Creating change
through incentives

Improving Healthcare Effectiveness

By Phyllis Yale and Kara Murphy

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Phyllis Yale is a partner in the Healthcare Practice at Bain & Company in Boston. Kara Murphy is a manager at Bain in Boston. **The authors also wish to thank the other members of the steering committee who participated in this study:**

Bernard Crump, NHS
Tom Granatir, Humana
Tom Lee, Partners Healthcare
Jack Lord, Humana
Nancy Steele, Pfizer

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Background

Following last year's governors' discussion on healthcare systems in the developed world, a group drawn from academia, nongovernmental organizations (NGOs), public and private payers, providers, healthcare suppliers and industry experts has been working on recommendations to improve the effectiveness of care.

The group has focused on understanding the cost to the system of not delivering effective care, the barriers to delivering effective care and the role of incentives as a means of changing patient and provider behavior. Our definition of effective care expands on the one articulated in the Dartmouth Atlas Project[1] to include prevention. We define effective care as preventive actions and medical services that have proven their value with no significant trade-offs, meaning the benefits of services so outweigh the risks that all patients should receive them.

The group studied the issue of effective care through the lens of three chronic diseases—diabetes, coronary artery disease (CAD) and congestive heart failure (CHF)—in the US and UK. The work focused on incentives as a key lever to drive effective care, which remain largely untapped despite emerging best practices, even though incentives can enhance the performance of other effective care levers. We emerged from our review with the belief that aligning incentives for both consumers and providers will increase the traction of existing process-of-care improvements and can generate savings and greater value from each healthcare dollar spent.

A tremendous amount of superb research has been done on these topics. What follows is an executive briefing of that research, our synthesis and our recommendations to multiple stakeholders.

Key findings

Effective healthcare today is the exception, not the rule

Less than one-third of patients with chronic diseases in the US and UK get effective care. In the US, for example, effective care levels are 12% for diabetes, 23% for CAD and 27% for CHF. In the UK, effective care for the three diseases is similar.[2]

Ineffective care costs billions of dollars

By eliminating ineffective care, the US healthcare system could save 15% to 25% of the estimated $160 billion spent on those diseases, or $25 billion to $40 billion. The improvement in quality of life for patients would also be substantial.

Incentives can change physician behavior

A growing body of evidence demonstrates that nonfinancial incentives such as performance monitoring can lead to improvements in the quality of care:

- The New York Cardiac Surgery Report Card System—arguably the gold standard for public reporting of hospital and physician performance[3]—generated a 43% reduction in mortality;[4,5]

- Similarly, in a study of Wisconsin hospitals,[6,7] the percentage of hospitals with statistically significant improvement in performance varied depending on reporting—12% with none, 25% with private reporting and 35% with public reporting.

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Pay for Performance (P4P) programs have been widely implemented and have had mixed success. But there is promise in programs that have "critical mass" in a market and meaningful incentives:

- The UK has paved the way in P4P with a landmark program whereby up to 25% of physicians' incomes are dependent on their compliance with the Quality and Outcomes Framework. Group practices achieved 96% of total points vs. 75% predicted in the first year. The UK is seeking further improvements in next-generation research[8] to validate the program, since self-reporting and the lack of a performance baseline has made it difficult to monitor changes in behavior. But even without solid data on its success, the UK program offers lessons for US payers—highlighting the need for critical mass and meaningful incentives, as well as the potential risks in implementing such programs.

- In the US, the Centers for Medicare & Medicaid Services (CMS) has had early success with its three-year Premier demonstration project.[9] All five tracked conditions improved in the first year. For example, quality measures improved to 93%, from 90%, for patients with acute myocardial infarction, and jumped to 76%, from 64%, for patients with heart failure.

Figure 1: Blueprint for change (by stakeholder)

Providers	Employers	Government/ private payers	Regulatory/ public policy	Public health	Healthcare suppliers
• Collaborate with payers to implement P4P care in inpatient care; shared incentive to reduce tertiary overuse • Collaborate with payers to implement public reporting • Adopt proven tools and aids for engaging patients in managing chronic diseases (e.g., alphabet strategy) • Implement IT • Organize into structures that can accept P4P and have sufficient scale to adopt IT and can improve quality/ safety/efficiency	• Understand and track healthcare spending – Direct and indirect – By disease – ROI on programs – Clinical outcomes on programs – In what time frame • Integrate wellness with benefit design and institute incentives for employees and their families to: – Live healthy lives – Enroll in disease management if appropriate – Comply with therapy • Leverage broader array of incentives to drive behavior: – Financial and nonfinancial – Carrots and sticks – Group and individual • Insist your health plan participates in industrywide P4P consortium	• Government payers to take lead on common P4P scorecard – Common data elements – Shared data across payers • P4P programs should put enough dollars at risk—approximately 10% of physician income • Government payers to require providers to be "IT-enabled" within a certain time frame to earn reimbursement • Reimburse for online patient-physician consultation • Extend P4P to specialists • Eliminate per diem incentives—move to case rate reimbursement • Commit to doing what it takes to guarantee access	• Launch campaign to go after chronic disease – Big goals – Clear time frame • Government payers should fund preventive care • Fund nationwide body to be arbiter of evidence-based guidelines	• Determine how to integrate public health goals with the delivery system • Fund institute to codify incentives/ drive behavior change (existing institution or collaboration) – Evaluate full range of incentives to drive behavior – Share incentives best practices • Develop model framework for regional collaborations and enable performance of existing regional collaborations – Study and codify existing best practices – Pilots in the US and UK	• Develop tools/ product offerings for consumers to help them manage their health – Compliance, vital signs, activity • Harmonize CME with evidence-based guidelines • Fund patient incentive programs around compliance in conjunction with payers

- On the commercial side of the equation, Bridges to Excellence (BTE), a multistate, multiemployer not-for-profit coalition, found similar success with critical mass and adequate incentives. Offering incentives of $50 to $160 per patient per year, totaling more than 10% of physicians' income, saved $110 to $350 per patient.

But success in implementing physician incentives in the US will require an unprecedented level of cooperation across payers

The US needs a common P4P scorecard, with metrics and data shared across payers, since the number of patients covered by one payer is often not an adequate sample to influence physician behavior.

Given its size and influence, Medicare should take the lead in setting standards. That will require US payers to forgo using provider payment structure and mechanisms as a source of competitive advantage.

Incentives can change consumer behavior

Employers are leading the way. Company wellness programs have achieved three to five times return on investment with two- to four-year paybacks,[10] which is shorter than the six-year average employee turnover.

Cost savings are available even in countries with publicly funded healthcare systems, since 80% of total healthcare costs of employees are indirect costs, in the form of presenteeism and absenteeism.[11] Only 4% of large employers use benefit design to reinforce their wellness and prevention objectives, but the success stories are encouraging:

- Johnson & Johnson, for example, employs a combination of "carrots and sticks" in its wellness program, delivering an annual cost savings of $225 per employee in four years;[12]
- Pitney Bowes also found success by offering a comprehensive set of incentives and reducing disincentives (by reducing co-pays on certain drugs). The total costs for asthma and diabetes have declined 15% and 6%, respectively.[13] Pitney Bowes has realized an average of two to three times return on investment on its programs, with costs for "Health Care University" participants 10% lower than nonparticipants;
- International Truck and Engine Corp. has aggressively integrated wellness with benefit design, and uses a broad range of financial and nonfinancial incentives for its employees,[14] achieving approximately 10% cost savings vs. the national average.

Creating incentives in the form of sticks is controversial, and many companies are uncomfortable with the "nanny" role created. But an incentive study by the Agency for Healthcare Research and Quality showed that sticks generated impact 90% of the time, while carrots generated only 60% to 80% effectiveness.[15]

Blueprint for change

Improving healthcare effectiveness will require changes in how each stakeholder behaves, shifting where healthcare systems invest and putting the right incentives in place:

- Care of chronic disease needs to take place within and outside the traditional medical system, and a greater investment in prevention is paramount. We can't look to the medical system alone to improve chronic care—its reach is too short and

healthcare behavior change is not its core competency. A broader set of stakeholders, including schools and employers, needs to play an active role in driving effective care, particularly prevention;

- Ultimately, change needs to take place at the local level. Well-organized collaborations across traditional organizational boundaries are the key to tapping into these opportunities;

- We need to align incentives and eliminate disincentives. While the use of incentives to motivate appropriate behavior is not new, they are often too small and too confusing to work. We believe the application of best practices needs to be scaled up enormously.

Recommendations to the Governors for 2007

To help drive the actions listed in Figure 1, the working group recommends the following:

To individual Governors, acting as employers: Create change at the company level

- Ensure that you are playing a leadership role in your own global organizations to promote healthy employee behaviors.
- Understand and track healthcare spending (approximately 80% of which will be indirect costs).
- Integrate benefit design with wellness programs.
- Institute a broad range of incentives to change employee behaviors.

To Governors collectively, working through the Forum: Create change at the community level

- While guidelines and broad improvement programs are in place within healthcare organizations, the biggest obstacles to adopting effective care practices are the lack of aligned incentives and the barriers that separate the healthcare system from the places in which people live, work, eat and form habits.

- No individual public or private company alone can address the issue of health system effectiveness. Each local market, whether in the US or Europe, requires a collaborative approach across various stakeholders through public-private partnerships (PPPs).

- With the intention of better integrating healthy habits, healthcare, and incentives, the Steering Committee recommends a two-year project be initiated to increase the number of successful PPPs by leveraging local resources across employers, hospitals, physicians, government and insurers in order to improve the health of defined populations.

- This project would help develop new community PPPs and enhance the efforts of existing PPPs by studying and codifying best practices of existing local collaborations. It would identify good work done in this field, recommend a framework for organizing and engineering change in a community, offer a forum for sharing best practices, and support PPPs in those markets selected by the Governors.

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We realize that helping an organization change requires more than just a recommendation. So we try to put ourselves in our clients' shoes and focus on practical actions.

[1] Wennberg, "Effective Care," by the Dartmouth Atlas Project, 2006.

[2] Analysis from the Department of Public Health & Epidemiology and Health Services Management Centre, University of Birmingham, UK.

[3] Jha and Epstein, "The Predictive Accuracy of the New York State Coronary Artery Bypass Surgery Reporting System," *Health Affairs*, Vol.25, No. 3, May/Jun 2006: 844-855.

[4] Chassin, et al., "Achieving and Sustaining Improved Quality:L essons from New York State and Cardiac Surgery," *Health Affairs,* Vol. 21, No. 4, Jul/Aug 2002.

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[9] Milgate and Cheng, "Pay-for-Performance Under Medicare," *Health Affairs*, Mar/Apr 2006, Vol. 25, No. 1.

[10] Aldana et al., "Financial Impact of Health Promotion Programs: A Comprehensive Review of the Literature," *Am J. Health Promotion 2001:* 15(5) 296-320; Chapman, "Meta-Evaluation of Worksite Health Promotion Economic Return Studies," *Art of Health Promotion Newsletter*, Vol. 6, No. 6, Jan/Feb 2003; US Department of Health and Human Services, "Prevention Makes Cents."

[11] Partnership for Prevention, "Leading by Example: Improving the Bottom Line Through a High-Performance and Less Costly Workforce."

[12] Ozminkowski, et al., "Long-Term Impact of Johnson & Johnson's Health & Wellness Program on Health Utilization & Expenditure," *JOEM*, Vol. 44, No.1, Jan 2002.

[13] Pitney Bowes primary interview.

[14] International Truck and Engine, "Report to Wellness Councils of America 2006."

[15] AHRQ, "Economic Incentives for Preventive Care," *AHRQ*, August 2004, No. 4-E024-2.

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