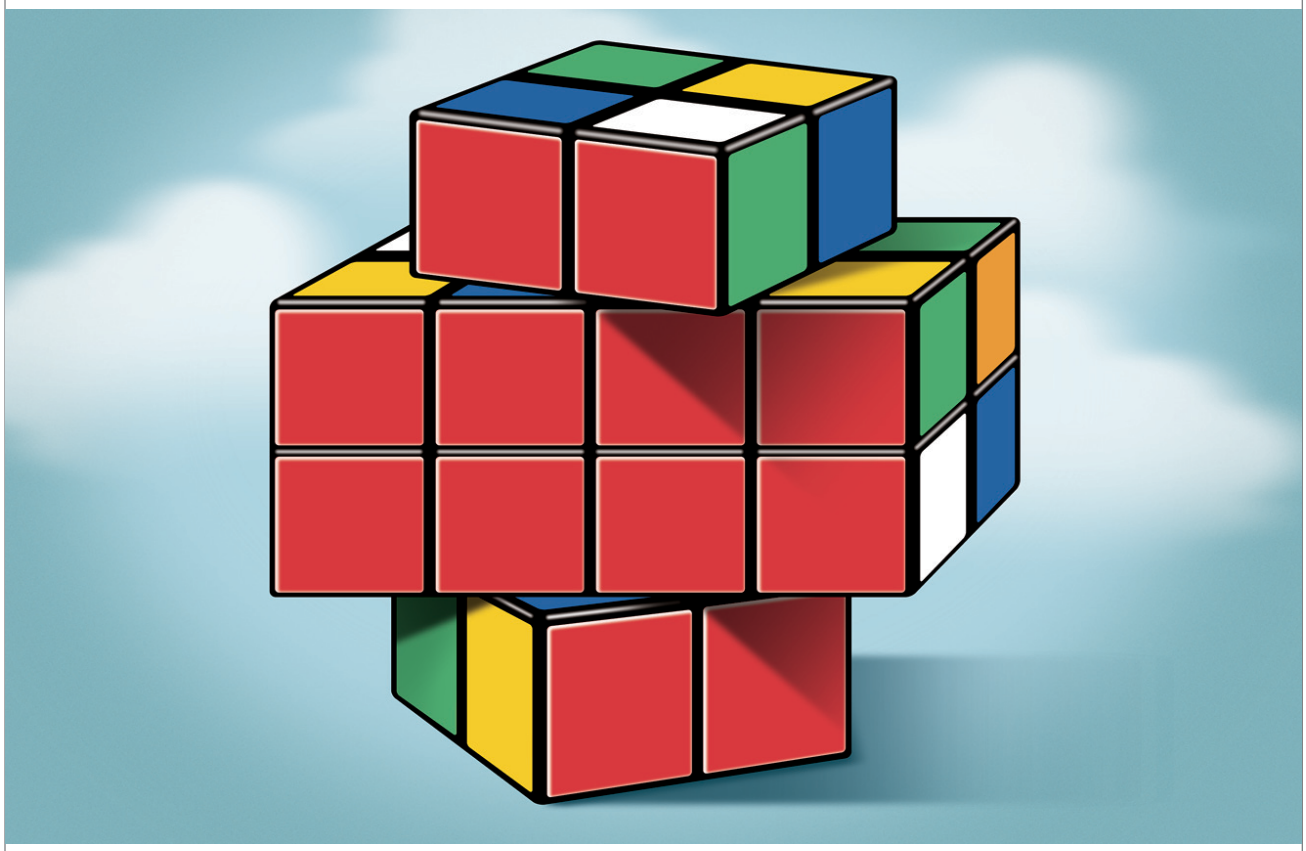
McKinsey on **Health Care**

An in-depth look at the problems facing senior managers | Published by *The McKinsey Quarterly* | February 2007



Lloyd Miller

Transforming US hospitals

Battered by competition and regulation, hospitals need fast, dramatic treatment: leadership that thinks strategically, builds quality, and aligns doctors with the goals of hospitals..

Article at a glance

US hospitals must learn to compete on value to cope with new competitive threats and greater transparency about quality, service, and prices. For most, this effort will require nothing less than a total transformation.

Hospitals can take lessons from a few pioneering hospitals that emphasize excellence by competing in carefully chosen service lines rather than trying to excel in all clinical services.

Such a hospital aligns the behavior of physicians with its own priorities by changing the way it manages and compensates them. Further, it systematically attempts to excel in clinical quality, service, and patient satisfaction.

Related articles on mckinseyquarterly.com

"Hospitals get serious about operations,"
2001 Number 2

"IT remedies for US health care: An interview with WellPoint's Leonard Schaeffer,"
Web exclusive, December 2005

"Getting patients to take their medicine,"
2006 Number 4

Transforming US hospitals

Kurt D. Grote, Paul D. Mango, and Saumya S. Sutaria

US hospitals are under siege. Their operating model once was simple: amass—under one expensive roof—powerful technologies, skilled physicians working at arm's length, and a volume of patients sufficient to leverage enormous fixed costs. Now, however, intense competition from more focused health care providers, as well as the increasing ability of payers and consumers to obtain information about a hospital's quality, service, and pricing—in short, about the value it provides—threaten to change the equation.

A hospital's historical strengths—superior quality and technology, a productive environment for physicians, and access to capital—are now less distinctive.[1] Focused competitors, including stand-alone ambulatory-service centers, diagnostic-imaging centers, endoscopy suites, and specialty hospitals, have access to tremendous amounts of capital. Physicians are often coinvestors, and many specialists can match the technology and quality of care that hospitals offer at lower cost and with better-perceived service levels.

What's more, payers are beginning to exploit the power of information technology to collect and evaluate mountains of data on the quality, service, and pricing practices of hospitals. With this information, the payers design sophisticated benefits plans that show consumers the value they can expect from each provider, as well as various coverage options as they assume increasing responsibility for their own health care spending.[2] Payers and patients are increasingly aware of the hospitals' deficiencies and more open to competing alternatives.

Today's challenges demand nothing less than a fundamental rethinking of the hospital system. A few pioneers are showing the way by reorienting their go-to-market strategies to emphasize excellence in a more limited set of service lines rather than trying to excel in all clinical services. These systems are restructuring the management and compensation of doctors to align their behavior with the hospitals' quality, service, and cost priorities. They are learning to issue credit and to improve collections (see sidebar, "Collecting from consumers"). And they are supporting these changes with a commitment to excellence in processes by helping service lines and individual physicians to make dramatic improvements in quality of care, cost-effectiveness, and patient satisfaction.

Organizing service lines as business units

Most hospitals function and measure themselves as stand-alone entities and market themselves by touting the broad reputation of the institution as a whole. But today's patients, payers, and employers can now evaluate a hospital's quality, service, and costs in individual service lines (such as cardiology or orthopedics) and even in the treatment of particular episodes (such as heart attacks).[3] All but the largest hospitals lack the critical mass of patients necessary to match the performance of competitors specializing in particular service lines. Many hospitals will therefore experience a downward spiral of average performance and subscale patient volumes.

To compete, hospital systems—particularly those with more than one facility in a given market—should shift their focus from individual hospitals to clinical-service lines across all of the hospitals they operate. This approach requires them to pivot their

[1] For more on the traditional strengths of US hospitals and the challenges they face today, see Kurt D. Grote, Edward H. Levine, and Paul D. Mango, "US hospitals for the 21st century," *The McKinsey Quarterly*, Web exclusive, August 2006.

[2] The shift to value-conscious health care partly stems from the advent of high-deductible health plans, whose growth has accelerated since the US government introduced health savings accounts (tax-advantaged financial products that oblige consumers to put aside their own money to help pay for medical care until insurance kicks in). For more on HSAs, see Paul D. Mango and Vivian E. Riefberg, "Health savings accounts: Making patients better consumers," *The McKinsey Quarterly*, Web exclusive, January 2005. Other public policies are reinforcing the shift. On August 22, 2006, for example, an executive order instructed US federal health care agencies to implement programs measuring the quality of health care services and to promote high-quality care by reimbursing top-performing providers at higher rates.

[3] Sources of quality data include Web sites such as healthgrades.com and hospitalcompare.hhs.gov. Efficiency scorecards developed by leading payers are among the sources of information on costs. Data on the experiences of patients come from sources such as the Consumer Assessment of Health Care Providers and Systems (CAHPS) survey (created by the Centers for Medicare and Medicaid Services) and the Department of Health and Human Services.

business-unit focus (including their profit-and-loss statements and quality-and-service metrics) from geographic locations to clinical-service lines. In a well-established service line, physicians and administrators can more easily exchange views and share best practices with colleagues elsewhere in the system. By adopting this approach, a hospital system could achieve scale and higher throughput rates within its service lines, allowing them to standardize processes and procedures more easily, help support staff set up and turn over rooms efficiently, and provide better service to patients and doctors. Other efficiencies include opportunities to streamline the purchase and use of supplies and to focus human resources: rather than having a manager for each of five different heart clinics, for instance, hospitals with a service line orientation might have one manager oversee the operations of all five clinics, while other managers focus on introducing new technologies or quality-improvement programs. Finally, when the leaders of service lines become more accountable for economic performance, they often make better capital-investment decisions.

There are some hurdles. Choosing where to focus is a high-stakes bet that demands a deep understanding of the market for individual service lines and of the competitive dynamics across geographies. Getting physicians and administrators from different hospitals and

Collecting from consumers

Because of more frequent co-payments and higher deductibles, in the past decade health care not covered by insurance in the United States has grown at 5 percent each year, rising to $28.8 billion in 2005. Growing numbers of patients pay for these expenses from their own pockets, health savings accounts, or health care credit lines established to pay for specific procedures. Hospitals, accustomed to dealing almost exclusively with insurers and other third-party payers, are not prepared to collect from consumers at the point of sale, so they have amassed huge amounts of bad debt. US hospitals collect, on average, only 50 to 60 percent of their patient balances after insurance. By contrast, credit card companies and large retailers that issue credit collect more than 95 percent of their accounts receivable. As the source of health care financing continues to shift from third parties to consumers, hospitals should learn from retailers about how to manage revenue cycles and improve collections.

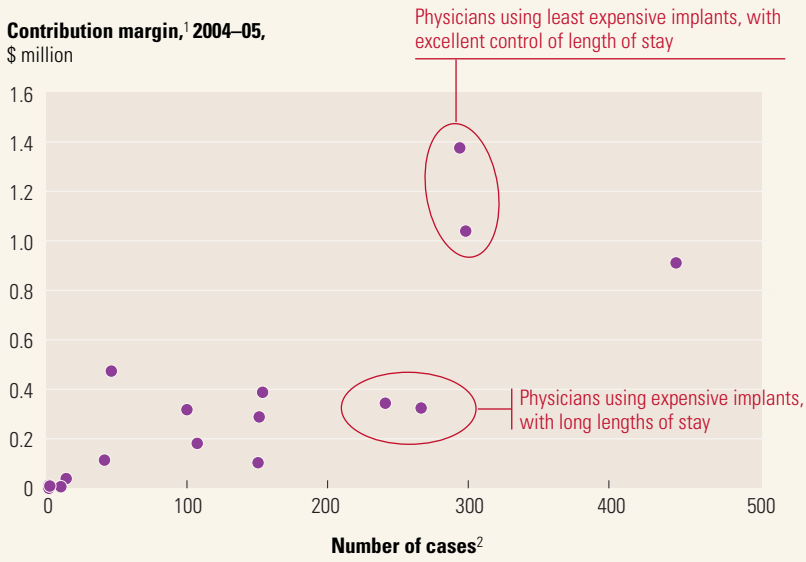
Like car dealerships, hospitals should offer financing to patients as they walk in the door; simple payment plans and relatively low interest rates may increase the likelihood of payment. Because many hospitals lack the skills needed to issue credit or run a finance business, some have partnered with big financial services companies—traditional payers and large retail banks. Hospitals that neither find partners nor learn on their own to make good, rapid decisions about extending credit will lose prospective patients and drive up bad debt, which is now rising quickly. It might also be controlled if patients received easily understood cost estimates and bills, consolidated across care providers in hospitals.

Hospitals face formidable challenges. A minor inpatient surgery can generate three bills: from the hospital, the surgeon, and the anesthesiologist. The amount due to any of these is a complex function of three variables: the insurance company's decisions, the insurance plan, and the often unpredictable specifics of the care provided. Further, the amount that patients must ultimately pay is affected by their previous payments and deductibles—information unavailable to physicians and hospitals. To succeed, hospitals, physicians, and insurers will have to coordinate their systems, data, and people in an unprecedented way.

Exhibit 1

Measuring physician profitability

Performance of orthopedic surgeons at a community hospital



[1] Revenue minus variable costs.
[2] Based on elective cases only, which represented ~60% of all cases; share of elective cases varied widely by physician.

practices to work as an integrated team requires skilled leadership. What's more, a system that emphasizes some service lines typically deemphasizes others, prompting a backlash from affected communities and physicians. Though managing the change is difficult, the payoff in competitiveness is considerable.

Deciding where—and where not—to compete

To make investment decisions about service lines, hospitals must assess where demand might be growing or shrinking, as well as their current market share,[4] competitive position, revenues, and profitability in each service line. With such an understanding of current conditions and likely future demand, hospitals can decide which service lines can be local leaders and which have an attractive profit potential. To become a leader in the chosen service lines, the hospitals can then set targets for investments in technology, administrative staff, the recruitment of physicians, marketing, and operational improvements.

So far, few hospitals have more than a general sense of their competitiveness in different service lines, and fewer still have cost databases that track profitability by service line, patient, or physician (Exhibit 1). Fortunately, even a rudimentary analysis can facilitate good decision making. A 140-bed community hospital in Missouri determined that although a neuroscience line had empty beds, it was still worth investing in because the service line faced only modest local competition and had a 36 percent profit margin, roughly three times the hospital's average. The hospital hired a full-time neurosurgeon, using its market analysis to show

[4] The relevant market is a hospital's primary service area, defined as the local geography where roughly 75 percent of its patients live.

candidates their potential earnings. It also invested in a basic set of neurosurgical tools and earned a Primary Stroke Center certification from the Joint Commission,[5] which increased its volume because payers often steer patients to hospitals with this form of accreditation. The hospital then began marketing its neurological service line aggressively to local primary care referrers. It forecast 20 to 30 percent growth in volume for the line within 12 months.

A second challenge is the reaction when a hospital shifts resources away from service lines that cannot be market leaders: somehow, the hospital has to assuage complaints from physicians and the surrounding community. Before a hospital makes any decisions or announcements about curtailing the marketing of a particular service, devoting less floor space to a specialty, or closing a service line altogether, it must develop a compelling case for change based on economics, competitiveness, quality, and service. Such an analysis can help the hospital explain why deemphasizing certain service lines will improve its overall financial health and long-term ability to serve the community. No matter how strong the rationale, though, systems that cut back service lines must be prepared to face criticism from community leaders, citizens, and the media. Some hospitals conclude that it's worth sustaining certain mediocre service lines.

Similarly, hospitals must reassure physicians in the remaining service lines that they won't lose too many internal referrals when other lines shrink or close. To prepare, management should review each physician's sources of patients and overall volume, as well as the mix of payers among the patients that he or she accepts. Hospitals can determine how many community-based referrals will be in jeopardy should a particular line close. This information frequently reassures physicians and helps hospitals to judge the trade-offs associated with reducing capacity in one service line to free up resources for another.

Making the new structure work

Hospitals reorganizing by clinical-service lines need CEOs who vigorously champion the change, as well as physicians and administrators who can make important operating decisions as they take greater responsibility for their lines. Consider the experience of a hospital system that in 1999 operated two hospitals, each a separate business unit with its own management. With the system as a whole anticipating a loss of $70 million, it decided to reorganize along service lines, first by creating independent business units for the largest and most competitive clinical areas: cardiology, oncology, neurosciences, orthopedics, and women's health. For each service line, the hospital made administrative and clinical leaders accountable for innovation, the growth of patient volumes, service, clinical quality, and overall financial performance.

Early in the process, the system's CEO devoted himself to explaining the new approach, its rationale, and its organizational implications to frontline nurses and physicians, whose support was critical. Some of this cheerleading involved speeches to large groups, but much of it took place in the trenches. The CEO, for example, helped to deal with a few dissenting physicians who resisted taking the time to manage the performance of their service lines actively, as well as those who had clinical grounds for rejecting the reorganization plan. In these instances, the CEO backed up service line leaders when they met with recalcitrant doctors and had to discipline them by withholding productivity pay.

At the same time, the hospital made each service line's leaders responsible for the quality, service, and financial performance of their lines—including where to invest the limited capital available, which suppliers to use, and which physicians to recruit. The relationship between these newly accountable service line leaders and their physician colleagues contributed significantly to the reorganization's

[5] A nonprofit organization that evaluates and accredits health care organizations in the United States.

success. In one service line, inconsistent standards specifying how close on-call doctors must be to the hospital had created long delays in treating some patients. The service line leader pulled physicians together to arrive at a standard (a maximum response time of 30 minutes) that all of them respected.

Over time, physicians in the key service lines established standard approaches for developing, executing, and disseminating best-practice clinical protocols. Service line leaders began to use metrics such as profitability by service line, patient satisfaction, quality of service, and the number of patients referred and treated by each physician for various diagnoses. As the hospital's key service lines began to offer more value—higher quality, better service, and lower prices—than less-focused competitors did, patients voted with their feet: from 2002 through 2005, admissions grew by 6 to 7 percent a year, about half coming from gains in market share.

Restructuring relationships with physicians

Often, hospital physicians work autonomously in the equivalent of an activity-based reimbursement system. These independent physicians try to serve their patients effectively while balancing their desire for personal income and leisure time. Striking this balance might involve spending mornings in the operating room, visiting clinics in the afternoon, and doing patient rounds at night. Physicians become comfortable with such practices, so they resist behavioral changes needed to deliver better quality and service at competitive prices. Many hospitals therefore need to restructure their relationships with physicians. The possibilities include direct employment, programs that let hospitals and physicians share the gains from productivity improvements, and joint ventures between hospitals and physicians.

The last time hospitals tried to change their relationship with physicians, during the 1990s, the results were disappointing if not disastrous. But the rationale for those changes—preserving patient volumes—was different from today's need to encourage changes in the behavior of frontline employees so that hospitals can deliver more value. Hospitals also used a different method then: buying out the practices of physicians, often at inflated prices, without creating incentives to improve performance.[6] Today's challenges call for a more sophisticated approach that rests on a detailed understanding of the likely revenue, quality, and cost benefits of new relationships.

Employing physicians

The legitimate interests of physicians sometimes collide with those of hospitals. Physicians, for example, tend to base their selection of medical devices and pharmaceuticals on familiarity rather than on cost-effectiveness or medical evidence. Similarly, the hospitals' common practice of granting doctors block time in operating rooms, with individual surgeons reserving particular rooms on a set day and time each week, imposes large opportunity costs because not all surgeons fill up every minute of their block time.

One of the most effective ways to align the interests of the two parties is for hospitals to employ physicians directly and to offer them variable compensation linked to metrics on quality, service, and cost. The resulting changes in behavior generate incremental earnings, which a hospital can share with physicians to offset the costs it incurs by departing from old operating practices.

Consider an example. One hospital in the southeastern United States turned around its previously unprofitable primary care and obstetrics practices by changing its structure for compensating physicians. The hospital began offering below-average base salaries plus generous productivity payments tied to collectible revenue, control of costs, and adherence to clinical-quality measures. The new incentive system

[6] For more, read Michael L. Figliuolo, Paul D. Mango, and David H. McCormick, "Hospital, heal thyself," *The McKinsey Quarterly*, 2000 Number 1, pp. 90–7.

spurred physicians on to reach higher levels of activity, to pay careful attention to the mix of payers among the patients, and to participate in quality-improvement initiatives. These changes contributed to productivity improvements of 15 and 30 percent for the primary care and obstetrics physicians, respectively.[7] Furthermore, as physicians became more efficient and their compensation grew, their sense of satisfaction increased. As a result, the hospital now attracts more physician candidates and has tightened its selection criteria. Today, the hospital deems only 40 percent of its applicants "qualified," down from 90 percent several years ago, when attracting applicants was more difficult.

Creating joint ventures

An alternative to direct employment is the creation of joint ventures, with groups of physicians having an ownership-like stake in their specialties or service lines. This approach can align incentives if legal considerations (such as laws that ban self-referrals by physicians who provide certain services for Medicare and Medicaid patients) or market conditions give physicians a financial incentive to maintain arm's-length relationships with hospitals.

Joint ventures are more complex than direct employment. Making them financially rewarding for both parties requires a detailed understanding of the assets that hospitals and groups of physicians jointly own. (Some service lines, such as stand-alone outpatient facilities, are easier to value than others, such as inpatient facilities with strong ties to other aspects of a hospital's operations.) Furthermore, some physicians, even in established groups, may object to the greater degree of professional and financial cooperation needed to make a joint venture work. And other doctors, whose specialty areas aren't suitable for joint ventures, may hear about deals being struck elsewhere in the hospital system and demand more favorable terms than the hospital can afford.

The experience of a 300-bed hospital in Florida shows how to address some of these challenges. The hospital sought a joint venture for its ambulatory-surgery center, which was underutilized. It also had significant potential to expand its presence in orthopedic surgery, a lucrative specialty in which competitors controlled at least half of the region's volume. In most ambulatory-surgery centers, orthopedic surgeons carry out a substantial portion of procedures. After analyzing a range of possibilities for making the most of its ambulatory-surgery center, the hospital determined that the most valuable option was to create a partnership with a group of unaffiliated orthopedic surgeons (Exhibit 2). That finding was counterintuitive, because a loyal group of orthopedic surgeons already operated at the hospital. But analysis of local market conditions and competitive forces showed that bringing in an outside group would not infringe on the business of the loyal physicians, who were not interested in a joint venture. Communicating these findings helped the hospital to retain and reassure its physicians.

Committing to superior service and quality

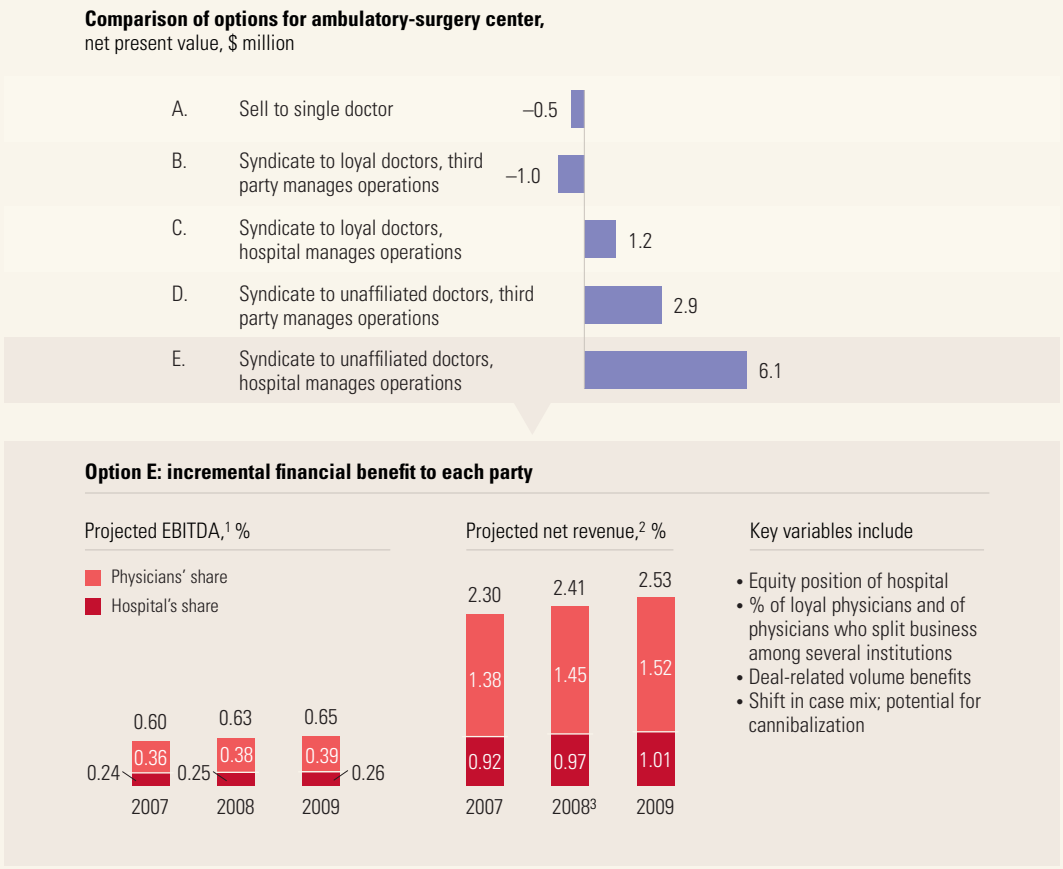
Economic alignment between hospitals and physicians is necessary but not sufficient to achieve superior clinical quality, service, and satisfaction among patients. Hospitals also need processes and support procedures that help the medical staff to follow best practices, avoid errors, and operate at the highest levels of safety. Quality improvements help hospitals to cut costs by reducing malpractice insurance premiums (often priced at hundreds of millions of dollars a year for a large system); the time patients stay in hospital beds; and the amount of drugs, supplies, and nursing attention that patients require.

A systematic approach to improving quality is particularly important today as pay-for-performance programs, "center-of-excellence" designations by commercial payers, and widely

[7] The hospital measured productivity by volumes of patients per physician, adjusted to reflect the complexity of treating each patient.

Exhibit 2

Comparing the options



[1] Earnings before interest, taxes, depreciation, and amortization.
[2] Net revenue excludes discounts such as account adjustments, contractual discounts, direct write-offs.
[3] Figures do not sum to total, because of rounding.

available information about performance metrics start to shape the decisions of patients about where to seek care. One payer, for example, has rated the quality and cost efficiency of physicians and published the results. This company's Web site makes it difficult for members even to find lower-ranked physicians. Programs to improve quality can help hospitals to attract more patients and boost the odds of retaining physicians, who naturally gravitate toward environments that support the delivery of high-quality, cost-effective care.

To see how improving quality and service can support the shift to a service line orientation, consider the experiences of two hospital systems in a single clinical area: cardiac care.

- Before a major quality push in the first hospital system, only 60 percent of its cardiologists' decisions to carry out procedures met the standards of the American College of Cardiology (ACC). The leader of the cardiology service line identified 35 specific factors that influence the

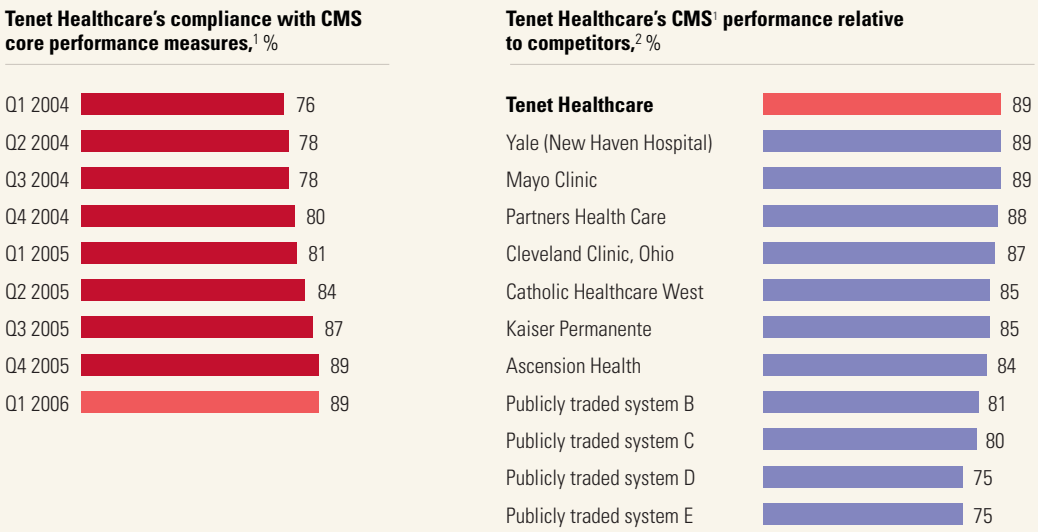
quality and outcome of procedures—for example, the point when prophylactic blood thinners are administered and the role of consultations before emergency angioplasties. A team of physicians codified best practices and set up a system to monitor performance. The team created new metrics (such as the percentage of time blood thinners were properly administered) linked directly to ACC standards. Within 12 months, 97 percent of this system's procedures met them, and the resulting standardization also promoted greater flexibility in the staffing of nurses and a massive reduction in supplies consumed as practitioners became more efficient.

- At Tenet Healthcare, a publicly traded hospital chain with dozens of hospitals, cardiac service line teams now monitor their medical and administrative performance for every acute-care episode, following a set of more than 100 standardized metrics, such as the time taken to read echocardiograms. The teams—each comprising 5 to 15 quality managers, physicians, nurses, and other staff members—identify areas that require improvements and find ways to make and sustain them. Cash incentives for the leaders of the service line are tied partly to its performance against these metrics. This effort and other operational changes raised the quality of the service line's work substantially (Exhibit 3).

As these examples indicate, quality-improvement programs are huge undertakings. In our experience, success often requires CEOs to take personal responsibility for the effort and to commit up to 20 percent of their time to influencing the

Exhibit 3

Rising to the top



[1] CMS = Centers for Medicare and Medicaid Services; includes core performance measures for treatment of acute myocardial infarction, pneumonia, and congestive heart failure; data up to Q1 2006 (when operational improvements were substantially complete) provide accurate before-and-after snapshot of Tenet Healthcare's performance.

[2] Q4 2005 data for competitors (latest available data), Q1 2006 data for Tenet Healthcare.

Source: CMS Hospital Compare Web site

attitudes of thousands of frontline employees. Hiring a director of clinical quality and giving this person modest resources to overhaul processes (such as patient admissions) won't suffice.

The degree of change we advocate may sound daunting, but the potential rewards are enormous. Hospitals that shift to a service line orientation, restructure their relationships with physicians, and undertake systematic quality-improvement efforts will transform their overall value proposition and become more relevant in the increasingly value-conscious US health care system.Q

Kurt Grote is an associate principal in McKinsey's Los Angeles office; **Paul Mango** is a director in the Pittsburgh office; **Saumya Sutaria** is a principal in the Silicon Valley office.