A strategy to fix healthcare

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I want to thank Reform for convening this meeting. I want to thank all of you for being here – it’s a tremendous honour to me to speak to this group. Pound for pound I don’t think I’ve ever been in front of a more distinguished group of people in healthcare anywhere. That we’re all taking our time to be here today and to talk about this subject is enormously impressive to me, and it’s been a real pleasure for me to get to know some of you.

This is a moment where I think we understand we need to take stock of where we are in the UK health system and in the transformation of that system. This has already begun. There has been lots of discussion and debate about what needs to be done. There has been lots of discussion and debate about what needs to be done. There has been lots of activity. There is a political cycle which raises the sense of urgency to get clarity and alignment among the various actors in the system. This is a very, very important time to talk about where we go in healthcare– not only in the UK but everywhere. It’s an enormous challenge in the United States and everywhere else in the world that I work.

I have been now heavily engaged in thinking about healthcare for more than a decade. It’s become a bit of a consuming issue for me because it’s so important in every society, not only to human beings but also to the budget and to the direction of the entire country. I’ve had the particular privilege of having the opportunity to be involved here in the dialogue in the UK now for a number of years.

I think it was about three years ago almost exactly that I started spending a considerable amount of time here in the UK. I’ve gotten to know many of you. I see some of you here: Malcolm Grant, Nick Seddon, David Fish, Paul Burstow, Jeremy Hunt and others. I’ve had a chance to touch and feel and listen and absorb the activity and the thinking here in the UK. Many people from the UK have come over to Harvard and we’ve had opportunities to have dialogue and discussion there.

All that has led me to really be very, very impressed with the degree to which there is a genuine open dialogue about healthcare reform here. It’s not a show. We’re not just going through the motions. People here really care. You really care, and I think that makes it very, very important that at this particular moment to come together again and try to get new insight and new clarity about where to go next.

Now, as of course is no surprise to anyone I think that the starting point for any effort to answer the question of where we go next in the UK in healthcare is actually to have extreme clarity on the goal.

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Value for patients means delivering excellent health outcomes, hopefully improving health outcomes, on the things that really matter to the patient, and doing that very, very efficiently. It’s the relationship between the outcomes we deliver and how many pounds we have to spend to deliver those outcomes that really represents the true north of any healthcare delivery system. If we’re improving value for the patients and if we know we’re succeeding – what my work has revealed – and what I think most of you must agree with – is that the central purpose of any healthcare system is value for the patient. That’s what it’s all about.

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I believe that in the UK I have felt and very much tangibly experienced a lot of consensus around this central goal of value. I can tell you that that’s not true all around the world. Some countries are still
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debating what the purpose of their system is. Some countries are way back at ‘access is our number one goal’. But ultimately, access to care that doesn’t deliver value is not success. Value is the ultimate measure of success in healthcare.

There is growing consensus in the UK, I think, about value. This word is now being widely used. I think there’s general agreement around it. Some of the key concepts of value are now active, not only in discussion, but also in practice. There is a tremendous amount of activity around outcomes, which is, of course, the central idea in value. There are a lot of ideas about costing and how we need to think differently about costing, which is a key idea in value. There is an active discussion about payments and payment models and how to reconfigure such models around value.

So I’m very heartened by the fact that, compared with three years ago, we’re much farther along in understanding the key purpose [of healthcare reform] and also starting to move in the direction of how such things are achieved in the real world. This is particularly heartening given a legacy structure in healthcare that we have in the UK which is not necessarily well aligned with value. The question we have today is not about the key concepts. I think those concepts are starting to be well understood by many of you. In fact, many of you are leading and teaching me about these concepts. I think the key question we have today is how to put those concepts into practice: how to make it actually happen, here in this system with the assets that we have.

Now I have long said that the UK has profound assets in moving to a value basis. You have universal coverage. You have GP coverage for everybody. You have a single payer that should give you the capacity of actually moving much more rapidly than many other countries can have. There are a lot of assets here for moving to a value-based system, but ultimately we still have to get over those complicated systemic transformations involved. That’s what I’d like to talk a little bit about today. How do we take the next step? What are some of the critical ideas and learning about moving towards a value-based system? What can we learn from what is happening elsewhere in the world? And then of course how do we get it done?

So, in talking about value and moving towards a value-based system, the first thing to get clear on is what the unit of value is in healthcare. Right now we have an institutional structure in healthcare around hospitals and GP practices, around outpatient services, and around social care. Our structure in healthcare delivery in the UK is organised around some existing organisational units that have evolved historically. In many ways, they’re not unlike many we see around the world.

I think the key question we have today is how to put those concepts into practice: how to make it actually happen, here in this system with the assets that we have.

But what we understand is that the organisational units we have today are not the right units for thinking about value. In thinking about value we have to think, not about the organisation but about the patient – and the patient’s needs and the patient’s problem. When we look at this value equation, when we measure outcomes, we must measure the outcomes for the patient’s condition.

The outcomes for the hospital aren’t that interesting. The hospital is dealing with a lot of different patients for a lot of different problems. Understanding what value is for a hospital is almost impossible. In fact it’s almost meaningless. It’s actually value around dealing with a particular patient’s condition where we must centre our understanding of the transformation that has to be put underway.

When we think about outcomes, we have to recognise that those outcomes are going to differ depending upon the patient’s condition. The outcomes for prostate cancer are different to outcomes for diabetes. Rather than being centred on historically created organisational groups, we have to learn to think about how we organise, manage, measure and deliver care, condition by condition, patient segment or patient group by patient group. That’s a core principle that we’ll come to later because we’re not getting this quite clearly in some of the steps we’re already taking.

When we think about cost, once again it’s not the cost of a hospital. That’s not interesting. It’s the cost of providing the full cycle of care for the patient’s condition. That’s what’s important. If we have a diabetic patient, what is the cost of care for that patient over his or her very, very long care cycle? How do we understand what those costs are at the patient level in delivering care for this set of patients with this set of medical circumstances? That’s the way we think about value.

It is when we can put together the outcomes for a condition with the cost of providing care for that condition that we have the magic information that we’ve never had before. It is this information which allows us to actually drive value and which is the ultimate information that should guide all of the restructuring and all of the choices we make about actually how to provide care: Decisions about who should provide care, where should they provide care and about which set of care processes to employ.
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Our starting point (and this is a very hard starting point) is that the transformation in healthcare that has to take place today in the UK and elsewhere requires us to change our unit of thinking and organisation. We have to move from the traditional entities, departments, hospitals, GP practices, outpatient units and homecare services. We have to move away from those traditional organisational units, and we have to start realigning our entire thinking about groups of patients and their conditions. Because all of us in the system work in one of those organisational units, and we have to start realigning our entire thinking about groups of patients and their conditions.

So in delivering – and moving to – a value-based system, we’ve come to understand through the work all around the world that there are really six fundamental transformations that have to happen. I’ve already started talking about the first. The first transformation is we have to reorganise our thinking about the care team and the care process. I’ll give you an example a little bit later.

Now in specialty care I think we have a good clear, intuitive understanding of what that means. We’ve got to stop organising around the services or around the entities or around the sites of care, and we have to start organising around the team that provides the care for the patient’s condition over that cycle of care.

For GP care, however, we also have to transform our organisational model. A GP that tries to provide good care for hundreds and hundreds of patients with every conceivable medical problem you can imagine can’t possibly deliver value. That’s mission impossible. If GPs are going to deliver value, they have to reconceive that– and understand that GP care is not one service. GP care is a lot of different services for patients with fundamentally different needs.

The frail elderly need a different kind of GP care to healthy adults. A patient with two or three complex chronic conditions needs a different kind of GP care to a frail elderly person. When we’re thinking about care for a defined disease, we have to think around conditions. In GP care, we also have to think about how to segment the needs.

The fundamental principle of organisation is to organise around the need, rather than organising around the supply of individual discreet services. It’s this organisational transformation that is giving us so much trouble all around the world. That is the starting point for moving to value. We’ve got to get that done. We’ll talk a little bit more about that.

Now we also have to learn to measure outcomes and cost because if we don’t know the outcomes we’re delivering, and if we don’t understand in a clear way the cost of actually delivering those outcomes, how are we actually going to improve? What we found in many systems around the world is that nobody knows these things. Healthcare is a fact-free zone. We don’t have the key facts that we need to know to actually make choices. Therefore, there is a lot of opinion, politics, confusion and lack of progress.

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If you could do any one thing on my six agenda items really well, really fast and really aggressively, the one that would make the greatest difference overall would be this: really understanding outcomes every time for every provider, providing every service for every condition and having a very intelligent way of thinking about the cost, what it actually cost and what really drives those costs.

So that’s number two. Number one is reorganisation. Number two is measurement. Number three is reimbursement to align the payment with value creation. Fundamentally, the idea there is we have to align the payment structure with what it takes to create value. That means that the payment has to be around medical conditions or primary care for a particular set of patients over the full cycle of care because if we can align payment around that, we’re going to align payment with value and value creation. This is challenging because our traditional payment methods have been very different – we’ll talk about that a little bit later.

Number four has to do with turning our delivery systems into systems. In the UK we have lots of hospitals. Often, in a given geographic area we have academic medical centres and community hospitals. We have lots of GP practices that tend to be small along with lots of other entities involved in providing care of one sort or another. These entities do not form part of a system – they’re a bunch of standalone units doing their thing.

There is a tremendous tendency in healthcare for every entity to try to do...
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everything that it can possibly do in its category. Hospitals tend to provide almost all the services that any hospital provides, and a GP practice is going to try to see every conceivable type of patient that might show up and walk in the door. We’ve had a very local model of healthcare delivery where the local provider provides all the services that anybody in that particular geographic area needs. Ultimately this is not conducive to value. Again, we’ll talk more about that a little bit later.

We’ve got to start to tie the pieces of the system together. GP practices have to be connected to hospital care and to hospital-based outpatient care in a very tangible way, and we haven’t really found a way to do that. We have a GP system and it’s over here, and we have a specialty and acute care system and it’s over here – everybody is doing their own thing. We’ve also got a lot of hospitals, many of which may not be that far from one another. Every one of them is doing their own thing, and we’re not thinking about the system.

We’re not thinking about where the services should be and how to co-ordinate across these interfaces and how to structure that so it works. We’ll talk a little bit about how that’s starting to happen in other parts of the world much more rapidly than it’s happening here. We can do it. We can do it. We understand the concepts. We’re just not moving ahead. We’re still stuck in our structural configuration that we’ve historically inherited.

Number five is expand geographic reach. If we have a world-class academic medical centre in cancer care, that world-class academic medical centre shouldn’t just be serving the patients in a particular geographic area. It ought to be building affiliations across the entire country and partnering with local community hospitals to collaborate in providing excellence across the whole country – not just in its particular county or region.

We’re seeing that around the world. We’re seeing excellent providers start to be the hub of hub-and-spoke systems, of affiliation, where cancer care for relatively common cancers can be provided in the community setting, in a community hospital by community oncologists. On the other hand, when you get a complex head and neck cancer, the patient in question really better be centrally looked at and cared for in a very high volume academic medical centre.

Payment has to be around medical conditions or primary care for a particular set of patients over the full cycle of care because if we can align payment around that, we’re going to align payment with value and value creation.

It’s a question of how to allocate the services and get the patient to the right place to meet his or her needs. That is the fundamental path to value, rather than everybody trying to reinvent the wheel and do it the best they can – we know that that’s impossible to do. It’s getting harder because the need for patient volume to deal with modern technology and modern equipment and this rapid growth of expertise is only continuing. We’ll talk about that a little bit more in a minute.

Then of course there’s the IT issue. I promised I wouldn’t talk much about IT today because it’s very painful in this country to talk about IT. But I think we understand that these kind of things – reorganising care around teams and cycles of care, measuring outcomes and costing well, creating this different kind of reimbursement structure, co-ordinating across systems – are tremendously enhanced by the right kind of IT platform.

Where everybody has access to the same information, where all the actors involved in care can get the same information and where the patient has access to information and can communicate with the clinicians, IT becomes a really key enabler. There’s now a lot of learning and accelerated progress on what a value-based IT system looks like. We won’t talk much about that today (but I actually heard at our dinner last night there are some interesting and exciting examples underway here in the UK – hopefully, things are looking up here).

What I’d like to do is to take a few of these topics where I believe we can move more rapidly, clearly and decisively, and give these just a little bit more colour.

So, let’s talk about the care organisation. The basic challenge here conceptually is very simple: It’s just really hard to do. The traditional care
processes on the left were organised around services, or care locations or care sites. You see in this care cycle for migraine – this is a German example – that it all starts with the GP. If the GP does his or her thing, and if the patient still has a problem, then the patient may need a variety of other services. You see those here, probably starting with an outpatient neurologist if the GP’s interventions have not ultimately been successful in controlling the disease.

The patient going through this care cycle on the left goes through a sequential process where they go to one person, they do their thing, then they go to another person, then they go to another person. We often describe this as the patient is a ping pong ball bouncing around from entity to entity. Each of these is a separate entity, a separate administration, a separate waiting room, a separate appointment, a separate location.

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What’s also particularly unfortunate about the traditional system is the patient doesn’t necessarily get to the place where there’s a real expertise on their problem. So if they’re going to go to an outpatient neurologist, they get an appointment with the outpatient neurologist with time on the schedule, not the outpatient neurologist that’s really interested and passionate and a deep expert on severe migraine. It’s what you might call a pickup team: who is available, who you can find, who is on the schedule. It’s not a real team. It’s not a group of people with these modalities and expertise that actually work together regularly. It’s a pickup team.

And as a result, despite the fact that everybody in the yellow bubbles works really, really hard and cares a lot, ultimately you have badly co-ordinated care. You often have a lack of experience to deal with that particular patient’s problem. We all know the consequences. You also have inefficiency, delay, and frustration.

What do we do about it? Well, we follow organisational thinking 101. Instead of organising around the supply of services, we organise around the need. The need is care for severe migraines. This is a big problem. It involves lots of people. There are enough people with that problem that we need to aggregate those people and provide care in an integrated way in what we call an integrated practice unit. That’s illustrated in blue. That takes all the skills that we think are necessary to really diagnose and provide therapeutic assistance for a particular condition and then put those in the same organisational unit.

Now note that Primary Care Physicians are on there. They’re connected. Note that there is inpatient care. It’s connected. Patients that see this headache centre that need an inpatient stay – which sometimes happens – get that inpatient stay in an affiliated inpatient unit. Note that there’s an imaging unit that’s affiliated. Rather than have every imaging unit try to provide imaging for every conceivable kind of problem that any patient might have, we build an affiliation around an imaging unit that really develops expertise – in this case the head scans – and the interpretation of that kind of imaging.

Then when the patient is doing well and maybe needs an outpatient referral to a neurologist for follow-up care or back to the GP, again, we have those lines. We have affiliations. So the patient just doesn’t wander back to any neurologist. If they need continual follow-up by a neurologist, there’s a neurologist that’s affiliated with the integrated unit that shares the same practice standards, who is part of a joint learning environment. So the whole process actually is truly integrated.

We’ve had a very local model of healthcare delivery where the local provider provides all the services that anybody in that particular geographic area needs. Ultimately this is not conducive to value.

There’s a lot of confusion here in the UK around the word integrated. Being Integrated consists of having a team that works together. Being integrated involves co-ordinating across time in terms of the various services that are provided, and across locations, and across specialities and expertise. That’s what being integrated means. You can put everybody in the same building and not be integrated.

You can call it anything you want, but integration is about the software that happens among the people working together. Everybody that it involves doesn’t have to be owned or part of that same organisation. You can have affiliations and relationships so that you get to know how to work together on a particular class of patients. This is the organisational model that we know – we absolutely know beyond a shadow of a doubt – dramatically improves value. In this particular example we had epic improvements in outcomes almost overnight, and ultimately about a 25 per cent cost reduction at the same time.

Where we organise around the need, where we put the right team together, where that team sees itself as a team, whether it’s inpatient, outpatient, imaging or whatever service, we get great outcomes – and we can do it much more efficiently. Think about the world of the patient. You listen to patients that go to this headache centre after having ten years of awful headaches, and what they tell you is – and I’ve heard them say this – ‘finally we’ve found somebody that understands our problem and what to do

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about it.’ They’ll have seen not just a person on the schedule or somebody like an outpatient neurologist that’s seeing a stroke patient one minute and a migraine patient and then an MS patient and then a cystic fibrosis – you know, that’s the typical model. We’ve got to get away from that model.

Now unfortunately I wish it was easier because this means we’ve got to break down the barriers between outpatient care from the hospital, and inpatient care, home care and the role of the GP. We’ve got to break down those barriers around the major conditions where we have groups of patients with similar needs. That’s the fundamental organisational problem.

Now I just brought up this picture. This picture is like a historic event. This is a meeting at the Brigham and Women’s Hospital in Boston, and all those people in the room are rehab experts – in this case for shoulder problems. The Brigham and Women’s Hospital shoulder IPU has gone out and found the rehab organisations in the Boston metropolitan area that they believe are competent and skilled at rehab for shoulder problems, and they’ve said, ‘OK, we’re going to form a relationship with you’.

These people are at a meeting at the Brigham and Women’s Hospital – rehab people – talking to the surgeons, and they’re having a conversation about how to most optimally rehabilitate after rotator cuff surgery. Traditionally the surgeons in the Brigham and Women’s Hospital did their surgery: [claps hands] ‘I’m done’. Now the surgeons in the Brigham and Women’s Hospital say: ‘Wait a minute, I’m not done. I’m responsible to make sure that I send my patients to a good, qualified place to do the rehab part of the care cycle which has a big, big, huge impact on the outcome’.

So, since I’m responsible, I’m going to meet those people, I’m going to get to know them, and we’re going to have an exchange of information. In the payment mechanism being created for this, actually the money’s going to go to the surgery, the IPU at the hospital, and then the hospital is going to pay the rehab people. That’s an example of a
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bundle payment model where you make sure that everybody is aligned economically and everybody is getting paid for their part of the overall care cycle. Even though the rehab people don’t work for the hospital – they’re not employees; they’re not owned – but there is a partnership created.

So let’s stop thinking we have to blow up all the hospitals in order to do this. We can do this today in the UK. If every hospital identified some of those big groups of patients, internally reorganised around an integrated practice team for those patients, and then reached out to the external entities that are necessary to be part of that care cycle, we can do that today. Even if we changed nothing else, even if there’s no new bill in parliament, we can do that.

But it’s a philosophy. It’s an orientation. It’s an understanding of what value looks like and how we actually deliver it. Now of course if we can actually measure, we will be that much more successful.

I’ve got some people with serious chronic conditions. Those are different. I can’t provide the same service to those people. I have to provide a very different kind of service. They have different needs, and we need a different team to deal with the frail elderly than we do with healthy adults.’

We need different sorts of preventative care and primary GP interventions in those groups, so we need GPs to start to recognise that they’re actually serving different needs as well. But rather than viewing every patient as one-off, what if we tried to think about the major segments of patients we had and organise ourselves internally as a GP practice around meeting those segments?

Now to do that you can’t have a one-doctor GP office. What we’re finding around the world is GPs have to get bigger. They have to have better facilities. They need support services. They need better nursing and other skilled practitioners so that a structure can be created to systematically deal with the needs of these very patient groups.

That’s value-based organisation.

Now in order to create a value-based delivery structure, we need volume. If you only have one patient every week with a given kind of problem, we treat it as a one-off because we have to. But if we can create some volume, if we can have 50 diabetics a week or people with a severe cardiac condition, then we can have a team. We can do that on Mondays and Tuesdays. We can get the right people there in that team to deal with that group of patients. We need some volume in order to organise the right team, in order to systematically manage that care cycle.

However, the problem we have in healthcare around the world – and this is just some data from Sweden – is that we’ve fragmented our volume. Since everybody tries to do a little bit of everything, nobody or only fairly few entities have enough patients with a given condition in order to create the right structure that has any hope of really delivering excellent value and doing it efficiently. If you’re doing one total knee replacement a week, there’s no way you can create value. You can’t possibly do it efficiently – even with the right team that’s highly skilled.

But if you’re doing these every day, seven or eight or nine a day – I’ve actually been in operating rooms doing total knee replacement – and if you’ve got the real volume and you’ve got an IPU there, nobody even needs to talk. You don’t have to remember what this surgery is like versus the others you’re doing all week. It’s a machine. The team is a machine. It does excellent work. The people in the recovery room know exactly what to look for in terms of the recovery for that condition. They’re ahead of it. They’re ahead of the game. They’re seeing complications emerging before they emerge, and everybody is involved in the patient’s rehab, not just the rehab people that they get sent to.

If we have volume, we can deliver excellence. If we don’t have volume, we struggle. We do our best, we work hard, but ultimately we don’t achieve success.

That’s the benefit of volume. If we have volume, we can deliver excellence. If we don’t have volume, we struggle. We do our best, we work hard, but ultimately we don’t achieve success. The evidence is overwhelming about this point that in many, many fields of healthcare delivery we actually need some volume and experience if we’re going to deliver success. This is just an example from Germany of the different outcomes, in this case mortality of low birth weight babies depending on where the baby is being born. Why would any mother want to have their baby born in one of these hospitals? If she knew, if we have good outcome data, of course she’d want her baby to be born in one of these hospitals.
No provider has the right to provide any service. You only have the right to provide a service if you can deliver value in providing that service. We’ve got to face this reality. We have a healthcare system where you have a lot of organisations doing things that they are – it’s not that they’re not trying hard. It’s not they don’t have good intentions. They just don’t have the experience and the volume and the team to do it really well. We have to understand that that means they [either] have to stop doing it, or do it much better.

We’ve been very timid in this country in particular about those kind of consolidations. We’re just letting things roll. We recognise the problem, but we actually haven’t been able to do something about it. Some countries are starting to put in place minimum volume standards. If you can’t show that you’re doing an adequate number of cases per year in this area, don’t do it. Then grow your practice in those areas where you have adequate volume and get better and better at it. Let’s have patients with the problems you’re good at come to you, and patients where you really don’t have the volume and experience or the right team go somewhere else.

This is what systems integration is all about. It’s about getting the patients to the right place. Now, we have this thing about whether patients should travel. What do you think? Would you travel to have your baby if you knew that getting to a place that was excellent in dealing with these complex children was going to do a much better job? Of course you’d travel. Even if you don’t think you want to, we as a society and we as a leadership group in this healthcare system need to help our patients understand they need to travel rather than have this political game where we say: ‘it’s OK, of course your local hospital should provide every service’. That’s what politicians say, but that’s not about value. That’s not us doing our job.

So measurement and volume are fundamental to driving value, and we have to get on with that much faster. In terms of measuring, the big point I want to make is that we’ve got to learn to
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measure outcomes much better. We are measuring processes of care. We’re looking at evidence-based guidelines. We’re looking at all kinds of clinical indicators that are absolutely appropriate. We’ve got to do all these things.

We’re measuring patient experience in the Friends and Family Test and that’s great. It’s really important for us to measure how our patients experience our care. All those things are good to measure. I’m not opposed to any of those things, but all of that is much less important than actually measuring the outcomes, the true results. Having the patient experience is good, but the reason it’s good is that it might improve the ultimate outcome. Unless we measure the ultimate outcome of the care, we don’t know if it’s good.

We have a lot of hospitals in the US that really worked hard on patient experience: They put TVs in the rooms and they had designer dinners. We don’t want to get distracted from what the ultimate purpose is. The ultimate purpose is to deliver good outcomes. We’re now developing all around the world a rapid evolution in how we’re thinking about measuring outcomes – how we’re identifying those outcomes.

We’re learning that we have to measure a set of outcomes for every medical condition. There is not just one outcome. We’ve got to measure not just the kind of clinical status but also the functional status. Can our patients live normally? Can they eat normally? Can they go back to work? All those things are critical outcomes that are going to have a profound impact on the cost actually of delivering care.

We’ve got to measure all the time and difficulties and safety problems and complications that take place in the process of recovery because we want the patient to quickly get back to normal life. The faster they can get back to normal life without adverse effects and discomfort and a horrendous care process, the better the outcome. By the way, we are going to lower costs the more quickly and simply we can go through that. We also have to measure outcomes over time. We have to track what we call the sustainability of the health before there is a recurrence, before there is another problem. This is what we call the outcomes hierarchy. We have to measure across the whole hierarchy.

Here’s an example of why it’s important to measure across the whole hierarchy. This is in prostate cancer, and you can see that five years from now – which is what most cancer centres measure – it’s pretty high. It’s a slow-growing cancer. You know, thank goodness this is high. Again, this is German data because in this disease there happens to be very good German data.

“Rather than viewing every patient as one-off, what if we tried to think about the major segments of patients we had and organise ourselves internally as a GP practice around meeting those segments?”

You can see that the average hospital and the best hospital in Germany look virtually identical in terms of five years’ survival. If we just measured mortality, we’d say, ‘wow, we’re perfect’. But actually if you think about what really matters to the patient that has prostate cancer, you quickly figure out that this is not what is going to be the big issue. You actually start to understand that there are some other things that matter that have to do with their functional situation for the rest of their life.

We’re just starting to have prostate cancer care units start to measure these things – erectile dysfunction, incontinence – and look at the difference between the best and the worst. It’s epic. So if we just stop here, we think our outcomes are good. But if we start recognising that there is a whole set of outcomes that matter to the patient, then all of a sudden we see there’s room for improvement.

So how are these guys doing it? How do we diffuse this knowledge? Let’s get our prostate cancer care folks together and figure out how to do those surgeries or other procedures in a way that raise our standards on these other outcomes that are so important – not only to the patient’s situation but also to cost. You have a patient with incontinence for the rest of his or her life, that’s expensive. So we’d better understand how to minimise the risk of that in dealing with this procedure if we’re going to deliver value. This is the kind of measurement thinking and approach that we need to follow.

On costing then, again, the basic idea is that we can’t cost the institution. The cost of the hospital is completely uninteresting. For budgeting we need to know the cost of the hospital, but for purposes of value it’s the cost of providing care for the patient’s condition. That has to do with the care cycle for that condition, the services that are necessary, the people and resources and facilities involved in those services, and then adding that up over the whole care cycle.

In terms of the current costing methods in the field, there’s some progress here in the UK, there’s some movement towards patient-level costing, but we have a long way to go. But now there is excellent methodology for really truly understanding patient-level cost by condition, and we in our group at HBS have probably 30 or 40 major projects going on with leading delivery organisations all around the world on activity-based costing. The tools are here – we just have to get on with it.

Everybody in this room can do this. Everybody in this room can do this. Accurate costing starts with mapping your processes, understanding who is involved, understanding how much it costs to have that person involved per minute or per day in the care process, and then ultimately figuring out, based on that insight into what it actually costs, how we can actually reduce the cost.

What we’re learning about cost in healthcare is that if you think about cost reduction as across the board price cuts, ‘let’s just squeeze down on everything’, that’s really dumb. But if you think
strategically about how we can restructure and streamline our care delivery process, what we’re finding is that cost reduction opportunities in healthcare over and over again are 25, 30, 35, 40 per cent.

So getting to your £30 billion isn’t actually crazy. You can do that, but you can’t do that by just squeezing everything a little bit. You’ve got to do it by actually getting in and thinking about how this is being done and making sure it is being done efficiently and effectively. This slide just gives you some of the big opportunities that we see when we actually get into this work.

Every one of you can do this. Every one of you can start looking differently at your cost, figuring out what things you’re doing that actually don’t add value, that don’t actually contribute to the patient – areas where you’re not utilising your staff, not utilising your facilities, doing a service in a very expensive place that you could do in a much simpler place. These are the opportunities. They’re huge. We just have to get on with them. We don’t have to wait for a NHS reorganisation. In whatever unit we’re in, we can start.

Bundle reimbursement, I’ve already covered the key concept which is that we’ve got to align the payment with the value creation unit. There are some interesting pilots underway here in the UK around bundles for depression and anxiety care and bundles for frail elderly people. We should see bundles around orthopaedic problems, and orthopaedic solutions and surgeries.

Here’s a bundle – a real-life bundle in Stockholm County that’s going on today. There are thousands of patients that have been cared for under this bundle pricing in total joint replacement, and you can see that it covers pretty much everything involved in the process: both outpatient and inpatient tests, devices, drugs, and rehab. It does not yet include outpatient rehabilitation, but that’s coming soon. That was a little more complicated. They didn’t try to do that in the first round but now they’re adding it as they refine this process.

You see that a good bundle pricing structure has care guarantees. The idea here is that we’re going to pay you a certain amount of money – in this case
No provider has the right to provide any service. You only have the right to provide a service if you can deliver value in providing that service.

$8,000 USD or £4,800 GBP – and you’re responsible for this whole care process. You figure out how to use the money, and then if you can save money, then you get to keep it. But you also have to report your outcomes so we want to make sure that you’re delivering good outcomes for that money. You’re going to provide a care guarantee so if there’s a revision to that surgery within two years, you’re going to do that. That’s part of the guarantee that you did it right. If there is an infection that’s related directly to that surgery or that joint, then you’re responsible for managing that infection.

OK, that’s a kind of operational, successful bundle pricing structure. It aligns everybody’s interests. It aligns the patient interest. The patient knows they’re going to get somebody that’s going to worry about their whole care cycle and make sure that they get a good outcome, and make sure that they don’t have any of these complications that should be avoided. Everybody’s incentives are aligned.

Of course if the provider can do a better job and use its operating rooms more efficiently and minimise the need for lab tests that don’t really provide additional information, then it gets to reinvest all that in the other things that it wants to do. That’s the kind of payment model we have to move to. It’s not easy, but we can start.

Notice they didn’t take on complex patients. They just picked patients with ASA scores one and two. All the really complicated patients got treated in the normal kind of fee for service type environment that they had in Sweden. But for great majority of patients that were relatively healthy and didn’t necessarily need to be in an academic medical centre with all the complexities and cost of that situation were treated with this bundle mechanism. The outcomes improved because, again, everybody was focused on those outcomes and the interests were aligned.

The point I want to make here is that the concepts of value almost everybody in this room already understands. They’re very basic. When I talk to you here in the UK – and I’ve now been doing this for three years and I’ve met hundreds of people, and I’ve met hundreds of people in Boston talking about this, very sophisticated, very thoughtful people about these ideas and as I say some of our case studies that we teach about value-based outcome delivery are UK cases – there’s nothing about the UK, nothing about the water or the rain in the UK that prevents any of this. There are real-life examples.

We as a society and we as a leadership group in this healthcare system need to help our patients understand they need to travel rather than have this political game where we say: ‘it’s OK, of course your local hospital should provide every service’.

I think our real challenge right now is just to get unstuck and start doing things, and not to strive for perfection. Find those areas within the hospital or those areas in the GP practice, or those areas in a given region where we can start moving in this direction and changing things and doing things. Let’s not think of ownership and restructuring, let’s think of affiliations and partnerships and collaborations. Let’s think about taking the simple and obvious opportunities and doing them first and not thinking that we have to make a wholesale reorganisation.

The UK tends to be a very top-down place in my experience. This is certainly true of economic development in my other field that I’ve worked extensively in here. Ironically, in this single payer system, the transformation really needs to be bottom-up. Institution by institution, hospital by hospital, GP practice by GP practice, and I think we – many of you here are providers – providers need to lead.

Providers need to be proposing these ideas. Providers need to be trying experiments. Providers need to be knocking on the door of the commissioning organisation and saying: I’ve got an idea about how we could deal with our total joint patients. I’ve got an idea about how we could deal with our migraine patients. I’ve got an idea of how we could create an integrated way of dealing with our diabetes patients. Let’s start bubbling up ideas. Let’s start doing things. Let’s not wait for the next government to give us the answer. There is no answer in that sense.

This is fundamentally about an agenda. It’s about a journey. It’s about moving forward. It’s about learning how to do this. If there’s one thing we could mandate for anybody in government here it would be that, within three years or five years, we will measure outcomes for everything. And if we can’t do it perfectly in three years, we’ll do it imperfectly. But we’re going to measure outcomes for everything. What I find is in this field is that if you actually know the outcomes, then that creates lots of possibilities for lots of other changes. Everybody in healthcare cares about outcomes, and it becomes the great unsticker in contemplating change. You’ve seen that from your own experience.

Look what happened in the Greater London stroke case. When we got away from every hospital having to provide every service, hundreds of people lived that would’ve died. It was all done much more efficiently. The sky didn’t fall, and clinicians ended up working in the HASUs but they also worked in their traditional setting, and they collaborated and it became part of an integrated process.
The cost of the hospital is completely uninteresting. For budgeting we need to know the cost of the hospital, but for purposes of value it’s the cost of providing care for the patient’s condition. That has to do with the care cycle for that condition, the services that are necessary, the people and resources and facilities involved in those services, and then adding that up over the whole care cycle.

I would swear to you that all the people involved in that experiment are happier for having done that, even though your first instinct is: ‘oh my hospital should have a stroke centre, OK?’ So let’s get started. Let’s not seek perfection. Let’s view it as a journey. This country has the foundational conditions to lead the world in value-based delivery. We have a much harder problem in the US to do this because of our structure.

So given the horsepower sitting in this room, if we set out to do this and we’re as bottom-up as we can possibly be, I’m very confident that you can get this done. I’ve got a bet with Dr Emma Stanton that the UK is going to make it on value. Don’t make me lose my bet. Thank you.”

Q&A session

Andrew Haldenby: “Michael thank you, looking at the twitter coverage there are two key questions marks that have been raised. I’m just going to read them out. Here is one from, you don’t mind me saying, Mike Hobday criticising your words on the value of experience vs outcomes. He tweets: ‘Michael Porter is wrong about this. Compassionate, supportive, enabling care is an outcome.’ The second key challenge, I think, was on the idea of patients with multiple conditions.”

Michael Porter: “Let me talk quickly about that. I just want to say again so everybody hears it: we should measure patient experience. Let’s all say it together. We should measure patient experience. I didn’t say that we shouldn’t. What I’m saying is that that is not enough. We actually have to see how the patient experience hopefully improves our outcomes and how, if we improve the patient experience we can actually hopefully improve the other, and what dimension of the patient experience has the greatest impact on the outcomes.

Maybe that’s the educational part or maybe it’s the group activity where we can get patients with a similar problem together and they can experience the disease with peers. But again, this is not a religious thing for me. I just believe that we have to think about the ultimate results that matter to the patient and that we can’t be satisfied [or think] that if they would recommend us again, that means we’re perfect and we’re done and we don’t have to think any further about how to improve our care. Patients are very forgiving. They want to believe. They want to have a good experience. So I think we have to go ‘what’s the proof?’

If we stay at patient experience at a high level, if we do the Friends and Family Test, if we ask people did you like your doctor, then I think we clearly are talking about something different than outcomes. But when we start to think about how long did it take to go through this care process, when we start thinking about ‘was the pain that you experienced during the care process, was that really unpleasant and debilitating?’, when we start asking patients ‘what is your functional status and are you back to normal?’; those then become outcomes.

And there is a big movement now, which most of you are, I’m sure, fully aware of, about patient reported outcomes – PROMs. Every excellent clinical care organisation now is thinking about how to get the patients’ input on how they’re doing against critical outcomes – particularly those functional outcomes and those discomfort type outcomes that are so critical.

So I think my view is I think it’s good that we’ve gone through the patient experience surveying process, gotten the infrastructure so that we’re doing that. But now let’s build on that and take that more concretely into the specific outcomes by the condition that that patient is being treated for. Let’s not give every patient the same patient experience survey. Let’s have orthopaedic patients get one survey and cancer patients get another.

Then I think we can build a synthesis of these perspectives.

In terms of the complex patients with multiple needs, we get it. We need a primary care GP system. This is not about organising life around medical conditions or disease areas. It’s about that because that is how we get really good at dealing with prostate cancer. We get really good at dealing with migraine, and we get really good at dealing with multiple sclerosis.

But patients can have multiple problems. So they may have cancer, but they also may have diabetes. Or they’ll have an orthopaedic problem but they’ll have MS. So what do we do there? Well, in some cases where the medical problem is so severe and so complex we find that you actually need to put the primary co-ordinating care right in the integrated practice unit for that complex disease.

In cystic fibrosis, for example, a lot of primary care is actually provided in the cystic fibrosis units because it’s so unique to that disease that the GP practice is not going to potentially get involved in that. But in most cases what we want the GP to be is the co-ordinator. We want the cancer problem to be dealt
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If you think strategically about how we can restructure and streamline our care delivery process, what we’re finding is that cost reduction opportunities in healthcare over and over again are 25, 30, 35, 40 per cent.

with by a cancer expert organisation. We want the orthopaedic problem to be dealt with by the orthopaedic IPU.

We actually believe that if we organise care for each of the problems the patient has in the way that I’ve described, then it gets much more easy to co-ordinate across the units and across the disease than if we have the yellow bubble chart with 70 bubbles, rather than four or five which I had for the migraine case, and there is a poor harried GP that is trying to run around a keep everything from not falling apart.

I believe that this integrated practice unit concept, combined with properly organised GP structure will lead to much easier co-ordination of complex patients than the status quo. This question comes up a lot. What I find is that people in healthcare get really paralysed by the exceptional case. If we can think of an exceptional case, we say the whole thing doesn’t make sense.

What we learn in most organisational settings is that we organise around the rule and then we deal with the exception as an exception. So let’s figure out what most every diabetic patient needs, or most of them need, including the co-occurrences that many of them have — let’s organise around that. Once in a while we’ll have a diabetic with cancer. So if that happens, then let’s take that unusual case and let’s find a co-ordinating mechanism to deal with that — rather than this yellow bubble model where every case is exceptional and every patient is treated as a one-off circumstance.

I think that’s a trap, and it’s a trap that comes from compassionate thinking and understanding of the reality of care delivery - I am not a clinician but I’m heading pretty steep in this, given how many provider organisations I’ve worked with —, but it’s still a trap. We’ve got to try to organise what we can organise, and deal with the things that are very idiosyncratic on top. I guarantee you that at the end of the day, everybody is going to be happier. The patients are going to be happier and the clinicians are going to be happier doing it that way.

On this ‘convincing the public’ point I think that’s a very important point. It’s a particularly important point in the political environment that at least I as an outsider observer in this country where we have these headlines and everything is so current and in-your-face in terms of the political dialogue and the political debate.

I think the public in general is pretty clueless about the tremendous variation in care, the different kinds of care experiences that they can get if they get care in different locations. I think part of moving to value-based healthcare is to get our patients to understand what they should demand and what they should expect. If I were a patient, I would demand to be treated by an IPU. I don’t want to go to one person and be a ping-pong ball. I want to go to one place where they can provide multiple services at the same time by a team.

So I want to be treated by a team. I want to have somebody clearly in charge, I want a place where they can demonstrate good outcomes and (demonstrate) that they have dealt with my problem many times before. Here is how they do it: There is kind of a set of patient rights here that go way beyond our traditional thinking of what patients should be asking for and demanding, and let’s teach the patients those rights. Then I think they will become a force to encourage restructuring around value rather than a retarding force.

I told a story last night at dinner I’ll tell all of you, and that is about the Cleveland Clinic. I have been working very closely with the leadership team of the Cleveland Clinic now for eight or nine years. The Cleveland Clinic is a multi-hospital system. It has a mother church which is the main downtown Cleveland Clinic, but it also has eight community hospitals surrounding it in the greater Cleveland northern Ohio area.

One of those eight hospitals was located just about two miles away from the mother church of the Cleveland Clinic. Of course, in the mother church, the most sacred part of that mother church is cardiac care and heart surgery. The modern versions of heart surgery, many of them were pioneered and really developed at the Cleveland Clinic. This hospital two miles away from the mother church did cardiac surgery. And by the way, it didn’t do it very well.

Every one of you can start looking differently at your cost, figuring out what things you’re doing that actually don’t add value, that don’t actually contribute to the patient — areas where you’re not utilising your staff, not utilising your facilities, doing a service in a very expensive place that you could do in a much simpler place.

The Cleveland Clinic said ‘OK, I’ve got a deal for the community. We’ll make this hospital which is old, sub-scale, obsolete, we’ll make that into a brand new outpatient unit and it will be designed to provide outpatient care for the conditions that are prevalent in this community – asthma and things like that. If somebody in this community needs to have heart surgery, come to the mother
church.’ It sounds like a great deal. Community picketing, opposition, political debate, for months and months and months and months.

OK, so this the level at which we have to get our communities and our public understanding what they should expect and what they should demand. We’re still living in a world where there was much less medical technology, there was much less to know, there were fewer treatments available. Pretty much you went to the hospital. There wasn’t much that happened in the hospital. You just stayed in the hospital for week after week. In that old world, having a hospital in the neighbourhood so people come visit you every day for three or four weeks made a lot of sense. The team there would know enough to be able to do pretty much what you needed. But in this modern world you’re having these massively complex procedures, you have to do hundreds and hundreds of cases to get good at them – we know that in many kinds of surgery. You need a deep team to provide all the supporting services to get a really good outcome. In that world going to your closest local hospital for every service is just not right.

I think part of our challenge here – and we have this challenge in America and this challenge exists everywhere in the world – is to get people to stop clinging to a historical structure that may have made sense at one point in time but is long since obsolete. So I think this notion of reaching out to the patient communities really needs to be part of the agenda of all the organisations represented in this room.

If I were a commissioning group, I would be doing consumer marketing, not just working behind the scenes inside the system. It’s a really big issue, and I think our politicians need to start explaining what excellent care looks like and encouraging people to travel rather than pandering to the few people that really think that they should get everything they need next door. That is what political leadership is all about. I think we had some political leaders involved in the discussions I’ve had here over the last day or two. I think it’s changing. I’m very optimistic.

I think on the workforce, that is an excellent comment. I think that the training in healthcare workforces is very siloed. Therefore, it’s just one other barrier to people thinking across their silo. That’s true with clinicians who tend to get trained in their field. But it’s not just the siloing around the expertise especially. It’s also the fact that what we know is that to deliver care is partly about your medical knowledge or your clinical expertise, but it’s also partly about teams. It’s about organisations. It’s about processes and understanding the processes you’re using. It’s about measurement.

These are things that I think we do need to introduce into the workforce development process in this field. I think the young people that we encounter are very excited about this, and they get this. They want to be part of high value delivery units. They want to work collaboratively with other clinicians to deliver care. So I don’t think we’re going to face resistance, but people have to be opened up to this perspective.

There was a discussion about rural areas. This often comes up when we talk about value-based healthcare. I think that we have to face the reality that a rural hospital shouldn’t try to care for everything, and it’s cheaper to put the patient in a helicopter. It literally is. There are many studies. It’s cheaper to put that patient in a helicopter. So I think we’re learning that transport is really critical to healthcare strategy and making transport easy and letting you go with your parent or with your friend if you need to go to the city for three or four days to get the technical care done.

The rural areas, the local areas should be first of all dealing with the things that they are very well equipped to deal with, but then they also need to be centres for referral and affiliation to
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getting you to the place you need to go. That is a very honourable and important role in the system.

Taking on a patient that they really can’t take on and handle because they don’t have the tools and expertise is not doing anybody any good. So we have to rethink. Once again we’re stuck with ‘you should get all the care near your home’, and that idea may have been fine 50 years ago with the technology available. But today I think we have to start breaking down the notion of what the roles of these various entities are in the system, and I think we’ve had a good discussion.

We should measure patient experience. I didn’t say that we shouldn’t. What I’m saying is that that is not enough. We actually have to see how the patient experience hopefully improves our outcomes.

In terms of competition: notice I didn’t bring it up in my talk. I’ve learned it’s a difficult subject in this country. Rather than talk about competition and use that word, I would rather use the word choice. I think that patients need to have a choice. And it’s a principle in the UK, in the NHS, that patients should have a choice. With their GP’s advice, who is fundamental to helping patients understand what is in their best interests, patients ought to have a choice. That requires competition. That requires that there is more than one or two places that you can go.

We found in competition theory in looking at normal industries we don’t need a hundred players to have competition. If we have two or three or four entities that can provide a given kind of service – and some of those may be far away and some of those may be nearby – that is plenty to create adequate choice. But choice is not meaningful unless you have information with which you can choose. That is again where this notion of actually measuring outcomes and making them transparent becomes very, very fundamental. So, again, competition is not good for its own sake. What competition does is it allows choice.

Another thing I would say in the UK is that we tend to think of competition more around the contracting part or the commissioning part. But I think where we really need to think about competition is in having a choice for the patient. So, in commissioning, I think part of our job is not to just have competitive tenders, but also to ensure through our commissioning that we have a number of good alternatives to give that patient choice.

I am very, very excited about what these gentlemen said. I think this is big progress. I’ve known Malcolm before and I think we’re moving. The discussion we had two years ago and what he just said: wow. So there is no reason why we can’t do all this stuff in the UK. I think your point was very true and I just want to end on that, and that is let’s get started. Let’s do more experiments. Let’s try this stuff. Let’s not try to take on the hardest case first. Let’s take on the things that are kind of no-brainers. Let’s get moving. Let’s get some momentum. I think this will feed on itself.

One of the things about value-based thinking is that because it has these multiple dimensions, and because they are mutually interdependent, getting started is hard. There is a lot of inertia. You get stuck. You can’t move because pulling one string causes resistance in all of these different areas. But once you get started, once you get rolling, the good news about this value framework is it gets easier over time. It doesn’t get harder. It gets easier once you start down the path.

Last night I was talking about a rocket ship. You know, when you see those launches of rockets, the rocket sort of hangs there. It gets off the ground and it sort of hangs there. It shakes and shakes and shakes, and then it rockets into orbit. I think in the UK this rocket is off the pad. It’s hanging there. It’s starting its slow, agonising lift-off process. But I think that rocket can take off and move if we’ll just do the stuff that we’re already doing and do it more vigorously, take some risk, try some experiments and not wait for somebody to tell us what to do. Let’s just do it."