Healthcare Systems and Services Practice

Value-based care: Is it sustainable?

Shubham Singhal

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Four fundamental questions can help payors and providers improve productivity and better control utilization—the prerequisites for making value-based care sustainable.

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Most people in the healthcare industry agree—in theory, at least—that the time is right for value-based care. Fee-for-service reimbursement is becoming increasingly unaffordable. Data liquidity, rapid advances in data processing and analytics, and the ability to store massive amounts of data have combined to enable us to quantify value. And there is conceptual agreement among healthcare industry stakeholders that such a shift is necessary. Given the bipartisan government support evident in recent years at both the federal and state levels, it is likely that the shift to value-based care will continue.[1]

But is the shift to value-based care sustainable? In other words, can payors and providers find a way to ensure delivery of value-based care without destroying their economic underpinnings? The problem is this: at present, the US healthcare sector is essentially a zero-sum game, and the sector has considerable installed capacity that cannot easily be removed. Thus, financial improvement for one group often comes at the expense of another.

To date, value-based care has driven reductions in healthcare expenditures, but the impact has largely resulted from either decreased utilization or the movement of a small minority of services to lower-cost sites of care. In a zero-sum game, stakeholders put up defense mechanisms to preserve their position when volume is taken out of the system. Furthermore, in thriving economies (or thriving sectors of an economy), value creation results not from delivering less, but from delivering the same amount, or more, with fewer resources. Thus, volume reductions alone are not a long-term recipe for ensuring the sustainability of value-based care.

The only real way that the healthcare sector can get around this problem—the only way it can thrive while delivering greater value to patients and consumers—is to increase its productivity significantly. In the past 35 years, most US industries have achieved major productivity improvements. The healthcare sector has lagged in this regard.

Our recent white paper, "The next imperatives for US healthcare," includes a discussion of actions that healthcare industry players can take to improve productivity.[2] To make value-based care sustainable, incumbent payors and providers must achieve productivity gains along with utilization control. To do so, they can begin by asking themselves four questions:

Do they need greater focus? Most incumbents have been trying to be generalists. Achieving higher productivity is likely to require incumbents to become as efficient as possible through greater specialization and greater scale within those areas of specialization. For example, it is well understood that surgeons who perform a high volume of specific procedures achieve better outcomes.[3,4] Similarly, McKinsey research shows that the minimum effective scale for payors is generally above half a million lives in any one business line. (This threshold is even higher for some lines of business.)

Do they need a clean-sheet operating model? Most healthcare incumbents built their operating

models in the 1980s and 1990s for a world that no longer exists. Today, we have different technologies, different information flows, and different ways of delivering care. Few incumbents have truly modernized their operating models—and asset bases—in response. As they rethink their operating models, incumbents should focus on the integration of data, not facilities. If greater specialization results in wider distribution of assets, effective use of new technologies to integrate information from those assets will be necessary for the delivery of value-based care.

Are they using labor optimally? Incumbents, particularly providers, may not be optimizing their labor force to promote productivity. Reimbursement policies of payors can exacerbate this dynamic.

To enhance productivity of the labor force, providers could take steps to access additional capacity within the current workforce, for example by rationalizing appointment types to reduce scheduling gaps. Physicians could also improve productivity of the existing workforce by interacting with patients through a variety of modalities (e.g., video conference, phone, email), which have the potential to enhance efficiency for the clinician as well as convenience and satisfaction for the patient. Current payment systems can discourage this type of productivity enhancement, given that clinicians are often only reimbursed for in-person patient visits.

Other steps that providers can take to enhance workforce productivity include improving the allocation of tasks based on skill mix and increasing the use of technology to promote clinician efficiency.

Do they reward innovation? Too many actors in the healthcare sector still have what is essentially a cost-plus pricing mentality. As a consequence, innovations rarely achieve the impact they should. All too often, if someone finds a way to reduce costs, the innovators don't see a good return on their efforts. Industry executives need to determine what new pricing and reimbursement models, and what new rules, are needed to ensure that innovation is rewarded.

Without answers to these questions, healthcare will not be able to achieve the types of productivity improvements that are fundamental to sustainable growth of value-based care.

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FOOTNOTES

[1]Singhal S, Jacobi N. Why understanding medical risk is key to US health reform. McKinsey white paper (updated). April 2017.

[2]Singhal S, Coe E. The next imperatives for US healthcare. McKinsey white paper. December 2016.

[3]Sahni N et al. Surgeon specialization and operative mortality in United States: retrospective analysis. BMJ. 2016;354:i357.

[4]Clark J, Huckman R. Broadening focus: spillovers, complementarities, and specialization in the hospital industry. Management Science. 2011;58:708-22.

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