

► **Consumer Health: The Next Generation of Managed Care**

Value-Based Partnering in Health Care

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► **Many companies are beginning to focus on value in their health care purchasing decisions, and some are going beyond value-based purchasing to value-based partnering.** *Value-based partnering recognizes the interdependencies among stakeholder groups in the health care system and creates a strategic reason for them to exchange information and create long-term strategic alliances. This article discusses the principles of value-based partnering, impediments to practicing it and its future role in the health care system.* ◀

Imagine being offered a personal computer (PC) for \$300. A good PC currently sells for about \$1,500. How could you turn down this low-cost opportunity? Easy—it doesn't provide you with value. Most of us have become quite sophisticated at knowing what questions to ask about computer purchases: type of processor, processor speed, size of hard drive, amount of memory, service contracts, and so forth. Once we know the benefits, we can judge whether the low-cost alternative is a good deal. The same approach is possible in health care, although anyone who has read his or her health plan's conditions knows that assessing the benefits of the plan is considerably more difficult than purchasing a PC.

Despite these difficulties, many companies are beginning to focus on value in their health care purchasing decisions. General Electric (GE) Corporation is a case in point. Recognizing that its managed care plans were essentially vendors, GE began to work with them in much the same way as it did with many of its other vendors. With its major vendors, in particular, GE had established strategic alliances; it expected high-quality performance at low cost from these business partners, but it did not necessarily expect the lowest cost. Instead, it focused on value—a measure of the relationship between benefits and costs—and it worked closely with its vendors to maximize value.

Over the past several years, GE has become quite concrete in defining value for its health care purchasing decisions. Its employees must be satisfied with the treatment they receive from their health plans and providers. The quality of care must be high as measured by a variety of industrywide standards. The health plan must provide responsive service and accountability to GE management. In total, cost represents only about 25% of GE's purchasing criteria.¹

GE is not alone. Several other employers, including General Motors, Digital Equipment Corporation, GTE Corporation and Pacific Bell, are incorporating value into their health benefit purchasing decisions. Similar approaches also are being taken by some employer purchasing coalitions, such as the Dallas-Fort Worth Business Group on Health, the Chicago Business Group on Health, Gateway Purchasing Association, Pacific Business Group on

Health and the Iowa Community Health Purchasing Corporation.²

Many other employers—including those that use value in making other purchasing decisions—have not attempted to apply value-based principles to purchasing health benefits. In part, that is because performance measures are hard to define, and the data needed to measure performance are frequently hard to come by. But it is also because doing so requires a strategic approach to purchasing a service that has largely been considered a commodity. Yet, with the emergence of quality and patient satisfaction as dominant considerations for many employers—and, by extension, for their employees—value-based thinking has become essential.

FROM VALUE-BASED PURCHASING TO VALUE-BASED PARTNERING

Value-based purchasing is not enough, however. If value is to play a role in employer decision making, then employers, health plans, providers and patients all must *partner* in developing a cascade of value-based thinking. To be successful in the complex health care marketplace, the value-based effort must extend beyond employers to encompass all other stakeholders in the health care system: health plans, physicians, hospitals, other providers and consumers. That is, each stakeholder must develop its own value equation. As with GE, those value equations will have some financial elements, such as revenue and costs, as well as some nonfinancial elements, like satisfaction.

Because of the interdependencies among the various stakeholders in the health care system, stakeholders must communicate their value equations to one another and build a shared understanding of what is important to each. Otherwise, some stakeholders might move in directions that are incompatible with the others. For example, a health plan might develop a program that is not seen as valuable by providers or consumers, or providers might be undertaking care-related activities that do not increase the value equations of consumers or employers.

As the various stakeholders begin to collaborate and share their value equations, an important transition takes place: Their thinking

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shifts from value-based *purchasing* to value-based *partnering*. This is more than just semantics—it reflects the fundamental complexity of the health care marketplace and the fact that patients will probably lose if stakeholders play a highly competitive, zero-sum game. Thus, if customer satisfaction and outcomes are to be important ingredients in a care management strategy, all stakeholders must collaborate to increase everyone’s value.

Although this sort of collaboration may appear to portend a major paradigm shift in an economy where “competition is king,” it actually does not. Rather, competition—perhaps even *intense* competition—will be among several health plans for an employer’s (and its employees’) business, based on competing proposals and success records in adding value. Similarly, competition can be among several providers for a health plan’s business, based on their ability to deliver value. But competition need not be between employers and plans, plans and providers, or consumers and other stakeholders.

The medical profession, as represented by the Institute of Medicine (IOM), has embraced this idea and is encouraging physicians to compete based on meeting customers’ needs. Indeed, IOM’s recently presented quality model includes not only the domains of safety and practice consistent with current medical knowledge, but also customization.³ IOM defines *cus-*

EXHIBIT 1

The Seven Principles of Value-Based Partnering

1. Health care is not a commodity.
2. Health care is not purchased in a single market.
3. Each stakeholder has a unique value equation.
4. The value equations must be simple.
5. The value equations must be linked.
6. Negotiations must be collaborative.
7. Accountability for value is essential.

tomization as “. . . the ability to meet customer-specific values and expectations, permitting the greatest responsiveness to individual values and preferences and maximum personalization or customization of care.” In short, value-based purchasing between employers and plans is not enough. Rather, there is a need for an alliance approach that encompasses all five stakeholder relationships, and in which they all collaborate to enhance their value.

Principles of Value-Based Partnering

The concept of value-based partnering relies on seven key principles, which are shown in Exhibit 1. Using these principles as a foundation, employers can manage their health benefits in new and improved ways. This will be true whether they do so individually or, in the case of smaller employers, through participating in a purchasing coalition.

Principle #1. Health Care Is Not a Commodity.

Value-based partnering is based on the idea that health care is not the commodity that a pure cost model would suggest. There is—or can be—sufficient product differentiation so that, rather than focusing exclusively on cost, employers and others can use a “value equation” that considers both benefits and costs. Indeed, just as a company would not buy a PC based exclusively on cost, it should not buy its health benefits only on the basis of cost.

The importance of looking at benefits as well as costs is clear from recent data. Al-

though the past several years have seen relatively flat cost trends in the health care sector, due at least in part to the expansion of managed care and competition, clear evidence suggests that cost pressures are reemerging. Many employers saw double-digit premium increases in 1999 and 2000, and they expect similar increases in 2001. Overall health spending is projected to increase to \$2.1 trillion by 2007 (almost 17% of GDP). At the same time, while cost is a dominant consideration, many consumers and patients appear to be concerned about the possibility of being denied health care when they need it most. In response, legislation has passed or is pending in some states to ensure their access, generally over the objections of managed care plans. In effect, the time has come for value-based thinking.

Principle #2. Health Care Is Not Purchased in a Single Market.

The health care system in any given state or region comprises four separate stakeholder groups—consumers (as employees and patients), employers, health plans and providers—that combine to form five submarkets: consumer-employer, employer-health plan, health plan-provider, provider-consumer and consumer-health plan. Each submarket has a different pricing unit and, if its participants wish, could also have different ways of measuring value. Exhibit 2 shows the different markets and pricing units.

These markets are currently in a state of considerable disarray. On the provider side, many hospitals are posting multimillion dollar losses. Some are merging in an attempt to gain market share and avoid losses. Others, frustrated with infringements on their autonomy and the resultant loss of control, are attempting to regain market power by taking on more risk. In a few instances, hospitals have bypassed their health plans altogether to contract directly with employers. Similarly, the unionization effort through the American Medical Association is a telling symptom of physician frustration in this complicated marketplace, and the spate of consumer protection legislation at both the state and national levels is a clear indication that patients are attempting to protect their power in the marketplace.

EXHIBIT 2

Submarkets and Pricing Units

Submarket	Pricing Unit
Employee-employer	Monthly premium sharing
Employer-health plan	Monthly premium
Health plan-employee/consumer	Deductibles
Employee/consumer-provider	Copayments
Health plan-provider	Fees, discounted fees, bundled prices, diagnosis-related groups (DRGs), and so forth

This sort of market shakeout would be acceptable—and, like the battle for market dominance in the PC hardware industry, interesting to observe—if the stakes were not so high. But they are very high. Access to quality health care is on the table, and patient care could be compromised if employers, health plans, providers and consumers do not take appropriate action.

Principle #3. Each Stakeholder Has a Unique Value Equation.

To move beyond a cost-based system, each stakeholder group must define its value equation, including the costs and benefits that it considers to be important. Importantly, the benefits can and should include both financial and non-financial factors. For employers, these nonfinancial benefits might comprise such items as employee retention and satisfaction. For health plans, they could be reputation and member retention. For providers, they might involve clinical autonomy and patient compliance. And for consumers, they might include health status and service coverage.

Once completed, these value equations serve several purposes. First, they create the opportunity to identify and measure quality, outcomes and benefits beyond pure cost reduction. Second, they allow each stakeholder not only to define its desired benefits but also to stipulate how they can be measured. Third, they allow each stakeholder to use its value equation as a tool to help other stakeholders better understand its needs, thereby creating a more complete definition of the relationships among the stakeholders. Fourth, they provide an opportunity

to create specific action plans to achieve the desired results.

Principle #4. The Value Equations Must Be Simple.

Measures of value do not need to be fancy. Indeed, the simpler a value equation is, the easier it can be communicated to other stakeholders in the system, including providers who ultimately must deliver appropriate services to patients.

Imagine, for example, that a health plan proposes to an employer a new program for addressing hypertension (high blood pressure). For, say, a \$2 increase in each employee's monthly premium, the health plan would develop a specific program to manage the company's hypertensive employees. With appropriate preprogram data as a baseline, the company could estimate the program's effect on employee productivity and absenteeism. The benefit-cost analysis could be done with hard financial data. The same approach could be followed with many other conditions, such as diabetes, allergies, lower back pain, asthma, and so forth. Even smoking cessation programs would be candidates. These programs generally are considered to have such long payback periods when measured in terms of preventing smoking-related illnesses that they are not cost-effective for an employer. Under a value-based alliance approach, the program's impact could be measured in ways that allowed the employer to assess the near-term financial benefits of an increase in premiums. Consider, for example, the low productivity of smokers just prior to a

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break, and how that productivity might change if the employee no longer smoked.

Principle #5.
The Value Equations Must Be Linked.

Defining the linkages and interdependencies among the various value equations allows stakeholders to better understand how value flows within the overall health care system. When that happens, the various stakeholders become linked by more than just cost factors, which is in direct contrast to the cost-based model still used by many employers. Indeed, just as an employer would ask a variety of benefit-related questions of a vendor offering a \$300 PC, it would ask similar questions of a health plan offering comparatively low monthly premiums. And just as an employer might be willing to pay more than the so-called market price for a PC if the incremental benefits were sufficient, it might also be willing to pay more for its health care if the additional benefits were great enough to enhance its value equation.

The nature of the linkages among the equations also reflects their high degree of interdependence. For example, a health plan relies on its providers to deliver high-quality care that will facilitate improved health status for consumers and increased productivity for employers. Providers, in turn, rely on health plans to provide information that allows them to identify areas of focus for delivering these benefits and improving

overall value for employers and consumers. Thus, there is an opportunity to create value in the system by viewing these linkages as opportunities for partnerships. Indeed, health plans that seek to pay all providers a highly discounted fee may be missing an important value-enhancing opportunity. By establishing value-based partnerships with selected providers, the plan could pay them higher fees in return for greater benefits or increased financial performance that would enhance its own value equation.

Principle #6.
Negotiations Must Be Collaborative.

Value-based partnering alters the interactions at each connection point in the health care system, requiring each stakeholder group to understand the value equations of the other three and their interdependencies. With this understanding, each group can frame its value equations in terms that are meaningful to the others and identify opportunities for partnership that would enhance value. As a result, the nature of competition radically changes, and opportunities are presented to organizations that are able to enhance value by effectively partnering with other stakeholders instead of focusing exclusively on cost reductions.

Three stakeholder relationships present opportunities for value-based negotiations and contracting: health plan-employer, health plan-provider and health plan-consumer. In a value-based system, the contracting process is not viewed simply as a legal exercise but as a tool to better understand the value equations of the different stakeholder groups and to structure relationships that facilitate the requisite collaboration.

Principle #7.
Accountability for Value Is Essential.

Value-based partnering does not alleviate the need for greater accountability in the health care system, nor does it simplify how to achieve it. Indeed, with value-based partnering, accountability is both greater and more difficult to measure, since both benefits and costs are on the table. Moreover, given the multiple stakeholders involved, it can be extremely difficult to understand all of the value equations at work and how and where each stakeholder adds value.

Adding to this difficulty is the fact that members of each stakeholder group seek to maximize their value equations in different ways. Nevertheless, value-based contracts offer a mechanism for improved market accountability and value enhancement throughout all four stakeholder groups when they include performance measures that recognize all components of the value equations and the interdependence among stakeholders.

IMPEDIMENTS TO VALUE-BASED PARTNERING

There are at least two impediments to value-based partnering that need to be overcome. The first is the cost-focused perspective of the typical corporate benefits manager. The second is the difficulty of making sometimes implicit benefits as explicit as possible so that they can be measured. In addition, benefits must be explicit so that each stakeholder can understand the benefits and its role in achieving them.

Overcoming the first impediment will require significant senior management intervention because it tends to be deeply rooted in the incentive system of most organizations. Overcoming the second will require a series of collaborative discussions among all four stakeholder groups. During these discussions, each stakeholder must communicate its needs in terms of value equations so that the other stakeholders can understand and work toward achieving them. This is a novel activity in most health care arenas, and it no doubt will encounter many false starts and frustrations.

Revising the Benefit Managers' Perspective

In general, benefit managers focus on premium cost because the incentive systems in their organizations encourage them to do so. In part, this is a result of the artificial walls that exist between different functional areas in most large organizations. To illustrate, suppose that in exchange for an increase in a company's premiums, its health plan developed a new program in which providers engaged in some new forms of care. Suppose further that these changes led to healthier and more productive employees, resulting in a decrease in the company's manufacturing costs that exceeded the total of the premium increase.

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Ideally, these two cost-related elements (additional premiums minus decreased manufacturing costs) would be combined so that the company could determine if it was financially better off as a result of the higher premiums. Instead, it is likely in some companies that the productivity-based cost decreases will reflect well on the performance of the manufacturing manager, and the higher premium cost will reflect poorly on the performance of the benefit manager.

This problem is not solved easily. Its resolution requires rethinking the organization's network of responsibility centers, perhaps charging health care premiums to manufacturing and other departments via transfer prices, rather than treating them as indirect costs of doing

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business. Indeed, although most people would agree that combining the increase in premiums with the productivity-related costs savings is essential for determining the overall impact of the new program, many organizations are not prepared to undertake the kinds of changes in their accounting systems that would allow them to do so. Without these changes, however, a company will have difficulty engaging in the holistic thinking that characterizes value-based partnering.

Defining Value Equations

Stakeholder value equations frequently will include nonfinancial benefits as well as financial ones. In many instances, a benefit that initially appears to be nonfinancial might be translated into financial terms. For example, improvement in an employer’s retention rate could be quantified in terms of the cost of rehiring and retraining. Similarly, reputation and member retention for a health plan could be translated into financial terms by assessing the impact of these factors on the plan’s premium revenue. Physicians, on the other hand, might translate improved patient compliance into time that is freed up for other revenue generating activities, and hence into a financial benefit.

Consumers might translate expanded service coverage into a reduction in their out-of-pocket payments. Or, if sick days were resulting in lost wages, their improved health status

could be translated into financial terms. In general, though, it will be difficult for consumers to translate improved health status into a financial benefit, and they may find themselves much like the PC purchaser: They just know that their improved health status constitutes an improvement in value. Or they just know that it does not, given the additional time and effort they needed to expend to obtain the new services.

Overcoming these complexities in measuring benefits is extremely challenging. So too is measuring cost on occasion, as with the consumer who must expend additional time and effort to obtain some new services. Nevertheless, for value-based partnering to work, each stakeholder must be extremely specific about its chosen benefits (financial and nonfinancial) and costs, as well as find ways to measure them. It must also communicate the benefits and costs in ways that are meaningful to other stakeholders. In addition, each stakeholder must listen carefully to the needs and proposed measures of the other stakeholders to determine what part it must play in enhancing their value equations.


To further complicate the effort, what one stakeholder uses for a value equation may not suffice for another member of the same stakeholder group. For example, one employer might see reduced absenteeism as the most important benefit, while another might wish to focus on employee retention. Similarly, different physicians (younger versus older; rural versus urban) will have different value equations, and other providers (e.g., nurse practitioners) quite likely will have value equations that differ from those of physicians. And, of course, value equations will differ among consumers. For example, a benefit for a middle-aged blue-collar worker will likely differ considerably from that for a young white-collar worker, an elderly person, and so forth.

THE FUTURE

The concept of value-based partnering is being implemented in Cincinnati under the auspices of the Health Improvement Collaborative of Greater Cincinnati (an organization whose membership includes all four stakeholder groups). The collaborative is using the value-

based partnering model to improve diabetic care for a target population while enhancing value for all stakeholders at the same time. A work group comprised of the key stakeholders is designing an intervention that considers the value equations of all stakeholders and the interdependencies among them. The plan is to institute changes that not only show improvement in the short term, but are also sustainable over the long term.

This initial effort of value-based partnering is attempting to move all stakeholders away from a pure cost perspective and toward a framework that aligns incentives by focusing on value equations and the linkages among them. Beyond this, however, value-based partnering provides the opportunity to view relationships among the stakeholder groups not simply as contractual or financial, but as partnerships with multiple opportunities for collaboration and the potential for all to have increases in value. Indeed, by recognizing the interdependencies among stakeholder groups, the approach creates a strategic reason for employers, health plans, providers and consumers to exchange information and create longer term strategic alliances. This approach has proven successful for many employers in many other markets and with many other vendors. It can be successful with health care as well.

Many large employers and employer purchasing coalitions have moved toward value-based purchasing. While this move represents an enormous broadening of an employer's focus, it is not sufficient. Unless all other stakeholders become involved in the value-based effort, and the strategy shifts from value-based purchasing to value-based partnering, the goal of improving patient care is likely to fail as each stakeholder scrambles for its piece of a shrinking health care pie. 

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Endnotes

1. GE's approach to value-based purchasing is described in considerable detail in Robert S. Galvin, M.D., "What Do Employers Mean by 'Value,'" *Integrated Healthcare Report*, September 1998 and October 1998.

2. These employers and their approaches are described in Jack Meyer, Lise Rybowski and Rena Eichler, *Theory and Reality of Value-Based Purchasing: Lessons from the Pioneers*. AHCPR Pub. No. 98-0004, November 1997. Agency for Health Care Policy and Research, Rockville, MD. For an earlier discussion of this idea, see P. E. Greenberg, S. N. Finkelstein and E. R. Berndt, "Economic Consequences of Illness in the Workplace," *Sloan Management Review*, 36:4, Summer 1995.

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