Bracing for impact:

Preparing providers for a spending downturn

Health care providers can prepare for the anticipated funding shortage through a coordinated set of operational, financial, and structural levers.

"In the second half of 2010 the crisis will enter the health care economy . . . then the doctors and hospitals will surely be the ones to bleed."[1]

—Professor Günter Neubauer, Institute for Health Economics (Munich)

"Any managers of a public service who are not planning now on the basis that they will have substantially less money to spend in two years' time are living in cloud-cuckoo-land."[2]

—Steve Bundred, chief executive, Audit Commission (the United Kingdom)

Sean Hennessey, Florian Schaudel, and Tim Ward

From 1996 to 2006, health care spending in each of the G7 countries[3] increased faster than GDP, with the relative increase ranging from 2 percent in Germany to 22 percent in Italy (Exhibit 1). The rise in health care spending (which continued through 2008) opened up opportunities as revenues grew faster than costs for many providers. For example, last year Germany's largest private-hospital chains reported increases in earnings before interest, taxes, depreciation, and amortization (EBITDA) of 5 percent to 14 percent over the previous year.[4]

However, as government revenues shrink and spending is increased on economic stimulus packages and related initiatives,[5] health care providers in tax-based systems that have previously been used to steady growth are increasingly likely to come under greater budgetary pressure. In insurance-based systems, pressure to curb premium increases is likely to translate quickly into pressure to limit reimbursements. Furthermore, in countries where patients bear part of health care costs themselves—or where certain procedures are not reimbursed at all—some patients may choose to defer nonurgent care. Indeed, our analysis of the US market reveals that providers there have already seen a roughly 4 percent decrease in discretionary procedures from 2007 to 2008.

In response, health care providers will need to better control costs while maintaining or improving the quality of care. The most direct route to cost control—simple cost cutting—can be self-defeating if it impairs care quality. A decline in quality not only endangers patients' health but can also eventually increase costs if follow-up treatments are required to correct errors. Focusing purely on cost cutting can interfere with longer-term strategic plans as well. For successful providers, a downturn can provide a window of opportunity to strengthen their core clinical services and prepare for sustainable growth.

To enable providers to anticipate and cope with the effects of the current economic crisis, we have developed a coordinated set of actions based on our analysis of various providers' past experiences with economic downturns, as well as their more recent initiatives to improve their performance. These actions fall into three areas: operational, financial, and structural. Operational measures can range from rule-based cost controls to a full-scale service transformation based on proven approaches—

[1] Lukas Heiny, "Angst in Deutschland: *Gesundheitsmarkt fürchtet Krise*," *Financial Times Deutschland*, March 6, 2009 (ftd.de).

[2] Steve Bundred, "Our public debt is hitting Armageddon levels," *Times*, February 27, 2009 (timesonline.co.uk).

[3] Canada, France, Germany, Italy, Japan, the United Kingdom, and the United States.

[4] Company reports for Rhön-Klinikum AG (rhoen-klinikum-ag.com), Sana Kliniken AG (sana.de), and the Helios division of Fresenius (fresenius.de).

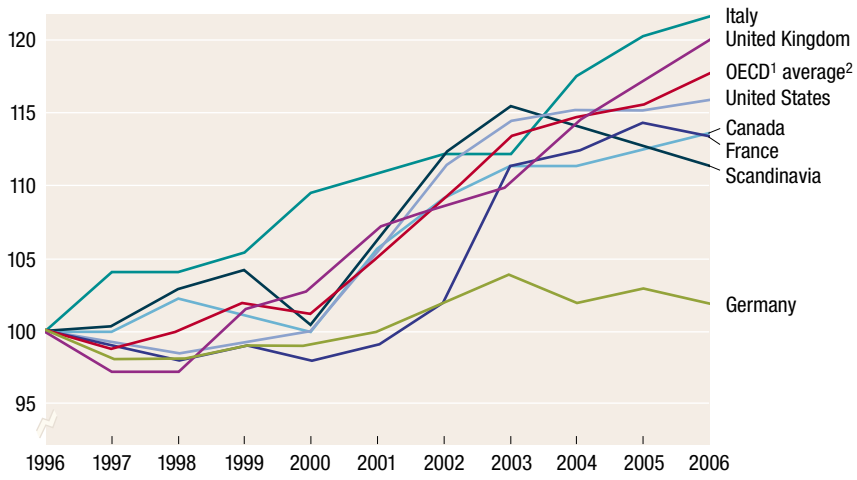
[5] Most European stimulus packages that have been passed as of March 2009 have not allocated specific funding for health care. Germany is an exception, but its stimulus funding for health care is restricted to infrastructure projects. Therefore, government economic stimulus packages in Europe are unlikely to remove the revenue and cost pressures on health care providers.

Exhibit 1

Health care spending on the rise

In many countries, health care expenditures have increased significantly faster than GDP has.

Health care expenditures in Western Europe and North America
Index: health care expenditure as % of GDP in 1996 = 100



[1]Organisation for Economic Co-operation and Development.
[2]Last 10 years for which data is available, ie, 1996–2006 (excepting Japan).
Source: Organisation for Economic Co-operation and Development (OECD), *Health Data 2008*

such as "lean"—from other industries. Finance-led actions can range from working-capital-management improvements to a full balance-sheet review and enhancement. Providers might also consider structural changes, from simple joint ventures all the way to vertical integration of multiple functions. Which actions a provider takes first will depend on its current position, especially how quickly it needs to achieve savings (immediately, in the short term, or over the medium term).

The coming squeeze

No one yet knows how long the current slowdown will last, how severe it will be, or exactly when it will start affecting health systems. However, our analysis of 51 individual European country downturns in the past 35 years shows that the majority of countries affected saw health care spending decline within one or two years of a fall in GDP. Exhibit 2 illustrates the impact of two general European recessions (1980–83 and 1988–93), and our analysis shows that all but 1 of Europe's 14 more localized but prolonged downturns in that time period followed a similar pattern. These case studies suggest that providers in countries whose economies are contracting today might experience a funding decrease within a similar time period.

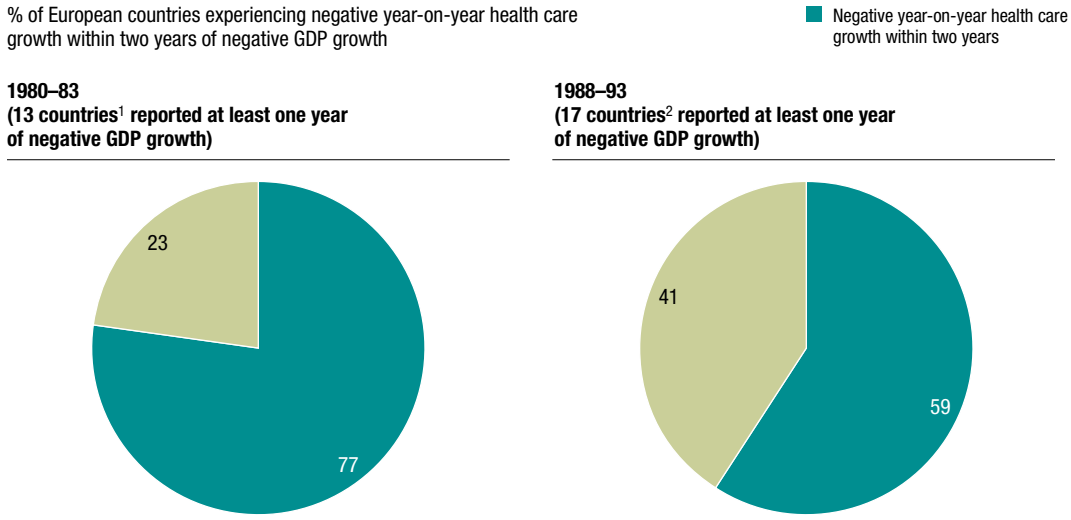
The transmission mechanism and precise timing may differ depending on how care is funded within a given country, but we anticipate that the majority of providers will feel the pressure. Providers in countries with purely tax-funded systems, such as Sweden and the United Kingdom, may be safe from cutbacks in the current fiscal year, since those countries' governments have already committed to spending

Exhibit 2

Post-crisis spending

The majority of European countries have seen health care spending decline within one or two years of a fall in GDP.

% of European countries experiencing negative year-on-year health care growth within two years of negative GDP growth



[1]Austria, Belgium, Denmark, Germany, Iceland, Ireland, Luxembourg, Netherlands, Portugal, Spain, Sweden, Switzerland, and United Kingdom.
[2]Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Norway, Poland, Portugal, Spain, Sweden, Switzerland, and United Kingdom.

Source: Organisation for Economic Co-Operation and Development (OECD)

levels for that period. But providers in those countries can expect to see an increased squeeze on activity levels and costs thereafter.

In countries with insurance-based systems, the first impact is likely to be felt by payors, which could come under pressure to control premiums. In Germany and certain other countries, limits on sickness fund premiums will be triggered automatically because those premiums are set as a percentage of pay. However, all payors will have to respond if customers reduce their own spending significantly. Most likely, the payors will seek to pass the financial pressure on to providers as quickly as possible (see sidebar, "Payor responses to the downturn," p. 12).

The resulting squeeze on health care spending will force providers to do more with less. There is no way to predict the potential magnitude of the impact, but the lessons of the past can help them avoid mistakes. Most important, cost-reduction measures should not be allowed to affect care quality—a phenomenon that has happened when providers have responded to financial pressures by, for example, lengthening waiting times, forgoing maintenance on equipment, or deferring purchases of supplies.

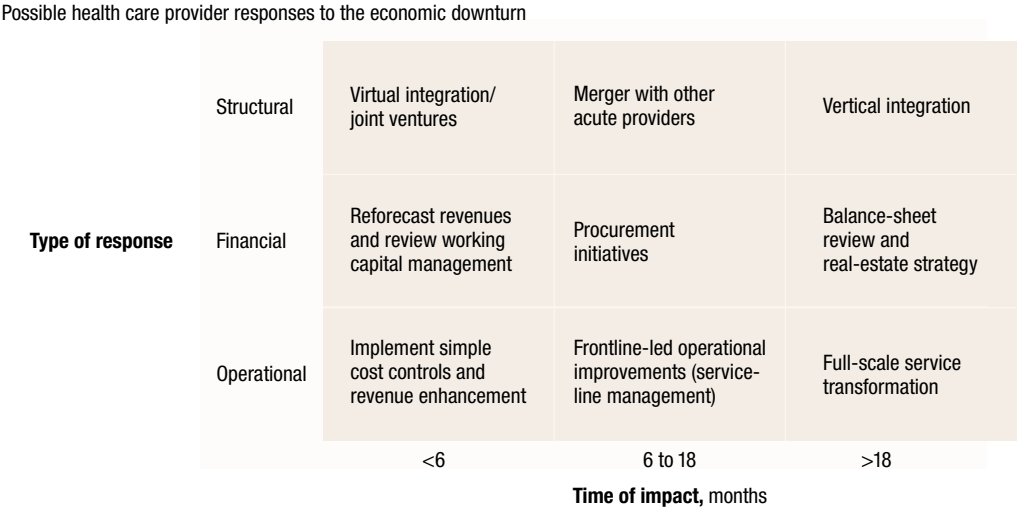
A decline in care quality harms hospitals in multiple ways. First and foremost, it puts patients at risk. In addition, it damages the provider's reputation and may eventually increase costs (for example, by increasing length of stay, the risk of complications, and the need for revision surgery). Ultimately, a decline in quality threatens a hospital's viability, because patients and payors may understandably choose to go elsewhere. Providers must therefore begin preparing now

Exhibit 3

Taking action

Providers can respond to the downturn with structural, financial, and operational changes.

Possible health care provider responses to the economic downturn



by planning an approach to navigate the crisis and building their capabilities to respond.

A framework for the crisis

Providers can take actions along three dimensions—operational, financial, and structural—to reduce costs without sacrificing quality. Some actions can provide near-immediate impact (within 6 months or less); those that we characterize as short-term moves can deliver results inside of 18 months; and the last category, medium-term moves, can take 18 months or more to produce the desired results (Exhibit 3). We discuss the dimensions in increasing order of complexity; for example, operational improvements are usually less difficult to implement than structural changes.

Admittedly, many of these actions are simply good business practices that most providers should already be using. But the recession gives all providers an extra incentive to improve their performance. Each provider must therefore assess its starting position to choose which actions are most appropriate to pursue. The ultimate goal must be to emerge from the downturn a fitter and stronger organization.

Operational improvement

In the immediate term, providers can implement *rule-based cost controls* to achieve better control over what they spend. This starts with a review of major pay and nonpay cost categories to understand where costs may have recently, and perhaps unnecessarily, increased. It is vital that cost controls be a result of underlying process improvements; cuts that are not based on operational enhancements might last for only a short time and could negatively affect quality. For example, providers could bring labor costs under quick control by curbing the unnecessary use of temporary doctors and nurses, such as when temporary staff is hired

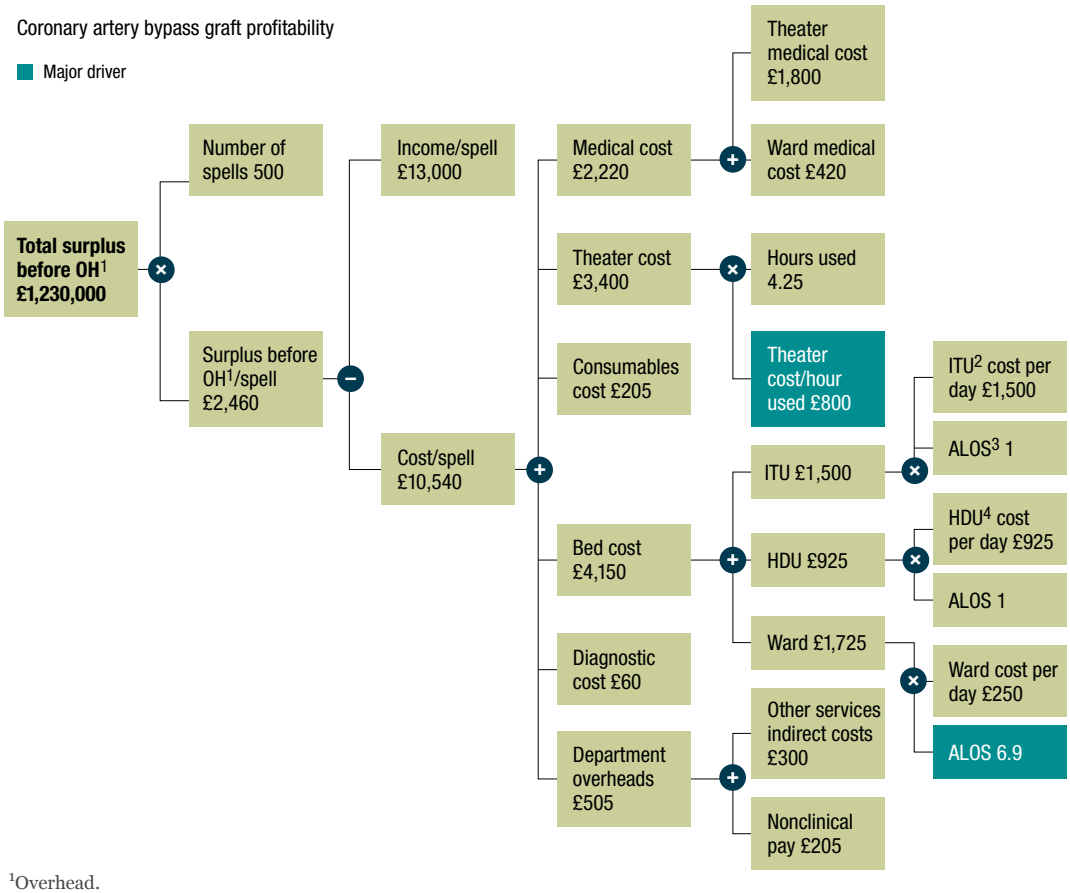
solely for convenience or to cover for poor scheduling practices. On the nonpay side, establishing or reinforcing thresholds for signing authority can highlight areas of duplicative or unnecessary spending. For example, purchases of excessive amounts of supplies may mask poor stock-management practices. In addition to examining cost controls, providers can immediately review their collection of revenues to ensure they are being paid appropriately for the work they do. They should also be certain that they are accurately recording all billable activities.

Within a span of 6 to 18 months, a provider could implement a *service-line-management program*. To do this, the provider needs to build up the management infrastructure so that clinician leaders have the tools and capabilities they need to manage their own services. Typically, for each hospital service line, the clinician leaders work with their colleagues—

Exhibit 4

Procedural breakdown

A 'driver tree' of specific procedures helps staff to identify and prioritize improvement ideas.



[1]Overhead.
[2]Intensive-therapy unit.
[3]Average length of stay.
[4]High dependency unit.

Source: Discussions with surgeons; McKinsey analysis

Payor responses to the downturn

The current downturn is expected to affect payors as well as providers, and it will have implications for a wide range of payor activities. Appropriate responses will depend on where a payor stands on what we call the payor evolution staircase (exhibit).

The staircase depicts the evolution of payors to a new business model, driven by two interrelated factors: the continuing rapid rise in health care spending and changes in the nature of medical risk that are driving up demand. In the traditional business model (shown in a simplified version in step one of the exhibit), providers drive all health care decisions; payors pay the bill but bear no responsibility for quality or value for money. In many countries, this business model has been slowly evolving over a number of years to step two: payors are assuming more active management of health care networks, thereby helping to ensure transparency and improve quality and value. In the final evolutionary step, a payor becomes a true partner with consumers, clinicians, and local stakeholders in the management of lifestyles, behaviors, and health care demand. Some payors are already moving in this direction. It is important to remember that these steps are additive: a good network manager, for example, will also be able to execute basic payor skills well (whether done in house or outsourced to vendors).

Given current economic conditions, payors need to ensure that they are delivering the best value for consumers and other stakeholders. Those actions that are most appropriate for them to take in response to the downturn depend on which step of the staircase most accurately corresponds to their current operations.

The "pure payor" can improve its operations by developing innovative new insurance products, streamlining processes through lean initiatives, and improving its management of claims. On the financial front, such payors—like providers or virtually any other organization—should reassess their forecasts and assumptions about growth in revenues and demand. Especially important, even for public payors that may have never done so before, is a new assessment of the payor's liquidity situation. Even payors that have government guarantees for their debts will have to decide whether they should establish true liquidity-management capabilities. Current risk premiums in the bond markets for subsovereign debtors (states, cities, towns, and municipalities) indicate very clearly that markets, at least in the medium term, will

Exhibit

The payor evolution staircase

Potential actions for payors at each level of the staircase.

How payors can respond to the downturn

	Traditional provider-led systems	Care networks and competition	Fully engaged consumers and clinicians
Role	**Pure payor** • Fund health care provision	**Network manager** • Develop provider market based on quality and value • Integrate care across different provider types	**Health care partner** • Work with patients, clinicians, and local stakeholders on the following aims: – Help patients make informed decisions – Actively improve health outcomes – Promote value consciousness
Potential actions	• Pursue insurance product innovation • Drive lean operations • Improve claims management • Consider payor consolidation	• Establish preferred provider networks • Develop tighter primary care and secondary care provider management	• Prioritize spending according to areas of greatest health need • Empower consumers to control spending through information, choice, and incentives

make significant distinctions between payors that receive their main sources of funding from the central government (the United Kingdom) and those that are only indirectly government guaranteed or that receive support from local authorities, if they receive support at all (Germany). More restrictive financing terms may necessitate better cash management. Structurally, if a payor thinks greater scale would offer advantages, it could consider consolidation with other payors that would deliver significant synergies.

If the payor functions as a "network manager," in addition to the steps just outlined, it can establish or further develop preferred provider networks and more tightly manage how primary and secondary care providers administer care. One idea in particular that the payor may want to consider is how to use available cash for incentives that could encourage providers to deliver better care more cost-effectively (for example, the payor could subsidize consolidation of subscale providers or encourage providers to move certain activities to appropriate but lower-cost care settings). And because the payor's cash position and credit rating are generally better than those of providers, it may want to reconsider how to use funding and liquidity in its relationships with providers.

For example, after reassessing its own capital and liquidity position, a payor might explore more creative financing options with a provider, such as coinvesting in future infrastructure.

A payor that has become—or is becoming—a "health care partner" has another option: it can work to prioritize its spending on the areas of greatest impact on health. To determine whether it is efficiently allocating resources, the payor will have to establish whether spending is being targeted at the right health needs and whether the most cost-effective interventions are being applied for each health need. Beyond this, the payor can also undertake initiatives to help empower consumers in an effort to better manage health care demand. Such initiatives may include providing information, enabling consumers to make lifestyle and health care choices, and offering incentives to improve consumers' health and change their use of the health care system.

While revenue growth will likely be constrained over the next several years, demand for health care will almost certainly continue to increase. The further up a payor is on the evolutionary staircase, the more tools it will have at its disposal to manage this tension.

Given current economic conditions, payors need to ensure that they are delivering the best value for consumers and other stakeholders

doctors, nurses, and other clinical staff—to understand the drivers of revenues and costs and to motivate those frontline employees to take ownership of improving their performance. One approach involves building a "driver tree" of income and cost at the procedure level (Exhibit 4) and then working with staff to identify and prioritize improvement ideas. In one pilot program that began in 2006, a UK hospital went from a £6.0 million deficit (against annual revenues of £225.0 million) to a slight surplus within one year. By the 2007–08 fiscal year, the surplus was roughly £8.5 million (on revenues of £275.0 million). Throughout this period, both the hospital's quality rating and its financial-risk rating improved steadily.

Ideally, providers would turn the crisis into an opportunity to conduct a *full-scale service transformation,* in which the leadership team mobilizes the entire organization to improve performance based on a clearly defined vision for the future of the hospital (for example, as a national leader in quality and efficiency). This type of transformation requires a consistent methodology that becomes a "common language" throughout the entire organization. One methodology that many providers have found effective for this purpose is lean, which has been adapted from manufacturing. A lean transformation enables a hospital to analyze its processes for providing patient care, to identify steps in those processes that are inefficient or result in poor-quality care, and to take the necessary corrective actions. To be effective, a full-scale service transformation also requires strategic investments in leadership training and improving the capabilities of the entire staff. The results can be dramatic. For example, a large hospital network in Germany conducted a transformation program after incurring a roughly €70 million deficit as a result of government measures to restrict health care spending. Its available cash was enough to sustain it for just nine days. The transformation program focused on ten areas covering the whole network, including medical processes, medical support functions, referral management, and performance management. Within 18 months, the organization had freed up €120 million and was able to begin considering acquisitions. At the same time, the hospitals maintained their clinical quality.

Financial management

From a financial-management perspective, a first step for any provider will be to reexamine its *financial forecasts and investment plans*. How well prepared is the organization financially for a downturn in revenues and profitability? Are the business cases still robust for major

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investments that are ongoing or about to start? Additional financial-management quick wins can be realized with a simple review of *working capital*, especially if the provider has not spent much time on this task in the past. By examining how it manages its creditors and debtors, a hospital can find ways to improve its cash flow and free up money for more long-term, transformational projects. Reviewing the risk profile of major payors may also be in order, particularly for providers dependent on private-sector or local-government payors, where there may be doubts about credit risk should the downturn be prolonged.

Within a matter of several months, hospitals can free up even more cash by reviewing *procurement practices*. Even organizations with very good procurement operations can often find significant savings with a thorough review. For example, a Swedish integrated care provider conducted a seven-month regional purchasing program that focused on several purchasing categories, including gloves, IT, medical aids, nutrition, stents, sutures, and more. This review helped reduce procurement costs by 13 percent, without any negative effects on quality. The process is relatively simple: analyze the cost base in several different areas, identify relevant vendors, send out requests for proposals, and negotiate better prices. The key to achieving optimal savings is to involve frontline staff in the effort, particularly when it comes to big-ticket items or those that are important from a clinical perspective. One example of an approach that works comes from the field of orthopedics: a hospital identified the surgeon most respected for clinical quality within an orthopedic service and then asked the other surgeons to follow his lead on which manufacturer's prostheses to use.

For more sustained savings over the medium term, a provider should undertake a full-scale review of its *balance sheet*. The intent of the review should be to decide whether the provider or some other party is the natural owner of certain assets. For example, should the hospital hold or sell certain pieces of real estate after analyzing their value and all the attendant costs of ownership? Should the hospital own or lease an expensive piece of diagnostic equipment in a rapidly changing field? These decisions are necessarily driven by the provider's clinical strategy, which must be created first. If the provider plans to phase out certain service lines over time, it may decide to phase out the corresponding assets. This could provide much-needed liquidity to help meet ongoing obligations at a time when private-sector financing is likely to be limited or available on less favorable terms, even for the most creditworthy providers. If, on the other hand, a provider has a clear strategy that involves expanding certain service lines despite the current economic situation, and if it enjoys stable funding and an adequate liquidity position, it may want to invest in new assets now. In many countries, demand for medical equipment is already falling and prices are dropping significantly.

Structural moves

As a defensive measure, European providers should begin considering *cooperating more closely* (sometimes called virtual integration) or *forming joint ventures* with other providers in the value chain. Throughout the continent, for all but the most acute conditions, there is an ongoing structural shift away from care in the hospital setting and toward outpatient and primary care settings. This approach is often more cost-effective for the payor and more convenient for the patient,

but it threatens an important revenue source for providers, particularly if they are reimbursed under diagnosis-related-group systems. Because the current crisis may lead to a push by payors and patients to accelerate this trend, providers must find a way to respond. This necessarily means that different types of providers should enhance their efforts to work closely with one another to better serve patients across the clinical pathways. For example, a hospital may want to cooperate closely with a community service provider to increase its share of referrals for patients who require hospital-based services. In return, the hospital can work with the community provider to smooth pathways and hand-offs between acute and nonacute care. This could be accomplished either informally or through a contractual joint venture.

Acute providers may also have to pull some capacity out of the system through *mergers and acquisitions*. These types of moves have been much more common in systems where hospitals operate in the private sector than in state-run hospitals. Nevertheless, the same logic with respect to finances and quality applies in publicly funded systems. Only the deal mechanics, and sometimes the timescales, are different. For example, one 1984 merger of public hospitals in London brought together several dozen sites into one entity. Although the benefits were not immediate, over time the entity was able to consolidate and reduce capacity quite successfully. Regardless of the operating environment, however, mergers must be managed carefully to succeed. Evidence from the United States suggests that the value created by capacity reductions that result from hospital mergers is very small. If it appears that political pressures will block the realization of available synergies, the parties to the merger should proceed with extreme caution.

Over time, providers can consider *vertical integration* to develop more efficient care pathways that ultimately remove waste from the system. This is particularly beneficial in the treatment of long-term conditions, to ensure that care delivery is seamless. For example, a hospital might take increased responsibility for managing the health of diabetes patients. Rather than just providing inpatient treatment when acute care is needed, the hospital might employ community nurses to check the patients' blood sugar on a regular basis. The hospital would acquire the necessary staff, facilities, and capabilities to provide care not only while patients are admitted but before and after the hospital stay as well. Another example could be integration of the payor and provider functions, which several health systems in the United States have done. One of these, the Geisinger Health System, serves roughly 2.5 million people as either a payor or provider and covers about one-third of that population in both capacities. The system's integration of these two functions has helped it better manage patients' health and pilot innovations. For example, its integrated chronic disease care optimization program has reduced drug costs in the management of kidney disease by $3,800 per patient per year.[6]

[6]Ronald A. Paulus, Karen Davis, and Glenn D. Steele, "Continuous innovation in health care: Implications of the Geisinger experience," *Health Affairs*, September/October 2008, Volume 27, Number 5, pp. 1235–45 (content.healthaffairs.org).

To determine which combination of immediate, short-term, and medium-term actions makes sense, a provider must analyze its starting position against a range of likely scenarios. For the markets in which the provider operates, when is the downturn expected to spread to the health care sector? Based on the experiences of past recessions and how the current situation compares with them, what is the potential size of the challenge the provider is likely to face? By acting now, a provider can avoid being forced to take desperate—and potentially damaging—measures when the downturn strikes. Conducting a proper planning exercise will not only protect the provider from the worst but also provide it with an opportunity to emerge from the crisis in a position of strength.

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