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cutting through complexity

Something to teach, Something to learn

Global perspectives on healthcare

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Marc Berg, KPMG in the Netherlands

A truly global outlook

This report aims to provide a snapshot of the thinking and learning that emerged from KPMG's Global Healthcare summit held in Rome in October 2012.

It also looks at some of the main implications of that learning for those who pay for healthcare, those who provide it and those who consume it.

On the following pages we explore:

- The emergence of the 'activist payer' – the role of this new breed of healthcare commissioner in shaping system change, driving payment reform and influencing behavior.
- The dilemmas facing providers in a changing environment – to transact or transform, to grow or to evolve, hospital or health system, passive partner or active change-agent.
- Patients as partners – changing expectations, shared decision-making, health literacy, looking beyond the rhetoric to make patient power a reality.

The report concludes with a number of key recommendations for action and sets out some important next steps that we believe global healthcare systems need to be thinking about in the coming months and years.

Contents

Wai Chiong Loke, KPMG in Singapore

Dr. Kevin Smith, St. Joseph's Health System, Canada; Prof. Benjamin Ong, National University Health System, Singapore; Dr. Arthur Southam, Kaiser Permanente, US

Gary Kaplan, Virginia Mason Medical Center, US

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Introduction

We all have something to teach and something to learn. Today, healthcare systems around the world are experiencing an era of rapid and dramatic change as they struggle to cope with aging populations, technological advances, rising expectations and spiralling costs.

Practical answers to difficult questions are needed. With this in mind, KPMG's Global Healthcare practice brought 40 senior executives and clinicians, representing some of the world's largest healthcare organizations from 22 countries, together for a conference in October 2012 to share their insights, ideas and outlooks.

Despite the differences between their national systems, the delegates found striking similarities in the way that payers and providers are rethinking their strategies and developing new approaches. Overwhelmingly, participants agreed that individuals, organizations, systems and nations alike all have something to teach and something to learn.

In particular, delegates identified five major trends reshaping healthcare today:

- Payers – whether governments, public sector bodies or insurers – are becoming 'activist payers' by focusing on value, contracting more selectively, reshaping patient behavior and moving care upstream to focus more on prevention.
- Providers need to rethink their approach as it is becoming clear that major transformational change can no longer be delayed. Some hospitals have the opportunity to transform themselves into 'health systems', providing new forms of much more extensive and integrated care and taking more risk and accountability for outcomes from payers. Others need equally radical approaches to reshape their operating models.
- There is an imperative to engage patients in new ways so that they become active partners in their care, rather than passive recipients. This requires new systems and ways of working – as one physician put it, clinicians need to change their role from 'God to guide'.
- The rise of the 'high-growth health systems', from rapidly developing countries in Asia, Africa and South America, is changing global outlooks. Unencumbered by traditional healthcare doctrines, they are innovating fast. It is a global phenomenon offering extensive learning, and opportunities for all.
- Sustainable change and better value are increasingly being seen as a direct result of new approaches to integration. A survey of our delegates revealed that 90 percent of payers, providers and professionals believed integration would produce better patient outcomes, while three-quarters were confident that it would cut costs.

Our payer and provider participants (listed at the end of this publication) shared some anxieties over the long-term sustainability of their respective health systems and existing care and business models, but remained confident that these challenges could be met.

A central paradox

The report looks at the major problems facing many health systems, as well as the scope for agile organizations to exploit new models and opportunities.

It also highlights, however, a central paradox.

While nearly all of the delegates expected 'moderate or major business model change' within the next five years, there was a consensus that too many systems are still behaving as though these changes only affect other people. They are focusing on minor transactional change rather than the major transformational reform required to address future challenges.

Making the first step along a different path requires an act of courage, and committed leadership. This report is a call for such a journey of leadership.

Ultimately, leaders and their organizations must learn to focus on patient value and outcomes.

In the past, many healthcare systems have been fueled and driven by supply-induced demand rather than concentrating on outcomes – what patients really need and want. Such perverse incentives cannot provoke cultural change or the implementation of best practices.

Anne McElvoy, The Economist; Mark Rochon, KPMG in Canada; Prof. Bastiaan Bloem, Radboud University Nijmegen Medical Centre, the Netherlands

Shifting the balance from volume to value will not be easy. Change is hard, risky and painful. Providers will need support as they bear the brunt of systems' streamlining and integration.

Strong leadership will also be required to shift the focus from short-term goals to long-term ambitions. The best leaders, while not shying away from the biggest challenges, will reduce complexity. They will look beyond process targets and they will allow space for their organizations and staff to innovate and experiment on the way to creating new models of care.

We would like to thank our member firm clients, partners and practitioners who have contributed their time and shared their learning so generously.

We hope you find this publication stimulating and look forward to continuing this global debate. Do join us.

Dr. Mark Britnell
Chairman and Partner
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The emergence of the **Activist Payer**

> "Today we see **both groups** are beginning to **recognize** that the **surest** way towards long-term **viability** lies in **improving** the **value** of the care **produced**, rather than the **costs**."

There should be little doubt that the world is changing rapidly for healthcare payers, whether these are private insurers, sickness funds or, as is the case in many parts of the world, governments. Whether they are dealing with subscribers, employers, taxpayers or ministries of finance the requirement is the same – higher quality and lower cost – even in countries such as India and China that are committed to increasing their spending. In countries where people are largely paying out of pocket, policy makers will need to create mechanisms to ensure that the health sector is efficiently producing good quality. Without this there are serious risks to the ability of many systems to continue to provide the current level of coverage.

In the past, public payers played a largely administrative role, while private payers focused mainly on reducing provider prices and managing risk. However, today we see both groups are beginning to recognize that the surest way towards long-term viability lies in improving the *value* of the care produced, rather than the costs. As such, population health management and value-based purchasing are increasingly becoming a priority for public and private payers, while a focus on value means that private payers are starting to realign their business models with the goals articulated in public policy.

Essentially, payers are starting to recognize that providing better value often means ensuring that care is consistently high in quality, lower in cost, appropriate and timely. This will require both public and private payers to develop a very different approach to their operations. They will have to become, in the words of one private insurer, truly *activist*. In other words, payers will need to use their leverage to help redesign care delivery systems that have existed in the same form for more than a hundred years. This will require payers to experiment with innovative payment models to move incentives towards outcomes rather than inputs, build new alliances with consumers and policy makers to help providers reinvent themselves and focus much more on prevention. For government, this means using the full range of policy levers to improve health, change behavior and incorporate health into all policies; for example in the creation of healthy cities, dementia-friendly places, and the use of taxation to create incentives for behavior change.

Higher value can only be realized by moving care upstream

While it may now seem like a given, it has only been in the last decade that health organizations have recognized *better* care – more effective, safer, more patient-centered – is usually *less expensive* care.[1] Indeed, by preventing disease and the complications that often accompany chronic illness or unnecessary or avoidable care, we can improve the quality of life for patients and reduce the cost for payers.

Put simply, care must be moved upstream, shifting the model from one where health systems prefer to wait for conditions to become acute (and then take care of patients in high-cost medical centers) to one where the focus is on preventing these conditions from becoming acute in the first place. This includes treating patients proactively in their own environment. One aim of the

[1] Dr John Øvretveit: Does improving quality save money? The Health Foundation, 2009.

Frances Diver, Victorian Department of Health, Australia and Chris Rex, Ramsay Health Care, Australia

health system should be to mobilize, activate and support a patient's self-management in his or her own home so that he or she does not have to be admitted to an acute hospital center or nursing home, which, more often than not, triggers further deterioration of the patient's condition.

Delivery must be integrated and coordinated

When viewed within the context of many of our current, highly fragmented care ecologies, the transition towards value seems practically impossible, leading payers and providers to come to the conclusion that care must be delivered in a much more integrated and coordinated way.

"We need to move towards population-based care, following the patient. The hospital is just a very small part of the continuum of care most patients need. Organizing our care around the hospital turns the whole focus upside down," said Sir Ian Carruthers, Chief Executive, National Health Service, South of England.

Achieving this level of integration will require wholesale change that moves systems from a provider-led organization of care towards a patient-led system of care. This, in turn, implies that the efforts of primary care professionals (GPs, home care, community nurses, and physiotherapists) should be coordinated with those of the medical specialists so that they work not just together, but also with the patient, as a single team focused on a common goal.

Case Study

Chris Rex, CEO of Ramsay Health Care in Australia, articulates why some payment reform programs have not met their objectives.

He tells the story of a facility in his hospital chain which, for many years, had run a successful inpatient mental health facility within a certain region. But when policy makers introduced a new capitated payment model for integrated mental healthcare, the situation rapidly changed.

As the only inpatient provider in the region, the facility's staff started to create programs aimed at moving patients outwards into community care, reducing inpatient admissions and the overall length of stay. This, in turn, improved revenues on a per capita basis, since outpatient care was less costly than inpatient care.

However, Mr. Rex points out that: "The program was successful in that it moved an amount of care from the inpatient setting to the community but with an associated adverse outcome for the inpatient facility." This is because as care moved upstream, net income for the facility declined. And while this was clearly the desired outcome from the policy maker's perspective, it did little to encourage investment and transformation from those providers whose core business model was running inpatient facilities.

> "**Perverse incentives** abound in most **healthcare payment** systems."

There is ample evidence to show that by organizing care in this way, health systems and payers can both improve quality and reduce costs. But, to date, all signs point to the fact that most healthcare systems are still far from enacting the changes that will ultimately help them realize these benefits.

In our experience, organizations that are able to make improvements in the following areas should start to experience major benefits in terms of both health expenditure and outcomes:

- More proactive care for the elderly and people with chronic conditions, including state-of-the-art acute care for patients who have suffered from strokes, heart attacks, traumas or other acute events
- High-level elective care that pays significantly more attention to a patients' preference for non-surgical alternatives[2]
- Top-level care for cancer (from prevention and early detection through to evidence-based treatment)
- Integrated and personal maternity care that is not overly-interventionist

While the evidence in support of this transition may be clear, actually delivering it is more easily said than done. Indeed, the current state of affairs within most health systems seems to show that while these insights are not new, actual progress has been slow. Yet there is one tool in the payers' hands that could quickly catalyze change and create the necessary conditions for change to occur – that tool is payment reform.

Payment reform is key

The reality is that, in most countries, current payment systems work directly *against* the delivery of integrated care. Existing payment systems tend to pay for care activities within organizations rather than rewarding the efforts to integrate care *across* them. Similarly, instead of paying for outcomes or integrated care paths, payment systems usually pay for individual activities and other input characteristics (such as beds used or the presence of professionals). Yet most now accept that this approach actually stimulates high volumes of these activities and input characteristics, whether or not they add value to the system or the patient. Few markets struggle with this challenge more than the US.

"In the US, the payment system is hostile to any meaningful change," Arthur Southam, Executive Vice President, Health Plan Operations, Kaiser Permanente, comments. "Virginia Mason almost faced bankruptcy by becoming very efficient and lean and preventing readmissions – it kills you financially. In the current system, you cannot expect high value care to arise. At Kaiser, we're able to do the right thing largely because we're not paid by the piece but by the package."

Addressing perverse incentives

These same perverse incentives abound in most healthcare payment systems.[3] Even those that have replaced their 'pay per piece' system with a 'pay per admission' or 'per elective intervention' system seem to suffer from a clear supply-induced demand effect. Similarly, the option to pay overall budgets achieves little more, particularly when

[2] Mulley et al. 2012.
[3] Contracting Value: Shifting Paradigms – KPMG International, 2012.

the system draws borders between organizations whose services should be more integrated.

It is clear, therefore, that payment reform – where perverse incentives become more aligned by encouraging the delivery of high-quality, appropriate care – is a necessary condition for health system transformation.

But it is not a sufficient condition. Indeed, unless more is done to address the perverse incentives ubiquitous to our payment systems, any calls for leadership, cultural change or implementation of best practices will ultimately fail.

Looking around the world, it becomes clear that there are several innovative contracting models available to respond to these challenges. So while population-based and episode-based models each have their place (depending on the type of care that is being paid for), there is a clear move towards establishing a more ideal model.[4]

How to get there, however, will vary depending on the characteristics of each system. And while different histories, regulations, needs and payment systems will all require different approaches, one thing seems certain: success can only be achieved by moving away from paying for inputs, and moving towards paying for outcomes,or value delivered.

From passive payers to activist change-agents

For this type and scale of change to happen, payers themselves will have to become actively involved. As Brian Ruff, General Manager from Discovery Health South Africa argues, "Payers have to reverse down their supply chains". Moreover, they must become actively involved in the required reorganization of delivery patterns and organizational structures, so that higher quality care will be delivered at lower cost.

The reasons for this far outweigh simple altruism. According to Mr. Ruff, "It is plain business sense that this expands and sustains markets for us and so ultimately is the best way to improve the bottom line."

Among other things, Discovery Health has rolled out a coordinating program for members with multi-morbidity and frailty by commissioning and funding new multidisciplinary teams of rehabilitation professionals. It is now piloting dementia services with willing collaborators in South Africa, thus beginning to fill a need which was not previously met, and is actively searching for other opportunities to stimulate providers to add value. Discovery Health is currently researching the financial feasibility of privately provided, midwife-driven maternity services for their lower income members.

Prof. Benjamin Ong, National University Health System, Singapore; Dr. Masami Sakoi, Ministry of Health, Labor and Welfare, Japan; Wah Yeow Tan, KPMG in Singapore

[4] Contracting Value: Shifting Paradigms – KPMG International, 2012.

> "It makes no sense paying for a **perfect hip replacement** if the patient would have been **better** not getting the **operation** in the first place."

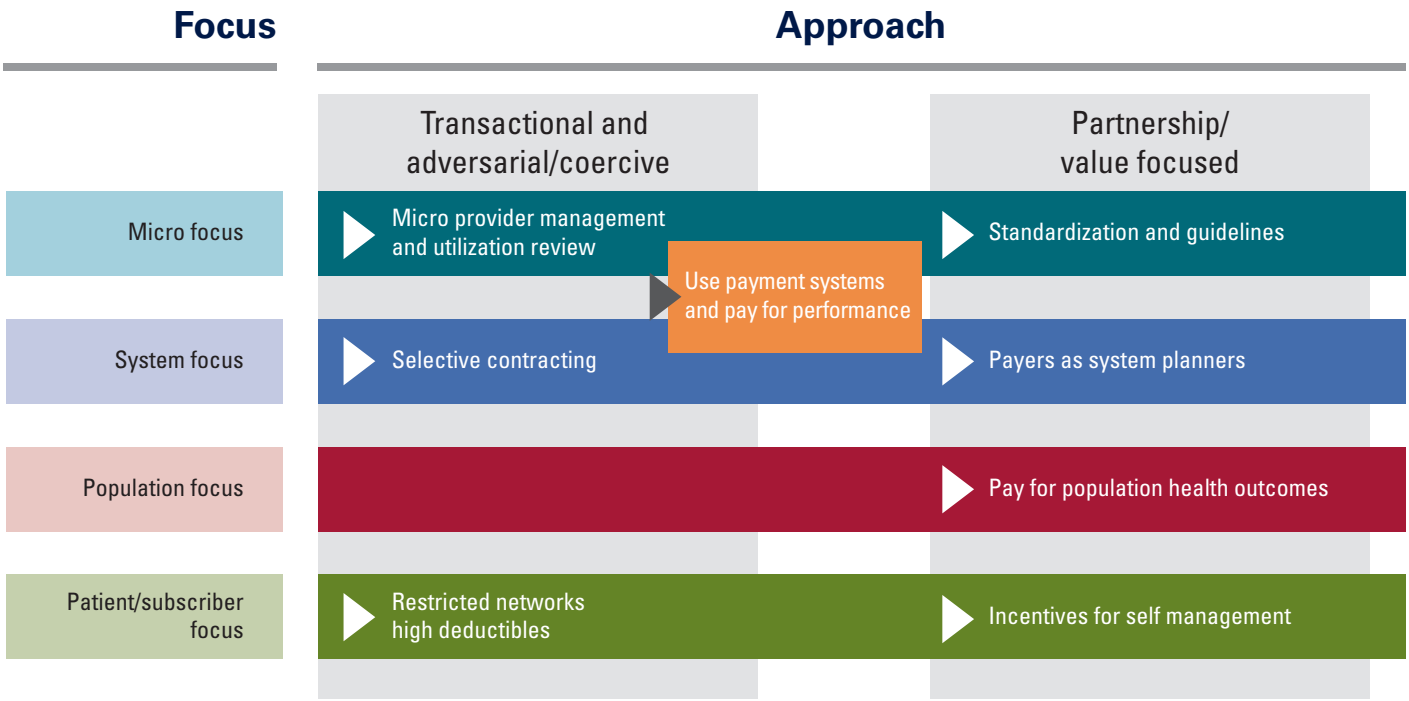
Similar developments are taking place in the US. Ron Williams, former Chairman and CEO of Aetna Inc. notes: "The payer no longer sits back, just paying bills. [They are] involved in continuous quality improvement now, helping providers improve, and in researching best practices. They're more and more interested in improving outcomes and the care itself."

Similar views can be found around the world. In the Netherlands, for example, activism has been around for a number of years. As Pieter Hasekamp, CEO of Zorgverzekeraars Nederland (ZN), the Netherlands' Association of Healthcare Insurers explains: "The activist role of the insurer was at the heart of the system reform in 2006. That was the core idea: insurers would be incentivized to selectively contract high-quality care and reduce costs, working with providers on how to reach this goal."

The story is the same for public payers. In the UK, where the National Health Service (NHS) has set financial targets, the newly formed Clinical Commissioning Groups will be expected to procure better care for less. Many are starting to recognize that the only way to achieve this is by transforming how care is being delivered.

"We know that we can [improve care], on a smaller scale: we have pushed down waiting times and reduced venous thromboembolisms, all through smart pressure and incentives from public payer(s) to providers," explains Sir Bruce Keogh, Medical Director of the NHS Commissioning Board. Sir Ian Carruthers of the NHS adds: "We know that we now have to do it on a larger scale…yet we do not yet know how – although the Clinical Commissioning Groups will have a vital role to play."

Figure 1: The range of options for payers



Source: KPMG International, 2013.

Ed Giniat, KPMG in the US, in conversation with Ron Williams, Former Chair & CEO of Aetna Inc. and member of President Obama's Management Advisory Board in the US

Leading strategies from 'activist payers'

By examining the approach taken by some of the more 'activist payers', we learn that the transactional strategies that have characterized this sector in the past will no longer suffice. More transformational approaches will be needed. The strategic choices for payers relate to how they want to approach the problem. Do they want to adopt a transactional approach which will often put them in an adversarial position in relation to providers and subscribers? At the other end of the continuum is a more partnership-based model focusing on value. There is also the question of where to focus. Payers can focus on the details of care delivery, on the system, on changing patient behavior and/or on populations. Below, we have set out how some of these strategies are being turned into action by payers in different systems.

Controlling the detail of utilization and activity

Techniques such as pre-authorization, strict treatment criteria and physician profiling (to target variation) are generally well understood. But they can also be expensive to operate and unpopular with providers and patients as they focus on individual episodes rather than value for the patient. This not only fragments care, but also steers dangerously close to micromanagement where payers take on risks and responsibilities that should sit with providers.

Setting standards and treatment guidelines

The use of evidence-based guidelines linked to payment mechanisms (such as pay for performance) also creates certain challenges by taking the payer into clinical territory. As a result, some of the risks that might be – in some systems – held by providers, instead rest with the payer. Even with the capacity that most of the major payers enjoy, scope for change is often limited. There is an issue about how many different approaches providers can manage and the costs associated with this. This suggests that more collaboration will be needed among payers to either agree on standards or use those set by national bodies.

Case Study

FierceHealthcare, a respected daily healthcare newsletter, reports that starting this year, hospitals can get more money from United Healthcare (an operating division of UnitedHealth Group, the largest single health carrier in the US) if they take action to reduce early deliveries without medical cause, as well as demonstrate lower C-section rates. Similarly, health insurer Aetna has adjusted prices for C-section surgeries and renegotiated maternity payments for 10 hospitals to cover the rising healthcare costs and risks associated with the procedure. Hospitals also are seeing no reimbursements at all for elective early deliveries from certain insurers, including South Carolina Medicaid program and BlueCross BlueShield of South Carolina.

"Payers are getting much better at using **payment mechanisms**, **incentives** and **contractual mechanisms** to change provider behavior."

Influencing the patient's behavior and choices

There are several approaches that attempt to change patient behavior by directly altering or restricting patient choices. For example, by restricting networks to only include providers that deliver better value (increased cost-effectiveness and/or quality) or use incentives – such as lower premiums or deductibles. This encourages subscribers to accept a choice of fewer providers and many insurers have found that they can increase their negotiating power and reduce the use of high cost providers. For their part, payers are also striving to influence patient behavior. Some, for example, are providing patients with advance information on provider costs and quality or on the effectiveness of treatment options. Others are encouraging patients to access lower cost services (such as going to primary care rather than the hospital) through co-payments and other incentives.

Prevention

While there are some experiments where payers incentivize subscribers to adopt preventative health behaviors, some payers have found that an investment in prevention may not pay back, largely because subscribers often shift to other plans and new patients, who have not been in preventative programs, replace them. To overcome this, a few payers are now working with employers to provide services that go beyond conventional insurance policies by managing health and offering a range of preventative and behavioral health management solutions. This can be linked to incentives such as lower deductibles, premiums, or other benefits.

Using payment mechanisms to change provider behavior

Generally speaking, payers are getting much better at using payment mechanisms, incentives and contractual mechanisms to change provider behavior. There is a clear benefit to creating more bundled payments and following the patient over longer periods of time (including recovery, in elective care and for a whole year in chronic care). There is also an advantage to integrating doctors' costs in these bundled payments. Likewise for primary care, including basic home care for the frail elderly, and fully capacitated payment models (paying a fixed fee per patient in the population per year).

Yet these tools may have started to reach the limit of their usefulness as

Case Study

Safeway Stores (a large pharmaceutical chain in the US), Unite Here Health (a health benefits trust in the US), and the employee health plans of some states and cities (including California, Massachusetts, Minnesota and the city of Los Angeles) all use patient communications and strong patient incentives to move market share to higher-value providers.

Harvard Pilgrim, a full service health benefits company, is launching an online software application this year called Now iKnow, which ranks doctors and hospitals based on cost and quality. The online app will give members options, including cost estimates for a procedure and the amount already spent toward their deductibles that are specifically based on their health plan. Meanwhile, Blue Cross (a health insurance organization based in the US) is rolling out a new cost estimator tool called Find a Doctor to help its members find providers and compare out-of-pocket expenses for more than 100 medical services. It is also preparing a 'very plain English version' of its explanation of the benefits form.

Source: New England Journal of Medicine, 2013; 368:1-3.

Delegates include: Glenna Raymond, Ontario Shores Centre for Mental Health Sciences, Canada; Lisbeth Norman, KPMG in Norway; Unni Hembre, European Federation of Nurses Associations, Belgium; Sir Jonathan Michael, Oxford University Hospitals NHS Trust, UK; Sir Bruce Keogh, NHS Commissioning Board; Sir Robert Naylor, University College London, Hospitals NHS Foundation Trust, UK

long as we do not incorporate the *outcomes* that these care activities deliver. Importantly, this includes the *appropriateness* of the care: it makes no sense paying for a perfect hip replacement if the patient would have been better off not getting the operation in the first place.

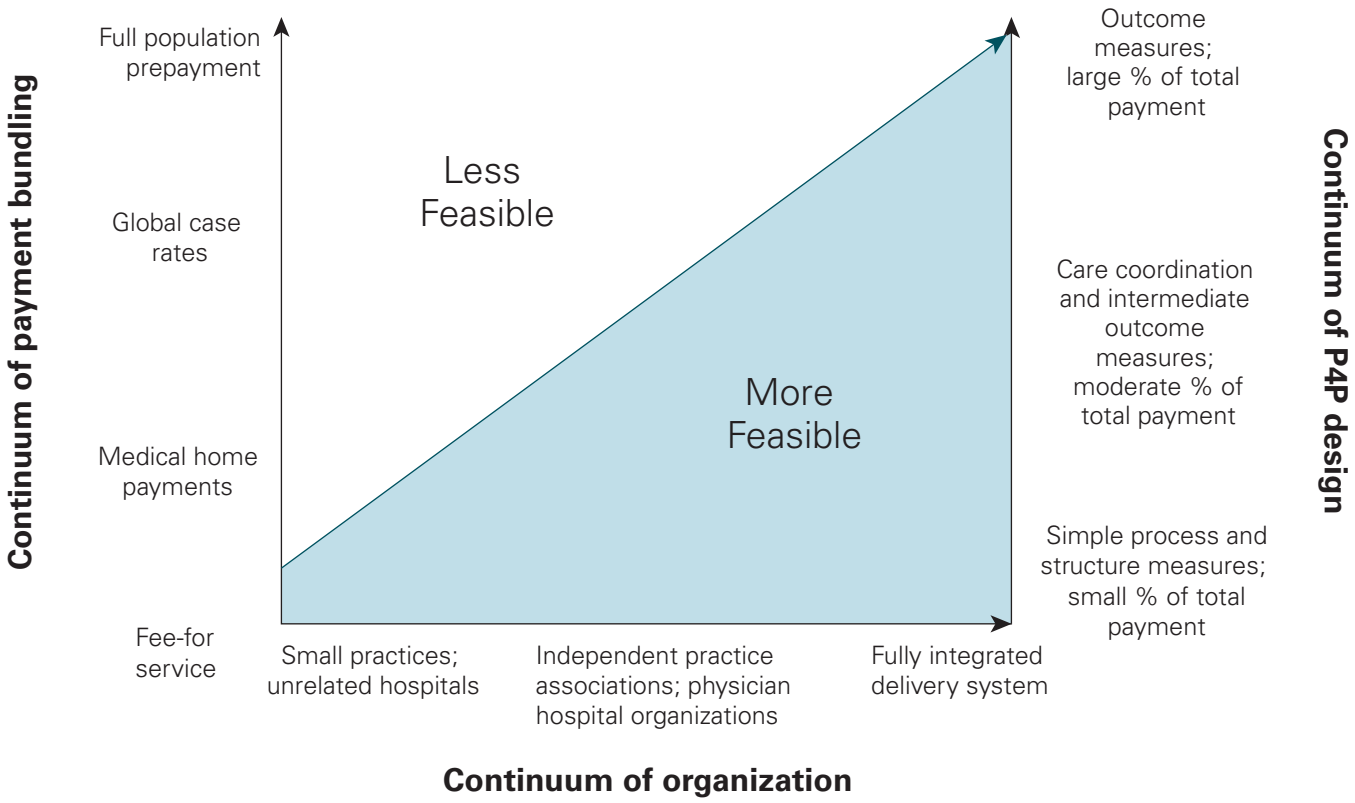
For some payers, this means stopping any mechanism that pays for volume, and shifting wholesale to full population management – an idea that lies at the root of many of the Accountable Care Organization initiatives in the US. For others, however, that shifts too much of the insurance risk to providers, and just recreates clunky, old regional budgets for single provider systems – with all the problems they entail. Whichever path is taken, providers will have to increasingly take responsibility for a population or an identifiable group of patients and take some of the risk through capitation payments or models where one provider becomes the coordinator of the patient pathway. In all these scenarios, the *outcome* of care is what the providers must sign up for. The range of options for payment models and the implications for the shape of the providers is illustrated in the framework below in an analysis of the US market by the Commonwealth Fund.

Case Study

Discovery Health South Africa's *Vitality* program is designed to incentivize members to be more committed to wellness by earning points for exercising, eating healthy foods and hitting physiological targets. This is done through a unique system based on the science of behavioral economics wherein members are provided with a range of immediate incentives similar to a consumer loyalty program.

The more points earned, the steeper the discounts in accessing the rewards, with the top of the points range often being free. These are typically lifestyle promotions such as deals on flights, hotels, car hire as well as discounts in many stores. Wellness promoting behavior is also made easy because the size of the member base allows *Vitality* to negotiate discounted access to gyms and retail food outlets as well as a wide range of health promoting partners. *Vitality* goes much further than similar schemes in richer countries; currently the scheme is paying for itself.

Figure 2: Options for organizations in the US



Source: The Commonwealth Fund, 2008.

> "We're learning that a partnership – with **sharp edges** where necessary – is the **best model**."

The payer as market manager

Payers are starting to use selective contracting techniques to influence the shape of the provider system. In the Netherlands and the UK, for example, payers are using standards set by professional bodies to refuse to contract with small volume providers and require the centralization of specialist services. In the US, Starbucks is moving key parts of its care for employees on the west coast to Virginia Mason and patients are flown to Seattle for some cardiac and back surgeries. In some cases payers are acting as the strategic planners for areas in which they operate. This is well established in the UK, Scandinavia, Italy and other systems with strong regional or national authorities. In the Netherlands there have been successful examples of insurance companies acting in this way to reshape the system.

Blurring the payer/provider divide

There are several cases where a perceived market failure has forced payers to also take on a provider role. So while the payer/provider split may be a neat concept to policy analysts, reality has shown that the concept is becoming increasingly blurred, particularly in cases where payers are filling a gap in the market or using new providers to disrupt some of the current patterns of service delivery. For example, one Dutch insurance company set up integrated primary care practices in areas where general practitioners wanted to participate, leading to proven

cost reductions through better referral and prescribing habits. There are some similar small experiments with this in South Africa. In the US, Optum Health Solutions works with employers to reduce costs through better care management, prevention and psychological support to their insurees.

A partnership with a healthy tension

Payers may be wondering *how* they might become more activist in their current environment. Clearly, neither an overly confrontational attitude of "I'm going to transform you", nor an approach that simply appeals to a sense of social responsibility to encourage cooperation will work. There is simply too much at stake.

This does not, however, mean that providers and payers cannot create a model for partnership that recognizes the functional and healthy tension between the two parties. Much like many supplier relationships found in industry, partnerships are a logical model that allows providers and payers to rally around a common goal of providing first-class services to their mutual clients.

Data sharing

In many countries, insurance companies and providers have taken a strong first step towards this goal by sharing their data. In many cases, professionals and providers are simply unaware of the outcomes of their care, or how these outcomes compare with the prices they charge, and so payers can make a significant difference just by *showing* them their results. This will require linked data sources between providers and insurers, which are often best managed through a trusted third party (TTP) solution due to regulatory concerns. This, in turn, lays the groundwork for incentivizing good outcomes. In time we might expect these data sources to increasingly cover issues of prevention and use data to facilitate and incentivize patient engagement in their own healthcare.

"Such partnerships are beginning to come to the fore in the US now," says Ron Williams, former Chair & CEO of Aetna Inc. and member of President Obama's Management Advisory Board. "This is quite something, because payers and providers used to fight each other to the ground until only a few years ago. That was the default, they were enemies. That is changing now, enlightened payers understand collaboration is the only way to create more value."

Pieter Hasekamp, CEO of The Health Insurers Association in the Netherlands, adds: "We're learning that a partnership – with sharp edges where necessary – is the best model. Just 'tough negotiating', seeing each other as adversaries, will not work, that's clear."

Cost sharing

As overall healthcare spending in most countries is expected to increase over the coming years, both payers and providers can reasonably expect their market to grow. Indeed, there are not many sectors where conditions for constructive partnerships between payers and providers are so good. In this market, payers may consider sharing some of the costs for necessary transformation processes, or supporting providers as they go through a temporary dip in revenues.

Of course, partnerships do not come without risks. For instance, payers will want to ensure that they do not become overly entangled with pre-existing providers for fear of obstructing the disruptive change that might be required. Clearly, a healthy tension in the partnership remains essential.

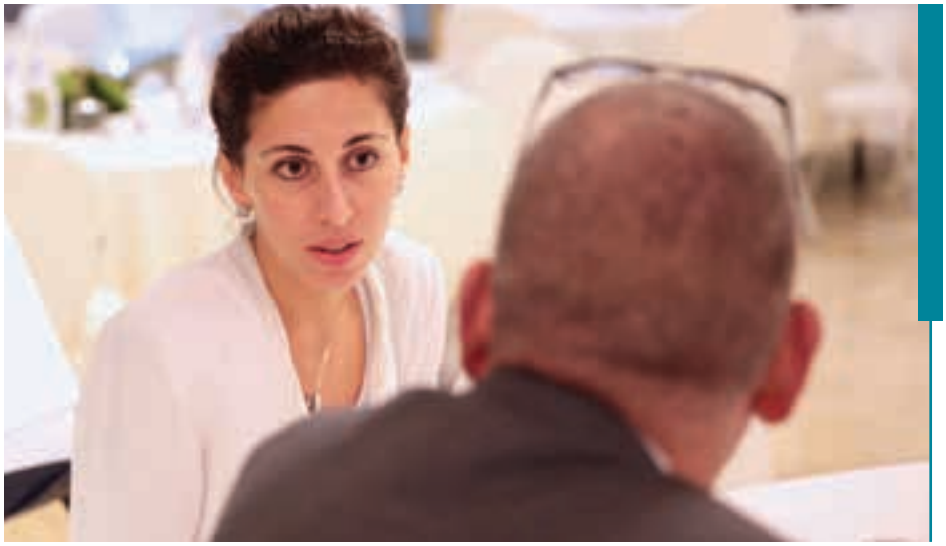
"The painful moments will come when the waste is really pushed out of the system; when you cannot help the hospitals to survive relatively easily; when organizations will simply not make it. Yet we have to face that," says Ron Williams. "With many of our larger hospitals, it is much more likely that they will be thoroughly transformed than that they will just fall over and die. And we can help them with that transformation – we must."

Perhaps the most important partnership in the future will be forged between patients and the wider population. Supporting patients in managing their own health, coordinating their own care and facilitating their participation in key decisions has huge potential.

Key take away points for payers

There is a strong logic influencing the way that payers are adapting and changing; based on this logic, the steps they need to take are quite clear.

- Pushing care upstream (towards prevention, self-management and home care) has become the clear mission for everyone who wants to increase quality while reducing overall healthcare costs. This will mean finding new ways to connect to patients and influence their behavior, which includes being more active in the management of their conditions and adopting more healthy lifestyles. To make this possible, delivery models need to become more integrated which, in turn, means that current payment systems (that maintain fragmentation and pay for waste) urgently require reform. And while there are choices about how much risk should be transferred to the providers, it is clear that much more attention must be placed on the management of population health.
- Public and private payers increasingly find themselves in the driver's seat; they can play a crucial role in realizing payment reform and influencing provider behavior. They are becoming increasingly engaged in actively pushing care upstream themselves – whether through interacting with providers or with their own clients.
- Incentivizing change will be essential. Change can be hard and the pain of that change should be shared between payers and providers. Payers will need to be open-minded and creative about how they support and incentivize providers in both the medium to longer term.
- Up-skilling in key areas such as data analytics, outcomes measurement, contracting, and care system design will be key, as will the inevitable leadership complexities that arise when moving from a traditional passive payer to a leader of the system.



Orsida Gjebrea, Supreme Council of Health, Qatar

Case Study

De Friesland Zorgverzekeraar – How the insurers took the lead in reshaping hospital care

This initiative started when De Friesland Zorgverzekeraar (DFZ), a Dutch healthcare insurer primarily active in the northern part of the Netherlands, had the ambition to provide the right care at the right place at the right time, now and in the future. The burning platform for this ambition is a set of familiar challenges including a rapidly aging population, a lack of specialist doctors and nurses and the risk that small hospitals will not be able to meet quality and volume requirements.

A driving force to realize the ambition was the outline agreement between the Association of Dutch Healthcare Insurers, healthcare providers and the government, which made the health insurance companies primarily responsible for improving quality and efficiency. This changed the role of healthcare insurers that could become commissioners of care with a strong responsibility for appropriateness and continuity of care in the region (a sort of private organization with some parallels with regional health authorities). DFZ was one of the first to pick up a leading role. While some health insurance companies used purchasing power to negotiate with providers, DFZ had a strong commitment to cooperating with the providers in the region. It was their belief that only in this way could change of such magnitude be realized sustainably.

What did they do?

DFZ took a coordinating role by working with healthcare providers in the region to shape networks of care for critical care and care close to home. The networks of care included: emergency and intensive care, birth care, oncology, complex vascular care, elective care and chronic and elderly care.

How did they do it?

To realize this ambition they set up a program with:

- A steering committee intending to reach common decisions, consisting of: an independent chairman, the board of directors of DFZ, CEOs, chairmen and board medical staff of the five hospitals, a board member of the regional university medical center, patient and general practitioner representatives and KPMG;
- A program office, consisting of DFZ and KPMG employees;
- Seven expert groups, which made proposals for change. Every expert group consisted of a chairman (an independent, leading medical specialist), representatives of the hospitals, general practitioners and representative of the patients; and
- a 'Council of Experts' which could provide the steering committee with advice upon request, consisting of national recognized governors/medical leaders.

Source: KPMG International, 2013.

What decisions were made?

- DFZ composed their healthcare procurement plan for 2013. In this plan the first irreversible steps towards the future were made. For instance, no contracts will be made with certain providers for some forms of complex care if quality and volume requirements can't be met.
- First fundamental decisions on scenarios.

What were the lessons learned?

- Speed during the process is necessary, but too much speed is detrimental.
- A program of this magnitude can count on attention in the local media; make clear agreements on media handling.
- Importance of independent chairs for expert groups; bringing in independent professional medical leaders is an important driver for change.
- The program brought the professionals and the clients/patients back in the lead. Management follows professionals – as one expert said, "We are currently realizing something that our management should have done 10 years ago."
- Relocating the care in the network will result in increasing pressure on primary care.
- Importance of maintaining the project infrastructure after ending the program; creating a platform for collective innovation from professionals.

Outcomes

- DFZ has delivered new medical centers that better connect primary emergency treatment; the centers claimed top prize in the Friesland patient representative body's latest annual healthcare awards.
- The pathway approach is delivering authoritative care plans, based on proven data and financial modeling, overturning legislative, practitioners and administrators' assumptions on healthcare and the supply agreements. In particular, the insurer has reduced its use of complex care contracts where providers could not guarantee its new volume and care quality targets.
- DFZ's new program is already having a profound effect on commissioners, providers and patients. Local treatment centers are more accessible to elderly patients. Primary care teams are working more closely with the new care centers and hospitals – providing better, multi-disciplinary care closer to local communities.
- Friesland's new primary care-led network is lifting demand from hospitals, with a 40 percent substitution from acute to care beds in one case.
- Improved quality of care with better targeting and reduced costs; the program's comparison of GPs found those with highest quality results also had the lowest costs.
- DFZ is now commissioning services more flexibly in line with anticipated local care demands because of the pathways' comprehensive number-crunching. DFZ also has the model to transform its cost base as well as those of its provider hospitals in the next few years.
- 'Incentivized' patients are becoming more active partners in the management of their own healthcare.
- The program put the professionals and the clients/patients in charge.
- Management follows professionals – as one expert said: "We are currently realizing something that our management should have done ten years ago."

Lessons from high-growth health systems

Three key words perhaps summarize what we can observe in the immediate and near-term future for emerging markets: growth, buzz, and leapfrog.

Almost by definition, emerging countries are experiencing economic growth while most of the developed world continues to face a slowdown which looks increasingly to be long-term. Populations are still growing at a fast clip, and with populations that are both growing and aging, some countries are experiencing the 'double barrel' impact of public health issues. Increasingly crowded urban centers, changing lifestyles and diets can be linked to a chronic disease epidemic among the middle-class, who also come with higher and harder to meet expectations.

Emerging healthcare trends in high-growth markets:

- Focus on prevention and primary care;
- Technology is seen as a key enabler to accelerate growth and is being rapidly implemented;
- There is much less nervousness about using private-public partnerships;
- Providers in these markets work their assets much harder; and
- Greater willingness to try innovative or novel approaches.

Within healthcare, as a fast-growing sector, the buzz is palpable. There is increasing private sector involvement and a rise in the number of public-private partnerships, as many governments realize their need to rely on private finance. New models for funding and financing healthcare are constantly being experimented with and implemented. We are seeing innovative use of information technology, the rise of remote care delivery models (through tele-care, mobile health and the like), and social networking playing a role in chronic disease management where lifestyle and behavioral changes are important. In a way, "green fields" and "white spaces" in underserved regions and countries offer more opportunity for truly disruptive innovations, which are often simply new ways in which a product or a service is produced, delivered, used or valued.

Indeed, we can expect to see healthcare technology adoption and innovation in emerging markets leapfrog their more developed cousins, and not just play catch-up. This can already be seen in telecommunications in developing countries, where the ubiquitous mobile phone has replaced landlines to provide connectivity reaching into the most rural of areas.

There are advantages of being a follower – not being burdened by the past or historical policies and structures, and the opportunity to learn from and not repeat the mistakes made by developed countries which have treaded the well-worn path of traditional healthcare system development. Already, we see electronic medical records and broader electronic health records impressively implemented in hospitals and systems in India, China and other developing countries. Mobile health in rural settings, retail-based clinics and other dis-intermediation models are thriving where primary care is weak. Low-cost delivery models and point-of-care diagnostics and interventions are capturing the imaginations of care providers, drug and device manufacturers and investors alike, and may well lead the next wave of "reverse innovation" which could see the developed world learning valuable lessons from their upstart cousin nations.

This is *the* space to watch and the scale and speed of change is extraordinary.

Providers: **transact or transform?**

Prof. Benjamin Ong, National University Health System, Singapore

> "Looking **around** the **world**, we see **mounting evidence** that the **status quo** cannot **last**."

As payers become more activist, the role of the provider is also being challenged by old and emerging pressures. How should providers react to the rise of 'activist payers'? How will providers adapt to demographic and epidemiological change? What is achievable given the ongoing financial and economic challenges in most parts of the world?

At KPMG's global summit, a number of providers from various regions suggested that the current model actually delivers strong margins for some hospitals. Why should they change, they asked, if profits are still flowing?

But looking around the world, we see mounting evidence that the status quo cannot last. Even in the fastest growing emerging economies, the current system seems in trouble. Indeed, the writing has been on the wall for some time, but it is only now starting to get tough. Provider executives in emerging economies and systems that are still growing have an opportunity to leapfrog some of the outdated models in the more established systems.

For providers, today's challenge is to balance the pressure of becoming as efficient as possible within their current models, while creating the right environment for transformational

change to new models. For some, this will lead to a more integrated system; for others, different options will emerge such as specializing or focusing their operations. Just about the only option that is not on the table, however, is to do nothing. Our delegates were clear that bold and innovative approaches would need to be combined with forward thinking and (in some cases substantial) changes to operational and business models for real and lasting change to emerge.

At the outset, providers will need to consider their objectives and future strategies based on two main sets of considerations: what markets they want to operate in (both in terms of geography and products) and whether improvement or transformation is required. This will invariably lead providers to three broad, overlapping sets of approaches:

- Continue to grow the current model while improving operations and delivery;
- Adopt new approaches built on existing models; or
- Develop very different models for new or current markets.

Regardless of the approach, the scale of change is huge. Opportunities abound for those providers prepared to move ahead, take risks and try to shape the future rather than respond to it. In some cases, the ambition and pace of change (particularly in the emerging economies) has been breathtaking; in other parts of the world, progress has been slower to come.

Over the following pages, we will look at the different components of each strategic option to show how providers across the globe are adapting and advancing their strategies.

"What we can learn is that regardless of what payer system we're in or what national scheme we're in… at the root is how do we care for people and how do we motivate those people who do the caring," says Dr. Kevin Smith, President and Chief Executive Officer of St. Joseph's Health System, Hamilton, Canada.

Developing new strategies

Continuing to grow and improve

In some markets, there is still the opportunity to grow the current model while driving improvements across operations and delivery. But above and beyond the organic growth that will naturally come from changes in demographics, aging populations and epidemiology, many providers are keen to explore new opportunities for rapid growth.

Mergers and acquisitions

For many providers, the purchase and consolidation of facilities and services remains a highly popular growth strategy. When fully realized, M&A can bring reduced costs through the sharing of functions, improved market power and greater negotiating clout. In other cases, governments and payers have looked to M&A as a solution to poor service quality or financial failure. But there are significant challenges with conducting M&A, and the track record in the health sector is not impressive. According to KPMG research, many of the root causes of poorly-executed M&A transactions come down to three main mistakes: a lack of clarity about the objectives, failure to conduct rigorous due diligence and a lack of attention to culture change and integration both before and after the merger.

That is not to say that mergers cannot be effective. Indeed, some jurisdictions have enjoyed strong success by using mergers as a strategy to shrink the overall size of the hospital system. In the Canadian province of Ontario, for example, the government imposed consolidations on independent hospital corporations and, as a result, reduced the number of providers from 220 to 150, while also closing 35 individual hospital sites.

Expansion into new markets

There are a number of ways providers can take advantage of new markets to drive growth. In the US, for example, a recent health tracking study found that in all 12 markets studied, hospitals employed one or more types of geographic competitive strategy, including buying or building full-service hospitals or freestanding emergency departments, buying or establishing physician practices, and developing a regional presence through emergency medical transport systems.[5]

In most cases, the aim of expansion is to improve efficiency and capture additional patients with more advantageous reimbursement rates. However, many payers fear this strategy will lead to price increases, a notion supported by recent data on mergers in the US market.

[5] Emily R. Carrier, Marisa Dowling, and Robert A. Berenson-Hospitals' Geographic Expansion In Quest Of Well-Insured Patients: Will The Outcome Be Better Care, More Cost, Or Both? Health Affairs 31, No. 4 (2012): 827–835.

"Most **healthcare providers** still have **ample opportunities** to improve their **quality** and **margins**."

There are numerous examples of this strategy at work around the world.

- Facing restricted growth opportunities in their domestic market, Ramsay Health Care in Australia looked for opportunities to take its operating model into different environments. The organization won contracts to deliver elective surgery in the UK, acquired a 57 percent stake in French operator Groupe Proclif SAS (now known as Ramsay Santé SA), and is now actively looking for further acquisitions in other markets.
- Narayana Hrudayalaya, a group of health centers based in India, is adapting its model to support entry into a number of different countries, including the Cayman Islands, which has given the organization quick access to the huge US market without the daunting regulatory hurdles.
- India's Fortis Healthcare Limited and the Apollo Group have both leveraged their clinical leadership in new markets to build new hospitals throughout the country and across the Asian region.
- In Japan, SECOM Co. Ltd. a leading security firm, and Toyota Tsusho Corporation, a trading and supply chain specialist, have formed an alliance with Kirloskar Group, a major supplier of high-tech medical equipment based in India to develop general hospital services. The partnership works because of the advantages that each party brings to the table: Toyota Tsusho can mobilize a global network and rapid business development capability; Kirloskar Group brings its local knowledge and networks; and SECOM brings operational expertise.
- In many markets, expert operators are taking over the management of public hospitals or bidding for contracts in service areas that, traditionally, have been the exclusive preserve of the public sector but are now being moved into the private sphere to reduce government liability and investment.

The success of any expansion into new markets relies on the organization's ability to effectively transfer their management model and methodology. To achieve this, organizations will want to ensure they secure a majority stake in any takeover, or win long-term concessions that allow sufficient time for new approaches to be applied and investments to be returned. Those expanding into new foreign markets may also consider creating

Cynthia Ambres, KPMG in the US and Marc Berg, KPMG in the Netherlands.

joint ventures with local partners as a way of navigating often complex local regulatory regimes while securing organizational capabilities in marketing, staffing and adjusting to local culture.

Redesign and improvement

In many systems it has been easier to focus on improving revenue. Reducing costs is difficult but techniques for doing this, and the areas where there is the most scope, are generally well known. In our experience, most healthcare providers still have many opportunities to improve their quality and margins. However, the more adventurous of these strategies may well require collaboration with other organizations, especially where there is a need to reshape the whole local health system, for example through the closure of sites. This may be an area of opportunity for partnership where an 'activist payer' can help to unlock change.

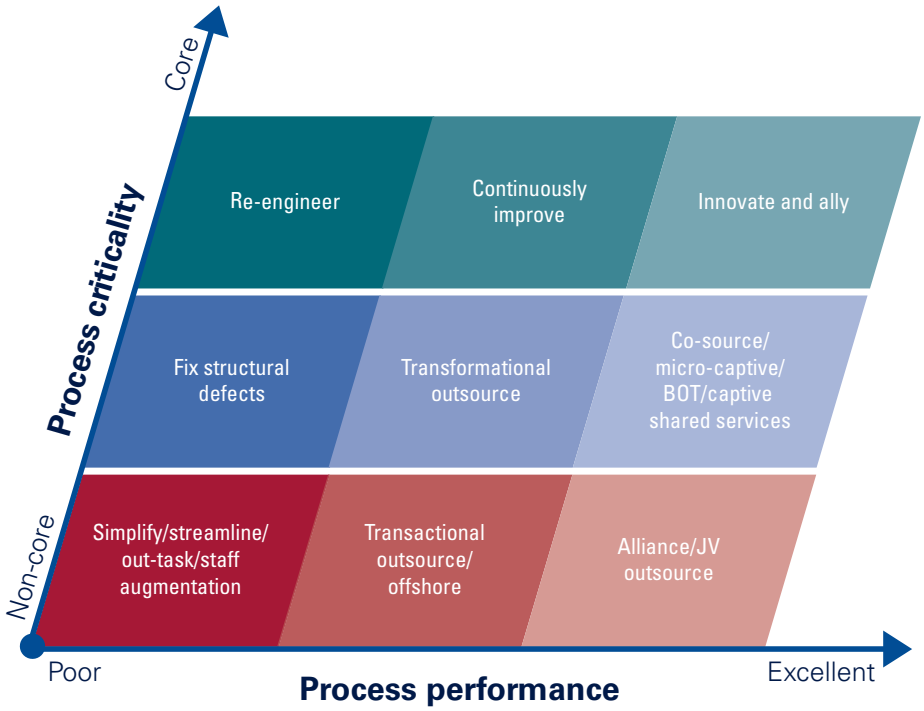
Outsourcing clinical and non-clinical services

Outsourcing non-clinical services is certainly not a new phenomenon. Indeed, in mainland Europe, providers have a long history of outsourcing functions such as cleaning, laundry and catering. Over the past few years, there has also been a strong trend towards the outsourcing of key operational functions such as facilities management, office services, financial functions, IT systems management, the transactional components of human resource management, procurement and logistics.

Today, there is growing interest in moving outsourcing closer to the front line in areas such as sterilization, patient transport, pharmacy, imaging, reporting images, laboratories and the operation of specialist clinical services such as dialysis, mental health, chemotherapy and even intensive care. Philips eICU (part of Royal Philips Electronics of the Netherlands, a diversified health and well-being company), for example, provides remote support to a large number of community hospitals in the US.

At the same time, the approach to outsourcing has matured significantly over the past few years, leading to a much wider set of models for improving value and efficiency that go beyond simply outsourcing individual function areas. Indeed, many organizations are now taking a much more strategic approach to outsourcing by considering their various options against the importance of the process to the business and the extent of the improvement required.

Figure 3: Strategic decision-making on outsourcing



Source: KPMG International, 2013.

"While all **organizations** aim to improve **quality and efficiency,** some are using **quality improvements** to create **transformation** on a much **larger scale.**"

Getting the best out of the workforce
Given that the most significant costs for most healthcare organizations stem from the workforce, it is not surprising that many providers are seeking ways to increase productivity and enhance employee efficiency. This will, in turn, require providers to pay closer attention to job design, pay and conditions, and developing the basic systems to improve workforce management. However, we have also noted a fundamental shift away from crude approaches to reducing cost, focusing instead on more strategic options based upon engagement and improvement. According to our research, leading providers exhibit five key habits to drive efficiency and productivity.

1. A strategic focus on value for patients is embedded into the DNA of the organization and reflected in the recruitment, staff objectives, appraisals and reward systems.
2. Professionals are empowered to take responsibility for creating value, supported by a focus on teamwork, the granting of appropriate autonomy, control over work processes and high-quality leadership at the front-line.
3. Task and process redesign is encouraged and supported.
4. Staff performance is actively managed using outcome measures.
5. High-quality staff management practices are embedded into the operating model of the organization.[6]

Building new approaches on existing models

Quality improvement at scale
While all organizations aim to improve quality and efficiency, some are using quality improvements to create transformation on a much larger scale.

- Intermountain Healthcare, a hospital system in Utah and Idaho, uses measurement, data systems, pathways, process improvement and structures to enhance accountability and – as a result – has made major cost and quality improvements. Just one of its new protocols to reduce unplanned caesarean sections and induced labor, for example, saved USD50 million in Utah alone – equivalent to USD3.5 billion across the US.[7]
- The Geisinger Health System in Pennsylvania is focused on removing unjustified variation, fragmentation of care and poorly-designed incentives as a way to move patients from passive to active recipients of care. Its ProvenCare products offer advanced primary care (a medical home), care bundles to ensure reliable chronic disease management, improved transitions of care, warranties for some treatments (those in which the system delivers best practice) and evidence-based care. The product also takes responsibility for complications.
- In Sweden, the Jönköping County Council's health system has a 25-year history of using quality as their key business strategy. This 'whole system' approach is based on a culture of systems thinking, process improvement and the development of a learning system.

[6] Value walks: Successful habits for improving workforce motivation and productivity. KPMG International, 2012.
[7] Brent C James & Lucy Savitz – How Intermountain trimmed healthcare costs through robust quality; Health Affairs May 2011, doi: 10.1377/hlthaff.2011.0358.

The Trillium Health Centre in Ontario, Canada has taken a similar approach.

- Salford Royal NHS Foundation Trust in the UK has used patient safety as a key driver for improvement in their organization.
- The Institute for Healthcare Improvement in the US and the Initiative Qualitätsmedizin collaboration in Germany, Austria and Switzerland have also found benefits to being part of a wider network for improvement.

In examining the practices of these organizations, we have found that success in this area relies on the consistent implementation of a wide range of interventions over a long period of time. Moreover, the ability to define and measure value while developing a methodology to help staff and front-line leaders to make improvements is vital. For example, the Virginia Mason Medical Center in Seattle and the Royal North Shore Hospital in Sydney have both successfully deployed lean methodologies to strip out non-value adding activities and streamline pathways. In Canada, the province of Saskatchewan is now rolling out lean processes across the entire health system to support their Patient First Review.

However, it is also worth noting that some initiatives have met with less success, suggesting that the model for scaling up quality improvement is still poorly understood.

Integration
The definition of this varies between systems, but at its heart the strategy aims to offer coordinated care across the whole patient journey. As payers start to move towards purchasing outcomes and value rather than individual interventions, more risk is passed to providers, thereby making a compelling case for ensuring that care is properly integrated. The US offers strong case studies of how changes in payment methods and payer policy can drive organizational strategy and design. We have also noted growing interest in Europe and elsewhere in getting providers to be more accountable for outcomes for populations. (See below.)

Hospitals into health systems
The question is how to build a better system without losing the advantages that primary care can offer. One answer may be for hospitals and other providers to be encouraged to enter the market. Another option would be for primary care to become more specialized or to focus on particular segments of the population. However, in many countries, the model of primary care is currently not set up to adapt to meet these challenges.

Hospitals and health systems do have the potential to develop new partnerships to support home care providers and residential and nursing homes to deliver a range of services such as: improving care for patients, medicines management, end-of-life care, and the prevention and management of acute illness. Closer working relationships with mental health services can also reduce hospital admission and the length of stay, particularly for older people with dementia. Similarly, depression and anxiety are important aspects of chronic disease and, by ensuring high-quality mental health support for these patients, providers can help to reduce their use of other services substantially. Clearly, hospitals will need to make a concerted effort to reach out to – and work with – these service areas.

Different definitions of integration

Payer driven integration: The Blue Cross Blue Shield (BCBS) Massachusetts Alternative Quality Contract and BCBS Michigan Physician Group Incentive Program have an organized system of care programs that incentivize physician groups and hospitals to collaborate in order to produce improved outcomes. A number of payers in Europe are also promoting vertical disease management and models that improve the primary/secondary/rehabilitation interface.

Government driven integration: Scotland, Catalonia and the Basque regions of Spain are creating integrated health and social care provision. France and Sweden have both been experimenting with various types of provider networks for chronic disease.

Provider-led integration: In the US, our research suggests that many providers will quickly move to integrate with medical groups. There is also increased interest in hospital systems acquiring primary and ambulatory care, home health, skilled nursing facilities, rehabilitation and other parts of the supply chain.

> "While the **technical aspects** of integration are **certainly important,** it is the **cultural component** that is perhaps the **most critical element.**"

It is worth noting that it is not always necessary to create new organizations or restructure them to provide integrated care. Indeed, the key components of a new system are more focused on creating the right processes, systems and ways of working than they are about governance.

While the technical aspects of integration are certainly important, it is the cultural component that is perhaps the most critical element. In other words, organizations will need to develop effective ways for professionals to work together, taking into account their differing approaches and attitudes to risk.

This may be particularly difficult for hospitals whose costs are locked into buildings and infrastructure. However, change is ongoing: some forward-looking hospital boards are starting to recognize their organization's role in not only running health systems, but also in taking responsibility for the health of the population.

Networks

In a well-known article, American surgeon and journalist Atul Gawande suggests that there is a growing trend towards creating networks of hospitals with the potential to develop standardized approaches that take advantage of economies of scope and scale, emulating developments in other sectors.[8] This goes well beyond sharing back office services and procurement by focusing on the development of networked approaches to laboratories, imaging, shared specialist expertise and the use of large volumes of network information. As a result, these organizations are refining and improving processes as a key source of competitive advantage. In some markets, such as the UK and the Netherlands, networks are also seen as mechanisms for rationalizing capacity and regionalizing specialist work.

Networks may also be made up of individual sovereign organizations that come together to organize particular services in areas where it is necessary to share scarce expertise or have referral pathways for complex patients. Some challenges do exist with this model however, particularly in decision-making. Experience suggests the drive to secure the full benefits of networks often requires a single management structure for the network which allows individual operating units a high level of autonomy to respond to their local market. The US, in particular, has been active in this area, led by private equity

Prerequisites for an integrated system

- A clearly defined population.
- The ability to stratify risk reliably and develop registries.
- Accountability for outcomes, supported by aligned contracts and incentives.
- Systematic clinical care.
- Staff and systems to support coordination.
- Shared records.
- Shared quality governance arrangements between participants.
- Payment mechanisms that support these arrangements.
- The development of a workforce with new skills including the ability to manage multiple morbidity including dementia and work in multidisciplinary teams.

[8] http://www.newyorker.com/reporting/2012/08/13/120813fa_fact_gawande

Georgina Black, KPMG in Canada in conversation with Christine Roughead, KPMG in the US

groups who are purchasing community hospitals to create chains. It is, however, too early to tell whether this strategy will succeed.

A number of attendees of our healthcare summit also noted that they were engaged in developing informal networks, including:

- International networks that link those institutions undertaking very specialist work in order to achieve efficiencies in research and pool expertise for image reading, interpreting results and advice on complex cases.
- Networks that provide increased reach for referrals and the opportunity to extend the brand of centers of excellence.
- Networks for learning and sharing, largely made up of aligned international players.

Hospitals as healthcare hubs

Following the logic of outsourcing and networks, some small hospitals may find benefits from becoming an outsourced venue for care delivery by granting other providers concessions for hospital space and service delivery. That being said, this route can create some interesting complexities and may be easier to achieve in situations where the hospital is part of an existing network.

Research and academic links

For those providers closely aligned to research universities, opportunities exist to develop academic networks that not only provide competitive advantages in recruiting, but also allow for the differentiation of services on quality. At the same time, fully-fledged academic health networks may also be able to leverage large amounts of additional research funding to create efficiencies in service delivery.

There are a number of existing approaches to achieving this.

- Charité-Universitätsmedizin Berlin, a major university hospital in Europe, has a close collaboration with pharmaceutical giant Bayer to support drug development.
- King's Health Partners, an academic health sciences center in London, has brought mental health together with acute hospital services in order to align their research interests with the main burden of ill health in their community.
- UCLPartners, an academic health sciences partnership in London, is building on areas of clinical excellence and conducting strong translational research through participation in a network that goes beyond the boundaries of the hospital.
- The Karolinska Institutet in Sweden, the Mayo Clinic in the US, Partners HealthCare in Boston, the University of California, San Francisco Medical Center and Johns Hopkins Medicine have a similarly broad multi-specialty approach.
- The Cleveland Clinic, a not-for-profit organization operating in the US, offers a strong example of a focused strategy capitalizing on their expertise in specialist areas.
- For-profit organizations – such as the Apollo Group in India, who have research and academic excellence as a key part of their strategy – are also focusing on specialist areas.

Asian hospitals, in particular, seem well positioned to take advantage of their research and academic links, often supported by significant government and commercial backing. Singapore is making progress and forging powerful collaborations with academic centers in other parts of the world, while South Korea has become an increasingly powerful player with big investments at the Yonsei University Health System, the Severance Hospital and the Asian Medical Center. Their experience shows that, in addition to large caseloads, networks and specialist expertise, the ability to mobilize large databases that will allow the study of complex factors in big populations will be a key competitive advantage for providers going forward.

According to Claudio Lottenberg, Chairman of the Albert Einstein Israelite Hospital in Sao Paulo, Brazil, "Things that I thought were happening just in my country, we can see all over the world. One of the most important learnings for me is the importance of adding value for those that are going to take part in the resolution of the problem. Doctors… have to be more and more involved because they are close to the patients and can be the best teachers and explain what quality really is."

"The health sector **seems to lag far** behind other sectors of the economy **in their ability (or willingness)** to move services to online, **telephone and other modes.**"

New models are emerging
While some providers adapt existing models to create new benefits, others are building entirely new models that stand in stark contrast to the traditional hospital.

Focus
Organizations implementing strategies where providers focus on a process (e.g. ambulatory surgery or imaging), a procedure (e.g. cataracts, heart surgery, hernia repair or joint replacement), or a disease area (e.g. kidney disease) all largely follow the same five-step process, as outlined below.

1. They gain deep skills in a limited range of activities and create single processes that do not interact or overlap.
2. They standardize as many activities, consumables, implants and operating procedures as possible.
3. They develop approaches to continuously improve their specialty areas.
4. They redesign work processes and shift work to the most appropriate level.
5. Finally, they move to high utilization models that ensure that only the equipment needed for the range of activities is purchased.

However, for a focused strategy to work, providers must have access to high volume markets where consumers are willing to travel for reduced price and improved quality.

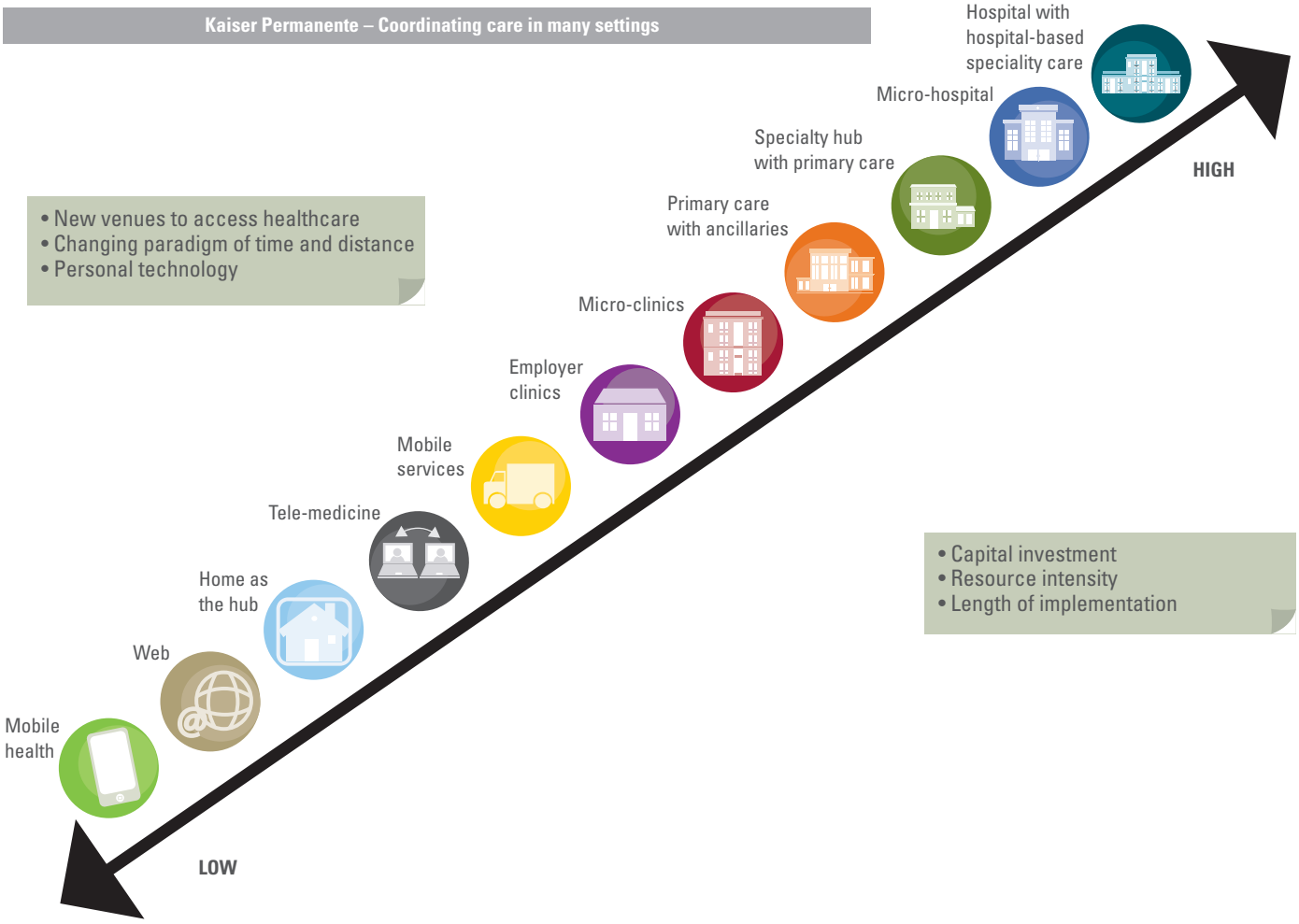
Well known examples of this approach can be found at the Shouldice Hospital in Canada (hernia repair), India's Aravind Eye Care System and Narayana Hrudayalaya (cardiac), Finland's Coxa Hospital for Joint Replacement (orthopedics) and Singapore's Fortis Healthcare, which has recently opened a hospital purely focused on colorectal conditions. Others are focused on specific patient sectors such as Vaatsalya in India which has developed a low-cost model focused on delivering care to middle-income patients based on high utilization and streamlined processes.

LifeSpring Hospitals Private Ltd. in India offers a strong example of this strategy at work. The organization offers low-cost maternity care using high throughput units where non-clinical tasks have been removed from clinicians, cases that need high-cost interventions are transferred to a specialist unit, hospitals are leased rather than bought or built, and outsourcing is extensively used.

Channel shifting
Kaiser Permanente, a US-based healthcare consortium, is aiming to shift many of its patient contacts to online or telephone channels. To achieve this, they have created a graduated approach that spans a range of different interventions designed to improve care coordination (see figure 4). Kaiser already uses video conferencing to provide specialist input to consultations with family doctors, internists and other front-line clinicians. Similarly, the Veterans Health Administration in the US enjoys very high rates of virtual contacts.

However, in our experience, the health sector seems to lag far behind other sectors of the economy in their ability (or willingness) to move services to online, telephone and other modes. And while the use of applications running on smart phones and tablets is starting to make some inroads, evidence shows that few organizations have embedded these technologies into their strategy.

Figure 4: New approaches to coordinating care



Source: Kaiser Permanente, 2012.

Disintermediation

In other industry areas, organizations are reducing costs and increasing value by taking steps out of the supply chain. But this approach seems – to date – to be less prevalent in the healthcare sector. However, the growth of retail-based clinics with a narrow repertoire of diagnosis and treatment services for primary care conditions, remote pharmacy with postal fulfillment and other potentially disruptive models will increase over the coming years, bringing both threats and opportunities to sector participants.

Strong examples of success do exist, however. MedLion Direct Primary Care, a health insurance company in California, has contracts directly with employers. WhiteGlove Health, a medical care provider based in Texas, offers a similar model but with a telephone front-end and the offer to come to the patient's home or workplace. In both examples, the provider has essentially removed the need for insurance claims to be made for the use of primary care and eliminated the retail pharmacy from the value chain by using postal fulfillment.

Particularly in regions where primary care is poorly developed, we have also seen the rise of approaches that take primary care out of the value chain by offering vertical disease management programs, direct access to specialists, and vendors who can provide screening services directly to the public. Similar examples arise in cases where the primary care service values are not a key part of the service, such as in the Parkinson.net example in the next chapter.

> "We have seen **growing interest** from providers in **working with patients** to redesign **care pathways.**"

Patients and their networks as a source of value

As other service industries move to involve the consumer into the production and design of products, we have seen growing interest from providers in working with patients to redesign care pathways. Other ideas are also starting to trickle into the health sector, such as self-serve models in which the customer does much of the work, supported by technology and online tools.

For the health field, this approach represents a huge shift in the way providers operate and requires both a mind-set and an organizational culture transformation to succeed (more on the implications of this approach can be found on the opposite page). Like all transformational strategies, this approach will take time and significant experimentation to succeed.

Leveraging Big Data to deliver better, more targeted services

While a few payers and providers have toyed with healthcare CRM technologies in the past, the evolution of data analytics now offers health systems new and powerful tools for increasing efficiency, enhancing safety and reducing costs. Predictive patient behavior models, highly-accurate demand forecasts or even guidelines tailored to individual risk factors would undoubtedly catalyze significant change.

It is likely that the greatest technological catalyst for driving more coordinated and effective care, however, will be the adoption of cloud technologies. The power of the cloud to assemble, analyze and share data in real time will be critical in building successful partnerships and affiliations between payers, providers and patients; will transform the way patients move through the care pathway; and will deliver tremendous insight to payers on the performance of their contracts.

And while the cloud will require health systems to understand and manage big issues like enterprise security, identity management and network management, it is clear that Big Data and cloud will be key to health systems unleashing the power of coordinated care.

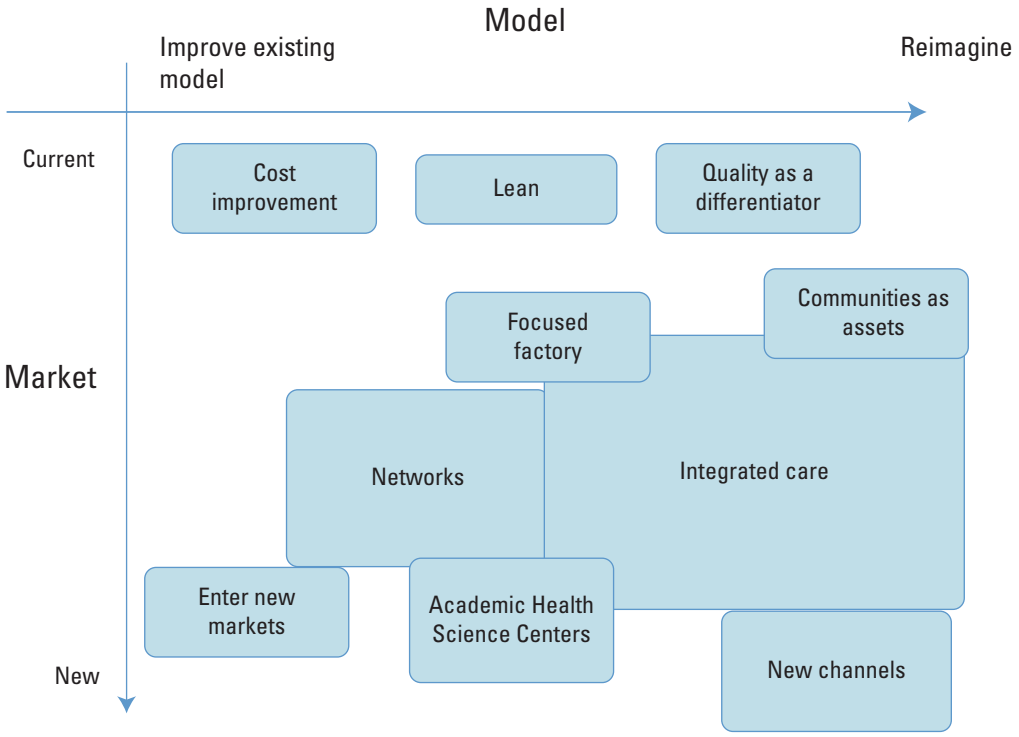
Putting the strategies together

While these strategies are not mutually exclusive, there are limits to how many components can be viably pursued at once. There are a number of dimensions of the strategic choices available. Perhaps the most significant are questions about the scope of market being served and the extent to which the model is reimagined. This informs the strategy map in Figure 5 and it can be seen that some of the options cover more of the territory.

The reality is that there is no silver bullet or off-the-shelf solution for providers; each will need to develop their own unique approach based on local conditions and the decisions made by the different players in the system.

Moreover, strategies based on small improvements and growth, while important, are not going to be sufficient to meet the challenges;

Figure 5: Strategy map for providers



Source: KPMG International, 2013.

wholesale change will be needed. Indeed, many hospitals will need to change their clinical, operational and business models much more fundamentally. This will require experiments and investment.

Small hospitals, in particular, find themselves threatened in this environment and will increasingly find benefits to being part of wider networks both locally (with primary and home care) and across wider areas (working with specialist providers). In many systems, primary care will also have to change radically to be able to provide the level of services and scale that is needed. Providers that have grown accustomed to running services in institutions are going to need to develop a range of new skills, take a different approach to managing risk and ultimately move many of their services out of their buildings and into the wider community. It seems likely that hospitals will need to reimagine themselves as the core of a health system and start to retrain staff, rethink their business models and think about their buildings and other assets in new ways.

> "**Strategies** based on **small improvements** and growth, while **important**, are **not** going to be **sufficient to meet** the challenges."

Key take away points for providers

Providers will have to act quickly to meet these challenges. Health system leaders at our summit in Rome were very clear about what needs to change in their organizations in order to fundamentally alter the status quo.

- Invest in leadership at all levels – University College London Hospitals has an internal leadership academy targeting the top 400 leaders in the organization.
- Rethink internal structures – for example, the Erasmus Medical Center in the Netherlands has moved away from structures based around medical disciplines to ones closer to the needs of patients with multiple conditions.
- Develop a focus on value and create new relationships with physicians and patients. Gary Kaplan, CEO of Virginia Mason in Seattle, has developed a new compact between the medical staff and the organization to engage them in helping to drive forward improvement focus of value.
- Invest in strategies to get the best out of the workforce – for more on this, see *Value walks: Successful habits for improving workforce motivation and productivity*, a report by KPMG International.[9]
- Use measurement, improvement and information to gain strategic advantage.
- Build networks – both internally and internationally.
- Learn from other markets and industry sectors.
- There needs to be a greater focus on outcomes not inputs. Leaders need to empower managers and physicians and give them the freedom to innovate and act in order to deliver quality and best practices.

Prof. Shan Wang, Peking University Peoples Hospital, China, meets Amit Mookim, KPMG in India.

[9] Value walks: Successful habits for improving workforce motivation and productivity. KPMG International, 2012.

Leadership and culture

KPMG's Global Healthcare conference featured a number of speakers who focused on the vital importance of leadership. This was not just about their personal contribution as leaders (which was clearly substantial) but rather about the importance of their teams, being humble about what needed to be accomplished, and being passionate about improvement. Indeed, much of the emphasis within organizations tended to fall on the followers (mid-level leaders and front-line staff), and how the leadership team created an effective culture that includes:

- a clear set of values;
- consistent leadership towards a shared purpose over a long period of time and, in particular, considerable stability and longevity amongst top leaders;
- commitment to real and deep engagement from the medical staff;
- a strong focus on the front-line, particularly the need to nurture and develop front-line and mid-level leaders. In all systems, this part of the organization was perceived as being both vitally important and underdeveloped;
- an expectation that teams and individuals act according to the culture and are prepared to be held accountable for their performance;
- the alignment of measures between medical, patient and organizational perspectives;
- transparency of information, both internally and externally; and
- curiosity about how other high-performing organizations achieve results.

This requires health system leaders to get basic operations, internal coordination, and the processes that support clinicians running very smoothly which, in turn, will improve quality and the experience of both patients and staff. But it is also the entry ticket to being taken seriously as a strategic leader.

It was clear there is a growing complexity facing all systems around the world. These include: regulators that are demanding ever more information; the growing complexity of the patient and the services they need; and the growth of internal and external monitoring systems.

The best leaders were finding ways to manage and even reduce this complexity by directing staff as much as possible by using outcomes (not detailed process targets) while at the same time creating space for them to innovate, experiment and continuously improve.

"I believe people should learn how to make more mistakes, take more risks, and risk public humiliation in the service of seeking new solutions and finding creative approaches to solve problems," says Tim Harford, author and columnist, the Financial Times.

"Leaders need to **empower** managers and physicians and give them the **freedom to innovate** and act in order to **deliver quality** and **best practices**."

Patients as **partners**

> "**Payers** and providers see the **significant potential** to use patient power to not **only modify** and **enhance** how care is provided, but also to **produce improved** outcomes at lower cost."

The case for change

Traditionally, patients have been the passive recipients of the care provided to them. But recently, this has started to shift as patient expectations change and payers and providers see the significant potential to use patient power to not only modify and enhance how care is provided, but also to produce improved outcomes at lower cost. There are a number of factors catalyzing this change in the industry.

Changing patient expectations
With the advent of the internet, providers have found that patients, their families and caregivers are increasingly well informed about their treatment options and care pathways. At the same time, consumers' experience with other service industries means that the services offered by many health providers is increasingly out of line with the client-focused and data-driven approaches being utilized in other parts of the economy. Indeed, patients are increasingly expecting to interact with their service providers through a variety of channels (such as the web and mobile devices) and will expect the same type of approach from healthcare.

Amplified patient voice
Along with changing expectations, patients have also started to proactively take control of their health management. Social media and the internet have not only provided valuable access to opinions and information regarding personal health issues, but have also amplified patient voices and allowed individuals to advocate for greater influence on their treatment and the quality of service they receive. In turn, this has shifted the balance away from the traditional 'doctor knows best' relationship and towards one where patients take a more active role in their treatment plans.

Growing value of shared decision-making
Evidence shows that, for a range of conditions, patients often make better (and more cost-effective) decisions about their care when they are fully informed about their treatment options. In many cases, patients tend to choose more conservative and often lower-cost options than those chosen by their physician. The incentives to get involved in decisions are even greater in circumstances where patients have a direct financial stake in the costs of a procedure.

According to Professor Al Mulley of the The Dartmouth Institute for Health Policy & Clinical Practice in the US, there is a widespread failure by clinicians to properly understand the preferences of their patients and how the proposed interventions will affect their lives. He calls this 'preference misdiagnosis' and argues that there is a major problem of wasted resources and harm to patients as a result.

There is also growing concern that there is an increasing amount of 'over-diagnosis' in which patients are over investigated and screened. As a result, some patients are being treated for conditions for which the benefits of the intervention are – at best – marginal and

Jackie Brown, KPMG in the UK

in some cases harmful. The bottom line is that an informed patient that is aware of the risks may be less likely to agree to these procedures.

The need to improve planning for end-of-life care

Advance planning and ongoing communication with end-of-life patients and their caregivers will improve decision-making and ensure the appropriateness of care for patients near end of life. And, since the clinical goal for medical support should be on preserving and enhancing quality of life, there is growing consensus that efforts need to be made to reduce the proportion of patients dying in hospital and the amount of expensive, futile and often harmful care given at the end-of-life. Shifting to more appropriate and less clinically intrusive care settings should be a priority.

Making chronic disease care more effective

Healthcare systems are increasingly recognizing that many patients with chronic diseases are already engaged in high levels of supported self-care. Experience from other industries that have adopted 'self-service models' shows that self-serve approaches are popular with customers, even though they effectively mean that the consumer is undertaking a greater share of the work load. In many cases, consumers enjoy the benefits gained in convenience and control, as well as the potential for lower prices. And, as patients and payers start to experience mounting costs in insurance premiums, deductibles and co-payments, these approaches become much more attractive.

The fact that patients already manage much of their own care means that they are often experts in the management of their own condition, and are more likely to follow treatment plans and be motivated in achieving their personal health outcome goals. In fact, in the case of rare diseases, many patients have shown that they have more information than their primary care physician. They also often know more about how their bodies react to particular treatment options. Interestingly, many providers have been rather slow to capitalize on new innovations such as the use of social media to connect patients who share conditions, which enables them to exchange ideas, tips for self-care, and other information.

Opportunities to reduce the costs of care through changes in behavior

As payers become more aware of the opportunities to improve quality and reduce costs by getting patients more involved in their treatment decisions, many are also exploring opportunities to promote more healthy lifestyles, and the use of preventative care. And while the economic arguments for this approach are somewhat less clear than the ethical ones, all signs suggest that the economic evidence is growing. Regardless, the shift in behavior represents both a major challenge and an opportunity to payers, providers and patients and will require some significant rethinking of traditional approaches.

Embracing the change

Ensuring that organizations are well positioned to take full advantage of the changes now at work within the system will be no simple matter. Based on our experience, we have identified a number of components that must be in place for providers to capitalize on this new environment.

Pathways

Patients have become key players in the care pathway and, as such, need to be able to understand the options available to them. There also need to be mechanisms to ensure that care is consistent. Moreover, any variation not resulting directly from patient preferences must be eliminated and outcomes must become more predictable. In the ParkinsonNet case study on page 36, we see how pathways can be written in partnership with the patient and, critically, in a form that can be used by the patient themselves.

However, while pathways need to provide patients with choice and discretion about important decisions, an individual's adherence to them and their reasons for non-adherence need to be captured and analyzed. This process can be effectively managed through automation built into the IT systems, workflow process maps and by better defining the roles and responsibilities of clinical and support staff.

The patient record

For patients to become more involved in their care options, they first need to take ownership of their records and care plans. And, as approaches become more integrated, patients will also need to be able to grant varying degrees of access to their records to health and other professionals. This is particularly important for complex chronic conditions where the patient or their caregiver may take on some (or all) of the role of care coordination. But while the technology that allows information sharing in this way already exists, getting it accepted by professionals remains a challenge in many markets, and there are technical and information governance questions that will need to be managed.

Health literacy, decision aids and coaching

Many providers are finding that getting patients involved in shared decision-making requires patients to have developed health literacy and the support of decision aids and coaching (either face-to-face or electronically). Already there is ample evidence to show that greater health literacy helps patients to make better decisions and – in the case of chronic disease – manage their conditions more effectively. In fact, studies have found that increased health literacy has a significant impact on reducing unplanned hospital admissions.

At the same time, the growing interest in reducing over-treatment has led to the development of more information aimed at helping patients make better choices, particularly about tests and procedures where there is strong evidence of over-use and limited benefit. In the US, a number of specialist medical societies are actively producing web guidance tools aimed at helping inform patients about disease areas and treatment options and, in some cases, these are being used as a routine part of care between doctors and patients. Adjuvantonline is a great example of how web guidance is being used in oncology centers around the world.

Continuity and access

While most patients seem to want rapid access to high-quality professionals, a significant proportion, particularly those with chronic diseases, also want to see the professionals that know their particular circumstances and understand their condition. And while it is possible to create some form of electronic continuity, this can never be

> "For **patients** to become more involved in their **care options**, they first need to take **ownership** of their **records** and **care plans**."

a complete substitute for relationship-based care. This means that either patient expectations will need to be renegotiated, or providers will need to undertake substantial reorganization of the work of clinicians in primary care and specialists dealing with chronic diseases.

Social networks

As noted in the case study on page 36, patients are increasingly using social networks to connect with their peers in other markets, communities and countries. Sometimes, this has been combined with specialist portals that allow the interchange of information between patients and their providers. For payers and providers, the challenge is in working out how to engage with these networks, particularly in situations where the service is provided by a third party and therefore outside of the payers' and providers' control.

Technology to support self-management

As technology advances, we are seeing a range of new technologies emerging that are aimed specifically at helping patients manage their own care more effectively and efficiently. These include devices that support and facilitate physiological measurement, health status tracking, and access to advice. Increasingly, these solutions are being incorporated into smartphones or as add-on devices to existing equipment already owned by patients. As is often the case, the introduction of a new technology can often be far less challenging than the redesign of work processes and job roles that are required to support it.

A note of caution

It should be noted that not all patients (or their families and other potential caregivers) want to take responsibility for the management of their own care. Particularly with the elderly and those that are less 'health literate', patients may decide to let a clinician make some of these choices for them.

We also know that there are different segments of the population that have very different attitudes to self-care and self-management. Indeed, a sizeable proportion of the population may belong to segments that are not very engaged with their own health, are fatalistic or in denial. These vary significantly between different countries and cultures, as does willingness to challenge professional views. Those providers and payers that do not properly understand this, may find that their approaches fail to get traction and, as a result, resources will be wasted.

In the UK, the Whole System Demonstrator program found that 30 percent of patients did not wish to participate, in some cases because it was felt that the technology would act as a constant reminder of their illness.

In fact, there is still some debate on whether the frequent measurement of physiology actually helps people manage their health, with some arguing that we run the risk of 'medicalizing' normal variation and turning risks into diseases, creating unnecessary anxiety. Great care and multiple experiments will be required to make sure that some of these mistakes are avoided.

Prof. Axel Ekkernkamp, CEO, Unfallkrankenhaus, Berlin; Prof. Shan Wang, Peking University Peoples Hospital, China; Mei Dong, KPMG in China.

Case Study

ParkinsonNet is a vision of the future for the management of a complex disease and illustrates the power of the patient as a participant in their own care. It is also an inspiring example of clinical leadership.

The model has been built by Professor Bloem, a consultant neurologist at the Radboud University Nijmegen Medical Centre in the Netherlands. His goal was to create a model that met the needs of the patient while dealing with some of the institutional challenges inherent in the system, such as: poor referrals being made to specialists, over-treatment, under-treatment, the wrong treatments being used, a lack of specific expertise and poor communication between professionals about patient care. His research led him to believe that the overall gap between evidence and actual clinical practice needed to be closed.

In redesigning his services, he identified five areas that were key to success:

1. Helping to create an **active patient** able to manage their care and take key decisions.
2. Defining what **value-based care** would look like from the perspective of the patient.
3. Changing the way that doctors and other clinicians work with patients from **'God to guide'** by shifting to a partnership approach with patients to identify the regimen that works best for them.
4. Creating a **network of experts**.
5. Linking all of these together with **information technology tools**.

Based on these assumptions, Prof. Bloem worked directly with patients to develop a set of comprehensive guidelines including a special version geared towards patients' use. Interestingly, Prof. Bloem's work found that a key part of the guidelines involved patients telling their professionals what they needed to stop doing rather than what they should be doing.

With these guidelines in hand, Prof. Bloem then set about identifying all the professionals working with Parkinson's patients in his region, and then train a selection of these in the most up-to-date approach in the management of the condition, including the provision of physical therapy, symptom control, and so on. Essentially, this meant that Parkinson's expertise was focused within a smaller number of providers.

The next step was to provide these specialists with tools that could facilitate greater communication and the sharing of best practices, new approaches and data about patient outcomes.

With this infrastructure in place, Prof. Bloem was finally able to enroll patients through a web portal, thereby allowing patients to choose an accredited provider, confident in the fact that they would be using the same approach as other professionals in the network. Patients are able to set their own priorities and build their own networks of care supported by electronic tools which also allow them to set their own priorities and goals for their care, exchange information with professionals, and connect to other patients. The same tools are used to connect the professionals to each other.

The results of Prof. Bloem's work have been extremely impressive and show that sometimes the best thing leaders can do is give away their power. Patient outcomes and satisfaction have seen enormous improvements and the initiative has led to a reduction of hospital visits, a 50 percent reduction in hip fractures and substantial savings for payers valued at EUR20 million across the Netherlands.

Delegates include: Dr. Claudio Luiz Lottenberg, Hospital Israelita Albert Einstein, Brazil; Prof. Bastiaan R. Bloem, Radboud University Nijmegen Medical Centre, the Netherlands; and Humberto Salicetti, KPMG in Brazil.

Key take away points for Working with Patients

It is perhaps odd that it has taken so long for the patient to be recognized as being central to ideas about how healthcare needs to change. Putting the patient at the center is a slogan that is regularly heard but has often just been rhetoric. This is not only misguided but it means that a significant opportunity has often been lost.

Shared decision-making, co-designed services, patient self-management and the use of technology to put patients in control of their conditions could be a very significant trend. In the US this has been further reinforced by a provision in the Affordable Care Act which calls for the increased use of shared decision-making.

Ultimately, those providers and payers that are able to find new ways to work with their patients to adopt these new approaches will enjoy a significant advantage, strengthen their ability to deliver better care (often with fewer resources) and improve their ethical standing.

However, the journey can often be difficult and will require a change in behavior amongst providers, greater education of patients, more integrated technology and a range of new organizational competencies.

This relationship between patient, provider and payer will be key. It requires commitment to partnership and trust. There is also a need to invest in communications, relationships and awareness, ensuring everyone understands the issues and has the opportunity to contribute.

> "**Sometimes** the **best** thing leaders can do is **give away** their power."

Experiments, adaptation and sometimes – failure

One of the most thought-provoking contributions to our conference came from Tim Harford, Senior Columnist at the Financial Times. He argued that today's highly complex challenges do not lend themselves to top down leadership; the world has become far too unpredictable and complex. Instead, we must adapt – improvise, work from the bottom up, and take small steps rather than great leaps forward.

A number of the strategies listed here are emerging and all of them depend on the local context. They need to be adapted and modified to match local circumstances and, in many cases, require experimentation and the testing of new ideas. This is a worrying thought, particularly in healthcare and especially in those systems that have a high level of political involvement, as it means that there will be quite a high level of risk and some failures. But there is no real alternative.

An important role for leaders is to create the environment in which this spirit of innovation and experiment can thrive.

Conclusion

Lord Nigel Crisp, Chairman of the All-Party Parliamentary Group on Global Health in the UK

Systemic change – making it happen

KPMG's *Something to Teach, Something to Learn* stands out in two fundamental ways. It addresses practitioners rather than policy makers - and it champions real and successful developments as well as showing how new theories can be applied in the real world.

It draws together the collective views and learning from 40 practitioners drawn from 22 nations who participated in our Global Healthcare summit, and the practical knowledge drawn from experts from KPMG's extensive Global Healthcare Advisory practice.

A new phase is underway, as leading organizations and systems are rising to meet their challenges by developing innovative new models of care built on evolving relationships between payers, providers and patients and designed to marry cost-effectiveness with quality.

They did, however, confirm that the world's various health systems, regardless of design, funding, or level of establishment, all share very similar issues. In coming together as a group, they found that they all had something to teach, and something to learn.

The fact, however, remains, that the majority of health organizations have yet to embark on the highly complex yet vital journey of transformation to cope with pressures made even more acute by the global financial crisis.

Surveys of KPMG member firm clients reveal that while nearly all healthcare leaders accept that the way the industry works will change over the next five years – with 65 percent predicting major change – only a quarter of them are preparing to overhaul their business models. Many argue that they will be able to get by without such a transformation. Put another way: "Yes, major change is undoubtedly coming… but not for me."

The consequences of such inaction, this report argues, will put the future competitiveness and commercial survival of organizations at serious risk.

> "The **consequences** of inaction, will put the **future competitiveness** and commercial **survival of organizations** at serious risk. Now is the **time to act.**"

As our conference highlighted, no-one can avoid addressing the issues. Now is the time to act.

As this report highlights, healthcare payers – be they governments, public sector bodies or insurance companies – are no longer willing to continue along a route that is both unsustainable and also failing to deliver the best possible value for patients.

Payers are becoming 'activists', seeing themselves as agents of change where once they were more administrative and passive in their functions. Increasingly, they are demanding that healthcare providers re-think their models, while also incentivizing patients to take a bigger role and to become active partners with clinicians in the management of their own, personally-designed care.

Payers are ensuring that the people they are looking after get better value from the system. Approaches range from actively working to re-shape the landscape of provision in order to safeguard quality, influencing providers to come up with more imaginative and innovative care solutions, through to influencing the way patients choose what care they have, thus combating the problems of quality variation and, in some cases, over-diagnosis and over-treatment.

From volume to value

Healthcare providers also need to change the way they operate. This means they too must make a fundamental shift from volume to value. Where traditional models have focused on increasing volumes, new ones are beginning to focus instead on outcomes, quality and the need for integrated, closely-connected services which directly benefit patients.

Similarly, today's care is increasingly honing in on prevention and patient self-management at home and in the community, where once it waited for people to become ill enough to require complex, expensive hospital care.

One of the most exciting aspects of the conference – inspiring this report's title – was the realization that healthcare systems across the world, despite their widely differing approaches and structures, have a great deal to gain from each other in terms of pooling knowledge and experiences over the building of clinical and business models and the development of leadership.

It is no coincidence that many of the most demanding people in healthcare are also the most curious, spending a great deal of their time examining what others are doing. Markets in Asia and in emerging nations, in particular, are experimenting with fresh models and structures that are dynamic, flexible and open to further change rather than merely copying more experienced systems.

Our summit not only identified key issues facing healthcare, such as the rise of the 'activist payer', the challenges facing providers and the opportunity to engage patients as partners, but it also built on the discussions of delegates to highlight concrete ways for both payers and providers to meet the challenges ahead.

Recommendations for payers

- Payers must make their organization capable of contracting for outcomes and value for the patient rather than simply the volume of cases treated.
- Much more focus will need to be placed on the management of overall population health.
- Delivery models need to become more integrated, which means current payment systems, many of which actually encourage fragmentation, will need to reform.
- Pushing care upstream has become the clear mission.
- Payers must find new ways to connect to patients to influence their behavior.
- They must develop new skills and organizational abilities in data analytics, outcomes measurement, contracting, and care system design.
- Payers must engage with providers in new ways to shape their behavior, create innovation and, where necessary, stop contracting them to provide care where they fail to comply with quality standards and/or price.
- Providers will need to be incentivized to change in both the medium and longer term. Payers will need to find innovative ways to support them through the transition.

Isabel Vaz, Espírito Santo Saúde, Portugal

Recommendations for providers

- Providers need to fundamentally reshape their approach and they must do it quickly. There are a range of options available, but all will require new skills and ways of working.
- Being operationally excellent remains important but much more must be achieved.
- Many providers think they can grow organically as the demand for healthcare grows. Many of them will be wrong. If their current model is not working, simply making it bigger will not make it work any better nor solve its fundamental problems. Failing to deal with this poses a significant risk to their survival.
- New approaches will include creating integrated health systems where appropriate, building specialist networks, or focusing on areas of special expertise.
- For many, the logic is to take more responsibility for the whole of the patient journey or for the longer-term health of populations. There is a need to move away from providing episodes of care to providing or orchestrating the whole package. As with payers, this means less focus on volume and much more on value.
- Investing in leadership will be key, as will the creation of new relationships with clinical staff.
- Building networks, learning from other markets and better use of information to gain strategic advantage will come to the fore.

Payers and providers will also need to develop their information systems and analytics as they seek to make transformational changes to both their own organizations and to those around them. Information systems, which will have to be increasingly shared and more accessible in future, must underpin attempts to integrate care as well as support new ways of interacting with patients.

Finally, high-quality leadership and the engagement of doctors and front-line staff will be vital to help individual organizations to adapt.

Transformational change is, by definition, never easy – more experiments are required and with this there are greater risks. Similarly, changes will not bring overnight benefits – redesigning care pathways and provision, developing new contracting and payment methods and introducing new IT will all take time and can all have relatively long pay-back periods. This means that for many there will be difficult transitions and things may get worse before they get better.

Doing nothing is not an option

It is difficult to establish a timeline for action. Each organization will have its own market and regulatory environment to consider. Some will already have taken action, others will not, so that their next decisions will be heavily conditioned by their current situation.

That should not be an excuse for a lack of urgency. Doing nothing is the one option that is not on the table. The case studies included in this report offer graphic illustrations of how different bodies and market sectors are already grasping the opportunities for driving through transformational change.

Time is of the essence. Just as each organization needs to follow its own path of transformation, so each will face its own deadlines if it is to remain competitive over the coming years. Health leaders believe the next five years will be crucial.

Simply by joining the discussion, many of those leaders are already taking steps to reflect on their approaches, both from a domestic and international perspective, and monitor how organizations similar to their own are starting to re-evaluate their futures. For everyone has something to teach, and something to learn.

Wouter Bos, KPMG in the Netherlands

Recommendations for both payers and providers

- Payers and providers need to find new ways to work together and need to move away from traditional adversarial and transactional approaches to one which focuses on population health and outcomes.
- To fully understand the strategic options and models available, many organizations will have to think deeply about what they do, how they work, who they work with and the fundamental nature of their business.
- Leadership at all levels will be an essential investment in driving through change. The best leaders are already finding ways to manage the ever-increasing complexity of healthcare by creating the space for staff to innovate, experiment and continuously improve.
- For many, significant structural change will be required, yet the payback for such investment will not be immediate and will take time to be realized.
- Payers and providers must ensure there is a deep understanding of what constitutes value for patients and build this into every process – including the development of shared decision-making.
- They must use new channels to talk to patients and to connect them to each other. Shared decision-making, patient self-management and the use of technology to put patients in control of their conditions will be a significant trend.
- The best-prepared organizations are investing a significant amount in both teaching and learning as they work towards new ways of operating.

Something to teach, Something to learn does not end at the conclusion of this report.

Indeed, harnessing the many experiences and ideas that have informed this document is just the start.

Our intention now is to use the important lessons from the global summit to begin a dialogue with healthcare leaders, practitioners and influencers across the world.

We will use our networks, the unrivalled expertise of our Center of Excellence team and our international reach to take the debate around the world and help facilitate the spread of innovation and good practices.

At the same time, KPMG's healthcare professionals will work hard to explore and develop the tools that will help enable health systems to prepare themselves for the challenges ahead.

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We wish to express our sincere thanks to the participants and contributors to this report.

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Global Healthcare

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We invite you to visit KPMG Global Healthcare (kpmg.com/healthcare) to access our global thought leadership. Here you can gain valuable insights on a range of topics that we hope add to the global dialogue on healthcare. Should you prefer a printed copy of the publication, please email us at healthcare@kpmg.com.

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This report identifies the five key habits that have proven successful to manage the workforce challenge by making substantial improvements in productivity and capacity.

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KPMG's Center of Excellence contains some of the world's leading healthcare professionals. Based in North America, Europe and Asia Pacific, the team is mobile and works alongside our network of member firms to design and implement creative and practical solutions for our clients that harness the latest in national, regional and global perspectives.

Dr. Mark Britnell, Chairman and Partner, Global Health Practice, KPMG in the UK

Mark has a pioneering vision of the future of healthcare in both the developed and developing worlds.

Dr. Wai Chiong Loke, KPMG in Singapore

By harnessing the power of collaboration, Wai Chiong helps generate innovative solutions and push them towards clinical and commercial success.

Dr. Cynthia Ambres, KPMG in the US

Through strategic leadership and effective change management, Cynthia has brought lasting improvements to both major healthcare providers and health plans.

Malcolm Lowe-Lauri, KPMG in the UK

Having led some of the UK's largest health authorities, Malcolm has spearheaded new delivery models to achieve cross-organizational change.

Dr. Richard Bakalar, KPMG in the US

Richard is helping push back the boundaries of healthcare through better use of technology; gathering, analyzing and sharing data to improve outcomes.

Mark Rochon, KPMG in Canada

A true healthcare strategist with the will to make things happen, Mark has played an important part in advancing the healthcare system of the province of Ontario, Canada.

Dr. Marc Berg, KPMG in the Netherlands

Marc's pioneering work on commissioning, purchasing and operations has produced dramatic advances in outcomes at lower cost.

Marc Scher, KPMG in the US

An advisor to healthcare providers on strategy, risk, operations, finance and transformation, who has advised a wide range of healthcare providers on financing.

Jan de Boer, KPMG in the Netherlands

A leading exponent of Health IT, Jan helps join the different parts of the healthcare community to improve healthcare by using new technology.

Ashraf W. Shehata, KPMG in the US

A vastly experienced healthcare professional who's been at the cutting edge of IT advances in the sector.

Janet Davidson, KPMG in Canada

Having been a nurse, an assistant deputy minister and a senior executive of a public hospital, Janet has a unique understanding of healthcare systems.

John Teeter, KPMG in the US

John's unique understanding of the challenges of federal government healthcare IT has a global relevance.

Nigel Edwards, KPMG in the UK

Nigel is a major figure in global healthcare, with expertise in national healthcare policy planning, design and reform.

Dr. Hilary Thomas, KPMG in the UK

A leading exponent of care system redesign, Hilary helps join the different parts of the healthcare community to improve efficiency and quality.

Dr. Sören Eichhorst, KPMG in Germany

With experience across a range of healthcare sectors, Sören brings together the different stakeholders to improve both quality and margins.

Roger Widdowson, KPMG in the UK

Roger uses his knowledge of both healthcare and what makes a successful transaction to ensure that corporate M&A adds shareholder value.

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