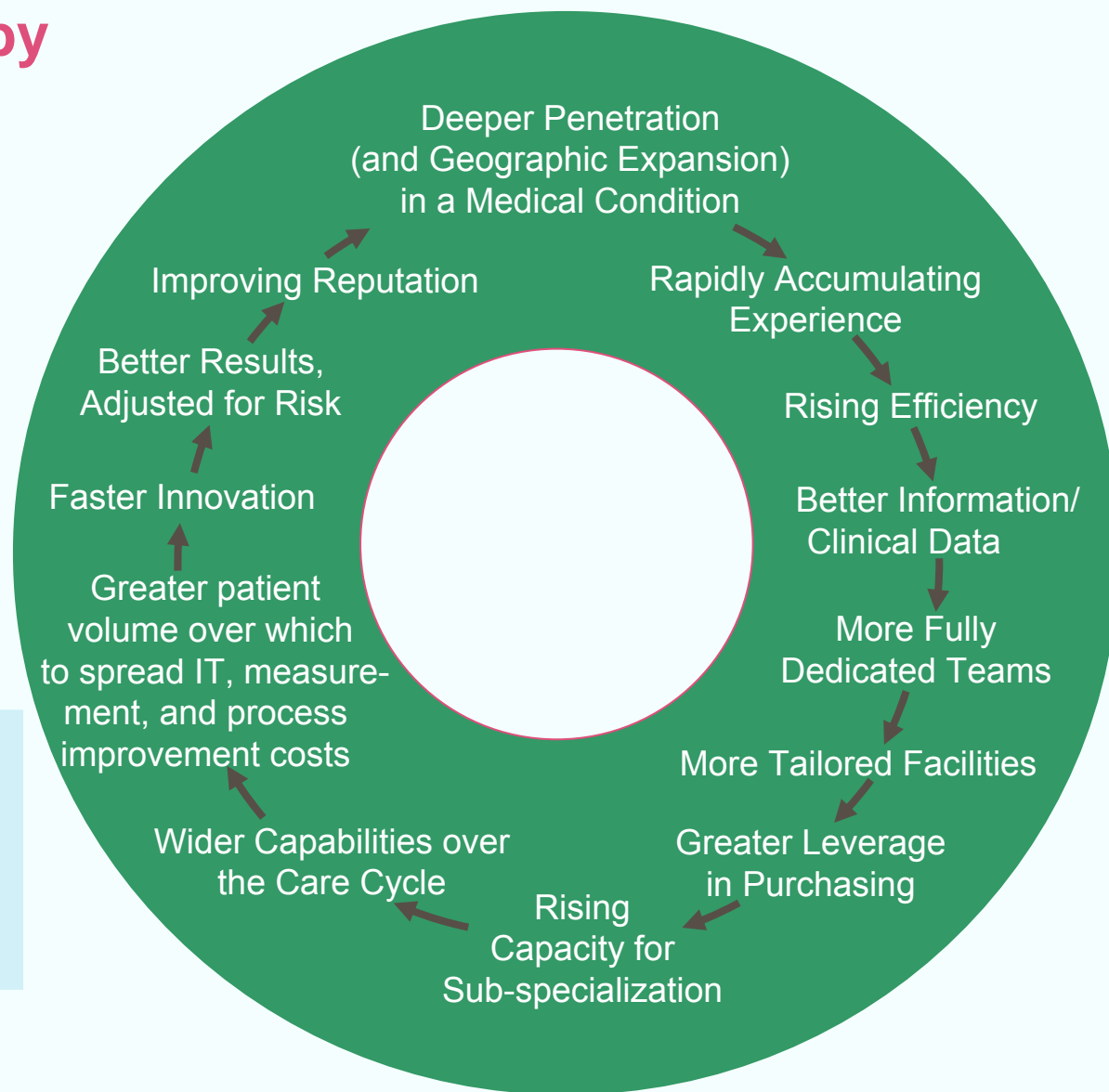


Migraine care in Germany:

Integration of care simplifies coordination for patients and patients have far fewer days of disabling pain.

3. Physician-led

Integrated Practice Units drive improvement by driving learning at the medical condition level.



This is not hyper-specialization .
Broad expertise develops over the care cycle for the patient.
Consider cystic fibrosis.

“But ...costs are rising worldwide, can we afford to focus on improving results and value?”

Yes. The best way to contain costs is to drive improvements in quality.

Health care IS different.

- Better health is the goal, not more treatment.
- And good health is inherently less expensive than poor health.
- We **can** afford to pursue better health for all... indeed we can't afford NOT to.

Health care IS different.

Even more than in other sectors, better quality inherently reduces costs

- Fewer mistakes and repeats
- Faster recovery
- Less disability
- Less invasive treatment methods
- Less long-term care
- Disease management
- Prevention of disease or progression
- Right diagnoses
- Treatment earlier in causal chain
- Right treatment to the right patients

Living in good health
is less expensive than
living in poor health.

Much delivered care does not meet best practices.

Process improvement, "waste reduction," and safety improvements can drive very large gains, but streamlining the pieces of a fragmented system and patching the fragments together have inherent limits.

We can achieve even more dramatic improvements in value by redefining care delivery across the care cycles for medical conditions.

There is no need to wait.

Begin with these steps:

- ❖ **Define the medical circumstances for which you will improve value.**
(Identify the service lines you provide and the care cycle for that service from the patient perspective.)
- ❖ **Measure outcomes for these patients by clinical team.**
(Discuss among the team, compare with others and develop insight.)
- ❖ **Redesign care cycles to improve outcomes for patients.**
(Today's organization is fractured and organized by medical specialty. Demonstrated value across the care cycle for a cluster of patients creates dramatic opportunities to improve care and to redesign payment.)

Implications for investment

- **Value-based competition creates a template** for assessing innovation: the nine principles provide insight that can be used in evaluation.
- **Results can and should be measured** – at the level at which value is created: by medical condition over the cycle of care.
(You would expect no less in any other sector. Don't accept excuses.)
- The best **outcomes measurement is designed to enable improvement and learning**, not as report cards. Measurement for teams is appropriate.
- **Early movers will compound significant advantages** from learning and accumulating data.

Implications for investment (cont.)

- **A variety of transition paths to Integrated Practice Units are possible:** look for organizations driving measured improvement at the medical condition level, and for reorganizing around the patient perspective of co-occurring medical circumstances.
- **The definition of primary care will evolve,** as the full cycle of care is coordinated, so the services and products of most value for primary care will change.
- **Encourage new contracting models** with health plans based on care cycle delivery structures and teams. Gain sharing and joint accountability will accelerate ongoing improvement.
- **Competition to improve results is not local.**
(Being the best locally will not be good enough if that is substandard.)
(Several models of geographic expansion are now succeeding.)
- **Suppliers** can work to improve care cycles and embed their products in more effective care cycles. Participating in results measurement and longer term studies will be critical.

Implications for investment (cont.)

- **Consumers cannot fix today's dysfunctional competition.**
Products or services to create a “consumer-driven” system are not enough. Ask how value is improved.
- **P4P is becoming administratively controlled care** (this happened with managed care and with some evidence based medicine). Process compliance and measuring inputs (rather than outputs) are not sufficient.
- **Look for measurable value from telemedicine** (error reduction, more accurate diagnoses, improved outcomes with fewer clinic visits, home managed care...).
- **Information technology is an enabler of restructuring care delivery and measuring results**, not a solution itself.
- Significant progress can be made by **clinicians, suppliers, health plans, employers and information services**. **Improvements in value are mutually reinforcing sector-wide.**

How Will Redefining Health Care Begin?

- It is **already happening!**
- Each system participant can take **voluntary** steps in these directions, and will **benefit** irrespective of other changes. *Altruism is not required!*
- Once competition begins working, value improvement will **no longer be discretionary** or **optional**. *Moving early has major benefits.*

There is no need to wait.

We **CAN** create health care systems
that drive improvements in value.

Imagine...

health care systems that are truly about
health and care.