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Redefining Competition in Health Care

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The U.S. health care system has registered unsatisfactory performance in both costs and quality over many years. While this might be expected in a state-controlled sector, it is nearly unimaginable in a competitive market—and in the United States, health care is largely private and subject to more competition than virtually anywhere else in the world.

In healthy competition, relentless improvements in processes and methods drive down costs. Product and service quality rise steadily. Innovation leads to new and better approaches, which diffuse widely and rapidly. Uncompetitive providers are restructured or go out of business. Value-adjusted prices fall, and the market expands. This is the trajectory common to all well-functioning industries—computers, mobile communications, banking, and many others.

Health care could not be more different. Costs are high and rising, despite efforts to reduce them, and these rising costs cannot be explained by improvements in quality. Quite the opposite: Medical services are restricted or ra-

tioned, many patients receive care that lags currently accepted procedures or standards, and high rates of preventable medical error persist. There are wide and inexplicable differences in costs and quality among providers and across geographic areas. Moreover, the differences in quality of care last for long periods because the diffusion of best practices is extraordinarily slow. It takes, on average, 17 years for the results of clinical trials to become standard clinical practice. Important constituencies in health care view innovation as a problem rather than a crucial driver of success. Taken together, these outcomes are inconceivable in a well-functioning market. They are intolerable in health care, with life and quality of life at stake.

We believe that competition is the root of the problem with U.S. health care performance. But this does not mean we advocate a state-controlled system or a single-payer system; those approaches would only make matters worse. On the contrary, competition is also the solution, but the nature of competition in

health care must change. Our research shows that competition in the health care system occurs at the wrong level, over the wrong things, in the wrong geographic markets, and at the wrong time. Competition has actually been all but eliminated just where and when it is most important.

There is no villain here. Poor public-policy choices have contributed to the problem, but so have the bad choices made by health plans, hospitals, and the employers who buy their services. Decades of “reform” have failed, and attempts to reform will continue to fail until we finally get the right kind of competition working.

The health care system can achieve stunning gains in quality and efficiency. And employers, the major purchasers of health care services, could lead the transformation.

Zero-Sum Competition

In any industry, competition should drive up value for customers over time as quality improves and costs fall. It is often argued that health care is different because it is complex; because consumers have limited information; and because services are highly customized. Health care undoubtedly has these characteristics, but so do other industries where competition works well. For example, the business of providing customized software and technical services to corporations is highly complex, yet, when adjusted for quality, the cost of enterprise computing has fallen dramatically over the last decade.

Health care competition, by contrast, has become zero sum: The system participants divide value instead of increasing it. In some cases, they may even erode value by creating unnecessary costs. Zero-sum competition in health care is manifested in several ways: First, it takes the form of cost shifting rather than fundamental cost reduction. Costs are shifted from the payer to the patient, from the health plan to the hospital, from the hospital to the physician, from the insured to the uninsured, and so on. Passing costs from one player to another, like a hot potato, creates no net value. Instead, gains for one participant come at the expense of others—and frequently with added administrative costs.

Second, zero-sum competition involves the pursuit of greater bargaining power rather than efforts to provide better care. Health

plans, hospital groups, and physician groups have consolidated primarily to gain more clout and to cut better deals with suppliers or customers. But the quality and efficiency gains from consolidation are quite modest.

Third, zero-sum competition restricts choice and access to services instead of making care better and more efficient. As the system is currently structured, health plans make money by refusing to pay for services and by limiting subscribers’ and physicians’ choices. Health plans and care providers restrict patients’ access to medical innovations or limit the services that are covered. Many health plans pay hospitals a set amount per admission for a given ailment rather than for a full treatment cycle. This creates an incentive for hospitals to use cheaper treatments rather than more effective, innovative ones—and if patients consequently must be readmitted, the hospitals are paid again.

Fourth, zero-sum competition relies on the court system to settle disputes. Yet lawsuits compound the problem. They actually raise costs directly (through legal fees and administrative expenses) and indirectly (through the practice of unnecessary, defensive medicine)—none of which creates value for patients. Moreover, of the billions of dollars that doctors and hospitals pay annually for malpractice insurance, less than 30% goes to injured patients or their families.

What Happened?

Zero-sum competition in health care is the consequence of a series of unfortunate strategic choices made by nearly all the actors in the system—encouraged, and in some cases reinforced, by bad incentives introduced through government regulation. These include:

The Wrong Level of Competition. The most fundamental and unrecognized problem in U.S. health care today is that competition operates at the wrong level. It takes place at the level of health plans, networks, and hospital groups. It should occur in the prevention, diagnosis, and treatment of individual health conditions or co-occurring conditions. It is at this level that true value is created—or destroyed—disease by disease and patient by patient. It is here where huge differences in cost and quality persist. And it is here where competition would drive improvements in efficiency and effectiveness, reduce errors, and spark innovation. Yet competition at the level

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How Reform Went Wrong

Attempts to reform the U.S. health care system have failed because they have been based on the wrong diagnosis of the problem.

These reform efforts have not resulted in meaningful competition at the level of specific diseases and conditions—the level at which value is created in medicine. With competition at the wrong level, all the system participants—consumers, providers, employers, and insurers—have acted counterproductively. Some historical perspective appears in the exhibit, “The Evolution of Reform Models.”

The managed care era was focused largely on cost; reformers treated health care as if it were a commodity. To cut their expenses, payers shifted costs and aggressively pursued bargaining power. Providers did the same. Services were rationed, and there were few true improvements in efficiency. Ironically, costs continued to rise.

In reaction to managed care, reformers tried to give patients more legal rights. Those efforts ended up saddling health care providers with extra regulatory layers—and increased costs. Requiring hospitals and doctors to adhere to a patients’ bill of rights did eliminate some of the more egregious examples of cost-driven rationing by providers, but it also left untouched the fundamental cause of providers’ behavior—namely, competition structured to compel players to focus on cost. Costs rose even higher.

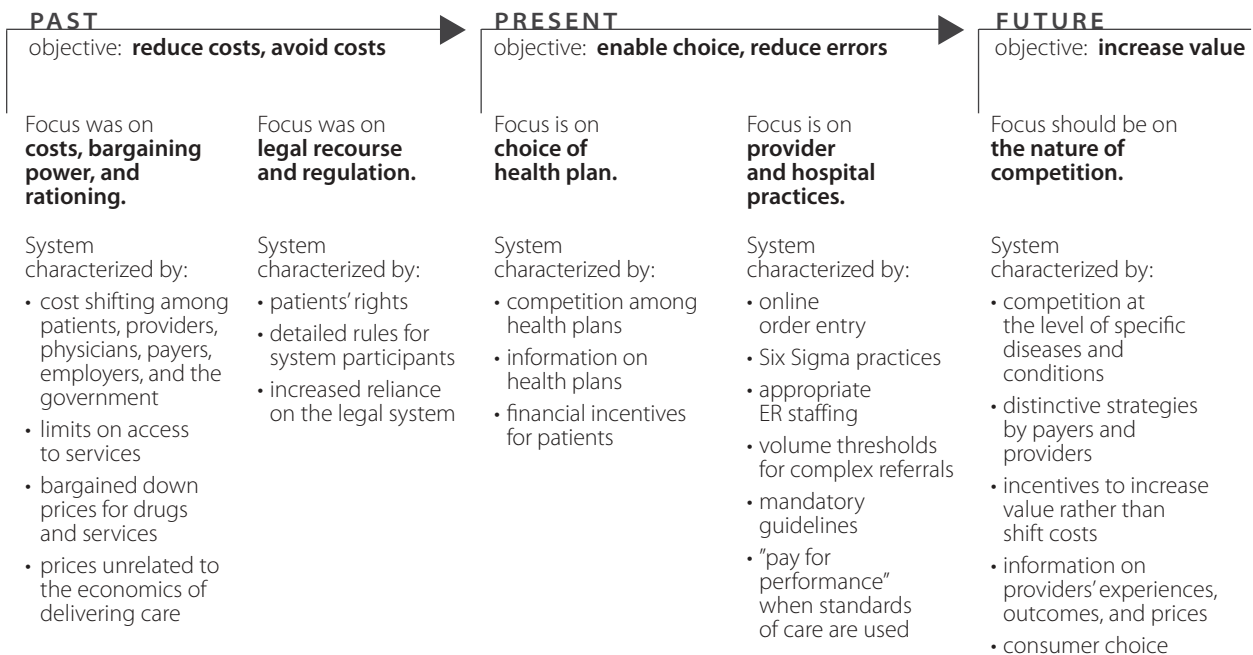
When their attempts to fix the system through legal and regulatory means proved futile, reformers began to focus on consumer choice—a good topic to examine, but subscribers’ choice of health plan is not the choice that really matters. Consumers today have little choice about providers and treatments and are in no position to make informed decisions given the limited information available to them.

Recent thinking on health care reform has migrated to improving quality and reducing medical errors. Employer consortia are attempting to improve hospital practices by requiring that facilities, for instance, enter treatment orders into a computerized system, maintain appropriate coverage in intensive care units and emergency rooms, and meet volume thresholds for some referrals. These are useful requirements, but they do not change the underlying incentives for zero-sum competition. Similarly, employer-proposed “pay for performance” initiatives will help in the near term to get more providers to comply with current accepted medical standards. But this will not be enough to reform the system because the incentives are to conform to specific processes, not to achieve real results. Effective incentives need to be tied to goals rather than means.

Some recently proposed reforms will even ex-

acerbate zero-sum competition. For instance, some employer groups advocate “system to system” competition, in which physicians are forced to commit to one closed network or another. This actually limits competition at the level of diseases and treatments while accentuating the power of a few full-line systems to completely avoid competing at this level. Meanwhile, other proposed reforms, such as the migration of some consumers from Medicare to private insurance and the purchase of prescription drugs from Canada, are not reforms at all. Shifting Medicare patients to a private system that is not working is not a solution. And buying drugs from Canada is the system’s latest attempt to shift costs rather than create value.

Missing in the discussion about health care reform is an understanding of the role competition plays in driving quality, safety, and efficiency improvements and the type of competition that will best do so. If the objective is to create value, then competition to improve outcomes and increase efficiency in specific medical conditions is essential. Getting the level of competition right will reduce error and encourage the spread of new, excellent practices. Reform must focus on the rules, incentives, information, and strategies that will enable positive-sum competition where it counts—at the level of individual diseases and treatments.



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of individual health conditions is all but absent.

The fundamental economics of health care are driven at the level of diseases or conditions. Numerous studies show that when physicians or teams treat a high volume of patients who have a particular disease or condition, they create better outcomes and lower costs. (For more on this concept, see the exhibit “Experience Matters.”) The renowned Texas Heart Institute (THI), for example, prides itself on having surgical costs that are one-third to one-half lower than those of other academic medical centers despite taking on the most difficult cases and using the newest technologies. Because of its specialization, THI attracts the most complex and demanding patients, whose needs produce even more rapid learning. In health care, as in most industries, cost and quality can improve simultaneously as providers prevent errors, boost efficiency, and develop expertise. As we have learned in many businesses, “doing it right the first time” not only improves outcomes but can dramatically cut costs. The

trade-off between cost and quality in health care, then, is significantly reduced by competition at the right level.

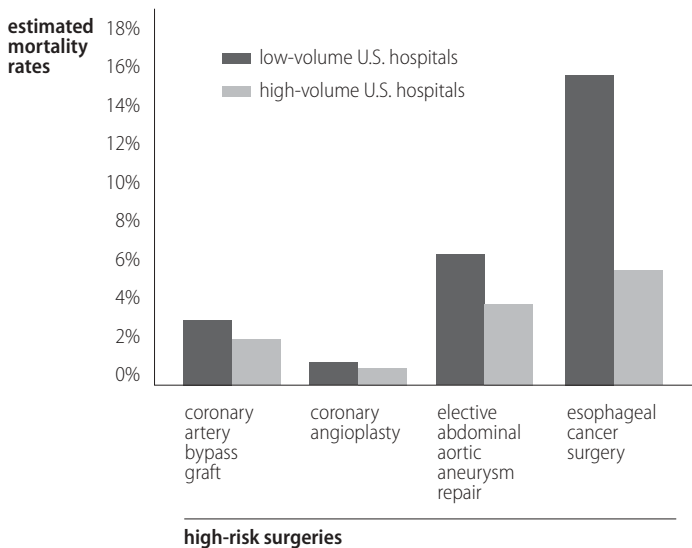
Competition at the level of individual diseases and conditions is getting even more important as medical research reveals that diagnoses and treatments should be increasingly specialized. Prostate cancer, for example, is now understood to be six different diseases that respond to different treatments. Providers should compete to be the best at addressing a particular set of problems, and patients should be free to seek out the providers with the best track records given their unique circumstances. In the current environment, where patients’ treatments are determined by the networks they are in, network providers are all but guaranteed the business.

The Wrong Objective. Competition at the wrong level has been exacerbated by pursuit of the wrong objective: reducing cost. Even worse, the objective has often not been to reduce the total cost of health care but to reduce the cost that is borne by the system’s intermediaries—health plans or employers. The right goal is to improve value (quality of health outcomes per dollar expended), and value can only be measured at the disease and treatment level. Competing on cost alone makes sense only in commodity businesses, where all sellers are more or less the same. Clearly, that is not true in health care. Yet that perverse assumption—which neither buyers nor sellers really believe—underlies the behavior of the system participants. Payers, employers, and even providers pay insufficient attention to achieving better outcomes and improving value over time, which are what really matter.

The Wrong Forms of Competition. Instead of competing to increase value at the level of individual diseases or conditions, the players in health care have entered into four unhealthy kinds of competition, all of which have unhappy consequences. One is the annual competition among health plans to sign up subscribers. Because of strong network restrictions, however, signing up for a health plan blocks most of the competition at the level of diseases and treatments. And because the commitment between the subscriber and the health plan is for just one year, both payers and employers are motivated to engage in short-term thinking rather than invest in practices and therapies that will improve value

Experience Matters

The more experience physicians and teams have in treating patients with a particular disease or condition, the more likely they are to create better outcomes—and, ultimately, realize lower costs. By performing particular procedures over and over, teams increase their learning opportunities and thereby reduce mortality rates.



Source: John D. Birkmeyer, *Leapfrog Patient Safety Standards: The Potential Benefits of Universal Adoption*, November 2000.

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over time.

Another form of unproductive competition occurs when providers compete to be included in health plan networks by giving deep discounts to payers and employers that have large patient populations. There is little or no economic rationale for such discounts. It does not cost less to treat a patient employed by a large company than a patient who is self-employed. Health care delivery does not become more efficient from treating twice as many patients with a random distribution of diseases; patients are still treated one at a time and according to their particular circumstances. Large discounts in return for increased overall patient flow simply shift revenue from providers to health plans or to large employers. This creates artificial benefits for large groups and shifts costs to small groups, unaffiliated individuals, patients seeking out-of-network care, and the uninsured—with little, if any, compensating value. Such cost shifting ultimately drives up overall costs—even to large groups—by increasing the number of uninsured patients who must be treated in expensive settings (emergency rooms, for instance) and hence the amount of free care that must be subsidized.

Providers also compete to see who can form the largest, most powerful group, able to offer a complete array of services. Here, too, there are few efficiencies to be gained, apart from modest opportunities to share overhead. Hospital mergers often result in two departments in the same specialty rather than one department, even when the facilities are close to one another. Provider groups are formed not to create value but to boost bargaining power vis-à-vis health plans and other system participants. Throughout Florida, for example, large hospital networks have won price increases far above the rate of inflation and unconnected to any improvements made in quality of care after threatening to cut off one of the region's largest health plans. And because their referrals are heavily skewed toward affiliated physician groups and institutions, large provider groups further limit competition at the level of diseases and treatments.

Finally, there is always a squabble over who pays. This struggle takes many forms. Providers and payers try to shift costs to each other. Payers raise rates on subscribers who become ill. Providers boost their list prices so Medicare discounts will not cut so deep. Patients seek

coverage for optional or cosmetic care. And employers allow health plans to deny payment to their employees. All of this is costly. None of it creates value for patients.

The Wrong Geographic Market. Competition should force providers to equal or exceed the value created by the best in their region or even nationally. For the most part, however, health care competition is local. Such competition insulates mediocre providers from market pressures and inhibits the spread of best practices and innovations. Throughout the United States, there is an almost threefold variation in annual costs per Medicare enrollee—from less than \$3,000 per patient in some areas to more than \$8,500 in others. According to studies by Dartmouth Medical School's John Wennberg and the school's Center for the Evaluative Clinical Sciences, the higher costs are not associated with better medical outcomes and cannot be explained by differences in age, sex, race, rates of illness (which affect the need for care) or cost of living (which affects the cost of delivering care). These studies did find, as have several others, major differences across regions in outcomes and in delivery of care at the disease or treatment level. Such differences are sustained by the absence of competition.

Localized competition is institutionalized by health plan policies that require subscribers to pay most of the costs of out-of-network care—discouraging them from seeking providers outside their immediate area—or that penalize physicians for making out-of-network referrals. Medicare, for its part, computes HMO capitation payments at the county level, creating little incentive for hospitals in different counties to compete, even if they are only a few miles apart. Localized competition is also the result of habit, inertia, and information; as a matter of course, physicians refer their patients to nearby doctors—even their Medicare patients, who have no geographic restrictions.

Though many health care services should be provided locally, health care competition should take place regionally, or even nationally, especially for more complex or uncommon conditions. In this way, all providers would be subject to competitive pressures to improve. And providers treating less common conditions, drawing from a wider area, could serve enough patients to develop the expertise and efficiency that come with repeated experi-

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ence and learning.

An ideal health care system would encourage close working relationships between local providers (for most routine and emergency services and follow-up care) and a wide array of leading providers (for definitive diagnoses, treatment strategies, and complex procedures in certain areas). These relationships would speed up the diffusion of state-of-the-art clinical care and would help to increase quality and efficiency throughout the system—but they are often resisted today.

The Wrong Strategies and Structure. Although value is created by developing deep expertise and tailored facilities in a set of areas where providers can truly excel, most hospitals and networks have instead pursued wide service lines to negotiate better with health plans. Hospitals and physician groups have broadened their services by merging with or acquiring other institutions, resulting in roughly 700 hospital mergers between 1996 and 2000 and very high levels of local industry concentration. In North Carolina, for instance, only 18 of 100 counties had multiple hospital systems in 2000. Rivalry is severely limited as a result.

This reduction in competition produces few offsetting benefits. As we have discussed, consolidation has led to few efficiencies. Nor is it at all clear that quality is better when the breadth of services is wider. Though some patients have multiple diseases, focused institutions can easily cope with this. The M.D. Anderson Cancer Center in Houston, for example, has staff cardiologists but does not maintain a full-line cardiology practice. When difficult cases arise or heart surgery is required, the physicians at M.D. Anderson consult with outside colleagues or refer their cancer patients to leading cardiac centers.

The Wrong Information. Information is integral to competition in any well-functioning market. It allows buyers to shop for the best value and forces sellers to compare themselves to rivals. In health care, though, the information really needed to support value-creating competition has been largely absent or suppressed. There is plenty of information about things that have a modest impact on value—health plan coverage and subscriber satisfaction surveys, for instance. But much more relevant is information about providers' experiences and outcomes in treating particu-

lar conditions. Even this basic information is unavailable. For example, most hospitals and physicians do not even provide data on how many patients with a particular diagnosis or condition they have treated. Instead, available information about medical experiences and outcomes is largely word-of-mouth, even among physicians, and may be unsupported by evidence.

There have been efforts to collect the right kind of information—among them, Cleveland Health Quality Choice, the Pennsylvania Health Care Cost Containment Council, and New York State's Cardiac Surgery Reporting System. But these have been small-scale experiments. Providers argue that data on the outcomes of treatments—appropriately risk-adjusted to reflect the complexity or severity of the patients' initial conditions—are complex and difficult to measure in meaningful ways. Indeed, the collection of outcome information has been actively opposed by some system participants—sometimes for good reasons (the difficulty of performing risk adjustments, for instance) and sometimes for not so good reasons (fear of comparison and accountability, for instance).

Some observers have tried to discredit the attempts that have been made so far to collect relevant information. But these experiments demonstrate both the critical value of having the right information and the feasibility of developing it. In Cleveland, the information collected was not disseminated to patients or referring doctors. Employers, faced with short-term cost pressures, did not use the data to select high-quality providers. Patients and doctors were left in the dark. Meanwhile, in New York, information was collected on risk-adjusted mortality rates following cardiac bypass surgeries performed statewide, and the data were made more widely available. In response to the data, cardiac surgery groups pursued process improvements, and some hospitals revoked the privileges of cardiac surgeons with low volume and high mortality rates. After four years of published data, New York had the lowest risk-adjusted mortality following bypass surgery of any state in the country.

Encouraging competition at the level of specific diseases or conditions will speed the development of the right kind of information. For instance, insurer Preferred Global Health (PGH) helps its subscribers choose among the

The locus of competition has to shift from “Who pays?” to “Who provides the best value?”

world-class providers and treatments it offers for the 15 critical diseases it covers. To find the highest-quality providers, PGH identifies those with the most experience in the most advanced treatments, documents their effectiveness and outcomes, and asks them to participate in quality-improvement processes. PGH’s experience belies the argument that there is too little information available for meaningful consumer choice in health care. America cannot afford to wait for perfect information to be developed before it can be disseminated. Nothing will drive improvements in information faster than making the existing data widely available.

The Wrong Incentives for Payers. Health insurers should be rewarded for helping their customers learn about and obtain care with the best value; for simplifying administrative processes; and for making participants’ lives easier. Instead, payers benefit financially from enrolling healthy people and from raising premiums for or denying coverage to sick people. Payers have incentives to complicate billing; they can shift costs by issuing incomprehensible or inaccurate invoices and by delaying or disputing payment. They also have incentives to shift costs or reduce services by putting roadblocks between patients and care providers, restricting patients’ access to expensive treatments and most out-of-network treatments. (Although out-of-network care is not inherently more expensive, hospitals charge out-of-network patients list prices that may be twice as high as negotiated in-network prices. The difference between the amount the payer will reimburse and the artificially high list prices essentially makes out-of-network care prohibitively expensive for many patients.) Finally, payers benefit from slowing down innovations that do not show immediate, short-term cost savings. All these incentives reinforce zero-sum competition and work against value creation in health care.

A single-payer system, which has been proposed, would end the practice of excluding high-risk subscribers. But it would only exacerbate all the other skewed incentives by eliminating competition at the level of health plans and giving the payer more bargaining power with which to shift costs to providers, patients, and employers. A single payer would have greater incentive to reduce its costs by restricting or rationing services and by slowing the dif-

fusion of innovation. The only real solution is to change these incentives and open up competition, not to make health insurance a government monopoly.

The Wrong Incentives for Providers. Providers should be rewarded for competing regionally and nationally to deliver the best-value care for particular conditions or diseases. Instead, providers’ incentives, just like the payers’ incentives, reinforce zero-sum competition in health care. Hospitals and physicians have incentives to not refer patients to other providers who may be more experienced or to make referrals only within their network. Reimbursement practices encourage physicians to spend less time with patients, discharge them quickly, and readmit them if there is a problem. While many physicians resist the pressure to undertreat their patients, this conflict between good medicine and economic self-interest demoralizes physicians and slows the diffusion of best practices.

The threat of malpractice suits creates opposing incentives for physicians to overtreat, overtreat, and overrefer their patients. Unfortunately, these incentives to overtreat do not cancel out the reimbursement incentives to undertreat. Instead, the result is less effective clinical practice and mountains of paperwork that drain doctors’ time. Worse still, the threat of malpractice suits creates risks for providers who try to learn from bad outcomes by measuring and analyzing them. Ironically, while technology has made knowledge diffusion faster and easier than ever before, the social and economic structures of the health care sector work against the rapid dissemination of learning.

Positive-Sum Competition

In a healthy system, competition at the level of diseases or treatments becomes the engine of progress and reform. Improvement feeds on itself. For that process to begin, however, the locus of competition has to shift from “Who pays?” to “Who provides the best value?” Getting there will require changes in the strategies of providers and payers and in the behaviors of employers purchasing health plans. In addition, some important system infrastructure needs to be put in place—rules and regulations that shift the incentives and create the right types of information. Let’s look at each needed reform in turn.

Provider Strategies: Distinctiveness. Under positive-sum competition, providers would not attempt to match competitors' every move. Instead, they would develop clear strategies around unique expertise and tailored facilities in those areas where they can become distinctive. Most hospitals would retain a wide array of service areas, but they would not try to be all things to everyone. In most businesses, it is common sense to develop products and services that create unique value. For many hospitals, developing unique-

ness is a significant change in mind-set and deciding what *not* to do is an even more radical idea.

No Restrictions to Choice. Under positive-sum competition, all restrictions to choice at the disease or treatment level would disappear, including network restrictions and approvals of referrals. Reasonable co-pays and large deductibles combined with medical savings accounts would let patients take some financial responsibility for their choices. But co-pays would be the same inside and outside of

Pitfalls and Potential: An Overview of What's Plaguing U.S. Health Care

In any industry, competition should drive up value for consumers over time. In health care, competition is zero sum—value is divided (sometimes destroyed) instead of increased. The system can change if the participants strive for positive-sum competition.

The Features of ZERO-SUM Competition in Health Care



The Wrong Level of Competition

Competition is among health plans, hospitals, and networks.

The Wrong Objective

Cost reduction; participants try to reduce their own costs by transferring them to someone else without reducing the total cost.

The Wrong Forms of Competition

Competition is to sign up healthy subscribers. Methods include discounting prices to large payers and groups, consolidating to increase bargaining power, and shifting costs.

The Wrong Geographic Market

Competition is local.

The Wrong Strategies and Structure

Participants build full-line services, form closed networks, consolidate with others (thereby reducing rivalry), and match their competitors.

The Wrong Information

Information is about health plans and subscribers' satisfaction surveys.

The Wrong Incentives for Payers

Payers try to attract healthy subscribers and raise rates for unhealthy subscribers. They restrict treatments and out-of-network services, shift costs to providers and patients, and slow down innovation.

The Wrong Incentives for Providers

Providers offer every service, but often below prevailing medical standards. They refer patients within the network, if at all; spend less time with patients and discharge them quickly; and practice defensive medicine.

the network. Antitrust authorities would scrutinize system participants so that one hospital system or health plan did not unfairly dominate an important market.

Transparent Pricing. Prices would be posted and readily available. Providers would charge the same price to any patient for addressing a given medical condition, regardless of the patient's group affiliation. Providers could and would set different prices from their competitors, but that pricing would not vary simply because one patient was insured by

Aetna, another covered by Blue Cross, and another self-insured. Payers could negotiate, but price changes would have to benefit all patients, not just their own. The cost of treating a medical condition has nothing to do with who the patient's employer or insurance company is.

Price discrimination not related to costs imposes huge burdens on the system today. Having multiple prices drives up administrative costs. Patients covered by the public sector are subsidized by private-sector patients. And



The Features of POSITIVE-SUM Competition in Health Care



The Ingredients for Change

No Restrictions to Competition and Choice

- No preapprovals for referrals or treatments
- No network restrictions
- Strict antitrust enforcement against collusion, excessive concentration, and unfair practices
- Meaningful co-payments and medical savings accounts with high deductibles, all of which will give consumers incentives to seek good value

Accessible Information

- Appropriate information on treatments and alternatives is formally collected and widely disseminated.
- Information about providers' experience in treating particular diseases and conditions is made available immediately.
- Risk-adjusted outcome data are developed and continually enhanced.
- Some information is standardized nationally to enable comparisons.

Transparent Pricing

- Provider sets a single price for a given treatment or procedure.
- Different providers set different prices.
- Price estimates are made available in advance to enable comparison.

Simplified Billing

- One bill per hospitalization or per period of chronic care
- Payer has legal responsibility for medical bills of paid-up subscribers.

Nondiscriminatory Insurance

- No re-underwriting
- Assigned risk pools for those who need them
- Required health plan coverage, which would create equity and value throughout the system

Treatment Coverage

- National list of minimum required coverage
- Additional coverage results from competition, not litigation.

Fewer Lawsuits

- More information means more disclosure of risks and better-informed choices by patients.
- Lawsuits address use of obsolete treatments and carelessness.

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within the private sector, patients in large groups are subsidized by the uninsured, members of small groups, and out-of-network patients, who pay list prices. Artificially high list prices make more patients unable to pay, driving up uncompensated care expenses, which leads to ever higher list prices and bigger discounts for large groups. The price disincentives for care outside of the network stifle competition, which in turn slows quality and efficiency improvements that would otherwise benefit all patients. Without service-by-service competition, costs spiral ever higher while quality lags. The cost of dysfunctional competition far outweighs any short-term advantages system participants get from price discrimination—even for those firms that currently get the biggest discounts.

Paradoxically, the most practical way to eliminate price differentials for favored groups might be to temporarily institutionalize them. The federal government could limit the spread between the most discounted price and the highest price charged by a provider for any service and then reduce this spread each year over a five-year period. Ending the price anomalies would put a short-run burden on the biggest beneficiaries of the current system—master cost shifters like Medicare and the largest health plans. But over time, all participants would benefit from the enormous improvements in value and efficiency.

Simplified Billing. A fundamental function of pricing is to convey information to consumers and competitors. Current billing practices obscure that information. Unnecessarily complex billing contributes to cost shifting, drives up administrative costs, and makes price and value comparisons virtually impossible. Under positive-sum competition, providers would have to issue a single bill for each service bundle, or for each time period in treating chronic conditions, rather than a myriad of bills for each discrete service. Many other industries have solved the problem of how to issue a single bill for customized services; among them aerospace, construction, auto repair, and consulting. A competitive health care industry could figure it out, too. Competing providers would also figure out how to give price estimates in advance of service. Such estimates would not only improve consumer choice but would also spur providers to learn about their real costs.

The other major source of billing problems is that currently, the patient bears the legal responsibility for bills, even with fully paid-up insurance. In positive-sum competition, payers would bear full legal responsibility for the medical bills of paid-up subscribers. If providers bill once and payers cannot shift costs to patients or providers, much of the confusion in billing will end.

Accessible Information. Under positive-sum competition, both the providers and the consumers of health care would get the information they need to make decisions about care. The government or a broad consortium of employers could jump-start the collection and dissemination process by agreeing on a standard set of information that would be collected nationally on a regular basis. Indeed, medical information is not unlike the corporate disclosures overseen by the SEC. The benefits of national comparisons are compelling and will unleash a tidal wave of improvements in quality and efficiency.

An obvious—and relatively uncontroversial—starting point would be to collect information on specific providers' experience with given diseases, treatments, and procedures. The data would be made publicly available after a waiting period during which providers could correct any errors. Over time, information about providers' risk-adjusted medical outcomes also would need to be collected and disseminated, allowing consumers to evaluate the providers' areas of expertise. This information would be specific to particular diseases or medical conditions, not aggregated across different areas of medical practice. A productive system would also collect or disseminate pricing information, enabling comparisons for specific treatments or procedures.

Nondiscriminatory Insurance Underwriting. Two anomalies mar the pricing of health plans. First, people who are included in large risk pools (such as those who work for big companies) can get a reasonably priced health plan even if someone in the family has medical risks. But those without access to such a pool (such as people who work for small firms or are self-employed) will pay very high prices if a family member has medical risks. Realistic reform efforts need to assume that health care coverage will continue to come mostly from employers. However, risk-pooling solutions need to be developed for those who are self-

employed, employed by small firms, employed part-time, or unemployed. For example, smaller companies are joining consortia for health plan purchases. For high-risk people unable to buy health plans, assigned risk pools, like those used in automobile insurance, will need to be developed.

In addition, people in small groups or with individual insurance policies face the likelihood that their premiums will rise sharply if someone in the family actually develops an expensive medical condition, even if the family has paid premiums for years without making large claims. This practice, known as “re-underwriting,” negates the purpose of health insurance and must be eliminated.

Fewer Lawsuits. Malpractice litigation and the associated defensive medical practices inflict huge costs on everyone, and they have done little to raise the quality of health care. Indeed, the threat of malpractice creates incentives for physicians and hospitals to hide their mistakes rather than own up to and eliminate them. Standards for malpractice litigation need to change. Lawsuits are appropriate only in cases of truly bad medical practice, such as negligence, the use of obsolete treatments, or carelessness, not when a patient had a bad outcome despite receiving appropriate, up-to-date treatment. With better information and no restrictions on choice, many lawsuits will be averted. The money spent on enabling information and choice is an investment in removing billions of dollars of administrative and legal costs from the system.

National List of Minimum Coverage. The current system of individual negotiation and litigation over coverage is expensive. A better system would mandate a minimum level of coverage with a national list (such as the one used in the Federal Employees Health Benefits Program). Health plans could choose to cover more services and treatments for competitive reasons, but they could not be forced to do so by lawsuits. This change would refocus health care expenditures from malpractice premiums to delivery of care for more people.

Payer Strategies: Choice and Efficiency. Positive-sum competition would induce payers to compete to create value, not just to minimize cost. They would simplify billing and administrative processes. They would

serve subscribers by identifying treatment alternatives and providers with excellent outcomes. They would help subscribers to know when and where it is appropriate to travel outside of their immediate areas for quality care. (Some payers have begun to post information about treatments and providers on their Web sites, but the information is often only about those treatments and providers within a small radius around the subscriber’s ZIP code.) The best payers would be able to recommend effective disease-management options for subscribers with chronic conditions. Competition would shift to providing information and excellent service. Attempts to limit patients’ choices or to control physicians’ behavior would end.

Accelerating the Transformation. Two other steps would accelerate the transformation in health care—one a transitional change and the other a larger, more controversial one. The transitional step, with major symbolic importance, would be the creation of a short-term mechanism to encourage the diffusion of promising new approaches to care that are initially expensive. One model would be for Medicare, traditionally slow to adopt new treatments, to create an Adoption of Innovation Fund to support the spread of promising FDA-approved therapies to patients. Providers, working with technology suppliers, pharmaceutical companies, and payers, would compete to win the funding under well-defined standards for institutional review and informed patient consent. In time, such a fund may not be needed as positive-sum competition takes hold. As a transitional device, however, it would speed treatments toward lower cost and wider adoption.

The larger, more controversial step would be for the government to require health coverage for all, with subsidies for low-income people. With required health care coverage, everyone would be a paying customer concerned with the value of health care. While subsidies to low-income people would drive up health care expenditures, there would be offsetting cost savings and revenues. The huge cost of free care would be eliminated, and providers would no longer have to raise their prices to cover it. Cost savings would result from more care delivered at the right time rather than after complications have developed, and in

cost-effective settings rather than in emergency rooms. Additional revenues would come from people who can afford coverage but who choose not to buy it and become part of the uncompensated care pool if they become ill or injured.

Employers Should Lead the Way

Companies have a lot at stake in how the U.S. health care system performs. Businesses' health care costs have outpaced inflation in 13 of the last 17 years, reaching more than \$6,200 per employee in 2003. Double-digit increases the last three years, projected to continue in 2004, have caught senior management's attention. A Hewitt Associates study of 622 major U.S. companies found that 96% of CEOs and CFOs are significantly or critically concerned about health care costs for 2004, and 91% voiced the same concern for the impact health care costs will have on their employees.

As major purchasers of health care services, employers have the clout to insist on change. Unfortunately, they have also been part of the

problem. In buying health care services, companies have forgotten some basic lessons about how competition works and how to buy intelligently. Ignoring differences in quality, companies have bought health plans based on price rather than value. They have delegated the management of their health plans to parties whose incentives were not well aligned with the companies' attempts to maximize value or with the well-being of employees. Hence, employers have become unwitting conspirators in a troubled system.

They should have known better. Few products or services are really commodities—especially not complex services like providing quality health care. The relevant standard should be value, not cost. Companies know that experience and expertise simultaneously improve quality and reduce cost. They know that innovation is crucial to progress, not an expense to be suppressed. And they know that relevant information is essential to good decision making.

Some employers have started to purchase health care services differently. And consortia like the Leapfrog Group (a coalition of 150 public and private organizations that provide health care benefits) are working to improve the quality of health care; Leapfrog's focus is on reducing the high incidence of errors in U.S. medical care. These efforts are important, but they will be even more effective when they focus on the power of competition. Rather than approve hospitals or tell them how to run their operations, employers need to insist that choice and information be made truly available at the level of specific diseases and treatments so that patients and referring physicians can choose providers that use efficient, state-of-the-art methods of care. Leapfrog is moving in this direction with its efforts to promote regional referrals for high-risk surgeries to highly experienced providers. Honeywell is also moving in this direction by hiring Consumer's Medical Resource, a decision-support service that provides independent information on diagnoses and treatments to employees.

The newest employer initiatives, known as "pay for performance," set higher reimbursement rates for providers that comply with specified standards of medical care. These measures aim to prevent subpar care by encouraging widespread use of well-established standards that are too often ignored. Pay for performance could be an important transitional

What Employers Can Do Immediately

- Select plans that do not restrict employees' access to treatments or out-of-network providers.
- Expect from providers information about their experience, their use of prevailing standards, and their outcomes.
- Ensure employee access to information on diagnoses and alternative treatments. Share collected information regionally and nationally.
- Insist that employees be treated by experienced providers.
- Require a single posted fee for each service.
- Require one bill per hospitalization or treatment cycle.
- Eliminate billing of employees by health plans or providers.


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Deeper Diagnosis

Improved health care delivery should be a top priority for corporate managers. Yet most companies continue to depend on government and industry “experts,” whose reform efforts during the past decade have failed to create effective competition in health care. In “Fixing Competition in U.S. Health Care,” professors Michael E. Porter and Elizabeth Olmsted Teisberg explain what’s wrong with the system from a business perspective and what changes will be required to improve the value equation. This report features in-depth analyses and comprehensive facts and figures gleaned from the authors’ exhaustive research. For more information, visit <http://hcreport.hbr.org>.

measure until experience and outcome data are widely available. However, it is an inadequate long-term solution because it rewards providers for following mandated practices, not for achieving excellent (risk-adjusted) outcomes. The system will improve much faster if providers face competitive pressure to produce truly good results, patient by patient and condition by condition.

By setting new expectations for health plans and providers and by purchasing health care

services differently, employers can realize the power of positive-sum competition in health care. (The exhibit “What Employers Can Do Immediately” outlines what employers should demand from their health plans.) Most employers resist the idea of an end to volume discounts, but these discounts contribute to the vicious cycle of cost increases and cost shifting in health care. If employers take the lead in creating productive health care competition, insisting that competition take place at the right level, firms and their employees will benefit from the increased value of services and the broader information available. Pursued seriously, such changes would radically alter the health care system, instigating a transformation of historic proportions. The system can be fixed. 

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