

The future of global healthcare delivery and management

An Economist Intelligence Unit
research program for KPMG International

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Introduction

Healthcare systems and governments worldwide are trying to curb rising costs while improving patient care and outcomes. This has led to a growing interest in healthcare integration—i.e., coordinating services among providers through formal or informal means. Supporters of integration say that, properly managed, it can yield a healthier population and save money. It can also help minimize hospitalizations, reduce the need for costly rehospitalizations, and prevent service duplication.

An impressive 95 percent of respondents to a global survey conducted by the Economist Intelligence Unit in May 2010 support greater integration within the healthcare delivery system in the next five years. Despite this near-unanimity among respondents, progress toward healthcare integration is patchy.

Successful integration will depend on various elements: the nature and structure of existing healthcare systems; jurisdictions' perceptions of the urgency of cost and quality issues; and resources allocated to implement it.

The survey, sponsored by KPMG International, investigates how government officials in health-related agencies—often the initiators of the process—and hospital administrators expect integration to evolve in their home countries in the next five years. Doctors, insurance providers, and life sciences companies were not surveyed, although they also play important roles in integration.

The research examines the barriers to integration and the changes necessary to overcome them. It then explores the role of government, the models that are likely to emerge, and the potential impact of integration on healthcare providers.

Healthcare integration defined

Integration is defined broadly in this research. It ranges from informal coordination among healthcare providers (e.g., among hospitals or between hospitals and primary care physicians) to a structured linkage among several parts of the system, such as through an umbrella organization that encompasses hospitals and other providers.

About the survey

A total of 103 executives were surveyed worldwide. Sixty-eight percent represented developed countries, and 32 percent were from developing countries.

Seventy-three respondents are hospital administrators. Of these, 55 percent are from hospitals with 500 beds or more, and 58 percent have a minimum of 2,000 employees. The minimum number of beds was 250, and the minimum number of employees was 500.

Thirty respondents are from government agencies or departments related to healthcare. Of these, 43 percent were from the national level; 50 percent from the state, provincial, or regional level; and the remaining 7 percent from the local level. Many carry out more than one function: 53 percent are involved in healthcare policy, 50 percent in providing healthcare services, 30 percent in regulation, and another 7 percent in other activities.



Seeing Double

Two main factors drive the current effort to integrate healthcare delivery worldwide: rising expenses and changing patterns in the demand for healthcare. “I would say it is a double movement,” says Eric de Roodenbeke, Chief Executive Officer of the Ferney Voltaire, France-based International Hospital Federation, which has members in more than 100 countries. “It’s difficult to say which one is driving the other one.”

The aging of the population has changed the nature of the services required and increased the incidence of expensive-to-treat chronic diseases. The World Health Organization (WHO) projects that the global population of those 60 years and older will rise from 600 million in 2000 to 2 billion in 2050,¹ while mortality, morbidity, and disability rates attributed to the major chronic diseases that now account for nearly 60 percent of all deaths and 43 percent of the global disease burden will rise to 73 percent of all deaths and 60 percent of the global disease burden by 2020.² (Terms defined in Glossary.)

These shifts in the nature of healthcare services will also change the kind of care required, from acute care to a ‘continuum of care,’ under which a full range of healthcare services are needed. Continuum of care service can be improved through close coordination among providers.

Another significant driver of healthcare spending is the increased use and cost of medications and medical devices. Global pharmaceutical sales are expected to increase at a 4–7 percent compound annual growth rate, rising from US\$825 billion in 2010 to US\$975 billion by 2013.³ The global medical equipment industry, valued at US\$280 billion in 2009, is forecast to grow by more than 8 percent annually to exceed US\$490 billion by 2016.⁴

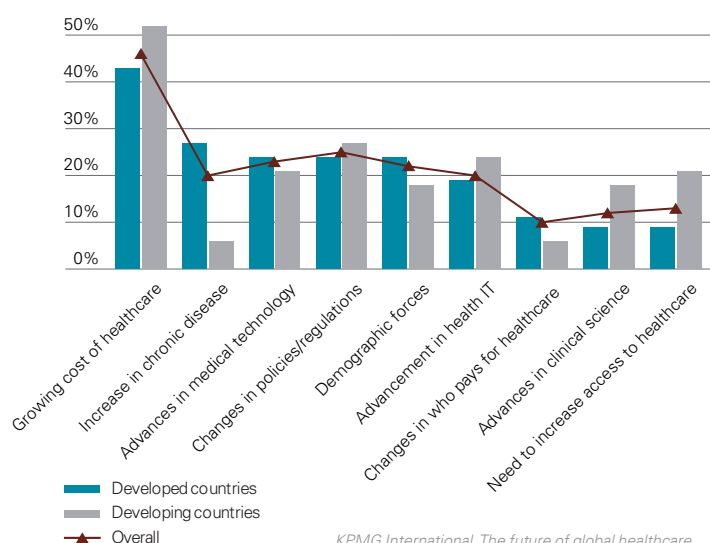
While cost and changing demographics are almost universal drivers of integration, their importance differs among developed and developing countries. For example, 52 percent of survey respondents from developing countries rank rising healthcare costs as a top driver of integration, compared with 43 percent of respondents from developed countries. Chronic disease, in contrast, is more likely to be important in developed countries:

it was chosen by 27 percent of those respondents compared with just 6 percent of those from developing countries. The challenges facing emerging markets such as China and Brazil, where large portions of the population are moving into the formal economy for the first time, are different from those of poorer countries that struggle to meet the most basic healthcare needs.

Drivers of integration reflect local realities

What forces do you believe will most affect the level of integration in the healthcare delivery system in the country in which you reside? Select up to two.

(% respondents)



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1 <http://www.who.int/features/qa/42/en/index.html>, Accessed 10/19/10.

2 http://www.who.int/chp/about/integrated_cd/en/index.html, Accessed 10/19/10.

3 <http://www.pharmaceutical-drug-manufacturers.com/articles/pharmaceutical-market-trends-2010.html>, Accessed 10/19/10.

4 <http://ebdgroup.com/partneringnews/2010/05/emerging-trends-in-the-medical-equipment-industry/>, Accessed 10/19/10.

Glossary

ACOs: Accountable care organizations are defined by the US Medicare Payment Advisory Commission as ‘a set of providers held responsible for the quality and cost of healthcare for a population of Medicare beneficiaries. An ACO could consist of primary care physicians, specialists, and at least one hospital.’⁵

Bundled payments: A payment model designed to reduce costs and encourage coordination of care in which hospitals and doctors share a single fee. There is no single model for distributing payment among the providers.

Care pathways: Plans of care over a defined time period for patients with a specific condition. They are structured and multidisciplinary, and include details of progress and outcomes. Their goal is to improve continuity and coordination of care across disciplines and sectors.⁶

Continuum of care: Delivery of a full range of healthcare services over a period of time. For patients with a disease, this includes all phases from diagnosis to end-of-life.

Gainsharing: A model for aligning providers’ goals by distributing savings generated by integrating care among them.

Health information technology interoperability: The ability of two or more systems or components to accurately, securely, and verifiably exchange and use information electronically.

Interoperability assures the clear and reliable communication of meaning by providing the correct context and exact meaning of the shared information.⁷

Morbidity rate: The ratio of sick to well people in a community in a given period of time.

Mortality rate: The ratio of deaths in a given population to that population in a given period of time. This rate is usually expressed in deaths per 1,000 individuals per year.

Global disease burden: The mortality and loss of health due to diseases, injuries, and risk factors for all regions of the world.

Population health model: A model of care in which an entity is responsible for managing healthcare for a defined patient population.

Standardized order set: A preprinted or electronic order form that covers all anticipated orders, such as tests, drugs, and precautions, for a particular condition.

Statutory health insurers: Competing health insurers in Germany, also called ‘sickness funds,’ that are federally regulated but self-administering not-for-profit corporations. They cover about 90 percent of the German population.

Singapore’s aging population⁸

Because of the impending silver tsunami, a term coined to describe the aging Singaporean population, the country’s healthcare system is undergoing a major reorganization. In 2009, Singapore’s Ministry of Health mandated that the Agency for Integrated Care oversee, coordinate, and facilitate this effort. The delivery system is shifting from ‘silo or compartmentalized episodic care’ to a more integrated approach via the creation of regional health systems. These feature an acute general hospital linked through partnership to a community rehabilitation hospital supported by a network of primary care providers, community home care teams, and day rehabilitation centers.

Close coordination and effective collaboration between the acute hospitals and their clinical partners are being emphasized so that patients can transition smoothly from one provider and setting to another. An electronic health record system will support the change.

⁵ http://www.medpac.gov/documents/Jun09_EntireReport.pdf, Accessed 10/19/10.

⁶ Based on definition of “clinical pathways” in <http://www.openclinical.org/clinicalpathways.html>, Accessed 10/19/10.

⁷ http://www.himss.org/Content/files/healthit_govt.pdf, Accessed 10/19/10.

⁸ <http://www.ijic.org/index.php/ijic/article/view/533/1045>, Accessed 10/19/10.





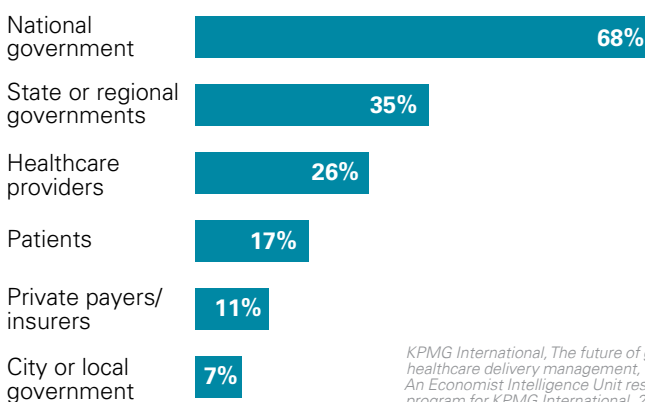
Governments Big and Small

Governments are intimately involved with healthcare worldwide, although their role differs among countries. They act as regulators in most parts of the world. Governments can also pay for and/or provide healthcare. In the UK, the government does both, although private doctors are an essential element in the provision of care and collect fees from the government. Canada provides universal healthcare to all citizens, paid through government-run insurance plans and provided by private entities. In the US, government coverage is limited to specific groups: the elderly, the armed forces, and the poor.

Because rising costs have an immediate and significant impact on government-funded healthcare programs and systems, national governments generally are at the forefront in pushing integrated care. Survey respondents, however, rank government policies as among the top hindrances to integration today. Still, they expect national, state, and regional governments to lead the way in the next five years. This is especially true in developing countries, the survey shows. Private payers—including insurance companies—are not considered relevant players in this transition.

National governments expected to take the lead

Which groups will take the lead in pushing greater integration in the healthcare delivery system in the country in which you reside? Select up to two. (% of respondents)



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Survey respondents and healthcare experts agree that government needs to encourage the use of electronic health records (EHRs), which is regarded as an important tool in coordinating care effectively among providers. This is a greater challenge for poor countries, which lack the means to implement advanced technologies.

EHR adoption efforts vary widely among countries. Government approaches include mandates that providers use electronic records, financial incentives to encourage provider adoption, and development of standards to ensure that record systems are interoperable. "Although healthcare budgets contribute to the bulk of worldwide industrialized government spending, healthcare IT lags far behind the technological capabilities of other global businesses," states a 2008 report by the Healthcare Information and Management Systems Society (HIMSS), a Chicago-based membership group focused on the use of IT in healthcare settings whose global membership includes professionals, companies, and associations.⁹

Interoperability is a particular problem, HIMSS notes. "All countries suffer from a lack of healthcare IT standards, [which creates] interoperability barriers for healthcare IT adoption at local and national levels." Strong national-level leadership can help reconcile competing goals and priorities of the individuals and organizations involved in healthcare provision.

⁹ http://www.himss.org/content/files/200808_EHRGlobalPerspective_whitepaper.pdf, Accessed 10/19/10.



Government has key roles in health system integration

What role, if any, do you expect the government to take in health system integration in the next five years? Select up to two. (% of respondents)

| Role | Overall | Developed countries | Developing countries |
|---|---------|---------------------|----------------------|
| Create pilot projects to test the concept | 44 % | 41 % | 49 % |
| Set uniform, national healthcare quality standards | 34 % | 30 % | 42 % |
| Create government-owned and operated integrated health networks | 28 % | 29 % | 27 % |
| Encourage the use of health information technology by providing public funds for its purchase | 25 % | 21 % | 33 % |
| Mandate the use of electronic health information technology | 21 % | 24 % | 15 % |

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Health records in Europe¹⁰

The EU is addressing the lack of interoperability among electronic health records on a multinational level. According to the European Commission, “The deployment of eHealth technologies in Europe can improve the quality of care, reduce medical costs, and foster independent living, including in remote places... To exploit the full potential of new eHealth services, the EU needs to remove legal and organizational

barriers, particularly those to pan-European interoperability.” The Digital Agenda for Europe, proposed in May 2010, aims to do that. By 2012, it requires a minimum common set of patient data that would make electronic patient records, accessed or exchanged across member states, interoperable. The plan also calls for pilot projects to equip Europeans with secure online access to their health data by 2015.

¹⁰ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:0245:FIN:EN:PDF>, Accessed 10/19/10.



Getting in Shape

The future shape of healthcare integration depends on where it occurs, because of differences in countries' health system structures and politics, Mr. de Roodenbeke notes. EHRs, for example, can improve coordination of care and health outcomes, but it is a low priority in poor countries that struggle to provide the rudiments of care.

The shape of change: Formal networks expected to dominate

What shape do you expect healthcare system integration to take in the country in which you reside?

(% respondents)

| | |
|--|---------------|
| Formal networks | 62% |
| Under public umbrella organization | 25% |
| Under private umbrella organization | 19% |
| With contractual relationships | 18% |
| Loose, noncontractual affiliations | 4% |
| Mix of formal networks and loose affiliations | 34% |
| Other | <1% |

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Yet one theme emerges: Care delivery is too fragmented among healthcare providers. A 2009 report by the Organization for Economic Cooperation and Development (OECD)¹¹ found that "for most countries, healthcare delivery occurs in a series of separate settings [or] silos." As there is no unifying system for remunerating care, providers have no incentive to work together.

Survey respondents anticipate that governments will use pilot projects to test new care models featuring integration. Some countries have already taken this step. A German pilot project, *Gesundes Kinzigtal Integrated Care*, uses a population-based approach toward integrating care across all provider sectors in the country's southwest Kinzig valley. Another example is the *Acute Care Episode (ACE) Demonstration*, in which the US Medicare program is paying participating

hospitals and doctors a single shared fee for in-patient care for certain cardiovascular and orthopedic procedures.

Both the *Gesundes Kinzigtal* and *ACE* projects seek to create healthcare 'efficiencies.' This term can raise concerns that the desire for cost savings could result in providers withholding needed care, says Helmut Hildebrandt, CEO of *Gesundes Kinzigtal GmbH*, the regional health management company running the project. But the goal is to focus not only on cost cutting but also on quality. For example, San Antonio, Texas-based *Baptist Health System*, which is participating in the *ACE* program, pays hospitals and physicians a portion of the savings they have achieved only if quality goals are met. *Gesundes Kinzigtal* is tracking quality, and independent bodies are monitoring the program to ensure that needed care is not being withheld.

These integrated programs use leading practices and care protocols as part of their focus on quality improvement. *Baptist Health System*, which has five acute-care hospitals with 1,750 licensed beds, has embraced nationally recognized, evidence-based protocols for cardiovascular disease and orthopedic care. Michael Zucker, the company's senior vice-president and chief development officer, says that physician compliance with standardized order sets (preprinted forms designed to expedite the prescription process) increased from about 30 percent to over 95 percent since participation in the *ACE* program began in 2009.

Alignment among healthcare providers on quality and cost goals is essential for integration to succeed. Bundled payment, in which hospitals and doctors share a single fee, is a model designed to encourage alignment. Another is *gainsharing*, in which savings generated by integrating care are shared

¹¹ http://www.oecd.org/document/42/0,3343,en_2649_33929_44043754_1_1_1_3740700.html, Accessed 10/19/10.

among providers. Gesundes Kinzigtal features gainsharing between the two participating health insurers and Gesundes Kinzigtal GmbH, which is majority-owned by physicians.

Baptist Health System uses both shared savings and bundled payment models. The hospital system generated US\$2 million in cost savings in the project's first year, mainly on medical devices and implants, Mr. Zucker says. Of this total, it distributed US\$350,000 in gainshare payments to participating physicians for that period. While Mr. Zucker could not disclose the hospital's gainsharing amount, he says that neither the quality improvements nor cost savings would have been possible without gainsharing and bundled payments to align the financial and quality goals of the hospitals and doctors.

The survey findings support the theory that payment changes can foster integration. According to 52 percent of respondents, governments must provide incentives to coordinate care to enable integration.

Government policies should encourage coordination

Top five changes needed to make integration possible.

| Changes | Rank |
|---|------|
| An overall government plan | 1 |
| Government payment policies that provide incentives to coordinate care | 2 |
| Cooperation among the various healthcare providers | 3 |
| Rapid deployment of a health information technology infrastructure that would allow communication among providers | 4 |
| Elimination of legal/regulatory barriers to care integration | 5 |

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Horizontal integration in Denmark¹²

From 2004 to 2007, Bispebjerg University Hospital, the City of Copenhagen, and the general practitioners in Copenhagen collaborated on a quality improvement project that focused on integration and implementation of rehabilitation programs for four chronic conditions. These include chronic obstructive pulmonary disease, type 2 diabetes, chronic heart failure, and falls among the elderly. The Østerbro healthcare center, which opened in 2005 as part of the project, provides the rehabilitation programs to patients with one or more of the health conditions mentioned above. These patients are referred by their general practitioners (GP). A working group was established for each condition comprising hospital department leaders; GPs; and healthcare personnel such as nurses, physiotherapists, and dieticians. Each group integrated care horizontally and developed clinical guidelines. The multidisciplinary programs have become part of routine care for patients with chronic conditions. The exception is diabetes, which was excluded because of resource constraints.

12 <http://www.ijic.org/index.php/ijic/article/view/507/1013>, Accessed 10/19/10.



An unusual approach in Germany

In 2004, a change in Germany's health insurance law allowed the country's statutory health insurers to participate in integrated care projects. Most programs focused on managing care for specific conditions or procedures. But the *Gesundes Kinzigtal* Integrated Care program set its sights on coordinating care for an entire population—the Kinzig valley.

The program is run by *Gesundes Kinzigtal GmbH*, a regional integrated care management company, which is owned jointly by the local physicians' network and *OptiMedis AG*, a German healthcare management company, notes Helmut Hildebrandt, CEO of *Gesundes Kinzigtal* and head of *OptiMedis*. Two insurers participate in the program, and *Gesundes Kinzigtal* is in charge of the healthcare budget for the 31,000 enrollees.

The philosophy is that improving health through preventive programs and care coordination will save money. As an incentive for providers, profits are shared between *Gesundes Kinzigtal* and the insurers.

Mr. Hildebrandt and others described some of the projects' techniques in a recent journal article published in June 2010:¹³

- Individual treatment plans with goal-setting agreements between patients at risk for certain diseases and their doctors.
- Patient self-management and shared decision-making between patients with chronic illnesses and their doctors.

- Follow-up care and case management after patients are discharged from the hospital.

Hospitals and other providers facilitate cooperation through jointly developed care plans or 'pathways' (structured, multidisciplinary plans of care for specific diseases or conditions) and synchronization of medications and electronic patient records.

Gesundes Kinzigtal targets particular health problems among the population it serves. For example, it has launched programs to encourage elderly patients to exercise and to manage the care of patients with chronic heart failure.

The results since July 2006 have been promising, Mr. Hildebrandt says. For example, heart failure patients in *Gesundes Kinzigtal* receive their medications 100 percent of the time, compared with 94 percent for the overall region. Their age-adjusted mortality rate shrank from 5.95 percent to 2.04 percent in the program's first two years. Meanwhile, the program saved €1.9 million in 2007 (most recent available data).

Gesundes Kinzigtal Integrated Care is succeeding in substantially improving the population's health and generating significant savings compared with standard care in the region. If the program and others like it succeed, they "might develop into a role model for large parts of the German health service system," according to the journal authors.

¹³ <http://www.ijic.org/index.php/ijic/article/view/539/1051>, Accessed 10/19/10.

KPMG Perspective

Global healthcare: same diagnosis, similar remedies¹⁴

It is becoming increasingly evident that healthcare systems around the developed world are facing many similar challenges—higher quality for less cost. Although healthcare is primarily organized within national geographies, the market trends are truly global. Changing demographic profiles, an aging population, new technologies, pharmaceutical developments, and rising consumer demands all create unprecedented fiscal pressures.

The good news is that there are many more similarities than differences between national healthcare systems. The globalized nature of healthcare in developed countries offers the opportunity to share knowledge about what works like never before.

To share some practical insights from healthcare organizations around the world that have successfully tackled productivity and efficiency challenges, KPMG worked with the Manchester Business School in the UK to select ten leading practice examples from Australia, Canada, Germany, Spain, New Zealand, the UK, and the US. These findings, together with desk research and insight from KPMG firms' partners offer a global perspective and practical guidance on how healthcare organizations can successfully manage the changes required.

Three clear characteristics dominate these case studies:

- Firstly, the projects all have inspirational and determined sponsorship from leaders.
- Secondly, clinicians and staff are supported in a variety of ways to critically re-examine care processes and simplify patient flows.
- Thirdly, and most importantly, the most successful and sustainable changes have been made by looking at the care process from the patient's point of view.

Put the patient first

Patient-centric care has not only been the Holy Grail in the quest for quality, but it is also the nirvana for productivity and efficiency. High-quality, patient-focused care can, and does, save money, but these benefits cannot materialize without dedicated planning, program management, excellent information, and highly supportive technology. Often, disruptive innovation comes from external agencies to the organization but the change has to be owned by the staff.

Work in partnership

There are other characteristics of high-performing health systems which may point to some global convergence. A key facet of high performance seems to relate to the individual and organizational capacity to partner—be it with patients, clinicians, social care organizations, or insurance companies. In both the UK and Canadian examples, the ability to look holistically at an individual's needs and provide funding and care support from 'pooled' budgets has reduced unnecessary bureaucracy and streamlined the care process, thereby making it more personal to the user, and more effective and efficient as a result.

Similarly, purchaser-provider partnerships in different parts of the United States have demonstrated impressive results in sharing capitation risks and integrating care. Dramatic improvements in productivity seem to occur where a single organization and dedicated team of clinical staff take responsibility for the entire value chain and use sophisticated information technology to stratify patient need and focus attention and effort for those at risk.

Support innovation with evidence

What is also clear is that sustainable change cannot be "an evidence-free zone." All of the major clinical change programs noted in our study have relied heavily upon good baseline information, excellent modeling capability, risk stratification, and change management skill, often facilitated by external agencies. Radical change often requires disruptive innovation and the ability of any healthcare system to be open-minded and inquisitive is a fundamental precondition for success.

Align objectives, accountability, and incentives

Finally, countries have different funding and payment systems reflecting both cultural and political differences which range from socialized insurance and state-run provision to private cover and private supply of healthcare. This diversity makes meaningful comparison of incentives difficult to ascertain on a global scale, but it would appear that clear clinical objectives, when coupled with full professional accountability and linked to well-defined incentives, can deliver high-quality and cost-effective care.

¹⁴ A Better Pill to Swallow: A global view of what works in healthcare, KPMG International, © 2010., Accessed 10/19/10.



Who Does What

As integration is implemented, who will coordinate patients' care? Nearly three-quarters of survey respondents say that primary care physicians will fill that role. While primary care doctors are already being pushed to manage care, they often are not properly paid for the extra work, Mr. de Roodenbeke says. Furthermore, those responsible for coordination (i.e., doctors, hospitals, or other providers), must acquire the "so-called soft skills" of patient counseling and guidance needed for integrated care to work, notes the OECD report.

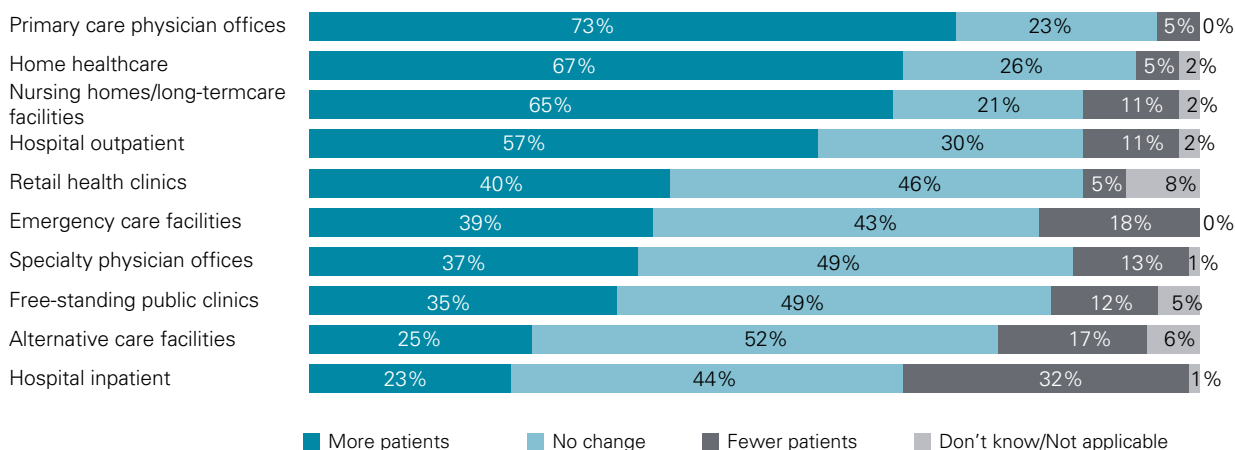
Physician training was an issue in 1994 when Brazil embarked on the Family Health Program. Under this federal initiative, which is managed at the local level, doctors, nurses, and other health professionals work as a team to provide care in their communities. Although municipalities increased fees paid to doctors and some universities created targeted training programs, there is still a shortfall in the number of doctors trained in family practice, says Marcos Ferraz, physician and professor in the Department of Medicine of the Federal University of São Paulo, Brazil. Only about one-third of the population has access to the program, he estimates. Access varies depending on the extent to which individual municipalities have embraced and invested in the initiative.

In Germany, *Gesundes Kinzigtal* recognized that the added work involved in managing patients' care deserved extra pay, says Mr. Hildebrandt. Participating physicians receive additional reimbursement for certain tasks such as development of individualized treatment plans, participation in project group meetings, development and implementation of preventive programs, and case management of chronically ill patients.

In addition to training and payment for care management, assurance that the program will be long-lived is an important incentive for physicians, says Dr. Ferraz. Physicians may not want to make the personal investment in a program if they are unsure it will last.

Volume at primary care physician offices set to rise

In your opinion, how will integration affect patient volume at the following venues?



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A major goal of integration is to manage chronically ill patients' care well enough to prevent hospitalizations. This could intensify the current shift toward outpatient care. A 2008 paper in the journal *Health Affairs*¹⁵ envisages integrated care that enhances the care experience, improves people's health and reduces per capital costs. The authors say that hospitals involved in such efforts "would be trying to be emptier, not fuller." Already, Mr. de Roodenbeke notes, "there has been a shift in the sense ... that hospitals are more and more there to provide highly intensive care."

Although primary care physicians will have growing responsibilities, hospitals will also play a role in the shift toward integrated care. For example, Gesundes Kinzigtal has contracts that feature care co-ordination components with six hospitals. In the US, the health system reform law, signed in March 2010, creates two demonstration programs testing accountable care organizations (ACOs). In its June 2009 report, the Medicare Payment Advisory Commission defined ACOs as "a set of providers held responsible for the quality and cost of healthcare for a population of Medicare beneficiaries. An ACO could consist of primary care physicians, specialists, and at least one hospital."¹⁶

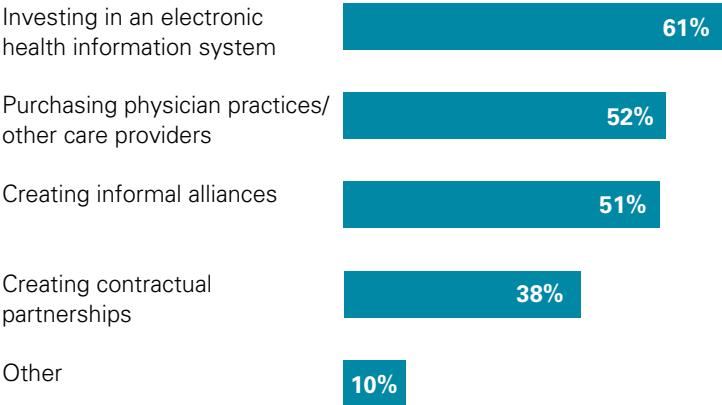
Mr. Zucker envisages hospitals as the drivers of ACOs and sees Baptist Health System's work on the ACE project as "the genesis" of one. "The past year's experience has shown that this works," he says. It has also raised the question of how to extend the lessons learned in the ACE program beyond the Medicare population.

The survey findings reveal that hospital organizations worldwide are purchasing, or creating alliances with, physicians' medical practices and with other providers. This supports respondents' expectations of a quick transition to greater system integration. A mere 15 percent of respondents say care in their countries is 'very' integrated now, but 62 percent believe it will be in five years.

15 <http://content.healthaffairs.org/cgi/content/abstract/27/3/759>, Accessed 10/19/10.
 16 http://www.medpac.gov/documents/Jun09_EntireReport.pdf, Accessed 10/19/10.

Health IT tops list of steps toward integration

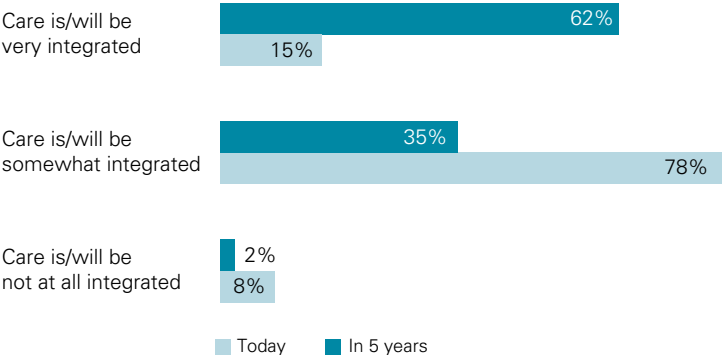
How has your organization prepared for greater integration in the provision of healthcare? Select all that apply. (% respondents)



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Integration will take off in next five years

Which statement best describes the level of integration today and in five years among healthcare providers in the country in which you reside?



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Constructing Accountable Care Organizations:

Some Practical Observations at the Nexus of Policy, Business, and Law

By Douglas A. Hastings

Introduction

We are at an interesting transitional juncture in the payment and delivery reform process in the United States. There is a lot of planning, thinking, positioning, and strategizing going on, but also a lot of waiting and watching. Among other factors, more specific guidance from the Centers for Medicare & Medicaid Services (CMS) on the requirements of Section 3022 of the Patient Protection and Affordable Care Act (PPACA) will assist healthcare provider organizations in making decisions as to a variety of structural, governance, legal, and financial variables relating to possible participation in the Medicare shared savings program. At the same time, organizations assessing Accountable Care Organization (ACO) development want to be able to deliver services using reasonably similar structures, provider components, financial arrangements, and clinical pathways in both the public and private sectors—to warrant the investment and do the most good. And, from a policy perspective, both sectors need to be reasonably aligned. Despite the inevitable uncertainty that is present in a period of transition, ACO construction is moving forward in diverse ways across the country.

Structural Considerations

The three basic structural approaches to provider integration—fully integrated structures, virtual or partially integrated structures, and contractual structures—all are in play. Full-integration, meaning common ownership and common employment in a single entity or corporately related family of entities (being ‘Copperwelded’ for antitrust purposes), has many advantages: greater size and scale to invest in accountable care tools, tighter decision making, clearer control over clinical activities in order to drive quality and cost-efficiency, and better legal protection under the fraud and abuse and antitrust laws. The exception to the latter is where an organization achieves a significant degree of market power, thus making further growth through acquisitions subject to greater scrutiny and possible challenge. In addition, there are other practical limits to the ability and desirability of trying to put every provider component of a potential ACO under the same corporate umbrella—including cost limitations, charter restrictions, and the willingness of potential partners to be acquired.

Virtual or partial integration, while often more complex, creates a pathway to greater clinical and financial integration without requiring a complete change of control. Joint ventures, joint operating agreements, and virtual parent governing bodies are all forms of virtual or partial integration. Inherent in the concept is some degree of financial integration as well as fairly robust clinical integration that can be achieved initially and over time. There is legal recognition of the appropriateness of the financial relationships and procompetitive potential of these kinds of joint arrangements, yet there generally also is a greater burden on the parties to demonstrate the benefits than in fully integrated structures.

Contractual structures may be short or long-term, but at their core, they contain elements of integration not through corporate structure but through language in an agreement. This is not to say that contractual models cannot achieve financial or clinical integration—a Physician-Hospital Organization (PHO) meeting Federal Trade Commission (FTC)/Department of Justice (DOJ) guidelines for clinical integration would be an example of a successful contractual model—but the agreements among the parties need to be strong enough and long enough to achieve the degree of sufficient integration sought. Given the constantly changing reality of healthcare financing and delivery, it remains likely that contractual approaches will be utilized to some extent in ACO development even by the largest and most integrated health systems.

Ultimately, there is a need for flexibility as to structural models and caution as to the urge to find the ‘best’ model to adopt wholesale. Each of the above approaches will be necessary for ACOs currently in different stages of development and all may be necessary for the same ACO as it addresses different levels of payment reform.

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Conclusion

Integration efforts in healthcare are at an early stage. Yet some pilot projects have used it successfully to reduce costs and improve quality. Proponents of integration recognize that governments worldwide already play an important role in their country's overall healthcare system. They argue that governments should take the lead in expanding these pilot projects to implement integration more broadly.

This is already happening in several countries. Although survey respondents are optimistic that change will occur quickly, the feasibility of a five-year time frame for a deep worldwide shift is open to question. Still, entities such as Baptist Health Systems and Gesundes Kinzigtal GmbH can point to measurable results in a short time period.

Some measures that would promote effective integration include:

- **Incentives to encourage integration.** Pursuing integration requires breaking down silos in healthcare delivery. Tools can include payment structures that make it advantageous for providers to cooperate to reduce costs, but should also include measures that value quality.
- **Technology systems that support integration.** Coordination among providers requires interoperable systems that enable sharing information securely. This is especially important where care occurs over a period of time. Interoperability standards for healthcare IT can help achieve effective integration.
- **Training of providers responsible for care coordination.** Primary care physicians or other providers responsible for centralizing patient care should be trained in skills that are crucial to integration such as patient counseling and guidance. They should also be remunerated for the extra work required to coordinate care.
- **Pilot projects to test models.** Barriers to integration are often country-specific. Pilot projects enable care providers and governments, at relatively low cost, to experiment with models to identify those that are most appropriate for a country's healthcare environment.
- **Allocation of sufficient resources.** Implementing integration will require up-front funding. The seriousness of the efforts may be measured by the resources allocated to them.

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