

Transforming the operating platform

An overlooked opportunity for health system improvement

An operating-platform transformation can enable a health system to improve care quality and accessibility and, often, lower costs—but two key elements are necessary to ensure success.

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A variety of economic, demographic, and clinical forces are buffeting health systems today. Costs continue to rise, driven by population growth and aging, technological innovations (new diagnostic procedures and treatments), and the growing burden of chronic disease. Governments and consumers have demanded greater transparency into health system performance, outcomes achieved, and continuity of care.

To cope with these challenges, health systems have been trying to find the optimal balance of care quality, accessibility, and financial sustainability. But this task has been complicated by the global recession. In the current climate, there is more pressure than ever to find ways to avoid having budget constraints impair quality and service levels.

Most health systems have therefore felt an urgent need for change, and they have usually taken one of two approaches. Some have attempted major organizational redesign, which can be an effective lever for long-term change. However, many health systems have limited control over their organizational structures, given political and environmental constraints. Moreover, structural change is far from sufficient on its own to drive the substantive, rapid results that most health systems need today; it often requires a long readjustment period and can produce significant unintended consequences unless buttressed by a clear vision and operational supports.

A second approach, operational-improvement programs, has been used successfully by many health systems. These programs can significantly enhance performance: for example, they can enable hospitals to assess service levels

and quality outcomes regularly, monitor operating costs routinely, and manage supply and service procurement carefully.¹ They can also help pinpoint and correct the underlying causes of underperformance. However, operational-improvement programs alone may also be insufficient to drive the substantive results health systems need today.

Between these two approaches is, we believe, the most important untapped opportunity for many health systems: a transformation of the operating platform (the infrastructure used to deliver care and the practitioners who provide that care). This type of change has two parts.

To transform the infrastructure, a health system must alter the balance of its investments in, or even physically modify, its existing facilities (hospitals, clinics, and other buildings) to create the mix that will best serve the local population's evolving needs for community-based care, acute care, and continuing care. Among the changes that can be considered are redirecting capital expenditures so that new facilities are built only in underserved areas and reconfiguring existing facilities so that less intensive services can be provided.

To transform the practitioner landscape, the health system must define roles, develop staff skills, and build the workforce that most effectively and efficiently meets the population's evolving needs. The system could, for example, redeploy staff (or give them incentives to move) so that all geographic areas are served equally, enable all practitioners to work at full—or an expanded—scope of practice, and create compelling career opportunities that attract and retain the needed number of practitioners with the requisite capabilities.

¹For a look at how an operational-improvement program can reduce wait times in the emergency department, see “A hospital-wide strategy for fixing ED overcrowding,” p. 6.

In our experience, all health systems understand the importance of the operating platform in their central design, but few have focused on it specifically. Too often, changes to the operating platform occur piecemeal or result from historical biases (large hospitals get larger, for example, not because of greater need but because of the way funds have always flowed). But a well-thought-through operating-platform transformation can increase considerably the value the health system creates for the local population. This type of transformation can produce substantive results undertaken on its own or as part of a broader effort to develop a health system strategy.²

An operating-platform transformation includes two elements: a critical review of services and a solid business case for the changes required. The critical review enables a health system to pinpoint problems in care delivery, as well as possible solutions to those problems (local innovations and global best practices). The business case permits the system to evaluate proposed changes to its infrastructure and practitioner landscape to determine which ones would have the greatest impact—and could actually be implemented. This additional rigor ensures that the system's investments in care delivery provide the strongest possible returns (higher-quality care, better access to services, and, often, lower costs).

In this article, we will detail the steps involved in an operating-platform transformation (Exhibit 1) and describe the impact this type of transformation is having in a large regional health system. The lessons are broadly applicable not only to other regional health systems but to national and large private health systems as well.

Common challenges

A regional health system we have been working with provides universal health care coverage to approximately 3 million people. About 80 percent of the population resides in urban or suburban areas; the remainder lives in widely scattered rural communities. The population, which is ethnically diverse, is growing at about 1.5 percent per year and aging rapidly—between now and 2020, the number of people age 65 or older will rise by more than 50 percent. Although the region is relatively wealthy, there are deep pockets of poverty in inner-city and rural areas.

The health system knew by 2007 that it was facing significant challenges—ones that other health systems will find all too familiar. Many of its hospitals and long-term care facilities were overcrowded, wait times for many services were long, and access to primary care was inadequate in some communities. Nurses and general practitioners (GPs) were in short supply. Both quality of care and patient safety varied widely, as did patients' satisfaction with the care received. Throughout the system, operational inefficiencies were common.

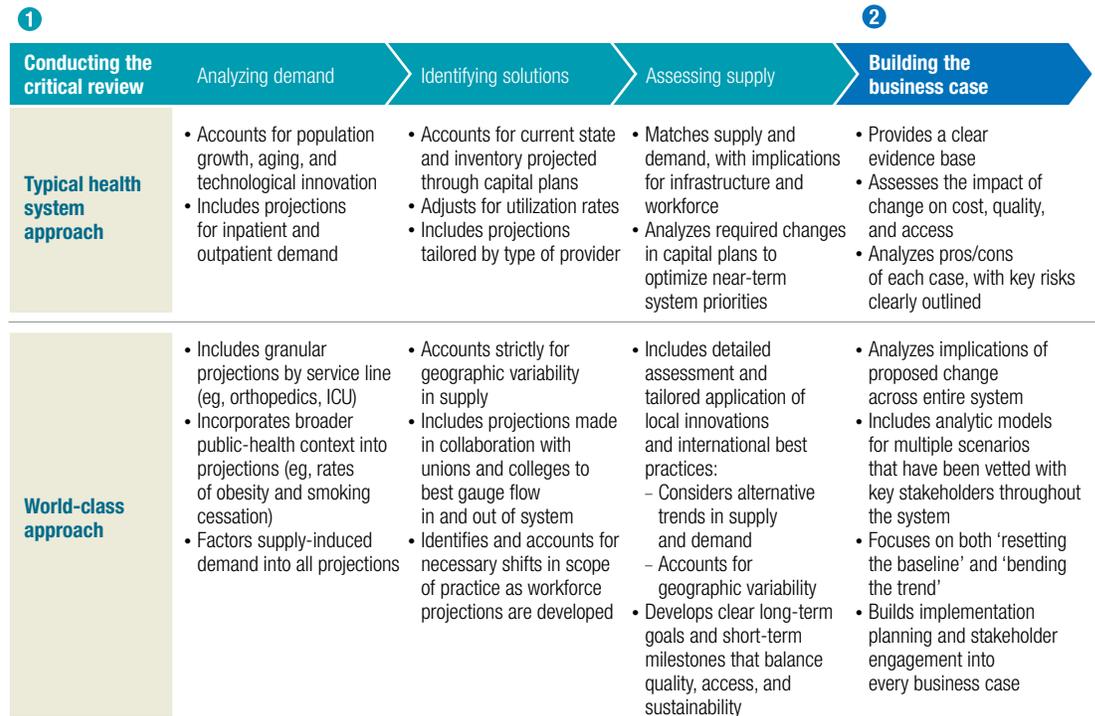
Furthermore, it seemed clear that the strains on the health system would worsen in the near future. Both population aging and rising obesity rates were increasing the prevalence of chronic diseases. Utilization rates for costly acute care and long-term care services were continuing to rise, outpacing even fairly generous plans for facility construction and workforce recruitment. If trends continued unabated, demand for health services in the region would skyrocket. By 2020, the system would need about 30 percent more acute care beds, 50 percent more long-term care beds, 40 percent more GPs, and 40 percent more nurses. As a result,

²For a health system that has already undertaken one or more operational-improvement programs and is not considering organizational redesign, an operating-platform transformation can provide added benefits in a rapid time frame. A health system that needs a broader transformation could consider developing a regional health system strategy. For a look at how such a strategy can be created, see Penny Dash, MD; Chris Llewellyn, MD; and Ben Richardson, "Developing a regional health system strategy," *Health International*, Number 8, 2009, pp. 26–35.

Exhibit 1

Operating-platform transformation

A world-class operating-platform transformation ensures that investments in care delivery yield the highest possible returns.



costs, which had already been rising by more than 8 percent per year, would triple by 2020.

The health system knew that this rate of growth was unsustainable. Absent significant changes, access problems would worsen and quality of care would suffer. It therefore decided to take action. It began with a critical review of services.

Conducting the critical review

A critical review analyzes the demand for and supply of health services and identifies potential solutions. To conduct a critical review well, a health system must consider the full continuum of care³—community-based, acute, and long-term care—as well as the interrelationships among them. This approach

ensures that the critical review is thorough, that all problems are explored comprehensively, and that changes designed to improve one part of the health system do not ultimately harm another.

1. Analyzing demand

The first step in a critical review is to investigate current and projected demand for health services in the next 10 to 15 years. It begins with demographics. What population growth is anticipated, and where will growth come from (births, migration from other parts of the country, immigration from other countries)? What is the population's age breakdown now, and what is it likely to be in the future? These calculations should be done both at the regional level and more granularly (in

³Community-based care includes primary care and other sub-acute services. Care delivered in hospitals and emergency rooms is considered acute care. Long-term care includes any type of health care delivered over an extended period in skilled nursing facilities, supportive-living facilities, or even homes. A critical review of services could also include public-health efforts; however, in the health system described in this article, public health was the focus of a separate effort and therefore was not included in the approach we discuss here.

individual communities) to ensure that local needs can be met.

Public health trends should also be considered. Is the population becoming more sedentary, more obese, or both? Are smoking rates changing? Are there other factors that leave certain population segments at increased risk of medical problems?

Changes in clinical practice can also alter demand. The advent of minimally invasive surgery, for example, has shortened the length of hospital stay following many procedures and has allowed some procedures to be performed on an outpatient basis. However, technological innovations, such as bariatric surgery and implantable cardioverter-defibrillators, have created demand for procedures that did not exist a decade or two ago.

Similarly, changes in service accessibility can alter demand. Long wait times, for example, can dissuade some patients from undergoing certain procedures or prompt them to seek treatment elsewhere. Once wait times shorten, demand can rise substantially. Any demand analysis must therefore account for the supply-induced changes in demand resulting from increased access, as well as from new services and technologies. The information gathered must be translated into granular calculations of health care

needs. It is not enough, for example, to assess demand for inpatient services; analyses must be done separately for general medicine, the various surgical subspecialties (for example, orthopedics, neurosurgery, and cardiac surgery), intensive care, and other forms of specialized care. Similar detailed calculations must be made for emergency, community-based, and long-term care. In all cases, the projections should specify the factors causing a change in demand and the extent to which each factor is influencing the change (Exhibit 2).

2. Assessing supply

The next step is to map present and future demand for health services to the infrastructure and workforce supply. How many buildings (for example, hospitals, outpatient clinics, and long-term care facilities) does the health system currently have? What additional facilities are included in current capital plans, and how do these numbers compare with the anticipated demand? How many more GPs and nurses will be needed to meet demand over the next decade?

A key question to consider when mapping projected supply to demand is whether some units or facilities can be adapted to other purposes. For example, it is often feasible to convert a small community hospital to an outpatient clinic. It is much more difficult to convert an inpatient general ward to an inten-

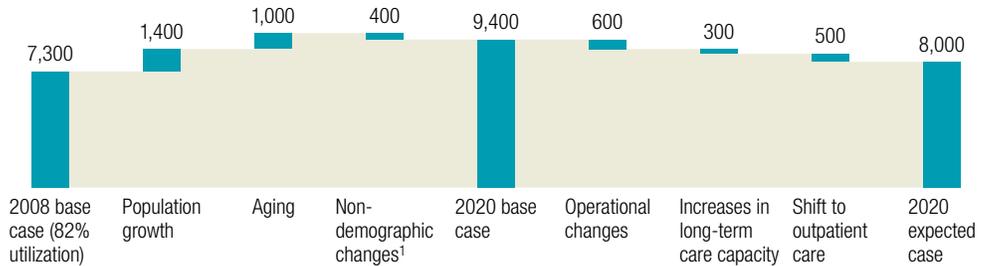
The higher a hospital's utilization rate, the more likely it is to have long wait times for services

Exhibit 2

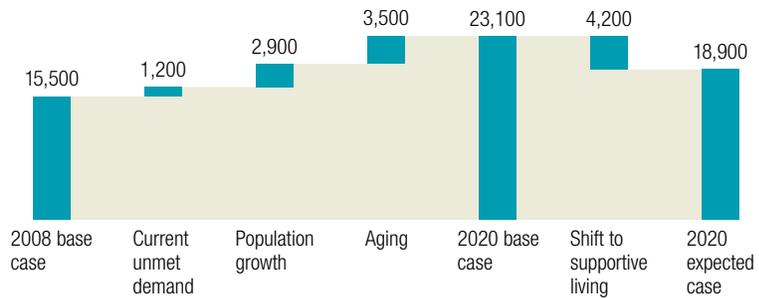
Assessing demand granularly

Detailed calculations, such as the ones shown here mapping the factors that influence inpatient bed demand, enable a health system to more precisely determine its needs.

Demand for inpatient beds



Demand for skilled nursing facility beds



¹Includes changes in demand due to changes in disease prevalence, technological innovations, and changing care patterns. Source: McKinsey analysis; regional health system data

sive care unit. In most cases, inpatient beds in general medical or surgical wards are interchangeable, and thus the supply of such beds can be grouped for analysis. However, bed supply in specialized units should be determined separately.

Utilization rates must be factored in when bed supply is calculated. The higher a hospital's utilization rate, the more likely it is to have long wait times for services. But low utilization rates can be equally problematic, because they can inadvertently encourage the delivery of unnecessary services. Moreover, when utilization

rates for certain services are low, the staff may be unable to meet the minimum annual volume required to keep their skills sharp, putting quality of care in jeopardy. We recommend that a hospital aim for an overall utilization rate of about 80 percent to 85 percent; a figure somewhere between its actual utilization rate and this ideal rate should be included when calculating bed supply.

However, utilization rates should not be the same for every service. Some services, such as obstetrics and intensive care, should have lower targets (below 70 percent), given

the frequency of patient turnover and the specificity of demand for those types of beds. Other services, such as psychiatry, can tolerate higher targets (above 90 percent) because of their long average lengths of stay and infrequent patient turnover. Because utilization rates can vary significantly from hospital to hospital, the critical review should also consider how a change in utilization at one institution could affect utilization elsewhere in the region.

To assess the workforce supply, the critical review must consider each type of practitioner separately—not only doctors and nurses but also pharmacists, paramedics, medical technologists, physical therapists, and health care aides. The supply of doctors and nurses must be broken down by practice type to account for their different skill sets: GPs should

be differentiated from specialists, for example, and cardiologists from gastroenterologists. Similarly, registered nurses should be differentiated from practical nurses.

Workforce supply projections will inevitably include assumptions about the ability and willingness of medical and nursing colleges to alter the number of students they train and to drive more graduates into generalist or primary care positions. These assumptions must be as realistic as possible—and they should be clearly spelled out in the review. Exhibit 3 provides a sample analysis of how workforce supply can be matched against demand.

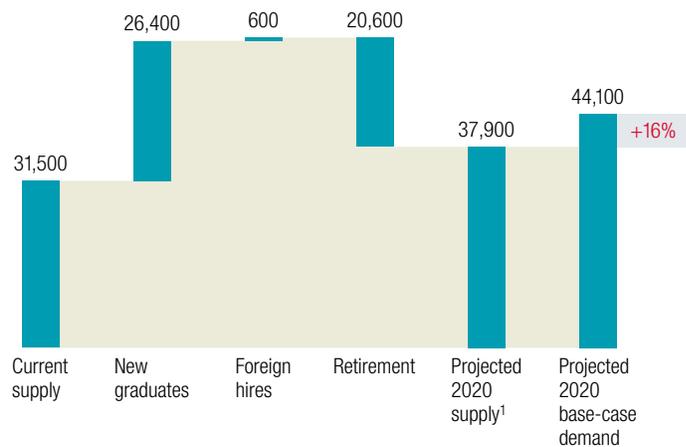
The supply projections must also take careful account of the distribution of practitioners across the region, especially in rural areas, where

Exhibit 3

Nursing supply and demand

By comparing the supply of and demand for services, a health system can estimate future shortages.

2020 supply of nurses
Head count



¹Projection assumes current number of nursing programs and current patterns of retirement.

Source: McKinsey analysis; regional health system data



shortages tend to be deepest. Many doctors, for example, are reluctant to work in rural areas. As a result, a health system could have an adequate number of GPs overall but a shortage of them in some places.

The workforce assessment should also investigate the flow of workers into and out of the system. How many new doctors, nurses, and other practitioners are being trained locally? How many are remaining in the region? How easy is it to recruit practitioners from elsewhere? Once they have entered the system, how long do they remain—and why do they leave?

3. Identifying potential solutions

The critical review often reveals common themes among the challenges identified. The regional health system we have been working with discovered four such themes:

- Overreliance on care delivered in high-acuity settings
- The need to increase the size, productivity, and effectiveness of its workforce
- Suboptimal service delivery in rural areas
- Poor care coordination

(For more details on this system's challenges, see sidebar "What a critical review can reveal," p. 44.)

To overcome these challenges, the health system needed to identify potential solutions, looking both far and near. Global best practices can be used to set a standard, but in any large health system there are likely to be innovative programs that have achieved success. By identifying and promulgating these innovations, the critical review can increase staff members' willingness to accept changes: they will take pride in their col-

leagues' accomplishments and be more likely to see them as applicable to their own practice.

A critical review should never assume that all the factors affecting supply and demand are immutable. There may be little a health system can do to affect some (population aging, for example), but there is often a great deal it can do to influence others. Thus, it should look for potential solutions that might reduce demand for services (particularly the costliest or least effective ones), help ensure that the supply of services is sufficient to meet its quality and access goals, or provide better delivery mechanisms to improve the equilibrium between supply and demand.

Once potential solutions have been identified, the most promising ones should be prioritized—there is never sufficient management attention, clinician attention, patient tolerance, or available funds to pursue too much change too quickly. Trade-offs will undoubtedly be necessary as solutions are prioritized, especially in today's economic environment. In all cases, however, patient care must come first. No solution should be considered if it jeopardizes patients' health.

Building the business case

By the end of its critical review, the health system we have been working with had identified a number of potential solutions. Next, it needed to determine which of these solutions would deliver the greatest impact.

The business case is designed to take a hard-nosed look at the prioritized options, evaluating each with regard to its effect on care quality and accessibility, return on invest-

ment (including both short- and long-term costs and savings), and likelihood of implementation. The business case also spells out the anticipated impact of each option and how that impact is likely to be achieved.

For each option, the business case must describe the fact base (number of patients affected, for example), the assumptions used to test the

options, the evidence available to support those assumptions, and the integrity of the fact base (how accurate the information probably is). It should clearly acknowledge whenever data reliability is questionable (for example, when a health system has used an inconsistent method for assessing patients' needs), and in these cases it should suggest more reliable methods for obtaining data.

What a critical review can reveal

Through a critical review of services, the health system we have been working with discovered four primary problems. First, it was overly reliant on care delivered in high-acuity facilities. A significant number of patients who could have been more safely and effectively managed on an outpatient basis were being admitted to hospitals. Too many elderly patients were being placed in skilled nursing facilities, even though they would have thrived in less expensive supportive-living centers. And too many patients were using emergency rooms for nonurgent conditions. The clinical risks associated with excessive facility-based care, the high occupancy rates of many acute care and skilled nursing facilities, and the high cost of operating those facilities posed a significant challenge to the health system's quality, accessibility, and financial sustainability.

Second, the health system needed to increase the size, productivity, and effectiveness of its workforce. Recruitment challenges were only part of the problem; the system was losing too many practitioners to retirement, part-time scheduling, and more lucrative forms of work. In addition, most doctors and nurses were spending too much time on administrative chores and tasks that could be performed by other health care personnel.

Third, service delivery in rural areas was suboptimal. The shortage of general practitioners and nurses was especially noticeable there. Furthermore, many of the region's rural hospitals had fewer than 20 beds, and the staff in those facilities often operated at procedure

volumes below the recommended safety minimum. For example, many of the region's rural hospitals delivered fewer than 50 babies each year, yet studies have shown that infant mortality increases substantially when hospitals do not perform at least 500 deliveries annually.¹

Fourth, care was poorly coordinated. Often, there was little communication between primary and secondary care providers or between hospitals and long-term care facilities. As a result, duplicate tests were ordered and inconsistent care plans were developed. These lapses in care coordination had an especially adverse effect on two groups that are heavy users of health services: the elderly and the mentally ill.

The health system needed to find ways to address these challenges. It therefore investigated international best practices to find potential solutions and studied innovations that practitioners in its local communities had implemented to improve care. For example, one community had opened a comprehensive health and wellness center to provide urgent care, preventive and well-child services, pre- and postpartum care, and mental health services to local residents. Since the center had opened, visits to the local hospital's emergency department had decreased 10 percent. This example helped the health system realize that it could convert several small hospitals to outpatient facilities, a strategy that would enable it to shift some inpatient and emergency medicine services to a less expensive setting. The change would also enable the health system to reduce wait times for many procedures.

¹G. Heller, D.K. Richardson, R. Schnell, et al., "Are we regionalized enough? Early-neonatal deaths in low-risk births by the size of delivery units in Hesse, Germany 1990–1999," *International Journal of Epidemiology*, October 5, 2002, Volume 31, pp. 1069–70; R.T. Lie, T. Markestad, and D. Moster, "Relation between size of delivery unit and neonatal death in low risk deliveries: Population based study," *Archives of Diseases of Children (Fetal and Neonatal Edition)*, May 3, 1999, Volume 80, pp. 221–5.

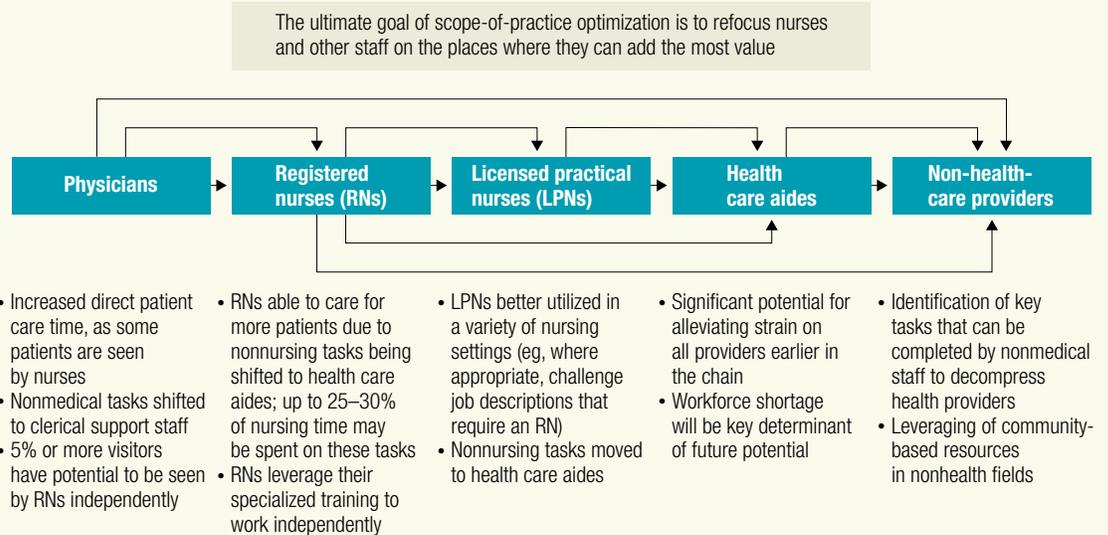
The business case must also have breadth and flexibility. It should consider the impact of each option on other parts of the health system and on other potential solutions, and it should accommodate changes in supply or demand over time. Finally, it should highlight any risks that could arise if an option is implemented.

(For an example of a typical business case, see sidebar “The case for supportive-living facilities,” p. 46.) The health system we have been working with was able to build robust business cases for more than a dozen initiatives. For example, it decided to modify many of its capital plans and to accelerate others. In addition, it is working

Exhibit

Expanding scope of practice

Optimizing scope of practice for health professionals requires that work be redistributed to the appropriate providers.



Another local innovation provided a model for how to improve care for the mentally ill. Two of the region’s hospitals had developed special short-stay programs for psychiatric patients in need of hospitalization. Intensive treatment teams provide rapid crisis resolution and symptom stabilization while patients are in the hospital, but they then work closely with community physicians, social service agencies, and patients’ families to reintegrate the patients back into the community as quickly as possible. As a result, the average length of an inpatient stay decreased by more than half, with no loss in care quality.

Changes from elsewhere demonstrated how other improvements could be made (exhibit). Nurses, for example, could be trained and legally empowered to provide select types of medical care that historically only physicians had been allowed to offer. This change would help alleviate the nursing shortage (by making the job more rewarding to perform) and allow the health system to deliver more services in rural areas. Similarly, paramedics could be trained and legally empowered to provide certain types of care without having to transport patients back to the hospital. This would also improve service delivery in rural areas.

The case for supportive-living facilities

The regional health system we have been working with had known for several years that it had an extensive wait list for long-term care services, but its critical review illuminated just how severe the problem was. On any given day, more than 600 hospital inpatients and 1,000 patients at home were waiting for long-term care beds. The critical review also revealed another problem: the vast majority of long-term care patients were residing in skilled nursing facilities. Yet three-quarters of those patients required only low levels of assistance and could receive more appropriate, less costly care in supportive-living facilities—or even at home. The health system therefore needed a business case to determine how best to shift its overall mix of long-term care services (skilled nursing, supportive living, and home care).

The critical review had made it clear that this rebalancing would benefit patients and their families. For example, patients in supportive-living facilities have much greater independence than do those in skilled nursing facilities, and in many cases supportive-living facilities could be located close to families' homes. What was less clear was whether the cost of conversion would be sufficiently offset by other savings, how many facilities should be converted, and what risks might emerge from making the switch.

The first step in answering these questions was to compare local best practices with international standards to determine approximately how many long-term care beds the health system would need over the next 10 to 12 years. The experience of one county within the region was consistent with evidence from elsewhere in the world (exhibit); this evidence suggested that the system should have approximately 120 long-term care beds per 1,000 people over age 75. This analysis also indicated that about 80 percent of the beds should be in supportive-care facilities rather than skilled nursing facilities.

In addition, the analysis revealed that the health system had a fairly good count of the number of inpatients awaiting long-term care beds. However, its estimate of the number of patients waiting at home was less reliable, because it had not been using a consistent, precise way to identify elderly patients needing supportive services. For this reason, a margin of error was included in the estimates of the number of people who would eventually need long-term care beds.

Next, the cost of providing services to long-term care patients was calculated in four settings: at home, in supportive-living facilities, in skilled nursing facilities, and in hospitals. The calculations were based on assumptions (grounded in interviews and analyses from select counties) about the specific needs patients in each setting would have. The results revealed that home care was considerably more expensive than supportive-living facilities for patients who require extensive personal care or frequent unscheduled medical assistance. Only patients without these needs could be served cost-effectively at home. This information would help the system develop a more precise way to determine where an elderly person needing support could best be treated.

Based on all this information, the system determined that it should convert enough subscale hospitals and long-term care facilities to create about 2,800 new supportive-living beds. This conversion would require about \$75 million in new capital investments over two years. However, the cost would be offset by more than \$350 million in operating cost avoidance during the same two years. More than \$150 million in savings could be achieved by transferring hospital inpatients to the appropriate long-term care facilities. Another \$175 million would result from the lower cost of operating supportive living rather than skilled nursing facilities. The remainder would come from moving certain patients from their homes to supportive-living facilities.

Exhibit

Long-term care redesign

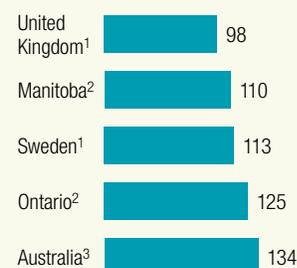
New approaches to long-term care delivery can be based on benchmarking data, local innovations, and global best practices.

International best practice has notable trends

From ...	To ...	International examples
Institutional-based services	Community services	• All countries implementing “aging in place” (eg, at home whenever possible), some very aggressively
Funding buildings	Funding individuals	• Self-directed and self-managed care where money follows persons
Rationing of services	Customization and choice	• Clients build own customized package (eg, New Zealand)
Health sector services	Integrated health, housing, and social services	• Case-management links comprehensive packages of services
Sole state-run services	Partnership with caregivers and communities	• Many countries have caregivers’ support programs and focus on community capacity (eg, Australia)
Short-term planning	Long-range financing planning communities	• Some countries have income/asset test where individuals pay capital and operating costs of long-term care (eg, New Zealand); some countries introduce long-term care insurance (eg, Japan)

Bed ratios (targeted or utilized)

Number of long-term care beds per 1,000 population over age 75



¹Actual ratio used.

²Target ratio.

³Approximate adjustment when shifted to people 75 and older, assuming 35% of people over the age of 70 are between 70 and 75.

Source: Australian Institute of Health and Welfare, “Aged care packages in community 2006–07, a statistical overview”; Health Services Restructuring Committee of Ontario, Canada, 1997; Laing & Buisson, April 2008; Manitoba Center for Health Policy; Statistics Sweden; Sweden National Board of Health and Welfare

While the health system would eventually have to build more supportive-living facilities to provide care for its growing elderly population, it could delay the capital investments for at least five years by pursuing this conversion. Furthermore, the amortized cost of building the new facilities would be dwarfed by the savings achieved from the supportive-living facilities’ lower operating costs. The annual operating cost avoidance would exceed \$400 million by 2013 and reach more than \$600 million by 2020. The conversion plan was not without risk, however. To obtain the full savings, for example, the health system would have to close the hospital beds vacated by patients awaiting long-term care placement.

If those beds were used temporarily to reduce the number of patients waiting for other hospital services, the savings would be smaller but still substantial. But if those beds were left open permanently, the net savings would be reduced significantly.

Another risk was the uncertainty about the number of elderly patients at home who would eventually need to move to supportive-living facilities. The health system is adopting new, more precise methods for assessing elderly patients’ needs. The results should enable it to determine when it will need to build more supportive-living facilities.

through the legal requirements to expand the scope of practice for nurses and paramedics. Together, the prioritized initiatives should slow growth in demand for acute care and long-term care beds by 50 percent or more by 2020. They should also reduce annual operating cost growth by as much as 6 percent by 2020 (Exhibit 4). The initiatives will also improve overall quality of care, enhance service delivery to rural areas, reduce wait times, and increase patient satisfaction.

Key success factors

Our work with multiple health systems suggests that five factors are crucial to the success of an operating-platform transformation.

First, the transformation must be rooted in the core objectives of the system and find an effective way to balance objectives that are in tension with each other. For many health systems today, the imperative to control costs is so strong that their primary goal is to minimize the impact of spending cuts on quality and accessibility. Other systems may want to improve care quality or accessibility through targeted new investments. These different starting points will result in dramatically different outcomes in clinical service design. All health systems must use a proper sense of balance to ensure that cost reductions do not impair patient care and that investments in patient care do not balloon budget size.

Second, no transformation will succeed without clinician involvement. Doctors in particular must be included, given their influence on service and infrastructure utilization and on patients' confidence in the care provided. Nurses and other practitioners are also critical because they deliver so much of the frontline care. The health system must also be certain to involve the unions that represent its practitioners,

as well as the institutions that train them, during both the design and implementation phases. Without the support of these organizations, the necessary changes may never occur. It is paramount that all stakeholders be involved from the earliest stages of the process onward. They should be updated regularly on the critical review's findings; lack of transparency will delay—and could prevent—substantive change. In addition, they should help build the business case so that they feel invested in its outcome.

Third, a health system can more easily obtain buy-in from clinicians and other important stakeholders if it bases as many of its change programs as possible on local innovations. Obviously, local innovations should not be used if they fall short of international best practices. But as discussed, most people take a natural pride in local innovations. And from a pragmatic standpoint, it is far easier to arrange for clinicians to learn from their colleagues a few towns away than from strangers in another part of the world.

Fourth, both the critical review and business case should be rooted in rigorous analytics and the best information available to ensure that decisions have a solid grounding. Even modest deviations from the optimal path can have profound effects on a health system's economic and clinical performance, and thus a robust analytical approach is crucial at all stages. We have developed a highly detailed approach, similar to the one described in this article, that can help health systems conduct the necessary analytics.

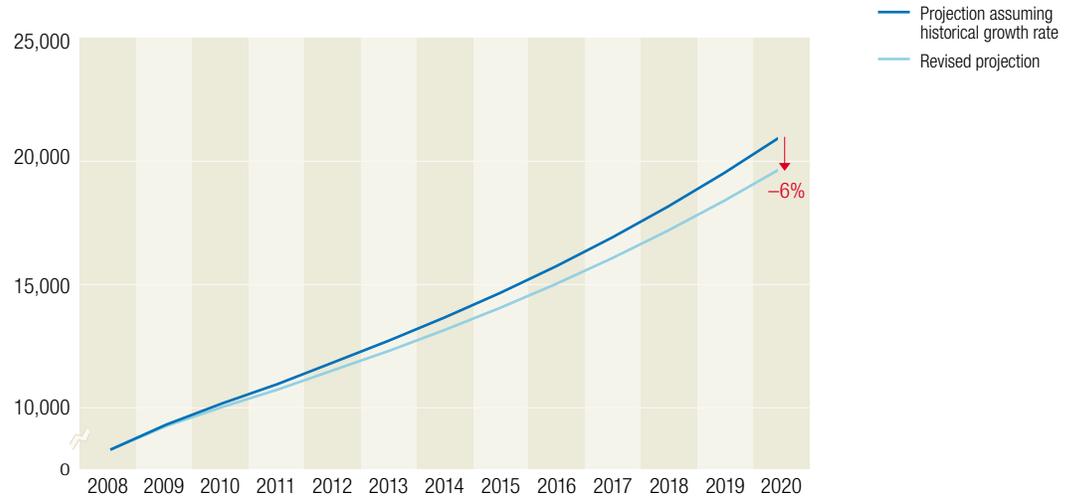
Fifth, the critical review and business case must lead to concrete, actionable recommendations, which requires that a clear implementation plan be developed. One

Exhibit 4

Holding down costs

Applying a number of levers in concert can improve care quality, enhance service, and increase patient satisfaction.

Projected spending 2008–20, baseline and optimal cases (numbers rounded)
\$ billion



Source: McKinsey analysis; regional health system data

approach is to create cross-functional teams composed of administrators, local thought leaders, and frontline clinicians. Each team is tasked with implementing one recommendation. The teams should be given a clear mandate to define operational needs, outline a detailed path to implementation, and help oversee the implementation. Moreover, the teams must receive strong, highly visible support from the health system’s leaders to ensure that the importance of their efforts is recognized.



An operating-platform transformation, if properly designed and implemented, can rapidly produce substantial results. When combined with frontline operational excellence, it can provide the financial breathing room a health system needs today to respond to budget crunches without compromising care quality or accessibility. Once the transformation is under way,

the system can address broader questions about its organizational design. For example, it can consider whether centralization or distribution of certain services, changes in its approach to performance management, or modifications to its regulations could enable it to further improve its performance. Over the longer term, these types of organizational changes can build on the success of the operating-platform transformation. ○

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