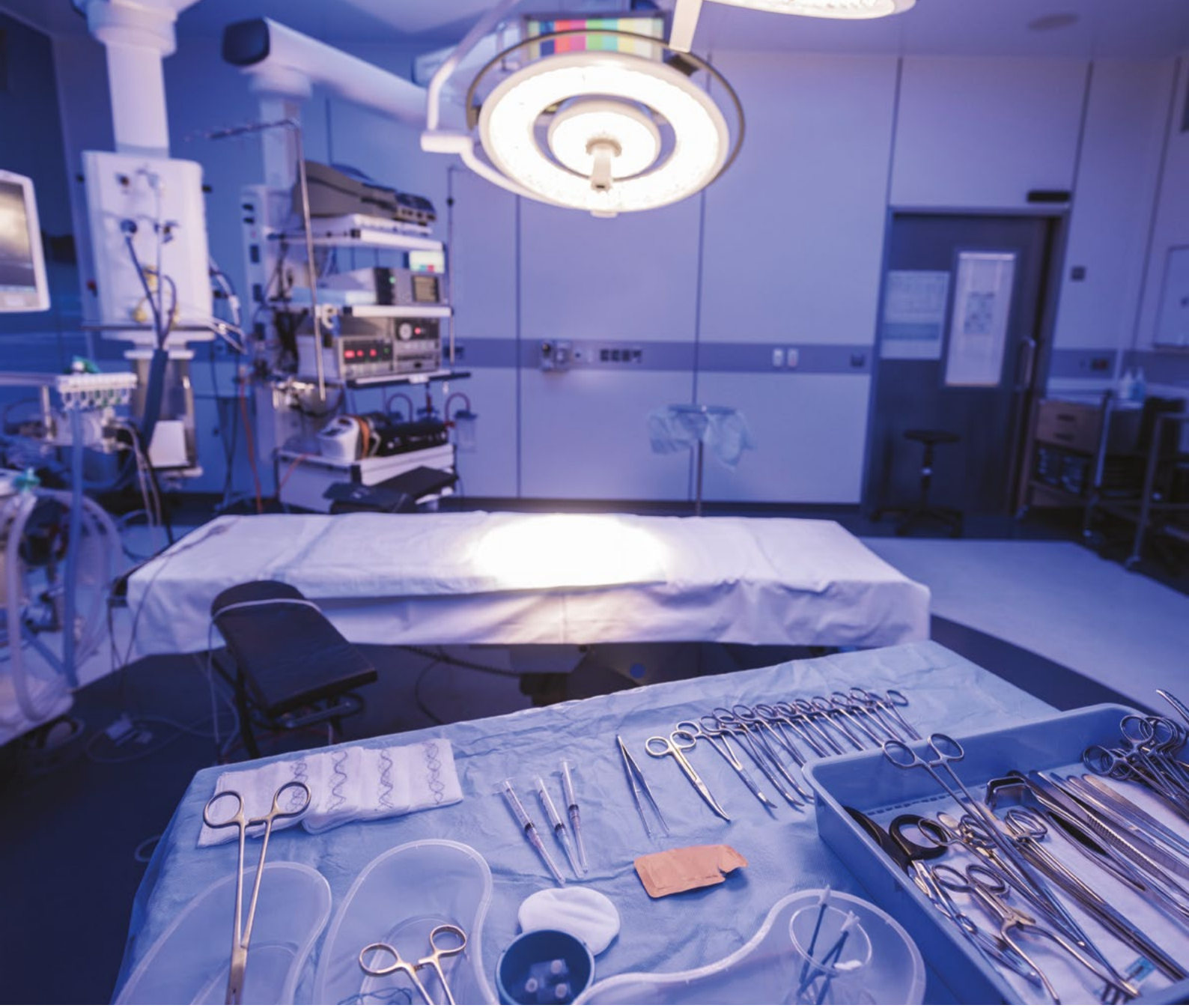


THE HIGH PRICE OF HEALTHCARE

THREE MISTAKES IN US HEALTHCARE THAT EMERGING ECONOMIES CAN'T AFFORD TO REPEAT

Sam Glick • Sven-Olaf Vathje

The healthcare system in the United States, with its technological prowess and massive infrastructure, often serves as a reference point for rapidly developing economies around the world while they build their own medical systems. With expanding middle classes demanding more comprehensive care, governments of these emerging markets are under pressure to invest as chronic disease rates – particularly those related to Western lifestyles – dramatically increase and the average age of their once-young populations begins to rise.

But replicating the facility- and labor-intensive American model – which is more costly than that of any other nation yet produces subpar results – will set these emerging economies on the same course of endless cost escalation that has plagued the United States. Still early in their healthcare-modernization programs, many nations in the Middle East and Asia are already struggling with double-digit annual increases in healthcare expenditures, well above the rate of expansion of their gross domestic products. Instead of copying the American model, these countries should leapfrog the United States by focusing more on keeping their populations healthy, tying care providers' pay to outcomes rather than the volume of services delivered, and using technologies such as telemedicine, in-home monitoring, and remote imaging to reduce the need for hospitals.

One major reason for the rapid cost inflation in healthcare is burgeoning hospital construction. As more countries try to provide American-style care, the number of hospital beds around the globe has begun to grow rapidly. China alone has set a target of having six hospital beds per 1,000 people by 2020 – more than twice the ratio maintained in the United States and the United Kingdom.

The rising flood of hardware, pharmaceuticals, and technical expertise from American manufacturers and hospital companies, which is connected to the needs of a growing number of hospitals, is also pushing many systems closer to the US model. Over the past five years, US healthcare exports to emerging economies have grown substantially. For example, shipments of medical, scientific, and hospital equipment to China have risen 69 percent since 2011. Over the same period, pharmaceutical exports have doubled. Comparing the five years between 2012 and 2016 to the period between 2007 and 2011, US exports to Saudi Arabia of hospital equipment alone increased 54 percent. There is a similar pattern across the Middle East, Latin America, and Eastern Europe, as well as in many nations in Asia.

To plot a sustainable course, emerging economies need to recognize the American practices that helped institutionalize high costs in the first place – and avoid them. Here are the three elements that our data and experience tell us have done the most damage in the United States:

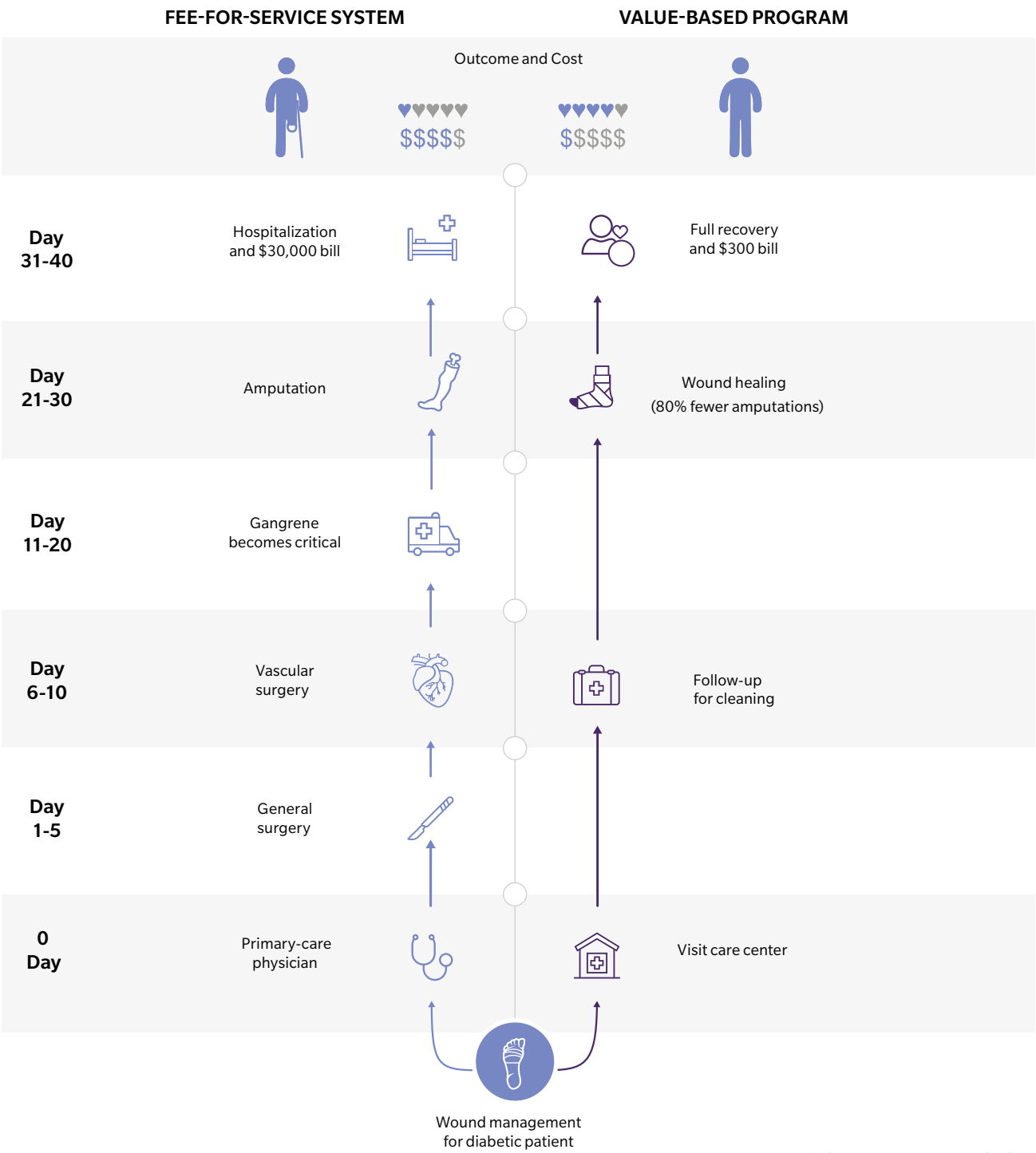
FOCUSING MAINLY ON TREATING THE SICK

This centuries-old approach to health still dominates worldwide. In countries from Singapore to Saudi Arabia, the focus is predominantly on medical care for the sick, not well care. Eventually, that will start getting expensive – primarily because spending to make sick people better is more expensive than keeping them well in the first place. Ultimately, it may begin to negatively impact standard measures of health, such as life expectancy, infant mortality, and morbidity, as lifestyle choices increasingly expose populations to chronic illnesses such as diabetes and heart disease.

In Qatar, for example, fewer than 10 percent of physicians are primary-care doctors, compared with nearly one-third in the United States and almost two-thirds in France, where healthcare is considerably cheaper than in the United States and the results are substantially better. The

EXHIBIT 1: A LOOK AT HOW THE US GOT INTO TROUBLE WITH A FEE-FOR-SERVICE APPROACH TO HEALTHCARE

Patients with the same ailment end up with very different outcomes in a fee-for-service versus value-based world: One still has both legs and racks up $300 in healthcare costs; the other lost a leg and spends $30,000



Source: APRC analysis on CareMore Communications

vast majority of physician visits in Qatar end up costing much more because the appointments are with specialists, and the remedy proposed often involves hospital stays and procedures. They are fix-what's-broken visits.

Even if someone does manage to see a primary-care physician, it's doubtful there's much time for real discussion of lifestyle, wellness, or prevention: The average primary-care visit in Qatar lasts less than seven minutes. If nations want to control healthcare costs over the long run, professionals focused on health prevention (nutritionists, prenatal-care providers, and smoking-cessation experts, for example) should play important roles equal to traditional physicians, and primary-care doctors should be coordinating care.

BASING A SYSTEM ON FEE-FOR-SERVICE PAYMENT

Currently, fee-for-service payments dominate the healthcare space in places as diverse as China, South Africa, and Vietnam. In a fee-for-service world, medical care is overutilized – by up to 50 percent, according to our estimates. The reason is simple: To increase revenue, healthcare providers have to perform more procedures or see more patients, which in turn pushes up the cost of care. Even the best-intentioned providers can easily fall into a pattern of ordering too many tests or recommending surgery rather than a less invasive, less expensive therapy.

So why would emerging markets still adopt this practice? First, because it's an easy way to measure productivity: Measuring quality and health outcomes is notoriously complex even in the most highly developed healthcare systems. Second, given that many emerging economies depend on outside funds to help them build healthcare infrastructure, demonstrating the potential to grow and be profitable using familiar business models tends to attract private investment to the sector and people to the profession.

> Inevitably, exporting US-style healthcare to other countries will end up producing US-style results

In Thailand, for example, 28 percent of healthcare facilities are privately owned, and there are no fewer than eight publicly traded hospital companies doing business in the country. The Thai government encourages such investment to provide for its country's own healthcare needs, as well as to maintain Thailand's position as a medical-tourism destination.

Medical tourism – an enterprise focused exclusively on procedure-based sick care or elective surgery – is common in many developing nations. It helps create business for the local medical industry by offering less-expensive medical procedures to Americans and others living with high-cost healthcare.

Healthcare needs to define productivity differently. Pay physicians for health outcomes rather than the number of procedures or visits; systematically incentivize prevention and primary care; and turn hospitals into cost centers rather than revenue engines. All of this requires a better understanding of how health transactions work and how much they cost. Transparency on clinical data and financial flows is crucial for establishing a meaningful incentives system.

PRIORITIZING PHYSICAL INFRASTRUCTURE

Each hospital bed carries a financial obligation – not only to fill it but also to maintain it. And to equip these modern hospitals and remain competitive, emerging economies must buy high-priced items, such as MRI machines and CT scanners, sometimes costing nearly as much as the building itself. Even more costly in the long term, hospitals must be staffed with doctors, nurses, medical assistants, pharmacists, and lab technicians. The system becomes self-reinforcing: Patients who see a great hospital in a major city want one in their community, and to attract and retain the best physicians you have to build ever-more-expensive, well-equipped hospitals.

As developing countries set priorities for investment in healthcare, they should learn lessons from their own success in building a mobile-first infrastructure rather than a much more expensive landline system for communication. Today, because many countries in Africa built cellular towers even when they didn't have landline infrastructure, about 80 percent of adults have access to cell phone service, vastly more than the number who are or would have been served by landlines.

Growing healthcare systems have a similar opportunity to leapfrog older approaches by constructing a system with a substantial digital component. Technologies like telemedicine, in-home monitoring, and remote imaging can gain traction rapidly and make a meaningful difference in quality, convenience, and cost of care – especially if they represent fundamental services and not just nice-to-have extras. Public health authorities can also take advantage of mobile-phone coverage to disseminate information on health issues, vaccinations, and even nutrition, and monitor the health of the population remotely.

The Dubai Health Authority, for example, recently announced that it would deploy so-called RoboDocs across all of its facilities to work alongside nurses, allowing immediate access to physicians, around the clock, regardless of location. We estimate that new models of care such as these can lower healthcare costs in rapidly developing economies by as much as 15 percent to 20 percent.

While the United States tries to reinvent its broken system, countries around the world have the opportunity to learn from American mistakes and create value-based, digital-first health systems that focus on preventing disease rather than simply treating it. The key is defining the priorities first and designing the system around them, rather than letting the system, with its appetite for scope and growth, define the kind of healthcare that takes shape.

Sam Glick is a San Franciso-based partner and **Sven-Olaf Vathje** is a Dubai-based partner in Oliver Wyman's Health and Life Sciences practice.

This article first appeared in Harvard Business Review.