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Claiming the $1 trillion prize in US health care

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By tying payments more aggressively to patient outcomes rather than to services rendered, the US health-care system could deliver substantial savings over the next decade.

As divisive as the debate has been, there is a clear consensus across political parties and health-care stakeholders that if the United States is to address its unsustainable health-care costs, it must change the way it pays hospitals, physicians, and other providers. The country needs to move away from fee-for-service reimbursement, which rewards providers for tasks performed, and toward a method of payment that compensates them for successfully addressing patients' health-care needs. These approaches are often referred to collectively as "outcomes-based payment."

Although the US health-care industry has in the past decade undertaken many useful experiments with outcomes-based payment, it has largely failed to make the transition at a significant scale. The challenges have been substantial, including the industry's sheer size and complexity, the comfort incumbents have with the existing payment models, technical barriers that have made it difficult to ensure fairness, and the risk of unfavorable unintended consequences.

That said, the preconditions for transformative change are much better now than at any point in recent history. McKinsey's broad experience in the health-care industry indicates that, with stronger leadership, bolder initiatives, and more collaboration between public and private payers, the US health-care industry could aggressively transition to outcomes-based payment over the next three to five years. We estimate that such a move could save consumers, employers, and taxpayers more than $1 trillion over the next decade while improving the delivery of care.[1] (For more on the benefits of outcomes-based payment and solutions for shifting to this approach, see our video interview with author Tom Latkovic, on mckinsey.com.)

To understand where savings of this magnitude could come from, consider the extensive media attention that has been paid recently to the wide variations in charges and unit prices for the same procedures or activities at different hospitals.[2] We have observed similar variations in end-to-end costs for "episodes of care"—medical situations characterized by a relatively clear outcome and relatively predictable start and end points (for example, most hospitalizations, pregnancies, upper respiratory infections, and hip replacements). Even within a single local market, we have found

[1] Our estimate assumes that by 2018, half of all payments would be outcomes based—a level that can be achieved if existing initiatives showing favorable impact are scaled aggressively. As a consequence, affected health-care spending would decrease by at least 10 percent. The savings assumption is supported by the results obtained in the more successful pilots we have observed and by inference from our analysis of unjustified variations in practice patterns and costs.

[2] Medicare provider charge data, available on the *Centers for Medicare & Medicaid Services* Web site (cms.gov).

that the cost to deliver the same episodes of care typically varies by 30 percent to well over 100 percent, even after we held constant the prices that hospitals, physicians, and other providers charge and risk-adjusted the costs to reflect patients' health status.[3] The cost differences were unrelated to any discernible variation in care quality or outcomes. These results make it clear that some providers are dramatically more successful than others in addressing patients' needs. The strong providers achieve good results not by cutting corners but by developing (or adopting) best practices that enable them to deliver high-quality outcomes at lower cost.

By encouraging other providers to adopt these best practices, US payers—including employers, health insurers, state governments, and the federal government—could capture the $1 trillion prize. However, payers will need to make significant changes in their approach to promoting outcomes-based payment. Our research and global experience suggest that at least five sets of changes are required.

First, payers (and patients) must redefine the roles they expect providers to play and clearly establish that they want these roles to match the needs of 21st-century patients. In a system characterized by complexity, specialization, a high prevalence of chronic illness, and a proliferation of drugs and devices, the United States needs fewer *component providers* who specialize in a single task, such as taking diagnostic images. Instead, it will need more *healers* (providers who can achieve specific objectives for patients during episodes of care) and *partners* (providers who can help improve a patient's health and wellness over a longer period of time). Today, few providers act as or are rewarded for being healers or partners.

Second, the transition to outcomes-based payment must happen at scale—a critical mass of providers in a local market has to be moved to outcomes-based payment, and a critical mass of each provider's revenue must be outcomes based. Anything less will be insufficient to overcome the providers' inertia and justify the required investments. Meeting this bar is likely to be difficult for any one payer. In most parts of the United States, such a payer typically represents only 5 to 30 percent of a provider's total revenue. It becomes more feasible if several payers join forces.

Third, the transition to outcomes-based payment should focus initially on episodes of care. Because episodes have, by definition, a finite duration, it is now relatively easy to mine data sets to identify which providers can solve specific medical problems more effectively and at a lower cost than other providers. Whether the category being considered is surgeons who perform hip replacements, oncologists who treat prostate cancer, or hospitals that take care of stroke patients, the goal of this approach is to reward providers for delivering a patient's desired outcome (say, walking, remission, or hospital discharge without readmission) with as few complications as possible and for providing the best experience at the lowest possible cost. Focusing on episodes of care makes it easier to compare performance across providers and encourages productive

[3] Our analysis includes all costs associated with the episode of care, including, but not limited to, professional charges, drugs, diagnostics, medical devices, facility charges, hospitalizations, complications, post-acute support, and hospital readmissions.

competition among them. We believe that more than $2 trillion of US annual spending on health care, which currently totals about $2.7 trillion, could be paid through an episode-focused approach.

Fourth, payers must share considerably more information and offer significantly more support to help providers make the transition. In recent McKinsey research, 84 percent of physicians said they are willing to change their behavior to reduce waste in health care. When asked what they needed to make the change, 30 percent suggested payment reform, but 70 percent called for greater support, including education, clinical leadership, and information sharing. Last, to implement effectively the strategies described above, private- and public-sector payers will need to collaborate. Only in this way will they be able to overcome barriers, achieve critical mass, and help providers make the transition to new payment models. To borrow an example from the consumer-electronics industry, no one company alone could have led the transition to Blu-ray technology; instead, a coalition of manufacturers and content providers worked together to define and embrace the new standard. The same is true in health-care payments. Payers should consider establishing more standards around new payment models and synchronized implementation at the local-market level.

The good news is that at the local level, real momentum is beginning to occur in these five areas, including the synchronized implementation of outcomes-based payment across multiple private and public payers. In fact, in the past two years, payment-reform initiatives involving a number of different kinds of payers and other stakeholders have started in more than 30 states. Several of these initiatives, such as those in Arkansas and in Cincinnati, Ohio, are attempting to achieve real scale within a few years—not decades. Moreover, the initiatives are being sponsored by both Republican and Democratic governors, highlighting the nonpartisan nature of the reforms.

If these and similar initiatives are to succeed, a wide range of institutional leaders—not only governors but also CEOs, community leaders, and others—must become personally involved with them. The leaders should actively participate in multistakeholder initiatives, demand payment-reform strategies that can work at scale, and support the efforts by making the required financial and human-capital investments.

For more information about outcomes-based payments and episodes of care, read *The Trillion Dollar Prize: Using outcomes-based payment to address the US healthcare financing crisis*, on mckinsey.com. ▢

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