



THE OLIVER WYMAN

# HEALTH INNOVATION JOURNAL

INSIGHTS FROM THE CUTTING EDGE  
OF AN INDUSTRY IN TRANSFORMATION

## **THE OLIVER WYMAN HEALTH INNOVATION JOURNAL**

### **Editorial Board**

**Sam Glick**, Partner, Health & Life Sciences Practice

**Shivani Shah**, Director, Health Innovation Center

**Terry Stone**, Managing Partner, Health & Life Sciences, and Global Chair for Inclusion & Diversity

**Kathryn Weismantel**, Director of Marketing, Health & Life Sciences Practice

### **Editors**

**Jacqueline DiChiara**, Editor, Health & Life Sciences Practice

**Hayley Reta**, Editor, Health & Life Sciences Practice

### **Creative**

**Tim Fadek**, Senior Photo Editor

**Yireli Pale**, Designer

**Michael Tveskov**, Art Director

**Jean-Guy Vezeau**, Designer

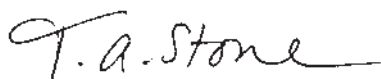
# INTRODUCTION

Welcome to the third edition of our Journal, which we're delighted to release at this year's Health Innovation Summit in Chicago. This collection of articles reflects the latest perspectives from thought leaders within our Health & Life Sciences practice and beyond, all at the frontlines of industry-wide disruption. We strive to create a healthcare system based on adaptability amidst uncertainty, where technology improves care quality, where partnerships create profound impact, and where a holistic approach to care delivery well beyond the clinic becomes mainstream.

Our 2019 Health Innovation Journal aims to create an introspective platform that represents our unwavering commitment to sparking discussions about (as our Summit theme captures) building for impact today to design tomorrow's healthcare landscape. You'll find articles across a plethora of topics, including: Medicare Advantage, artificial intelligence, specialty drugs, mergers and acquisitions, and social determinants of health.

We also feature key findings from Oliver Wyman's Women in Healthcare Leadership report. As you immerse yourself in all of this rich content, we hope to inspire your philosophies and challenge your thinking.

Warm regards,



**Terry Stone**

Managing Partner,  
Health & Life Sciences,  
and Global Chair for  
Inclusion & Diversity,  
Oliver Wyman

# CONTENTS



**5**

## IT'S TIME TO DRIVE IMPACT

### BUILDING FOR IMPACT



**19**

### NOW YOU SEE US, NOW YOU DON'T

The illusions and temptations of successful M&A

**26**

### FORTUNE FAVORS THE BOLD

Cost as an investment (not an inconvenience)

**32**

### ARE SOCIAL DETERMINANTS OF HEALTH THE HOLY GRAIL?

## THE ROLE OF DIGITAL AND TECHNOLOGY



## WHAT'S NEXT



**40**

**HOW AN INFUSION OF TECH WILL REVERSE THE WORKER CRISIS**

**46**

**MONETIZING HEALTHCARE'S C2B CONSUMER DATA EXPLOSION**

**50**

**CEO BRIEFING ROOM**

Strategies for succeeding with artificial intelligence

**58**

**SPECIALTY DRUGS**

A prescription for managing rising cost and care needs

**65**

**NOT YOUR GRANDMA'S MEDICARE**

Innovating in Medicare Advantage

**69**

**THREE WAYS COMPANIES CAN CLOSE THE GENDER GAP IN HEALTHCARE LEADERSHIP**

**74**

**THE HEALTHCARE LEADER OF THE FUTURE**

Building four design zones for company transformation



# IT'S TIME TO DRIVE IMPACT

**Charlie Hoban**

Partner, Health & Life Sciences, Oliver Wyman

**Josh Michelson**

Partner, Health & Life Sciences, Oliver Wyman

**Sihyun Choi**

Principal, Health & Life Sciences, Oliver Wyman

**Shyam Vichare**

Engagement Manager, Health & Life Sciences, Oliver Wyman

**H**ealthcare transformation. It's what so much energy and so many initiatives have focused on over the past decade in the US. Every sector has experimented with innovative models that promise an improved industry outlook: new value-based payment paradigms, new ways of engaging consumers, new access and care hubs, new digital and tailored therapies, and new ways of sharing information. The innovation economy has funded hundreds of businesses attempting to redefine healthcare's status quo. And many incumbents have increasingly realized traditional business models are no longer compatible with demographic realities, consumer needs, and – if they were to hold up a mirror – their company's mission. When we take a step back, we see a US healthcare industry saturated with breakthrough solutions – but have we really succeeded in moving the needle on impact?



ARE WE MAKING  
A DIFFERENCE?

WHAT'S REALLY  
POSSIBLE, ANYWAY?

HOW FAR HAVE  
WE PROGRESSED?

HOW DO WE RESET  
OUR TRAJECTORY?



## HERE'S THE CATCH

Despite this wave and many individual success stories, these isolated transformations have had an almost unnoticeable effect on Institute for Healthcare Improvement (IHI) Triple Aim metrics of cost, outcomes, and experience. Impact for each of these micro innovations – new therapies, new knowledge, and new best practices – has been narrow. In fact, we continue to trend in a worrisome direction, with premiums nearly quadrupling for families over the past 20 years, deductibles growing eight times faster than wages in the past decade, declines in overall life expectancy in consecutive years (for the first time since 1963), and an industry that ranks below nearly every other in net sentiment. Somehow, collective impact is much less than the sum of our innovative parts.

Some say our hands are tied and that we have intractable issues because of US healthcare's unique structural configuration: its largely not-for-profit supply, heavily fragmented distribution, highly variable state-based regulation, and limited price control or clarity. However, we can't keep waiting for a systemic, silver bullet answer that remains perpetually on the horizon.

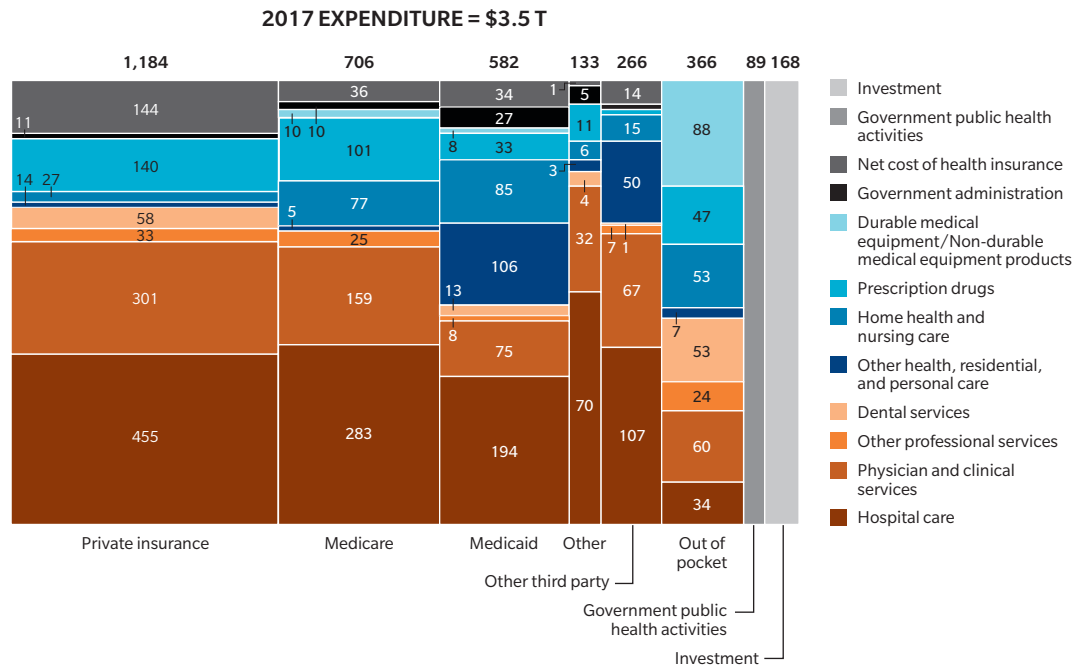
## A YARDSTICK FOR IMPACT

The IHI Triple Aim has offered the industry a useful framework for defining what we're trying to achieve. What we're missing is a clear yardstick for how high we should set our sights and what's needed to create step-change improvements. An important starting point is cost – where healthcare spend approaches 20 percent of US GDP and comparable percentages of household income. The unrelenting growth in the cost burden of care has triggered an urgency that can no longer be ignored. While cost is only one leg of the Triple Aim, the necessary actions to dramatically lower system AND consumer costs will also have a marked impact on outcomes and experience.



The US remains well out of line with our peer group of industrialized nations, both on how much we spend on healthcare (more than double the median) and health and life expectancy (near the bottom of the pack). Over the past decade, we've seen our performance on both dimensions accelerate away from that of our peers, as cost growth continues unabated and life expectancy has actually declined. One telling statistic is the mix of spending between healthcare and social programs that underlies determinants of health. The US spends roughly the same amount on both, while peer countries have a 1:2 ratio of healthcare to social services. In absolute terms, they spend substantially less on healthcare, and a little more on social programs.

EXHIBIT 1. OPPORTUNITY FOR IMPACT: CURRENT US HEALTHCARE EXPENDITURE (IN \$BN)



By dissecting today’s \$3.5 trillion healthcare economy and mapping potential opportunities to specific areas of spend and consumer hassles, as much as 30 to 35 percent total cost improvement opportunity can be credibly identified.

THE INDUSTRY’S NEW TARGET? OUR AMBITION FOR CHANGE

While we’ve achieved limited aggregate impact so far, there’s incredible opportunity to make progress across an array of levers:

- A. **Fully executing the transformation playbook for the integrated healthcare industry.** The waste, inefficiency, and misalignment of how health plans and health systems work together to deliver care today are the sources of at least 20 percent in cost-savings opportunity. These levers are a familiar agenda for the industry – but remain largely unaddressed by isolated, tepid efforts to restructure how the industry delivers care and engages people in their health.
- B. **Confronting the big adjacencies.** Adjacent to the core structures between health plans and health systems are key areas that must move to the foreground: pharma services and the spend that happens in post-acute, long-term care, and home settings. These have been separated from most industry transformation efforts and represent important drivers of both costs (20 percent of total spend) and outcomes. Transformation in these domains represents at least five percent of total cost savings opportunity.

- C. **Redefining the “sick care”-healthcare boundary.** Transforming healthcare can’t stop at improving how the industry treats people who are sick or in need of care. It must also extend to how people live their lives, affecting the dynamics that shape our healthcare needs and health-seeking behaviors. These levers, while notoriously stubborn to move, can deliver an additional five to ten percent cost savings and, importantly, change the pace at which healthcare spend is growing.

Changes in supply structure have muted impact if demand patterns don’t concurrently evolve. Siloed innovation, although a good start, will leave us well short of the potential impact this portfolio could deliver.

## THE CORE TRANSFORMATION PLAYBOOK: FIVE LEVERS WE CAN PULL TO SPARK IMPACT

Analysis of the current healthcare system’s failures – customer frustration, uneven quality, escalating costs, and deterioration in the health of our communities – has yielded a set of transformations many in the industry now view as inevitable. These plays have been the focus of innovation investment – both from within the industry and from newcomers. We have discussed necessary innovation and have celebrated innovators who have developed proven solutions. And yet impacts have mostly been limited to narrow pilots. The potential is there – adding the levers described below can drive cost savings above 20 percent – but getting there requires dramatically improved innovations and much wider diffusion and adoption.

Aggressively pulling the following ten corresponding levers below can trigger transformation: (And their combined interaction makes each lever more effective!)

### 1. HOLISTIC, PROACTIVE CARE MODELS

Purpose-built models against specific cohorts (especially high-risk, complex cohorts) can deliver incredible results. The likes of CareMore Health, Iora Health, ChenMed, and Oak Street Health have shown us the way. They integrate multiple disciplines, including behavioral health, nutrition, and pharmacy. They build treatment plans for the “whole person” rather than a specific symptom or event. They are proactive in touching patients on an ongoing basis. And they work – dramatically changing both cost and outcomes for patients with the greatest needs. But we need faster, bigger adoption – we should have at least 25 million complex patients managed under these models, and we can’t wait for innovators to build one clinic at a time, when collectively they only touch around 400,000 lives today. So, what can help us close the gap? Incumbent providers must start segmenting their clinical and operating models to tackle this challenging top-of-the-pyramid head-on. We must be intentional in delivering different kinds of care to different population cohorts. We need more partnerships that serve as scale multipliers – such as Walgreens and Humana delivering high-intensity care models across a retail footprint, or Oak Street and Advocate collaborating on an “extensivist” clinic. Where there isn’t sufficient population density, we need to lean into digital, closed-loop alternatives that can support advanced chronic disease patients, limit disease progression, and prevent costly complications. While additional care model advances will certainly emerge with advances in genomics and related technologies, we already have proven models that need to find their way to scale implementation.

## 2. REIMAGINED SITES OF CARE

There's been significant industry-wide focus on "downshifting care" to lower-cost delivery environments – from inpatient to outpatient to ambulatory to clinics. The emergence of convenient, retail, and tech-driven access points has pushed the shift a step further – moving care outside of traditional channels and making it more on-demand. Pulling this lever to the max requires a reimagining of care hubs and educating consumers in three specific ways: (1) embracing more digital-first approaches to both transactional and chronic care – digital-first needs to be the default status, not the innovative "new thing" (an estimated 30 percent of ambulatory visits could be delivered through virtual care); (2) advancing self-guided care that eliminates the need for downstream interactions – using more sophisticated technology interfaces as a "free" substitute for many avoidable visits; and (3) harnessing the home as delivery hub – not just for front-end-of-care needs, but also acute and post-acute management. These innovations can create impact across the entire population pyramid, from managing complex patients toward more cost-effective, consumer-friendly high-touch settings, to the large volumes of transactional care among today's healthy (and largely unmanaged) population. With these newly configured assets, the regulatory, benefit design, and payment structures will then need to realign to deliver value to consumers. The industry's massive fixed investment in expensive hospital campus infrastructure slows progress on this lever, but the economic advantages of new sites are providing relentless pressure.

## 3. UTILIZATION OF CARE

Care delivery's reduction of unnecessary variation, overuse, and duplication was once primarily up to payers' antiquated utilization-management programs. These frequently strain consumers (especially disenfranchised consumers), warping both incentives and outcomes. There must be a shift towards proactive, tailored approaches. This can happen by rooting out and improving care appropriateness at the clinician level where variation of care leads to \$210 billion of unwarranted spend. Or, by completely rethinking how and when to target individuals – not populations of individuals – to better align interventions like disease management programs that reduce the likelihood of major health events.

## 4. REINING IN OVERHEAD COSTS

An astounding 60 percent of healthcare workers aren't involved in care delivery. Huge swaths of resources simply manage complex system interactions – from coding to claims processing to prior authorizations. Most healthcare organizations are conscious of reining in overhead costs, but they tend to rely on labor efficiency. Step-change improvements require very different administrative processes – automating or eliminating steps or even whole processes, underpinned by technology and new operating models. Should coverage verification involve office staff? Should network credentialing and directory management be an entire department? There's a long list across the value chain. Industry after industry has realized redefinition of core processes as they move toward digitization and industry-level utilities – it's time for healthcare to begin that journey.

## 5. SHEDDING LIGHT ON PRICE NORMALIZATION

Healthcare is plagued by highly variable pricing caused by complex and opaque contracting, reimbursement, and supply-chain structures. This variability is hidden from consumers and employers within complex benefit structures. But there's evidence deeper price transparency can prove useful to consumers when shoppable services with clear price points and quality data drive decision-making. Some examples include the disruption stand-alone radiology centers are bringing to Houston's healthcare market or Walmart's recent announcement of narrowing their contracts to a small number of cost-effective radiology centers. But transparency's only effective in standard economic units – a radiology exam is relatively easy. We're painfully short on developing and disseminating a standard taxonomy and on helping consumers understand why there's an Explanation of Benefits waiting for them in the mail, anyway. Shedding light on an opaque process will spark new market-based behaviors in pricing and underlying operations. But we need a competitive spirit to drive change – one that ignites better control, for sure.

## CONFRONTING THE BIG ADJACENCIES

The above playbook is centered on industry integration – where large contracts, expensive procedures, and the highest-risk patients drive disproportionate impact. But when we step back to examine the \$3.5 trillion industry, we see two big pools of activity and spend areas not well addressed in that core playbook. Each is significantly contributing to the industry's rising costs, customer frustration, and poor outcomes – and must become a central part of our impact playbook:

## 6. REINVENTING PHARMACY SERVICES

Pharmacy represents 13 percent of today's total healthcare spend and is growing at a worrisome rate. Traditional formulary management, consumer out-of-pocket, and rebate approaches are ill-equipped to handle pharmacy spend growth currently on a trajectory to rival acute spend over the next decade. A robust specialty drugs pipeline is challenging traditional financing and coverage models. Integration of pharmacy and medical services is an important foundational move. But we still need to flip the cost-management model on its head by embracing pharmacy "pyramid management" principles akin to segmented population health. For the very top-of-the-pharmacy pyramid (0.3 percent of people drive over 20 percent of pharmacy spend), we need new classes of purpose-built care models and digital solutions in conjunction with tailored therapies. We must dramatically impact the pricing, utilization, care-management sites, and patient experiences around specialty medications – but not just "throw the kitchen sink" at every patient for every disease. We must get patients to take their medications as prescribed – approximately 50 percent of all prescriptions taken in the US aren't taken according to written instructions. We need greater patient-level pricing transparency and access to "best price" programs. Taken together, we can slash pharmacy spend by nearly 35 percent – with specialty pharmacy as the major driver. This could have a meaningful impact on healthcare's bottom line while helping avoid medical costs from unchecked disease progression.

## 7. TAKING ON “PERIPHERAL” COTTAGE INDUSTRIES

Most health systems define scope through things like the hospitals, clinics, and physicians at the core “continuum of care” for many health episodes. But there’s a large, growing care portion that falls into the “other” category – in post-acute settings, rehab and therapy centers, long-term care, and at home. These sectors are notoriously fragmented, often with small operators across a single geography. They have widely variable practices (and therefore widely variable quality). As we seek inexpensive acute care settings across the board, costs and outcomes across these settings will only become more important. The play to create structure and standardization in these sectors will be critical. Whether through consolidation into larger regional and national entities, greater alignment and integration with local health systems or payers, or the impact of scrutiny, measurement, and industrialization – bringing these cottage industries into the 21st century is essential. The economic impacts of these inefficient, unmanaged delivery models contribute to our cost and outcome challenges. Across these settings, we spend more than \$300 billion. Savings of between 10 and 15 percent can materialize through a shift towards innovators’ effective economic models. And as organizations such as Humana make moves – like its Kindred acquisition, for instance – the benchmark of what “good” looks like will keep rising.

These siloed categories represent real savings opportunities – almost five percent of total spending. Failing to address them leaves the whole system vulnerable to ongoing outcome and cost deterioration.

## IS IT HEALTHCARE, OR JUST “SICK CARE?”

The healthcare industry has fundamentally been a “sick care” industry – organized to finance and deliver care in response to consumers with needs. Within this \$3.5 trillion context, we can see a path (albeit a challenging one) to reduce healthcare spend by 20 to 25 percent and transform both experiences and outcomes described in the above playbook. This cannot just be a supply side agenda. We need consumers who are aware of, confident in, and ready to adopt more efficacious models. For example, scaling new front-end care models won’t change care patterns if consumers still seek care in expensive hospital settings. Changing care consumption patterns inside the “sick care” system isn’t enough. We must affect underlying drivers of healthcare demand – and reach beyond traditional boundaries to do so.

This is our next frontier:

## 8. RETHINKING THE FRAMEWORK OF DEMAND

A big factor that shapes how everyone seeks and accesses care is how health insurance – both private and government – structures decisions. This framework, for reasons of risk aggregation and administrative simplicity, has largely been one-size-fits-all. Large groups of people receive the same benefits, regardless of needs and preferences. We must better align how healthcare (not just “sick care”) is packaged, purchased, and mediated with people’s true needs. Sophisticated risk adjustment and predictive models are primed to help players tailor risk pools

and unlock more sophisticated pricing. This can, and should, lead to different segmented or truly mass-customized products (such as lifetime value products, subscription models, or health and wealth convergence) – and unlock growing consumer choice market segments.

## 9. ACHIEVING PERSONALIZATION AND INTERACTION

In the context of a patient/doctor encounter, the physician is trained to discover, contextualize, and interpret someone's unique needs. By contrast, all other aspects of how a consumer interacts with the system largely lack context, knowledge, and intelligence. Advances at the intersection of big data, advanced analytics, machine learning, and genomics are enabling marked improvements in customized solutions. We've likely only scratched the surface of what's possible in the next half decade – especially in terms of pooling demand/risk, the specialization of care models, targeting therapies, and streamlining processes to reduce consumer frustration. A key industry impact battleground will be won through increased levels of consumer-centric personalization – especially as people assume the burden of more healthcare costs. In our increasingly data rich and data accessible society, making the system “smarter” about the consumer can have profound impact.

## 10. EXTENDING INTO THE CONSUMER'S DAILY LIFE

Healthcare's supply side has been positioned as largely reactive. The consumer presents herself to the system at point of need, like a symptom or event. Most consumers would likely prefer their healthcare providers not become involved beyond that model. However, we know the most effective care models extend their reach beyond episodic encounters, using monitoring, coaching, and engagement to effectively drive compliance and change. Early evidence of digitally supported monitoring and coaching platforms in chronic disease management shows promise. As our mobile platforms become more health aware and more deeply integrated into, well, everything, this always-on, ubiquitous connectivity offers great promise for a level of activation and behavior modification once impossible through infrequent, in-person mechanisms.



## Impacting Demand A Case Study

From 1980 to 2000, treatment improvements and better education on risk factors cut heart disease-related mortality by half (from 543 deaths per 100,000 to 267). However, the US continues to lead the G7 nations (Canada, France, Germany, Italy, Japan, the United Kingdom, and the US) in cardiovascular mortality. There remains significant headroom to materially impact the demand side, especially long term. The Centers for Disease Control and Prevention's (CDC) Million Hearts® initiative found less than half of hypertension sufferers have their condition under adequate control and just 61 percent take their recommended daily aspirin. Only 55 percent of those with high cholesterol are receiving adequate treatment. There's ample room for Americans to improve their lifestyle and diet choices – nearly one-third report engaging in less than 10 minutes of weekly physical activity, and average sodium intake in adults was 50 percent higher than recommended. These factors drove 415,000 preventable deaths in 2016 and resulted in \$32.7 billion in cost (that's one percent of total healthcare spend). The CDC has targeted a six percent reduction in these events (or, \$2 billion in savings) by encouraging traditional intervention strategies. Personalization and proactive influencing of patient behaviors can magnify this impact – potentially preventing 25 percent of these deaths and saving \$8.6 billion. Such improvements would bring US cardiovascular mortality on par with the G7 nations.

Implementing these plays can significantly hinder disease progression across multiple conditions. Across the G7 nations, the US sees the highest mortality rates overall and the highest death rates from major chronic conditions like cardiovascular disease, endocrine/metabolic diseases, and pulmonary disease. A whopping \$300 billion (nine percent of healthcare spend) was caused by non-adherence to drug treatments. Dropping the incidence rate of metabolic disease and diabetes to align with the G7 average would save \$26 billion. It's impossible to know how much future influence we'll have on people's behaviors and how much potential these drivers can deliver. However, given the available headroom in many of these conditions and digital and personalization advances, we believe addressing these demand side drivers can reduce overall spend by an additional five to ten percent, better aligning our lagging health outcomes with that of other developed nations'.

**EXHIBIT 2. THE IMPACT YARDSTICK: 30 TO 35 PERCENT HEALTHCARE SPEND SAVINGS**



Source: National Healthcare Expenditure Data for 2017 from CMS | Oliver Wyman analysis

**FINDING THE ACCELERANTS TO IMPACT**

Driving 30 to 35 percent cost improvement and similar experience and outcome step-changes won't occur with campfires of innovation. We need hundreds, if not thousands, of organizations promoting and executing this impact playbook, changing the face of supply and demand. But what are the catalysts for systemic improvement at scale? What are the ways to accelerate requisite shifts beyond the regulatory pen? We see several important initiatives that require multi-stakeholder energy:

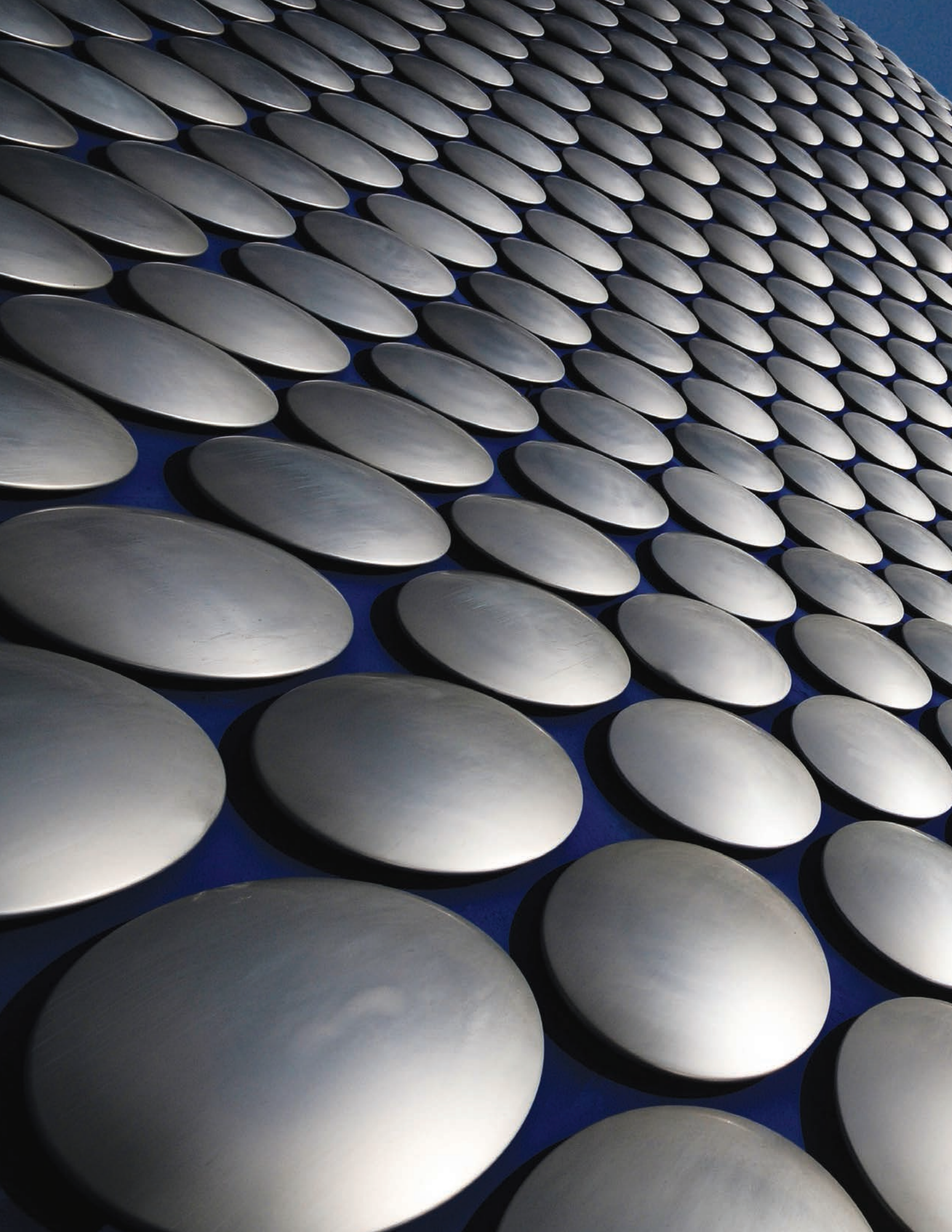


- **Creating taxonomy for an expanded definition of “healthcare.”** We’ve built a “sick care” industry with a corresponding benefit stack, network structure, formulary, and set of rules (episodes, encounters, and codes). When solutions don’t cleanly fill into a claim (such as digital/engagement models that are “always on”), it can take months – if not years – to work through the red tape of getting consumers access to effective models. As the industry expands to include factors like nutrition, stress, sleep, and companionship – not to mention alternative ways of receiving care and support – the lack of a common, structured framework to categorize both factors and the associated interventions has been a big impediment.
- **Breaking down community silos.** While healthcare can still be based on competitive principles, we must move beyond local market structures of leverage, share, and negotiating power as the axis of success. There’s valuable opportunity for the many actors in a given community to rally around shared action and impact targets – deploying integrated approaches to mental health access, collaboratively launching care models for high-risk populations, unifying the front-end experience, addressing health drivers such as housing, food security, and more. We need much greater coordination and integration of efforts like West Side United in Chicago or what ProMedica has helped catalyze in Toledo to root out major inhibitors of health improvement in impoverished areas. This likely requires employers to band together to set heightened expectations – marrying supply with demand to foster new ecosystems and promote wide-scale adoption of innovative models.
- **A new leadership and accountability model.** When growth and margin performance are facing off against the IHI Triple Aim, business objectives tend to speak the loudest. But the two need not be mutually exclusive. Boards and leadership teams that embrace an impact and innovation mindset will be successful stewards of investor, community, and consumer responsibility. They will become part of a sustainability legacy for generations to come.

Even within the constraints of the US healthcare structure, achieving North Star impact would put the country on sustainable footing. It’s time to move towards an ambitious playbook and hold the industry to a quantifiable yardstick.

## KEY TAKEAWAYS

- Even the most fruitful healthcare innovators have seen trivial industry-wide impact thus far.
- Unyielding growth in the cost burden of care has triggered an immediate sense of urgency.
- 30 to 35 percent cost take out and corresponding experience and outcome step change is possible by focusing on core system transformation, adjacencies, and redefined health boundaries.





# **BUILDING FOR IMPACT**



# NOW YOU SEE US, NOW YOU DON'T

## THE ILLUSIONS AND TEMPTATIONS OF SUCCESSFUL M&A

**Terry Stone**

Managing Partner, Health & Life Sciences, and Global Chair for Inclusion & Diversity, Oliver Wyman

**Sihyun Choi**

Principal, Health & Life Sciences, Oliver Wyman

**H**ealthcare organizations and industry players alike turn to mergers and acquisitions (M&A) as a fast track to innovate, scale, and maintain market relevance. Press releases promise golden possibilities – lower costs, enhanced experiences, better clinical outcomes, and healthier populations. In short, M&A promises a new world. So why does M&A regularly disappoint on delivering on those promises – with some transactions actually destroying value? Change is hard. In many cases, change goes against current incentives or business models. Execution fails due to a lack of planning and an overemphasis on control (such as deciding who will take which leadership role) rather than what modifications can command success. “When the partners depend on each other and also have bargaining power over each other, they often end up haggling over the surplus after the fact,” said<sup>1</sup> Benjamin Gomes-Casseres in *Harvard Business Review*. “It’s kind of like sumo wrestlers trying to dance. For bystanders, it’s often not pretty.”

**EXHIBIT 1: WHAT LEADERS SEEKING M&A SUCCESS SHOULD (BUT DON’T OFTEN) DO**



**Change first, control later**

Be specific about changes and non-negotiable outcomes, not processes and people. When you focus on the latter, you lose sight of necessary changes. Unlike outcomes, you can always adjust your processes and people as needed along the way.



**Make a game plan**

Design a blueprint to capture M&A value via change-oriented hypotheses across key value creation areas, like clinical products and services, administrative operations, and fixed assets.



**Get comprehensive**

Saying, “We’ll get to it later...” is almost always the wrong answer. Drive comprehensive conversations across all value creation vectors.

Source: Oliver Wyman analysis | #OWHealth

## ANALYZING A SMOKE AND MIRRORS MARKET

Two big flavors of M&A are present today: **Traditional** transactions emphasizing advantages through size and scale-based efficiencies (such as negotiating power and sharing common resources and investments). And, **nontraditional** combinations, bringing novel organizations together to disrupt how and what services are delivered. Sometimes, the latter ends up changing how the whole market functions.

### EXHIBIT 2. M&A HEALTHCARE MARKET SNAPSHOT: FLAVORS OF INNOVATION A SAMPLING OF RECENT DEALS AND MOVEMENT

 PROVIDERS	 PAYERS	 TECH	 PHARMA
CommonSpirit Health (Catholic Health Initiatives- Dignity Health)  Ballad Health (Mountain States Health Alliance- Wellmont)  Jefferson Health  Jefferson Health – Abington  HCA Healthcare-Mission  Hackensack Meridian Health-Carrier Clinic	CVS-Aetna  UnitedHealth- DaVita Medical  Humana-Kindred  UnitedHealthcare- Peoples Health	Roche-Flatiron Health  ResMed-MatrixCare  Allscripts-HealthGrid  InTouch Health-TruClinic  Babyscripts-iBirth	AbbVie-Allergan  Biogen-Nightstar Therapeutics  Bristol-Myers Squibb- Celgene  GlaxoSmithKline-Pfizer  Johnson & Johnson- Auris Health
 MANAGED CARE	 MEDICAL PRODUCTS	 DISTRIBUTORS	 CLINICAL LABS
Anthem-Beacon Health Options  Humana  UnitedHealth-Equian	Valley MPO  Baxter-Shire  Styker-K2M  Thermo Fisher Scientific- Brammer Bio	Haven  McKesson-Medical Specialties Distributors  Cardinal Health-Medtronic	LabCorp-Envigo  Quest Diagnostics

Source: Oliver Wyman analysis | #OWHealth



## Thoughts on M&A's present trajectory

The emerging M&A landscape is in play, a backdrop against which providers remain heavily scale-focused on acquiring new hospitals and physician practices – and where payer players are drawn to more disruptive transactions across the value chain (such as vertical integration) and targeted bets in new areas (such as capability adds and/or enhancements). Healthcare technology is also seeing a robust boom in transaction activity, supported by strong market demand for change. Although these innovation-focused tech players are gobbling up relatively smaller targets (versus payer/provider acquisition goals), their acquisitions are potentially disruptive capability-enhancement assets aimed at outflanking the competition in the battle for emerging relevance (and ongoing funding from venture capitalists and others).

Despite market excitement over each transaction's future impact, healthcare M&A transaction results often fall short compared to non-healthcare transactions. "Very few people have actually gotten any value out of [M&A deals]," said<sup>2</sup> A. Marc Harrison, Intermountain Healthcare Chief Executive Officer. In comparison, non-healthcare industries have very different outcomes when similar organizations come together.

One such example is Proctor & Gamble's (P&G's) purchase of Gillette. Although both companies operated successfully in their respective consumer product spaces, by extending Gillette's shaving technology across P&G-owned women's brands and integrating their lotions and deodorants into P&G's product line, the two brands collectively created an innovative experience and product suite. Are we seeing this type of value creation in healthcare? The answer is an emphatic no.

Today's M&A value creation tends to come from "fall out of bed" impact that stems from size and the negotiating clout that accompanies magnitude. That, however, is short-lived, just the tip of the iceberg. Full value extraction means making bold choices to optimize and introduce a new service and product mix. Shared services bring valuable scale across all facets of the operation, from supply chain to finance to information technology. New technical capabilities link operations.

A critical question for leaders: What can we learn from industries beyond healthcare where M&A activities have generated greater returns for shareholders, customers, and broader communities?

## PURPOSEFUL A TO Z INTEGRATION MEANS NO STONE'S LEFT UNTURNED

Traditional, scale-oriented mergers succeed by bringing a laser focus to operations and serving consumers. This means critically evaluating a mix of services and products and, where offerings are provided, optimizing newly formed options into innovative consumer-facing offerings. Payers have been on a consolidation track for a while now and have had success in using acquisitions of health plans and competitors to gain access to new markets. Payers' M&A playbooks emphasize rationalizing products and services, streamlining of operations for end-consumers, and designing for aggregated market demand.

Consolidation among providers has been the subject of many a headline in recent years. While many still struggle to integrate, there



are some bright spots among those organizations prepared to make use of their newly acquired assets and capabilities in braving a new future. Some examples include:

- A group of rural, community hospitals acquired by an academic medical center that brought underserved communities enhanced access to critically needed cardiovascular services. Despite market pushback, leadership kept its focus, engaging its team and community; the result was lower cost, better care, and improved community relationships.
- After many years of functional integration (such as back office and common staffing roles), a large Midwest health system changed its service mix and care delivery infrastructure. This meant transforming current care sites into purpose-built care facilities (such as getting an orthopedic hospital, a geriatric outpatient hospital, and main tertiary high-end facility to work together in offering the lowest cost/greatest value experience) to meet today's clinical and consumer needs in a specialized manner; the result was optimized cost structure via specialization and improved quality through concentration of clinical capabilities and volume.

These examples are perhaps still too nascent and isolated in comparison to bolder possibilities. Having worked intimately with these organizations, change requires strong commitment to future visions and a willingness to stay the course. Not to mention – managing diverse stakeholders through the journey, including clinician partners.

## TOMORROW'S NON-TRADITIONAL M&A'S FOCUS? CREATE NEW CONFIGURATIONS (WHILE CHAOS SURROUNDS YOU)

Unlike M&A between similar organizations, non-traditional M&A requires a nuanced approach to design and integration. Otherwise, healthcare leaders face risk of “organ rejection.” The reason is non-traditional M&A involves heterogeneous combinations of different business models and market perspectives. Despite the challenge, the desire for disruption has fueled non-traditional market tie-ups. That said, there are examples of unique value-creation formulas:

- **Amazon and PillPack – New Market Entry and Exploration.** This collaboration promised the opportunity for Amazon to venture into a new pharmacy-distribution market. However, Amazon did not completely subsume PillPack's virtual pharmacy operation and identity, recognizing the importance of independence during the experimentation period.
- **UnitedHealthcare and Optum – Vertical Integration.** UnitedHealthcare, directly and through its subsidiary, Optum, had a similar approach when acquiring care delivery capabilities across select markets (like DaVita).
- **Advisory Board Company and Optum – Force Multiplier.** At first glance, Advisory Board Company's sale to Optum may perhaps be a head-scratcher, given Advisory Board's core identity as a research, consulting, and technology firm. But through Advisory Board's acquisition, Optum may gain new channels to engage the market and fuel growth. Alternatively, Optum could integrate Advisory Board's broad provider understanding and accelerate OptumCare's market role in serving more patients with Medicare Advantage plans, as well as other elderly patients. There are likely many layers of additional value creation being addressed.



## The Key to M&A Success? Imagine 1 + 1 = 3.

Neil Olderman  
Partner at Drinker Biddle

While counseling and advising on dozens of hospital affiliation transactions over the past three decades, I've noticed a common theme among successful affiliations: parties can identify how their combination drives community value via innovation and consumer-focused quality care. (Or, imagining "1 + 1 = 3.") Admittedly, this time-consuming strategy requires a clear vision of what each party offers. Failures are common, stemming from things like postponing detailed planning, designing non-specific action plans, and trusting "shared governance" solves whatever challenges arise. Resolving to force change isn't the answer. Thoughtful integration planning is. More hard topics need addressing like cultural alignment, mutual leadership respect, medical staff buy-in, and best practice integration. These all must be confirmed as part of the partner evaluation process. Important resources and capabilities must be provided to achieve the desired impact including capital, analytics, telemedicine, information technology, supply chain savings, and care management skills. Although it's possible the "devil" in these details ultimately undermines an affiliation, it's critical to approach potential affiliations starting with this question: **Does this combination deliver an innovative, resilient, and consumer-friendly care delivery solution?**

- Iora Health and Flatiron Health – Strategic Investments.** Consider how some organizations, like Iora Health, which runs a network of primary care clinics around the US, are investing early for a seat at the table. Iora, which raised \$100 million Series E financing in 2018, aims to become one of the biggest players in digital healthcare and non-traditional health systems by advancing its collaborative care model, which involves a team of doctors, nurses, and health coaches tracking each patient's health with the aid of Iora's software platform. Or take Flatiron Health, a venture acquired by Roche in 2018. Flatiron Health has become a key driver in health technology. In addition to its OncologyCloud platform which includes electronic medical record for oncology, advanced analytics, a patient portal, and integrated billing management, Flatiron's platform serves as an aggregating data resource that enables oncology researchers to develop real-world insights. Iora and Flatiron made key strategic "bets" and provided an environment to fully test and validate their market hypotheses. How it integrates into the overall business is to be determined.

These examples cut across the industry but share commonalities. Rather than consuming the whole, as is common in purely built-for-scale deals, all involve nuanced approaches. Here, integration makes room for cohesion and independence instead of situations where teams suddenly working with larger behemoths find themselves become more stifled with each passing day. As organizations consider these transformative deals, there are several "baseline" considerations:

- Assess disruption readiness internally.** Understand your cultural readiness to tackle top challenges hindering progress. When working in healthcare, an industry where disruptive value comes from people, intellectual capital, and resulting innovations, the last thing you want to do is squander your source of competitive advantage. Align your teams towards change or else you will find yourself rowing in circles as others pass you by.

- **Beef up scenario planning and integrate it into the transaction thesis.** Unlike traditional plays, be nimble and prepared for external market shifts and the competitive landscape. Scenario plan rigorously to validate key assumptions (such as valuation shifts, market reaction, and impact on uptake of new concepts, unanticipated consumer response, scalability challenges, and more).
- **Be relentlessly intentional and focused.** M&A is, in short, a major time investment, demanding your full attention, not partial interest. Developing an M&A strategy – while trying to disrupt your business at the same time – is about prioritizing. Don't venture along an M&A voyage half-heartedly. Doing so will mean M&A will only serve as a distraction that puts you on the fast-track to value annihilation.
- **Recognize structure is merely a shell.** Joint ventures don't equal de-risking. Non-traditional tie-ups without balance sheet implications may initially seem low-risk, but that's purely from a capital commitment perspective. The truth is, the amount of time, resources, and organizational attention spent on poorly constructed joint ventures causes severe value decline. The stakes are the same regarding how many people and how much time is needed to make a non-asset M&A (like joint ventures or affiliation) successful.

## KEY TAKEAWAYS

- M&A execution fails because of a lack of planning and an overemphasis on control.
- Traditional and non-traditional flavors of M&A are most influential in shaping today's landscape.
- Leaders must prioritize whether M&A delivers an innovative, resilient, and consumer-friendly solution.

# FORTUNE FAVORS THE BOLD

## COST AS AN INVESTMENT (NOT AN INCONVENIENCE)

### **Mino Javanmardian, PhD**

Partner, Health & Life Sciences, Oliver Wyman

### **Frank Roberts**

Principal, Health & Life Sciences, Oliver Wyman

**C**ost takeout. Two dreaded words that often strike fear into the hearts of health system executives. Two words meaning the beginning of a painful exercise – one that’s time-consuming, demoralizing, and distracting – to identify wasteful spend. The continued pressure of margin compression unfortunately makes this distressing exercise necessary. Cost growth is outstripping reimbursement increases. Hospitals are quickly losing their center of gravity, as services migrate away from in-patient settings. These macro trends, along with other deleterious developments, show no sign of abating, forcing executives to take on the Sisyphean task of removing cost from their business.





Not all is doom and gloom, however. Cost, when viewed as an investment, means every choice becomes a strategic decision, rather than just another transaction. It means deciding where to put your money. When everything is on the table, you're forced to make the right trade-offs. Investments must align with the strategic direction, rather than on transaction-based efforts. A well-run health system puts its investment where its strategy is. Striking a balance between differentiating capabilities versus table stakes is critical. Even more important is deciding to discontinue investment in activities that don't add value. It's not unusual to see health systems with over 30 percent of investments in capabilities that don't add value.

We believe the imperative to take out costs represents an opportunity for health systems to sharpen their strategy and focus, and to redesign their core business processes. An effective cost takeout process does not merely improve margins; it is transformational and empowering, allowing an organization to chart its own course, instead of being pushed and pulled by broader market dynamics.

## SHARPEN YOUR ORGANIZATION'S FOCUS

**"FORTUNE FAVORS THE BOLD!"**

**"NECESSITY IS THE MOTHER OF INVENTION!"**

We strongly believe all organizations should base their strategies on old proverbs. (Well, okay. Maybe don't construct strategy around old proverbs just yet, but those two are pretty good ones, right?) The point is, taking an incremental approach to cost takeout just leads to more of the same. Identifying two to five percent of spend as waste probably means you're optimizing the same processes and operating through the same business model. What if your objective was to take out 20 percent of costs? You'd then be forced to ask the tough questions of "What? Where? How? What clinical services should I focus on? Where would I deliver them? How do I redesign my business to deliver care in the most effective way?" This mindset requires you to define what differentiates your organization. Are such drastic changes necessary? No...if you are content with the status quo. The status quo, however, is unsustainable. A typical "healthy" health system has a margin of three to four percent. If reimbursement rates drop by five percent (not an unreasonable assumption), systems will quickly find themselves operating at a deficit. As a result, cost management and strategy should not be viewed as different activities. Business considerations that typically fall under the strategy umbrella, such as mergers and acquisitions, must be viewed through the lens of not only whether they support strategic imperatives but also whether they accelerate cost transformation. If not, you risk reinforcing internal processes and structures that will limit your ability to effect transformative change.

## A SNAPSHOT OF CHANGE

As one example, OhioHealth, a not-for-profit health system based in Columbus, Ohio recognized hardened structural barriers were slowing its move to value. To remove meaningful cost from the system – and quickly – it partnered with ChenMed (a physician-led primary-care provider serving seniors) to run OhioHealth clinics. OhioHealth was now forced to become more

efficient by “handing over the keys” to a provider group more experienced in delivering value-based care.

“Models like ours are still somewhat unique because we are one of the few that actually get compensated for keeping people outside of the hospital and keeping them healthy,” Gaurov Dayal, MD, ChenMed’s Chief Growth Officer, said.<sup>3</sup> “In most markets, we are working with a select group of plans. Our success is contingent on the ability to garner members with those plans. And likewise, the plans are working with them, and with us. One of their goals is to grow market share and get better outcomes and cost controls. There’s a lot of alignment on that, and we work very closely with plans in accomplishing that.”

As another example, Mount Sinai Health System is partnering with insurance startup Oscar to run the non-clinical components for one of its primary care clinics. That’s correct: A health system chose a payer to run administrative operations. Why? Mount Sinai realized new business models were necessary to drive significant, sustainable changes to its cost structure.

“We’ve had a lot of fun with Oscar, peeling back areas where we can say, ‘You know what? Just because traditionally one organization does ‘x’ or ‘y’ doesn’t mean we have to do it the same way in this arrangement,’” Niyum Gandhi, Executive Vice President and Chief Population Health Officer at Mount Sinai, said.<sup>4</sup> “If we really want an outstanding experience that bridges clinical care delivery with health coverage, wellness, a yoga studio, or whatever else, let’s identify the jobs to be done and who’s best positioned to do them,” he added.

Both these examples underscore if you want a fundamentally different cost structure, you need to think differently about how you operate.

## REDESIGN YOUR BUSINESS

Once you’ve made strategic decisions – in other words, clarified your organization’s identity and its points of differentiation – you must change how you work to sustainably take out cost and meaningfully impact your operating margin. This entails bringing health systems into a more modern era of business operations. It isn’t just about installing new information technology systems as a means to an end. Instead, it’s about realizing the full potential of “digital” – the set of process transformations enabled by a new era of big data, connectivity, and advanced analytics, like:

- **Simplifying and standardizing business processes.** Wholly eliminate activities once believed to be critical; evaluate the trade-off between standardization and customization.
- **Novel data and analytics to drive better decision making.** Provide recommendations for real-time decision making, built from integrated data sets.
- **New tools to engage constituents differently.** Skyrocket engagement and behavioral change with external and internal stakeholders.

## BUT IT'S ALWAYS BEEN DONE THIS WAY...UNTIL NOW

Rejecting “business as usual” means embracing a new attitude about cost as a strategic investment, not as an inconvenience. Redesigning core processes requires a culture and talent model that supports your new focus. Some have compared large business organizations to tanker ships: slow to turn. Sure, it takes a long time to turn the wheel and change direction, but not just because of computers systems that don’t talk to each other and operating rooms that need updating. It’s also because of the people behind the wheel.

Unfortunately, businesses often realize the importance of people in driving change only after the fact, once outcomes have fallen short of expectations. What’s the secret to engaging people to accelerate change instead of stonewalling it? Well, there’s no single answer to that question. There have been thousands of frameworks and books written about behavior change. In our view – and experience – there are many approaches to making change possible and making it stick. But regardless of the approach, effective change boils down to aligning efforts against core processes, leaders’ conduct, rank-and-file behavior, and organizational incentives. Governance and change management – not organizational or hierarchical design – sparks change.

## POSITIONED FOR IMPACT

Impact starts from the top down. The chief executive officer and senior management must be aligned on the path forward to successfully activate change across the organization. Providers are responsible for 80 cents of each dollar of US healthcare spend. This outsized impact underscores the opportunity facing the industry today. Again, do not disconnect cost management with strategy. Our perspective is that sustainability comes from transforming your business and doing things differently, so cost becomes an outcome versus an objective. When you evaluate merger and acquisition opportunities, ask yourself how it will help you achieve your strategic objectives and organization’s focus, and how it can help you redesign your business processes and operating model, and re-invigorate your culture. When you evaluate an innovative direct-to-employer product, or potential partnership with a plan, ask yourself these same questions.

May the odds be ever in your favor! (Oops, wrong proverb.) ... Fortune favors the bold!

## KEY TAKEAWAYS

- Cost is an opportunity for every choice to become a strategic decision, not just another transaction.
- The imperative to remove costs will help health systems sharpen their strategies and focuses.
- Leaders must align efforts against core processes, conduct, rank-and-file behavior, and incentives.



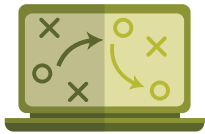
## EXHIBIT 1. FOUR QUESTIONS TO SHIFT YOUR COST TAKEOUT MINDSET

**What's your organization's current cost reduction target?**

Have a number in mind? Great. Now triple it. Figure out what it would take to realize three times your current cost reduction goal. Gather together a diverse set of internal stakeholders to chart what needs to get done next to achieve "the impossible." When thoughtfully organized, this session isn't your typical throwaway brainstorm. It can transform your business.

**What benchmarks should you add... and take away?**

Benchmarks can be more of a hindrance than a help, as they often enforce the current way of doing business. In some cases, benchmarks mean striving towards mediocrity at best. Instead, consider what benchmarks you want to add – even if they seem only aspirational – from other industries. For example, consider the number of data scientists you employ. Or, the number of meetings and participants required when making a decision.

**Do you have a digital strategy?**

Digital strategy is no longer the concern of technology and marketing companies only. Every organization needs to think about how it can adopt digital tools and adapt to an ever-evolving digital landscape that maximizes impact and minimizes (unnecessary) internal disruption. Yep, you need an information technology strategy. And yep, you need a digital strategy. Some organizations (such as CVS, Walgreens, and others) have explicitly outlined digital strategies to create seamless consumer experiences across their online and physical stores. Companies like these are arguably better positioned to stand at healthcare's "new front door."

**Who's the "Chief Architect" of realizing your vision?**

Trick question! It should be everyone. It's essential leaders and managers collectively assume the role of "chief architect" and bring a vision to life. The activity flow that changes the organization is important and should be concurrent, always at work, and supported by as many people as possible throughout the organization. Empowering people across an organization to become "chief architects" depends on our prior three questions. Without clear, unambiguous benchmarks and a "North Star" to your digital strategy, people don't know where to go. As a result, change is slowed.



# ARE SOCIAL DETERMINANTS OF HEALTH THE HOLY GRAIL?

**Esther Dyson**

Executive Founder, Way to Wellville

**Parie Garg, PhD**

Partner, Health & Life Sciences, Oliver Wyman

**H**ealth isn't something addressed only in a doctor's presence. "Health" is where patients live, who they communicate with, and how happy and safe they are. Social and economic factors – such as education, employment, income, family and social support, and community safety – account<sup>5</sup> for up to 40 percent of a population's health. Physical environment factors (such as the quality of someone's environment and how it makes him or her feel) account<sup>6</sup> for another 10 percent.

Social determinants of health (SDOH) – factors like income, literacy, education, and culture that shape someone's health – were once just another trending phrase. Now, they're something organizations are putting serious money behind. For example, a \$650 million Section 1115 waiver for North Carolina's Medicaid program – a pilot program approved<sup>7</sup> by the Centers for Medicare and Medicaid Services – is expected to provide services like housing, nutrition counseling, ride-sharing, and legal assistance for eligible individuals experiencing risk factors like homelessness or interpersonal violence. This announcement comes on the heels of multiple health plans and provider organizations announcing their own SDOH initiatives, including:

- Geisinger's Fresh Food Farmacy program,<sup>8</sup> which provides patients with healthy food to empower them to manage medical conditions through diet and lifestyle changes.
- Health Care Service Corporation's (HCSC) foodQ pilot,<sup>9</sup> a healthy food delivery service for people in areas where fresh food is hard to come by.
- University of Pittsburgh Schools of the Health Sciences' Homeless Continuum program,<sup>10</sup> whose services like assessment, outreach, and 24-hour on-call support help the homeless, mentally ill, and/or substance abusers.
- Humana's Bold Goal initiative,<sup>11</sup> which tracks people's "bad" physical and mental days over a 30-day period, simultaneously screening patients for factors like whether they have access to inexpensive, healthy food, and how lonely they feel. In 2016, they noticed<sup>12</sup> a 3.1 percent drop in people's "unhealthy" days across markets in Kentucky, Tennessee, Florida, Louisiana, and Texas, reportedly seeing this improvement because of investments in things like helping people manage their anxiety levels during an emergency, and ensuring food delivery services have a friendly point person between company and client.



"We provided food for our members – and more than half of them did not consume it. When we asked why, it was a mix of factors ranging from lacking the hand strength to open a plastic seal to not liking the food. It's not as simple as just providing something and expecting it will work."

*Health Plan Executive*

## ORGANIZATIONS WANT TO REDESIGN PATIENTS’ ENVIRONMENTS, BUT ARE THEY SETTING REALISTIC EXPECTATIONS?

Despite what may seem like straightforward logic – providing people with stable housing, healthy food, and transportation should improve their health – the data don’t all point to success. For instance, data from a 2018 *JAMA* article<sup>13</sup> showed a patient cohort with access to free ridesharing missed almost the same number – 36.5 percent versus 36.7 percent – of primary care appointments as a cohort without access to free ride-sharing.

Similar investigation by the Altarum Institute demonstrated cost savings generated by SDOH programs varied largely depending on condition. While the provision of non-emergency medical transport (through a ridesharing service or otherwise) was cost effective, it only saved money for those conditions studied a third of the time. (See Exhibit 1.) In this example, it’s noteworthy that cost-effectiveness is indicative of sufficient improvement in quality of life, life expectancy, or both. Similar studies focusing on other services including food and housing yield comparable results.

**EXHIBIT 1. SUMMARY OF CONDITION-SPECIFIC COST-EFFECTIVENESS FOR NON-EMERGENCY MEDICAL TRANSPORT**

CONDITION	TYPE	RESULT
<b>Preventive</b>	Influenza Vaccinations	● Highly Cost-Effective
	Prenatal Care	● Cost Saving
	Breast Cancer Screening	● Moderately Cost-Effective
	Colorectal Cancer Screening	● Moderately Cost-Effective
	Dental Care	● Highly Cost-Effective
<b>Chronic</b>	Asthma	● Cost Saving
	Heart Disease	● Cost Saving
	Chronic Obstructive Pulmonary Disease	● Highly Cost-Effective
	Hypertension	● Highly Cost-Effective
	Diabetes	● Cost Saving
	Depression/Mental Health	● Highly Cost-Effective
	End-Stage Renal Disease	● Highly Cost-Effective

Source: Cost Benefit Analysis of Providing Non-Emergency Medical Transportation, October 2005

Companies looking to expand patients' access to nutritious food, for instance, must consider the social-emotional needs of complex patient populations. Even something as simple as offering healthy food delivery for the homeless means addressing a range of questions often only tangentially related to traditional care delivery, including:

- Where should packages for people living in transitional housing be delivered?
- What type of service should it be – should the food be fresh, frozen, or packaged?
- How do you know people are buying foods that benefit their health? Is there a way to monitor or limit consumer choice? Should there be?

More organizations are, for example, learning why it's important to help someone who wants to go to the doctor, but physically can't, and doesn't know how to ask for help. This is big news. But a one-size-fits-all SDOH approach that doesn't address patients' realities or personalize offerings isn't the answer.

Yet it's the industry norm.

It's very encouraging the industry is extending the boundaries of traditional healthcare and taking into consideration the full scheme of social support required by those truly in need. But, for these initiatives to take root and not be dismissed as yet another flash in the pan, the healthcare industry must be careful and thoughtful in rolling out SDOH support.

The question to always keep in the back of our minds isn't, "Does this work?" It's "Will people actually do this thing?"<sup>14</sup> Action – not reaction – drives positive social and emotional change for all.

## FOUR STEPS FOR SDOH IMPACT

So, what does this mean? Should plans shy away from SDOH investment? Not necessarily. Should pilots require, say, multiyear, double-blinded studies to prove benefits don't just look good on paper? Not necessarily. But...there's a need to manage SDOH provisions appropriately so value is generated for members, patients, plans, and providers. Here are four specific steps plans and providers can take to ensure their SDOH programs and investments bear fruit:

1. **Prioritize members and services.** While social services can be used by almost everyone, plans and providers should be thoughtful about which individuals they provide certain services to.
2. **Coordinate provision of SDOH services.** Typically, individuals who need social support require multiple forms of such support. The various services offered should be well coordinated (either in person or virtually) and encompass various medical services as needed. If, say, food security is an issue for someone with congestive heart failure, it may be advisable to provide low-sodium food to facilitate some of his or her dietary goals.
3. **Utilize the community.** Not everything has to be provided by plans or providers – nor should it be. There are plenty of community-based organizations – like religious groups and



## ESTHER DYSON SDOH CHAMPION

**Q: Tell us about Way to Wellville and how it addresses SDOH.**

**A:** Wellville is a non-profit national project that works to answer this question: If investing \$100 in cultivating SDOH yields \$200 in lower costs and better outcomes, shouldn't individuals and communities double down on efforts? At Wellville, we're working to help five small communities actually implement the theoretical findings around SDOH. All these things "work" if they actually happen, but "providing access to solutions" is different from "creating an environment where people can (and do) actually take advantage of them." In short, "access to" doesn't mean "effective use of," unless you add in a lot of supporting fabric.

Wellville is a team of six people; we aren't working alone. Our team is coaching community members to do it – because unless they build it and own it themselves – whatever "it" is won't last long. We're helping local partners implement programs across five communities nationwide in areas like obesity, diabetes management,

and mental health. In Muskegon, Michigan, for instance, our partners are facilitating access to healthy food for low-income residents, like connecting more people with farmers' markets and providing grants to local health/food nonprofits. But that also means making the food available conveniently – at the right times and the right places. Like running cooking classes, but also offering child care so more parents and caregivers can take advantage of these classes, and so on.

**Q: What lessons have you learned regarding the successes and failures of SDOH pilots and programs thus far?**

**A:** Well, for starters, don't run pilots! What makes any initiative successful is making it long-term – not a program, but an institution – and embedding it deeply into the community so it complements other institutions. For example, imagine if caseworkers were directly connected to those who run housing, or if pharmacists knew where local food banks are, and so forth. People face multiple problems at a time, so they need multiple sources of

support at a time. We're slowly helping communities build the fabric between programs, which is as important as the programs themselves. Most programs "work," but are operated as pilots or innovations, not as fundamental, built-to-last community affordances. Some early examples are the Muskegon YMCA's diabetes prevention program, now scaling seriously, and operating in schools, churches, and other community locations. And Hello Family, a collection of intertwined family-support initiatives in Spartanburg, South Carolina. To make significant impact, we need to build something lasting, not just run a program until money runs out.

**Q: What guidance can you share with the healthcare community looking to make an impact with SDOH programs?**

**A:** Think long-term and bigger picture. Find allies to help advance programs. Don't worry about competition. Share information. There's so much data out there, and this data only increases in value when you share it with others.

institutions – that provide access to social services. It’s just a question of knowing what’s provided, understanding how to access it, and coordinating various services once received.

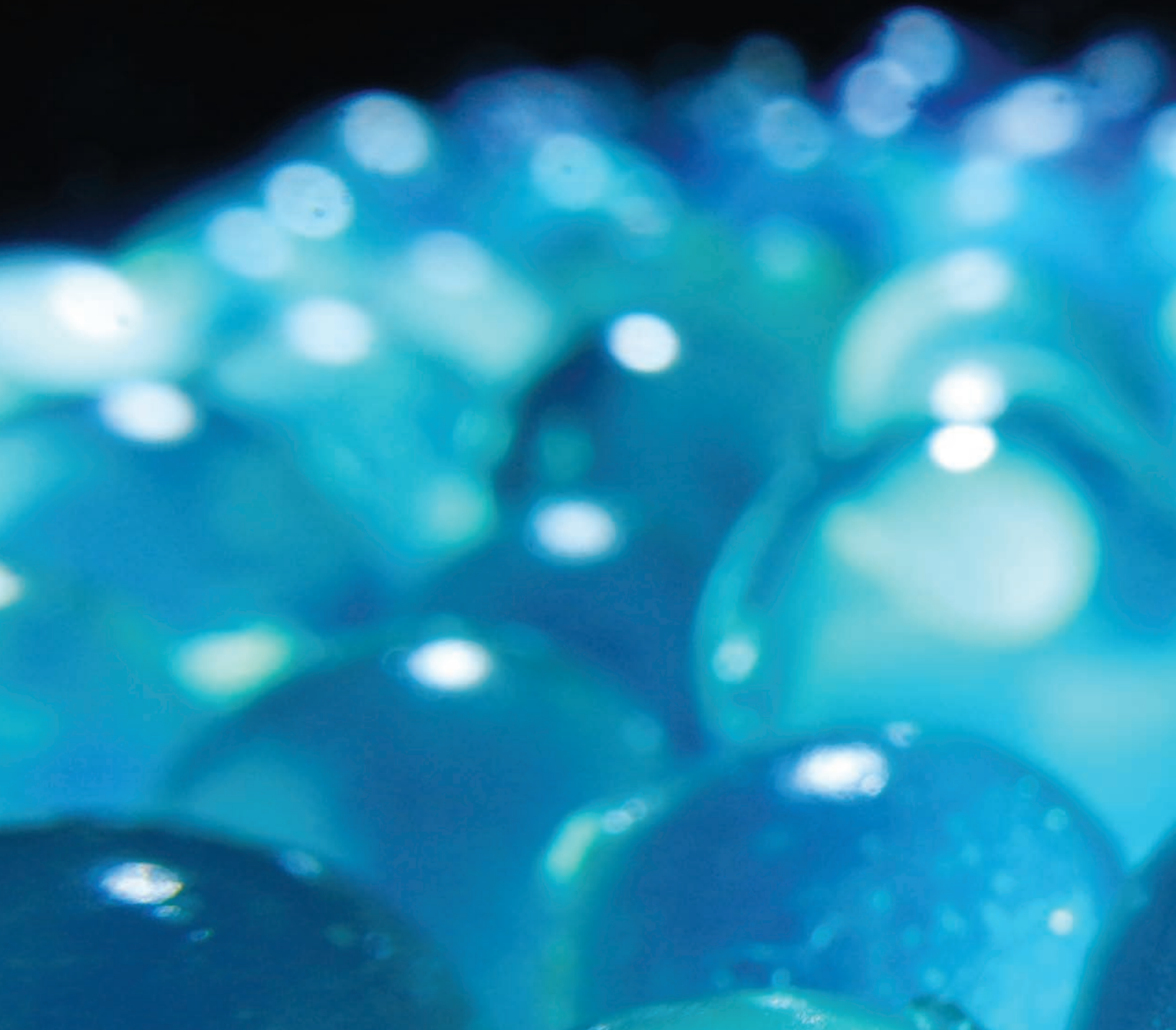
4. **Track and monitor usage to fail fast and continuously improve.** Use of services needs to be monitored. Was food consumed? Did transportation lead to fewer missed appointments? Did the provision of housing reduce emergency room admissions? Based on these observations, organizations can decide what to continue, what to sunset, and how to alter services so they’re of maximal use for individuals.

We believe everyone deserves a chance at a healthy life. “Health” often involves things beyond the “healthcare” bubble that need addressing – food insecurity, social isolation, and transitional housing, among many others. These factors have enormous impact on a person’s ability to be, and stay, healthy. By approaching SDOH with contemplation and analysis, health plans, providers, and community organizations can ensure precious resources target those most in need, or those most likely to respond. This way, the healthcare system can do well by doing good.

## KEY TAKEAWAYS

- Companies must consider the social-emotional needs of complex patient populations.
- An effective SDOH approach addresses patients’ realities and personalizes their offerings.
- Action – not reaction – drives positive social and emotional change for all.

# **THE ROLE OF DIGITAL AND TECHNOLOGY**







# HOW AN INFUSION OF TECH WILL REVERSE THE WORKER CRISIS

**Tomas Mikuckis**

Partner, Health & Life Sciences, Oliver Wyman

**David Waller**

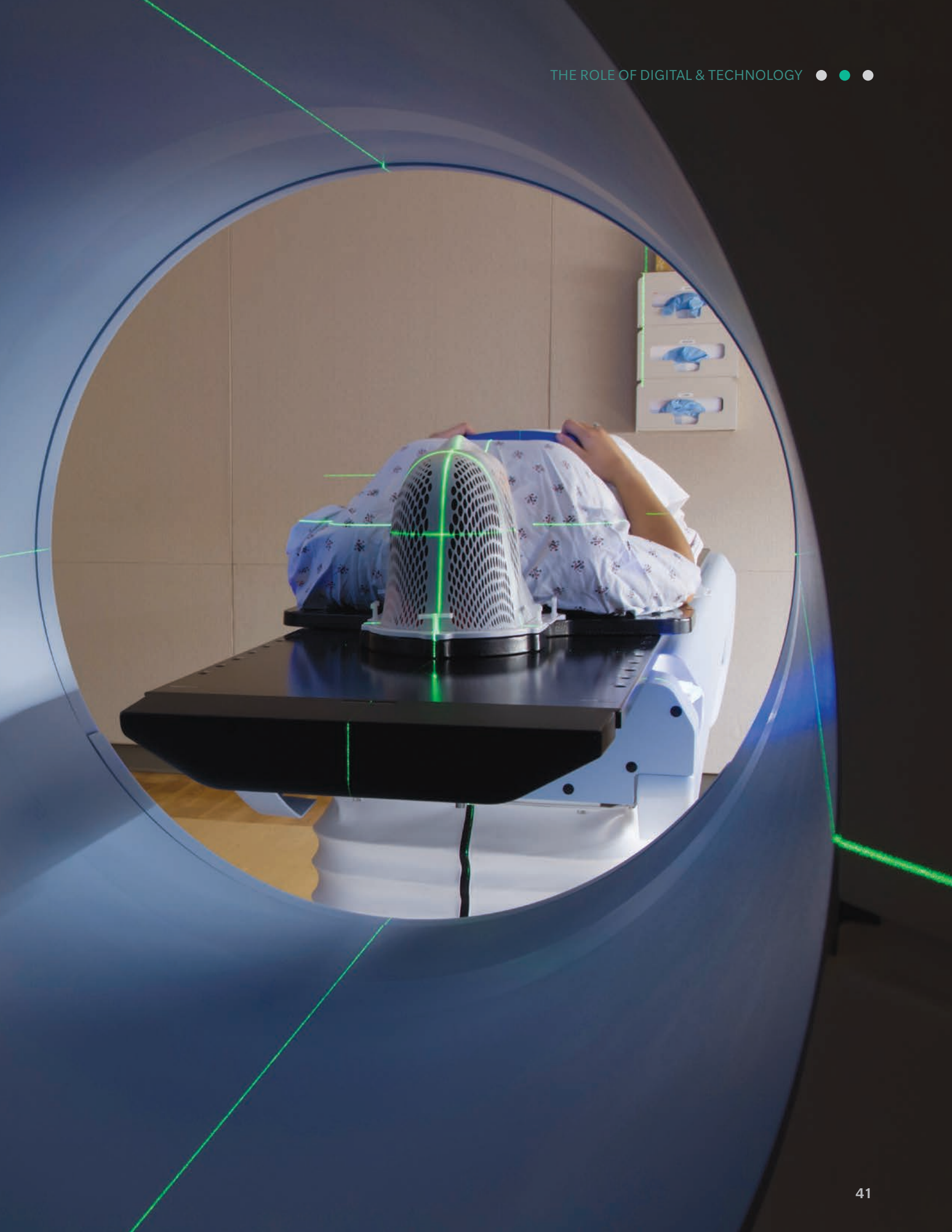
Partner, Head of Data Science and Analytics, Oliver Wyman Labs

**Aditya Lingampally**

Principal, Health & Life Sciences, Oliver Wyman

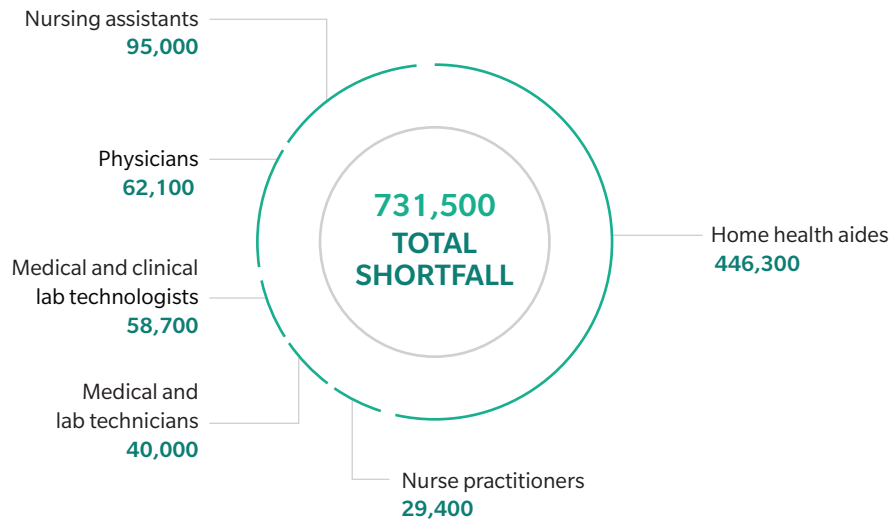
**Stacey Sloate**

Senior Consultant, Oliver Wyman



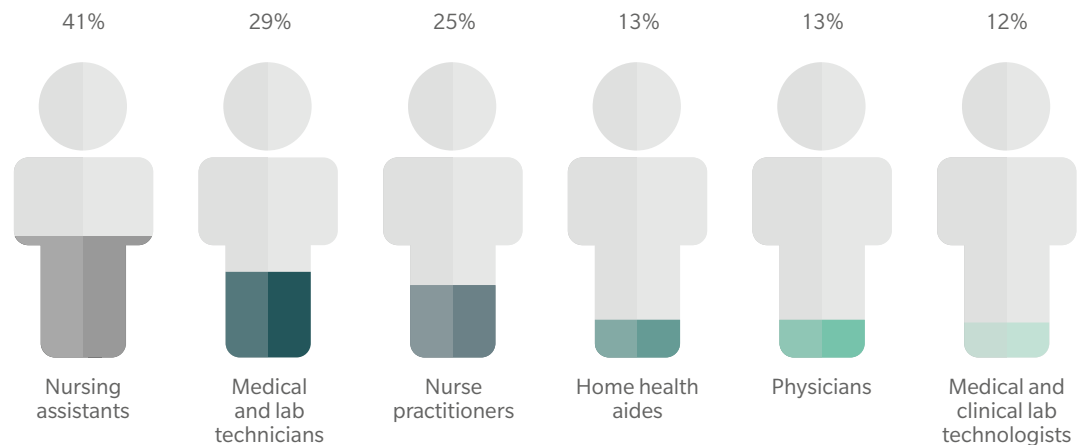
**W**e regret to inform you that this article has not been written by robots. Until then, we have three artificial intelligence (AI) predictions we believe are destined to come true in healthcare. We expect these changes will improve healthcare’s quality, lower costs, transform specialty care, and redefine care delivery. And, we think these changes will be dramatic. What’s more, they will have to be: With a big deficit of healthcare workers just around the corner, the advent of AI will quickly become a question not of if (or even when) but of how fast.

**EXHIBIT 1. BY 2025, DEMAND FOR HEALTHCARE WORKERS WILL OVERTAKE SUPPLY**



Source: Mercer 2018 analysis: Demand for Healthcare Workers will Outpace Supply by 2025 | Mercer’s US Healthcare External Labor Market Analysis | Association of American Medical Colleges: Complexities of Physician Supply and Demand: Projections from 2017 to 2032

**EXHIBIT 2. PERCENT OF MISSING HEALTHCARE WORKERS AI WILL “FILL” BY 2025**



Source: Oliver Wyman analysis

Because of this healthcare worker shortage, some US hospitals with patient populations dominated by the older, the sicker, and the inactive are even closing their doors.<sup>15</sup> But this isn't just about a shortage of healthcare workers – it's instead about a dearth in talent affecting the sector. According to analyses conducted by Mercer and the Association of American Medical Colleges, by 2025 – the year the World Economic Forum predicts<sup>16</sup> machines will do half of human workers' tasks, no less – healthcare will face a shortfall of more than 731,000 total jobs – including roles like doctors, surgeons, nursing assistants, nurse practitioners, lab technicians, and home health aides.

## CUE HEALTHCARE'S ULTIMATE COUPON: AI

Talk of robots replacing human doctors misses the point. When it comes down to it, even the most advanced AI tool is extremely limited, knowing a great deal about a very narrow area of knowledge – kind of like if someone could recite every work of Shakespeare from memory but didn't know Shakespeare's first name. Humans, in contrast, know a little bit about many different things – like if a doctor knew how to chop garlic, how to perform heart surgery, and how to write in iambic pentameter. The combination of people and machines, however, is where we see change happening first and fastest. We've seen this across countless industries – like when accountants transitioned from ledgers, to adding machines, to spreadsheets, from manual to fully automated assembly lines.

But will this play out in healthcare, or is healthcare just...different? We see a significant opportunity. Extrapolating AI at its infancy could have a transformative impact on several areas of clinical care, and even with a conservative view, could make upwards of a 20 percent dent in the industry's current labor shortage. These changes are already here, they're real, and we believe they'll scale quickly.

AI will transform diagnostic review and optimize testing pathways, slashing volume and waste while delivering faster, more accurate results.

- **Case Study 1.** In 2018, 118 out of 1,000<sup>17</sup> people in the US – nearly 350,000 – had a magnetic resonance imaging (MRI) scan. In 2025, it's estimated over 40 million MRIs will be conducted. When an MRI scan is conducted<sup>18</sup> without AI, the process takes about 50 minutes – about 5 minutes to explain an MRI to the patient and another 45 minutes to conduct the procedure, including time spent making sure the machine is physically positioned correctly



## PREDICTION 1

### The Decisive Diagnostician

We predict AI-based radiology solutions will significantly transform radiologists' diagnostic workflow, "filling" the equivalent of nearly 2,500 radiology workers by 2025. These solutions will also streamline diagnostic workflows of anatomic/clinical pathologists, ophthalmologists, dermatologists, and cardiovascular physicians – ultimately "filling" over 2,800 other specialty physician jobs by 2025.



## PREDICTION 2

### The Documentation Assistant

We predict AI-based tools will help close the nursing assistant shortage gap by 41 percent, “filling” at least 95,000 new jobs by 2025. And that technology will also “fill” nearly 7,500 nurse practitioner jobs by 2025.

to acquire necessary images and read the results that come in. With AI-assisted image capture, where much of the process is automated, everything from start to finish takes about 10 minutes. This translates to at least 1.4 billion minutes – or 24.3 million hours – saved in technologists’ time.

- **Case Study 2.** AI’s potential to streamline and transform radiologists’ and specialty physicians’ jobs (such as time spent on diagnostics) is not only notable – it’s measurable. With over 27,500 radiologists currently practicing in the US,<sup>19</sup> and another 540<sup>20</sup> anticipated to practice in 2025, it’s expected AI will benefit **all** practicing radiologists’ day-to-day workflows by 2025, about one-third of ophthalmologists’ and dermatologists’ workflows, half of cardiovascular-disease physicians’ workflows, and 90 percent of anatomic/clinical pathologists’ workflows by 2025.

AI will transform nurse practitioners and assistants from skilled craftsmen relying on experiences and skills to customizers of person-centric interventions.

- **Case Study 1.** Nursing assistants spend a reported 50 percent of a typical shift on patients, but the other half is spent on administrative tasks like documentation, writing out care plans, completing admission/discharge/medication paperwork, and transcribing orders. Over a quarter of their day on average – 27 percent – is spent documenting things, 16 percent on care coordination (like communicating with internal and external organizations), five percent<sup>21</sup> on indirect patient care (like reviewing documentation or planning care), with the rest (about two percent<sup>22</sup>) spent on patient education. But AI-assisted clinical data review and documentation means nursing assistants could get back seven percent of this time – that’s the equivalent of over 95,000 nursing assistants coming onto the workforce between now and 2025, according to Mercer analysis.
- **Case Study 2.** The average nurse practitioner spends over half of his or her day – 53 percent, or about six hours – working with electronic health records. Estimated AI documentation savings come to at least 10 percent.<sup>23</sup> With over 142,000 nurse practitioners in 2025 benefiting from these efficiencies, AI would have “produced” the equivalent of 7,500 new nurse practitioners.

Each year, one in three patients<sup>24</sup> is sent to a specialist, with specialist visits making up over half of all outpatient visits. AI will replace the reactive-responsive healthcare worker with predictive-proactive interventions that manage and monitor a patient's longitudinal health.

- **Case Study 1.** Patients in need of diabetic retinopathy screening won't have to visit eye doctors for their annual exams as separate from their annual primary care checkups anymore, thanks to primary care tools built on AI. Instead, they'll do both at the same time. Of the 23 million<sup>25</sup> diabetic adults in the US, about 48 percent<sup>26</sup> get an annual eye exam. A reported<sup>27</sup> 85 percent of optometrists and 15 percent of ophthalmologists perform these visits. In the future, ophthalmologist capacity should increase when software such as Idx-DR (an AI diagnostics software program that analyzes retina pictures to determine diabetic retinopathy) is used for screening in primary care.
- **Case Study 2.** Surgical site infections (SSI) are the biggest and costliest<sup>28</sup> cause of infections for hospital patients. But AI models can predict which surgeries are most likely to be associated with an infection, enabling a surgeon to take additional preventative actions before – not after – an infection happens. These interventions will reduce the number of patients with surgical infections and lower the total amount of time patients spend in intensive care units. Intensivists and nursing assistants therefore will see a bit more hours “gained” from not having to care for this category of patients.



## PREDICTION 3

### The Downstream Work Eliminator

We predict AI will identify interventions early and eliminate inefficient downstream work currently being done by surgical specialists – closing the labor shortage gap by an additional five percent.

## ALEXA, TELL ME WHAT'S NEXT FOR AI

Technology will shift care delivery. Will payers have to find new and different ways of reimbursement? What will tomorrow's cultural norms look like for consumers? Is AI coming for healthcare's jobs faster than we thought? When healthcare saves money, time, and energy, then what? One day, a robot may instantly tell us all we need to know. For now, it's up to us humans to think about these questions – not “someday,” but today.

## KEY TAKEAWAYS

- By 2025, healthcare will face a shortage of over 731,000 jobs.
- Even the most advanced AI tool possesses limited intelligence.
- Extrapolating AI at its infancy could transform clinical care and alleviate the healthcare labor shortage.

# MONETIZING HEALTHCARE'S C2B CONSUMER DATA EXPLOSION

**Chris Schrader**

Principal, Health & Life Sciences, Oliver Wyman

**B**oom! Healthcare is smack in the middle of a seemingly never-ending data explosion. Many industry players are already combining claims data, lab values, and risk assessments with less traditional data sources. In the meantime, most consumers never dream of leaving home without their phones – powerful, handheld computers that continuously collect and synchronize thousands of data points to make everything from reading the news to staying fit more personal. Consumers' habitual interactions with apps that call cabs on demand, bots that book yoga classes with the tap of a thumb, and personal assistants that predict their music preferences are now the norm.







## WHAT'S NEXT?

In an exciting plot twist, the next evolution of healthcare's data explosion will be owned by consumers – not payers or providers. According to Oliver Wyman's 2018 *Consumer Survey of US Healthcare*,<sup>29</sup> consumers are willing to share their health information (for the right value proposition, that is). We found 63 percent of consumers are quite willing to share their personal health data to ensure their medical care is the highest quality possible. And, 41 percent of consumers say they're willing to share their shopping behavior to ensure top-notch medical care, as well. This kind of consumer information provides opportunities for companies beginning to merge consumer data points together to better manage health costs and empower and engage consumers. This kind of information can also help companies launch new business models that create and capture value in ways brand new to healthcare.

One critical factor, however, is the recent evolution of consumer access to their own information. Regulation and technology are forcing the inevitable release of data out of closed ecosystems into an environment where consumers control their data and share it with whomever they choose, whenever they want. For example, earlier this year, The Centers for Medicare & Medicaid Services proposed rules dramatically increasing consumer access to their own data – requiring that healthcare organizations provide health data to consumers in a machine-readable format they can push to an app of their choice – for free. Apple, as just one example, is enabling consumers to aggregate their activity, biometric, and consumption data and share it with others. Legislation beyond the US (for example, The General Data Protection Regulation – a European Union framework driving Europe's digital privacy legislation) looks increasingly likely to make its way over to the United States from abroad over time.

Our potential to link physical, digital, and social assets to paint more holistic pictures of individuals' behaviors and habits is rich, vast, and must be executed with purpose. As healthcare's explosion presses onwards, here's (on the facing page) how to leverage opportunities amidst the clearing smoke.

## COMPELLING CONSUMER VALUE PROPOSITIONS WILL FUEL THE DATA EXPLOSION FIRE

As consumers take ownership of their data, there will be seismic shifts in strategic control for healthcare businesses. Companies with compelling consumer value propositions – those that are experiential, monetary, loyalty based, and the like – will earn the right to create innovative economic models for their shareholders and be better positioned to impact healthcare costs and future outcomes.

## KEY TAKEAWAYS

- The next evolution of healthcare's data explosion will be owned by consumers.
- Sixty-three percent of consumers will share personal health data for the best medical care possible.
- Regulation and technology are forcing the inevitable release of data out of closed ecosystems.

## NINE WAYS TO MONETIZE HEALTHCARE'S DATA SHARING BOOM

1. **Connector.** A third party creates a magnetic consumer healthcare platform that connects consumers to services. The platform owner collects rents through sponsorships or other payments from service partners. This could take the form of advertisements, but more likely will come in the form of curated experiences.
2. **Share of Care Stealer.** Providers use a broader view of a consumer's data (including whole-person claims and medical records) to shape relationships, care delivery, and marketing campaigns to capture more of consumers' greater "wallet share". This approach will likely succeed if designed around a compelling consumer experience.
3. **Permissioning "Middleware".** New activities around permissioning are required to access and create value from "consumer owned" healthcare data. Companies that emerge to meet this privacy and permissioning need will likely earn rents as they pass data to third-party apps.
4. **Consumer Data Mart.** Consumers monetize their own data and sell it on the open market to researchers, life sciences companies, marketers, and advertisers, all who pay a fee to consumers for their data. This will not require a compelling consumer experience.
5. **Trojan Horse.** Imagine a cross-payer consumer platform for healthcare engagement owned by an insurance company – that's free for consumers. The platform's compelling consumer experience gathers data through broad touchpoints and uses its unique knowledge to build trust and loyalty, ultimately steering members into personalized recommendations for downstream products and stealing share from the competition, all at zero upfront cost to the consumer. This will require a magnetic consumer experience to engage and keep consumers.
6. **Enabled Risk-Bearing Entity.** Health insurers or at-risk providers incent consumers to share more information with them through discounts, upgraded service, dollars, and the like. Payers and providers use data to better predict risk and better manage consumers' health through behavioral insights they couldn't have gleaned from in-house data alone.
7. **The (Non-Healthcare) Underwriter.** Consumers share their data with life insurance, auto insurance, home insurance, or similar companies that promise better rates for those who share their information. Insurance companies price more appropriately, selecting better risk for life/home/auto insurance products. This will not require a compelling consumer experience.
8. **The Direct-Pay Compelling Experience.** Third parties monetize data-enabled experiences by charging consumers directly for access to their platforms. This will require unique consumer value and a truly magnetic experience.
9. **The "Hopeful Participant".** Payers and risk-bearing providers take a passive approach, participating in consumer data sharing (rather than facing fines, that is) with the ambition that simply enabling consumers to do what they want with data will drive better healthcare outcomes and lower costs. For example, if consumers share data with a third-party well-being app to gain exclusive access to tailored workouts and recipes.



# CEO BRIEFING ROOM

## STRATEGIES FOR SUCCEEDING WITH ARTIFICIAL INTELLIGENCE

**Ash Gupta**

Former President, Global Credit Risk and Information Management, American Express

**Julie Murchinson**

Chief Executive Officer, Health Evolution

**Sam Glick**

Partner, Health & Life Sciences, Oliver Wyman

*EDITOR'S NOTE: Oliver Wyman recently facilitated a Briefing Room discussion with leaders from Health Evolution, American Express, Blue Cross and Blue Shield of Louisiana, and Allina Health at the 2019 Health Evolution Summit in Dana Point, California. During this discussion about how artificial intelligence is transforming healthcare, panelists from both in and out of healthcare shared their views before an audience of payers, providers, and life science chief executive officers to help push technology solutions beyond traditional boundaries. Below is a summary of key takeaways from this panel, as published in a joint report written by Health Evolution and Oliver Wyman.*

**A**fter decades of being considered futuristic, Artificial Intelligence (AI) is getting real in healthcare for customer experience, care management, and cost competencies, among other use cases. Smart payers, providers, and life sciences organizations, in fact, are looking across industries to learn from companies that have already implemented AI to reap impressive results.

To that end, leaders from all sectors of healthcare came together for this year's Briefing Room at the 2019 Health Evolution Summit to discuss how AI is transforming healthcare and to learn from the experience of Ash Gupta, an industry pioneer in transforming traditional analytics to big data and AI.

American Express, for its part, can now process ten billion transactions annually and detect fraudulent claims in under ten milliseconds – a degree of efficiency and precision many in health care are striving to achieve as they integrate AI inside and outside of clinics.

Against the backdrop of three major trends that signal where the industry is headed, nine steps to successful AI in healthcare emerged from the discussion. We'll delve into each as well as address a few key future workforce considerations.

## AI IS CHANGING THE LANDSCAPE

Based on insights shared in the Briefing Room, leaders pointed to three major shifts propelling exponential growth in healthcare's data analysis and processing capabilities.

1. First, the world is producing more (and much better) data than ever before. Over two trillion gigabytes of healthcare data are anticipated to be produced in 2020 alone, and this rate will continue to increase as healthcare data is projected<sup>30</sup> to have a compounding annual growth rate of 36 percent into 2025.



### Key Briefing Room Takeaway

Rapid change is sweeping the industry, led in part by AI's transformative impact. CEOs who embrace that change now, encouraging employees to be innovative and adventurous with data and analytics, can create meaningful partnerships that will lead healthcare's future.

2. AI-based source algorithms and cloud-based data lakes allow healthcare and other players to analyze data in ways previously unimaginable. Leaders pointed to how at American Express, for instance, queries once taking 120 days to complete now take 10 minutes or less. Quarterly endeavors have become daily tasks.
3. The third major shift is that more quantitative scholars (like mathematicians) opt to go into the private sector instead of academia; a reported<sup>31</sup> one in two university-hired scientists leave academia after only five years. People are entering fields that didn't even exist a few years ago—like AI and computational science.

## STRATEGIES FOR AI SUCCESS IN HEALTHCARE

1. **Embed big data and AI into your company's DNA.** Success requires executives to develop an informed understanding of AI and big data like they know their customers, products, and profit and loss statements. Moreover, managing a dynamic strategy requires healthcare leaders to understand the possibilities and limitations of technology underpinning future transformation.

Gupta shared that in order to understand the AI landscape, top executives in his team traveled to different parts of the world to interact with technology startups. "For two days, we would listen to see what types of problems they were trying to solve and how our use cases related to them," added Gupta. "We learned many things while touring the world, including: how new data sources like mobile, IP addresses, and bank statements might increase our informed understanding of customer need; how offline and online matching algorithms provide a 360° customer view to provide multi-channel marketing; how to build best-in-class data lakes and AI-based models while optimizing computing capacity; and how to turn analytics into production with minimal lag time." Healthcare CEOs agreed that in the future, they will likely be part of the problem-solving exercise rather than merely delegate this to information technology or analytics experts.

2. **Invest in talent.** Data transformation does not require hiring an entirely new workforce. Gupta believes 85 percent of employees working on data and analytics can be trained to build and leverage new techniques. However, for 15 percent, the right programs had to be established to ensure we recruited people "born" on big data and AI as catalytic agents of change. We need to create mechanisms as well, so people can reach cruising speed quickly. Leaders agreed that high turnover rates are not just a healthcare problem, and discussed that even Facebook employees leave after an average of two years. Why? According to Facebook's Human Resources team, their employees reported<sup>32</sup> it wasn't because of bad bosses, but bad jobs.

For Steve Udvarhelyi, MD, President & CEO at Blue Cross and Blue Shield of Louisiana, the transition to big data is more of a talent and organizational effectiveness problem than a technical challenge. "My biggest worry is whether the people running the business have the right questions to ask," he said.

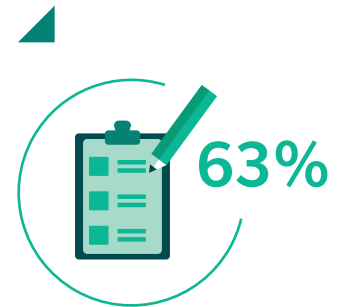
3. **Foster innovation.** Innovation must become a grassroots movement, something that happens from both the top down and bottom up. Employees should feel empowered when

solving problems and encouraged to take risks (and take risks often). Gupta emphasized, “The only weakness in our system is your imagination.” With the advent of cloud, open source AI-based modeling techniques, and vastly available new, cheap talent, it’s possible to analyze and execute on ideas that would historically take long lead times and cost. Plus, the new technology allows you to test and learn, thus rapidly arriving at a best-in-case solution. Three specific solutions are: 1) Evaluating a target list of customers for product upgrades; 2) Analyzing customer complaint data without human bias to improve servicing; 3) Analyzing customer calls to determine impending economic weakness.

4. **Avoid the fear of failure.** Failure is an inherent part of driving innovation. “When I doubted the project, the goal was not to prove them wrong. The goal was to prove myself wrong,” Gupta said of his experience greenlighting projects. In the Briefing Room, progressive healthcare leaders said they are also testing pilots knowing many of them might fail. “If you’re not failing, you’re not innovating enough,” emphasized Ron Williams, Aetna’s former Chairman and CEO.
5. **Implement, test, refine...repeat.** Home runs don’t happen on day one. Initial results are almost always worse than existing practices. A Briefing Room member shared how the first model predicting risk said, “late-stage kidney disease patients are going to be high-cost.” Not exactly revolutionary findings. At American Express, an early predictive model indicated that more line credit should be given to everyone—more line credit, more revenue, it reasoned. However, the algorithm failed to recognize the increased risk. “Leaders must engage business and analytics with the understanding that business knowledge comes first,” said Udvarhelyi. “You need to test and learn so the outcome gets better.”

When faced with high stakes and an aversion to change, algorithms should run in the background and offer suggestions while stakeholders make the final determinations. The first time AI suggests a solution, experts’ decisions will likely be better than those suggested by algorithms. In fact, the best results require collaboration between machines and humans. PathAI – a company looking to automate the time a pathologist spends reading slides – boasts a 2.9 percent error for the algorithm alone (compared to 3.5 percent error for pathologists). When combined with human input, however, the error rate drops to 0.5 percent.

6. **Collaborate.** Briefing Room members agreed healthcare players must continue to develop effective industry consortiums (a la Argonaut and Da Vinci). In finance, competitive entities share information for which IP addresses represent fraudulent accounts and should not be approved for credit cards. Players entering information into the pool benefit from collective common knowledge and network economics pay large dividends. Success requires collaboration and healthcare is rising to the challenge. The Da Vinci and Argonaut projects have enormous potential to turn isolated data into better outcomes and lower costs. Gupta also encouraged collaboration. “You have a lot of data silos you want to

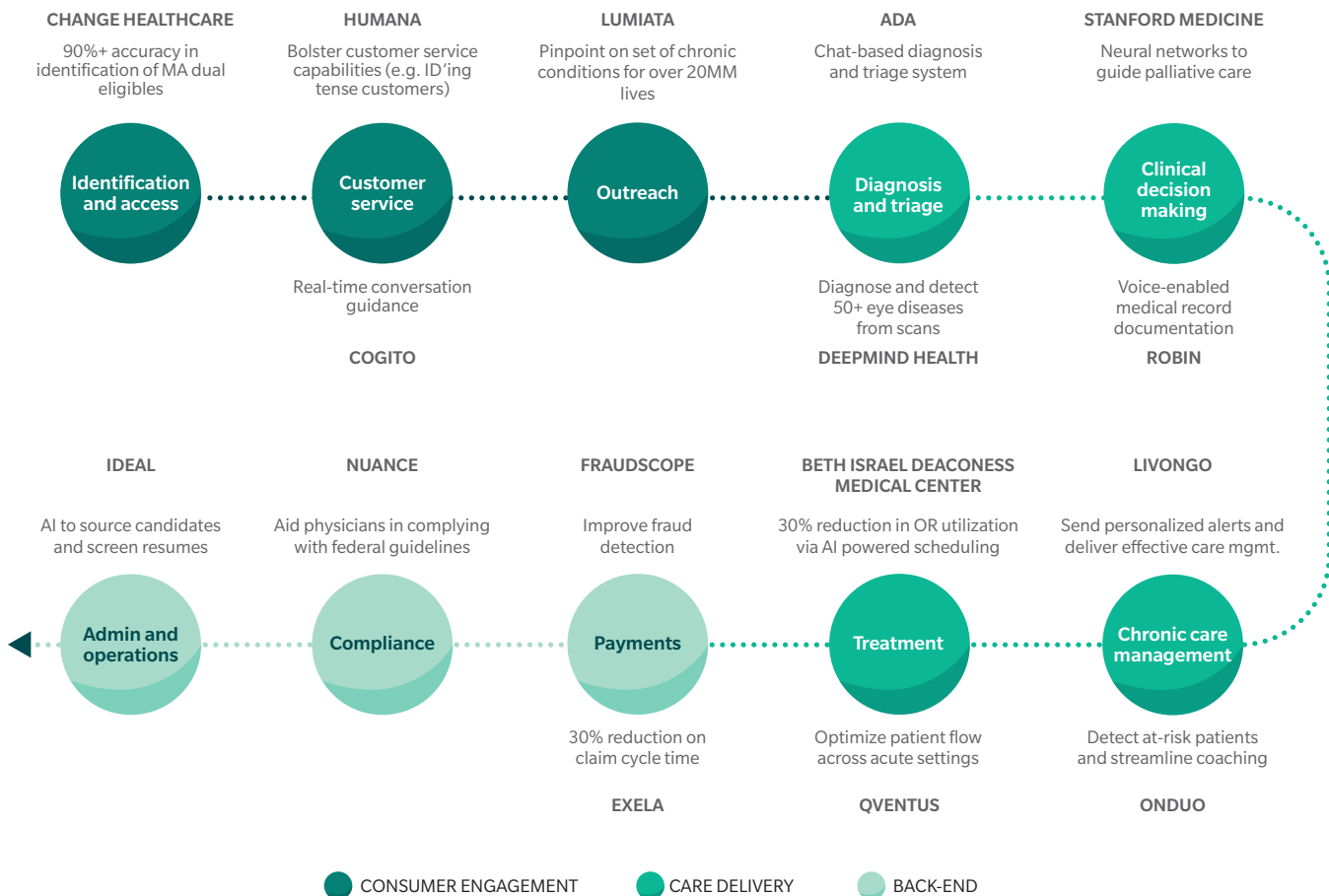


Percentage of consumers who would share more personal health data to improve care.

turn into a cloud-based data lake,” he said. Data should serve as a corporate asset, not the property of each company department, Gupta added. This is the only way to stitch data across disciplines (like marketing, servicing, and risk), across channels (like online and offline), and across businesses and geographies. He emphasized that controls are obviously necessary so use is “permissible” and in customers’ best interests. This way, your data asset becomes clean and free of error and can be leveraged by data scientists and decision-makers rapidly and innovatively. The advent of cloud, hard commodities, and open source has created big data lakes where providing great cost/benefit gain comes at a reasonable price. Looking beyond clinical data, Penny Wheeler, MD, President & CEO at Allina Health, urged members to collaborate on data that goes beyond traditional sources, including social determinants of health. “Electronic medical record data is not enough,” she stressed. Collaboration, of course, does not end at data alone...in fact, it transcends the entire ecosystem, including analytics and execution.”

- 7. **Be transparent.** The infamous Black Box, and its inability to explain algorithm results, occurs across industries. At American Express, every algorithm had to be able to give a plain-English explanation of why decisions were made, shared Gupta. “The adverse effect of an algorithm

**EXHIBIT 1. HOW HEALTHCARE PLAYERS ARE TAPPING INTO ARTIFICIAL INTELLIGENCE AND BIG DATA**





error is much larger in healthcare than in other industries,” said Rod Hochman, President and CEO at Providence St. Joseph. Algorithms must produce transparent answers that can easily be traced and explained. Briefing Room members agreed that healthcare leaders must not create opaqueness in the system.

8. **Keep customers front and center.** Healthcare leaders agreed that they need to consider what matters most to customers as much as possible. As more data is generated and collected, permissible use of data and focus on information security will play a big role. To foster customer trust, Gupta advised leaders to explain how data is being used in a way that is advantageous to their own needs. Ideally, customers should be thankful their data is in your hands.
9. **Use everything you have.** Start yesterday, was one of Gupta’s main takeaways, and healthcare leaders around the room agreed. Innovative players are quickly turning existing data into analysis. Every piece of data collected should be utilized. New hires and existing teams should immediately focus on creating insights. Udvarhelyi said physicians don’t need more data, but they do need more wisdom. “We need to blend business knowledge with analytics now,” he urged.

## PLANNING FOR THE FUTURE WORKFORCE

With so many changes coming on the horizon, healthcare CEOs are already forecasting new workplace needs in the next three to five years.

Seventy percent of healthcare leaders believe data is essential for growth and to improve consumer experience – and 54 percent believe widespread AI adoption is fewer than five years away.

Leaders emphasized how AI is making big waves across the industry. Alphabet’s DeepMind detects gender through eye scans. Mount Sinai’s Icahn Institute trained an algorithm on electronic medical record data to predict the onset of schizophrenia. FDA-approved Lucid Robotic uses AI to detect potential clots in stroke patients. And those are just three examples.

The landscape is changing. Healthcare organizations will need new skill sets to keep pace. Embracing the strategies outlined in this report will lay a strong foundation for the AI-ready workforce of the future.

## KEY TAKEAWAYS

- Thanks to AI, organizations’ quarterly endeavors have now become daily tasks.
- Data transformation does not require hiring an entirely new workforce.
- Innovation must become a grassroots movement that happens from both the top down and bottom up.

# WHAT'S NEXT





# SPECIALTY DRUGS

## A PRESCRIPTION FOR MANAGING RISING COST AND CARE NEEDS

**Marcia Macphearson**

Partner, Health & Life Sciences, Oliver Wyman

**Kara Clark**

Principal, Actuarial, Oliver Wyman

**Deblina Ghosh**

Principal, Health & Life Sciences, Oliver Wyman

**John Rudoy, PhD**

Principal, Health & Life Sciences, Oliver Wyman

In recent years, innovation has vastly increased the number of specialty drugs. There were just 10<sup>33</sup> specialty drugs on the market in 1990 – by 2008 that number had reached 200<sup>34</sup> and stood at 300<sup>35</sup> in 2015. In recent years, more than half of the novel drugs approved by the Food and Drug Administration have been specialty drugs. And more are on the way. Some two-thirds of the pipeline are reportedly specialty. As a class, specialty drugs continue to be expensive, with some new therapies priced at unprecedented levels. For example, a one-dose therapy course of Zolgensma, a recently approved gene therapy for spinal muscular atrophy, will cost up to \$2 million. Meanwhile, specialty drugs have moved beyond cancer and orphan diseases and now target some much more common conditions, like eczema and certain kinds of asthma.





Specialty drugs increasingly constitute a greater share of the nation's prescription drug spend. Specialty spending has reportedly<sup>36</sup> risen \$255 per person since 2009, even as spending on traditional net medications has decreased by more than \$210 per person. Specialty medicines accounted for just under half of per person drug spending in the US last year (\$517 of \$1,044 total), and it's projected they will make up more than half of all US drug spending this year.

## SPECIALTY GROWTH IS HERE TO STAY – LET'S EMBRACE NEW APPROACHES

Specialty drugs offer new hope for a growing portion of the population grappling with difficult conditions. These powerful drugs are some patients' only options, worth the price of life no matter how costly in the short term. While a high-cost specialty drug regimen that cures a chronic patient may be less costly on a long-term basis when compared to ongoing disease treatment, these near-term costs place strains on an already unsustainably expensive healthcare system. Novel approaches are required to navigate the rising tide of specialty drug costs. Traditional tools like formulary placement, prior authorization, and step therapy will still be necessary, but won't be enough to manage utilization of today's very diverse, very targeted, and very expensive specialty medications and the moral population health dilemmas they present.

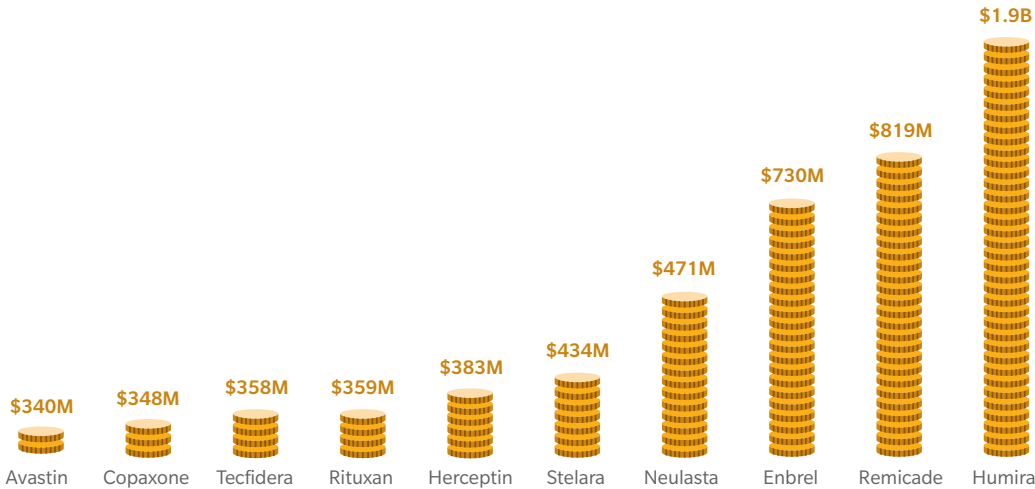
**The cost is concentrated.** The specialty category encompasses a range of high-cost drugs. However, there are standouts, even within this expensive class. Within the nearly 3,500 therapies we classify as specialty, the top 10 drugs make up approximately 25 percent of costs, and the top 50 drugs make up over half of costs. This pharmacy "population cost pyramid" is resonant of the commonly cited medical population cost pyramid where five percent of the population drives 50 percent of the costs. However, this pyramid is driven by a very different profile of conditions and patients now driving these costs. Effectively managing specialty pharmacy requires specific focus on these high-cost drugs – a focus that incorporates purpose-driven management approaches.

## A UNIQUE MANAGEMENT APPROACH

Specialty drugs fall into a wide range of therapeutic classes. For instance, there are maintenance drugs and one-course cures. There are drugs requiring significant management by expert clinicians and those that patients can self-administer with autonomy. There are drugs that offer the only alternative for patients with life threatening conditions, and others part of the armamentarium for conditions already well served.

## EXHIBIT 1. AN UP-CLOSE LOOK AT SPECIALTY DRUGS

### The top 10 most expensive US specialty drugs



#### DID YOU KNOW?

These 10 drugs accounted for \$6 billion in 2017, more than a quarter (28 percent) of specialty drug spend.

Six of these top 10 drugs are oncology drugs.

Source: Marketscan commercial database | Oliver Wyman analysis | #OWHealth

### Specialty drug spend by route of administration

Specialty drugs are administered in different ways. Their routes of administration inform management approaches and the complexity of these efforts.

Oral

32%

Subcutaneous

23%

Intravenous

22%

Other

(includes topical, inhalation, intraocular, and rectal)

14%

Multiple routes

9%

### Specialty drugs by therapeutic class

Although specialty drugs address a range of conditions across different action mechanisms, the most spend clusters across a few therapeutic classes.

Immunosuppressants  
(like Humira, Remicade)

25%

Molecular targeted therapy and other oncology  
(like Herceptin, Rituxan)

15%

Antivirals  
(like Harvonia, Truvada)

9%

Biological response modifiers  
(like Copaxone, Gilenya)

8%

Other

43%

### Specialty drug spend by type of condition addressed

Used primarily for short-term therapies or cures for acute conditions **27%**

Used for both long-term management and as short-term therapies **25%**

Other **4%**



Used primarily for long-term treatment of chronic conditions **44%**

Sorting drugs into these categories requires a drug-by-drug analysis, but the categories outlined in this graphic correlate strongly. The condition type addressed relates to outcome, as those addressing acute conditions are more likely to be curative, while those addressing chronic conditions are more likely to simply manage conditions. Therapeutic class can correlate with the complexity of care pathways; cancer drugs, for example, often require highly sophisticated management.

Source: Oliver Wyman analysis | #OWHealth

When it comes to managing specialty drugs' outcomes and costs, traditional approaches typically orient around therapeutic classes, which makes sense. However, another way to ensure the appropriate management approach is to align it around a combination of outcomes the drug therapy seeks to achieve and the complexity of the overall patient-care pathways. From this lens, there are three major categories to consider:

### 1. HIGH-COST, ONE-COURSE CURES

This archetype contains drugs that are extremely high-cost, one-course cures for complex conditions. Examples are Zolgensma, which treats spinal muscular dystrophy, and Harvoni, the Hepatitis C cure. These drugs also present some of the greatest moral dilemmas, as just a few patients receiving these treatments can drastically impact self-funded employer group or health plan costs – ultimately leading to increases in healthcare costs and premiums for all. Payers, providers, and manufacturers must closely collaborate to ensure these drugs are the most appropriate and best course of action for patients weighing both short- and long-term impacts. Balancing the application of a new curative therapy approach versus the continued use of a condition management therapy approach can be a difficult decision requiring deep clinical and population health expertise. With the rise of these types of curative regimens expected, additional focus, processes, and skills will be needed to navigate the issues around formulary coverage, pricing, and clinical approvals.

### 2. CHRONIC CONDITION MANAGEMENT

A second category consists of drugs used regularly over a long period of time to manage chronic conditions (and sometimes effectively cure them over an extended period). Effective engagement between patients and providers is critical for these drugs. Patient adherence ensures the drugs' benefits are realized. Even more critical? A highly coordinated patient care approach, as these drugs may require that a patient, for example, adhere to a strict diet, take a course of other medications to manage additional conditions or side effects, and faithfully report progress back to their physician. This calls for a synchronized approach to managing the patient's care across medical, behavioral, and pharmacy care aspects – something a focus on reducing specialty drug costs alone will miss. Value-based health models that align providers with total cost and care outcomes are appropriate tools for this category. It's also critical administration occurs at the appropriate place, that patients have accessibility to their overall drug regimen, and that patients' social determinants of health are taken into account.

### 3. ACUTE CONDITION MANAGEMENT

A third category includes drugs used as needed for the episodic management of an acute condition such as cancer. These drugs are complex to manage. They generally must be administered on-site and are often tangled with moral and ethical considerations around patient preferences, quality of life, and life extension. Traditional management techniques, like prior authorization, are certainly necessary but unlikely to have a significant effect on spending unless applied before the patient begins a course of treatment. Managing these drugs requires



a holistic approach where clinicians are engaged, and therefore more likely to follow the right care pathways to effectively manage side effects, attend to patients' full set of health needs, and transition therapies as appropriate, including intensive patient and caregiver support to help navigate difficult health and lifestyle decisions.

## OUR CALL TO LEADERS: INTEGRATE MORE WITHIN THESE THREE CATEGORIES

Managing the first drug category requires a predictable set of levers, ensuring patients are truly good candidates for the drugs they're prescribed, carefully setting dosing and course, and delivering drugs in the most effective setting (which can be at times in the home). The second category of drugs requires more complex management, integrating careful monitoring of the drug itself with numerous other healthcare and broader lifestyle facets necessary to ensure the drug accomplishes its goals and that adverse outcomes are avoided. The third category of drugs requires especially tight payer-provider communication to ensure the right therapies are applied and managed in the context of patients' other health needs. Ultimately, all three categories require a more integrated approach to care and costs – something that's historically been managed in a more siloed way within most payer organizations.

Today's (and tomorrow's) specialty drugs represent a massive opportunity to better serve patients. But they also pose serious risks to individual payer and self-funded employer group economics, and the healthcare system at large if pricing strategies and cost management aren't effectively navigated. They require a more active, specified, and integrated approach to both medical and specialty-drug management, one that requires purpose-built approaches incorporating provider partners, close collaboration with members/patients, and engagement in alternative reimbursement approaches alongside typical utilization management techniques. The goal is nothing short of ensuring that the remarkable achievements of medical science benefit patients – without destroying the healthcare system that serves them along the way.

## KEY TAKEAWAYS

- Traditional tools are effective as is, but aren't enough to manage utilization of specialty medications.
- Specialty drugs represent an opportunity to better serve patients, but also pose serious risks.
- Future management approaches must align around drug therapy outcomes and complex care pathways.



# NOT YOUR GRANDMA'S MEDICARE

## INNOVATING IN MEDICARE ADVANTAGE

**Melinda Durr**

Partner, Health & Life Sciences, Oliver Wyman

**Dan Shellenbarger**

Partner, Health & Life Sciences, Oliver Wyman

**Deblina Ghosh**

Principal, Health & Life Sciences, Oliver Wyman

**B**y the time you finish reading this article, another 30 Baby Boomers will have turned<sup>37</sup> 65 years old, aging in to Medicare. The “Silver Tsunami” is upon us. But don't try to put all Boomers in a one-size-fits-all box. Boomers currently range from 55 to 75 years old and are a more diverse generation in terms of their experiences, expectations, and attitudes – particularly when it comes to matters of health. Plus, they're the first generation to enter their Medicare years equipped with technology, tools, and information regarding their health and care options. They bring their experiences of having cared for the prior generation (some, in fact, are still caring for their parents).

However, Boomers also bring with them healthcare needs that are perhaps higher relative to past generations' needs. They're more likely to deal with obesity, and sixty percent<sup>38</sup> of Boomers have already been diagnosed with more than one chronic condition like arthritis, diabetes, heart disease, or osteoporosis. And, they're already on more medications and require more dietary interventions than past generations<sup>39</sup> – adding operational and financial stress to the US healthcare system.

Seeking beacons of hope, Medicare Advantage plans stand apart as a path to align this growing senior population with a reconstituted healthcare ecosystem. While there are proven models in operation nationwide, they still only reach a fraction of this market. Therefore, it will be critical that health plans, providers, and innovators continue to push the envelope if they are to meet the expanded demands of this new generation of seniors and their more complex medical needs.

There's an incredible opportunity to dramatically impact the future of this generation, but it rests on the notion of collapsing older, siloed models.

## MEDICARE ADVANTAGE'S RECENT STRATEGIC MAKEOVER

With 10,000 new Medicare-eligible beneficiaries per day – nearly 3.5 million per year – Medicare Advantage represents a very rare opportunity for new membership growth. Adoption of Medicare Advantage plans by seniors has picked up considerably<sup>40</sup> in the past decade, growing from 24 percent of the Medicare-eligible population in 2010 to 34 percent in 2019. With spending hovering somewhere near \$10,000 per member per year, and payments on the rise (3.4 percent for 2019<sup>41</sup> and 2.5 percent for 2020<sup>42</sup>), the rush is on to build products and solutions for this segment. (And, this is to say nothing of the possibilities that might arise from more accurate risk coding and improved Medicare Advantage Star performance.)

Yet, historically, Medicare Advantage strategies have not sought to fundamentally transform care or create differentiated, senior-focused networks and care models. Instead, most plans sought success by making small changes to underlying benefits and provider incentives and applying other managed care tools. However, as payers and providers have realized Medicare Advantage's growth, profit, and mission-fulfilling potential, competition has greatly intensified. This all suggests the days of simple "me, too" product offerings that lack purpose-built capabilities may soon be ending soon.

Fast-forward to now when we see many examples of payers and providers driving innovation in different geographic markets nationwide, with specific and very intentional strategies focused on winning the Medicare Advantage gold rush. Recognizing both the clinical and administrative complexities of serving this population, payers and providers are more frequently collaborating more to align incentives and deploy purpose-built care models.

Two prominent approaches are bringing this innovation to local markets:

- **Plan-led.** A networked health plan has created aligned incentives with its provider partners to drive much improved clinical management. The plan is aligning its network towards high-performing provider partners who have incentives tied to member success measures (like quality, outcomes, and cost). This model is founded upon integrated delivery systems that have deployed patient-centered medical homes, along with other provider partnerships that innovate through risk-based payment arrangements and customized product sets.
- **Provider-led.** There's a growing number of provider-led Medicare Advantage solutions where providers integrate tightly with health plans (or build their own), and then build focused care models to envelope the full patient journey – from needs identification to holistic management, thus sparking higher patient engagement levels. These plans are driving higher Star ratings, more patient satisfaction, and increased professional satisfaction for providers.

Inherent to all Medicare Advantage models is an intense focus on data, analytics, and technology that (1) creates greater insights around where and how to support members/patients on their journey; and (2) enables clarity as to who will engage these patients at varying points along that journey. Data and insights are only valuable when closely tethered to an integrated team and population-focused care model.

## EXHIBIT 1. INNOVATION FOR SURVIVAL

A Redesigned Model to Engage Populations, Align Provider Incentives, and Spark Profitability and Innovation

PROVIDER INNOVATIONS	PAYER INNOVATIONS
Needs-based primary care models that allow the care team – physicians, advanced practice providers, nurses, and assistants – to have deeply engaging interactions, in-person or virtually	Continued benefit innovation, including supplemental benefits (such as meals, transportation, and over-the-counter prescriptions) and value-based insurance design (like differential co-pays for select network participants)
Implementation of a “team-based care model” where the team constantly (re)aligns itself based on patient and staff need	Developing purpose-built Medicare Advantage networks that motivate and reward providers for managing Medicare Advantage members’ care
Continuous focus on key measures – like engagement, experience, clinical outcomes, coding, and financial results – to support risk adjustment, Stars performance, and patient value	Engagement programs that complement provider efforts to identify and close gaps in care
Focus on helping patients achieve their health goals through ongoing engagement, monitoring, and compliance	Embracing the notion that innovation is a team sport, which can come from anywhere, at anytime

Source: Oliver Wyman Health | #OWHealth

## HOW PAYERS AND PROVIDERS WILL EMERGE VICTORIOUS

Looking ahead, winning in the Medicare Advantage marketplace will require payers and providers to collaborate more closely on strategies, and then closely integrate operations and support models across the member/patient journey. Both are a departure from the norm. Rendering holistic, proactive care doesn’t easily fit inside a traditional fee-for-service model. Enabling proactive intervention requires data and analytics that many payers either don’t possess or haven’t traditionally shared with their provider partners. The resulting models will be far more impactful and will eliminate many of consumers’ current hassles. This will be a welcome departure from the status quo. And those payers and providers that drive these innovations stand to create immense value – not just for the health ecosystem, but for the communities they serve. Tomorrow’s winners will emerge victorious from models wherein benefits and care delivery become a singular idea focused on consumer value.

## KEY TAKEAWAYS

- Medicare Advantage represents a rare opportunity for both membership growth and massive value creation.
- The days of simple “me, too” product offerings that lack purpose-built capabilities may be ending soon.
- Models bringing about tighter payer and provider collaboration have shown superior results, and are in the stages of early proliferation.



# THREE WAYS COMPANIES CAN CLOSE THE GENDER GAP IN HEALTHCARE LEADERSHIP

## Terry Stone

Managing Partner, Health & Life Sciences, and Global Chair for Inclusion & Diversity, Oliver Wyman

**H**ealthcare is one of the only industries where women have surpassed men both in terms of their influence as consumers and their share of the workforce. In the United States, women consumers make 80 percent<sup>43</sup> of the healthcare decisions for their families. Women also make up more than 65 percent<sup>44</sup> of the hospital workforce, a higher share than many other industries such as financial services – where women constitute 46 percent<sup>45</sup> of the workforce – and technology – where they make up only 26 percent.<sup>46</sup>

But despite this, women are under-represented in leadership roles and it takes women longer to get to top positions. Women account for only a third of executive teams and just 13 percent of chief executive officers in the healthcare industry. Furthermore, our research showed it can take women on average three to five years longer to reach the chief executive officer position – if at all.

When women are in leadership positions in healthcare, they help companies improve their bottom lines in two key ways. First, companies become more consumer-oriented more quickly when more members of their leadership team reflect and relate to more of their employees and customers. BlueCare Tennessee for instance, led by Amber Cambron and a team that's well over 50 percent female, has received national recognition<sup>47</sup> for its ability to help its members live in their preferred setting and stay connected via text-based communication to their families and communities. Studies have also shown that diversity in companies across industries makes teams question their default assumptions<sup>48</sup> in a way that produces more innovation,<sup>49</sup> increases productivity,<sup>50</sup> and ultimately creates better financial outcomes.<sup>51</sup>

## SO, WHY AREN'T WOMEN MOVING UP IN HEALTHCARE?

To discover why so few women in healthcare reach the top and better understand the visible and invisible dynamics at play, Oliver Wyman analyzed the profiles of more than 3,000 healthcare executives at 134 US-based payers and providers, which account for more than 70 percent of the market based on revenue. We also examined the paths of 112 healthcare payer and provider chief executive officers to follow the route to leadership in traditional healthcare organizations. And, we spoke with over 75 men and women in healthcare, from directors to chief executive officers.

We found many organizations are well-aware of commonly cited obstacles such as gender pay gaps, the uneven burden on women due to more obligations at home, dynamics like “the imposter syndrome”, and unconscious bias. Many companies have also already invested in hiring inclusion and diversity executives – in fact, 70 percent of organizations in our study had received some type of inclusion and diversity award.

Yet despite investments (that have the best of intentions) in inclusion and diversity, the industry has still struggled to achieve gender parity at the top. Why? Based on our research, we found the main impediments appear to be hidden influences and implicit assumptions. For instance, there's a general lack of awareness for how trust is formed and how that influences key decisions such as who to promote or hire into very senior roles. This lack of awareness is not limited to any one gender. Men and women also have different perceptions and assumptions of what makes a good leader. These beliefs likely stem from how many have been socialized and culturally influenced throughout their lives, long before they even get close to the C-suite.

That said, there are female and male leaders and organizations who have managed to overcome these hidden obstacles, often with the help of key sponsors. Based on insights from them and many others, we have identified three key ways companies can close the gender gap in healthcare leadership. In the next two pages, we examine each.



## 1. FIND WAYS FOR WOMEN TO MAKE CONNECTIONS AND FORGE RELATIONSHIPS.

Trust is key to getting promoted to the most senior ranks. Essentially, the chief executive officer or others in the C-suite need to trust that someone is “right for the job.” Yet, most leaders don’t fully understand how trust-based promotion decisions are made. When we asked executives how they evaluated someone for a senior leadership position, respondents identified “ability” and “integrity” as key components of building trust.

However, trust also has an important third, often overlooked, dimension: “affinity.” As studies such as one in *The Academy of Management Review*<sup>52</sup> describe, people trust those they can empathize with or are personally invested in.

Companies hoping to create a more inclusive leadership team must raise awareness of the role affinity plays in building trust and evaluating candidates for promotions. When executives understand affinity’s role, they can proactively help foster it in situations where it doesn’t spontaneously occur as easily or quickly. Universally, those we spoke with who’d “made it,” stressed the importance of a sponsor helping them navigate who they should get to know better and how to create opportunities to build these relationships. As one female chief executive officer we interviewed put it, “I thought everyone was getting things because of hard work, and then realized that is not how it happens. I saw my boss building personal relationships. As you move up into more senior roles, personal relationships are more important.”

Being purposeful is critical. Women we interviewed, for instance, said they typically have fewer opportunities to create this affinity by connecting with men in

informal, non-work settings after hours or on weekends. Furthermore, the traditional places where affinity develops may not attract women. As one female chief executive officer we interviewed described, “When you’re looking at how people network or forge relationships, there’s a huge problem. Most of these activities are aligned with typical male interests – golfing and cigar bars. But it’s in those settings that trust is established. It’s having a bigger impact than people think.”

To remedy this issue, companies must be more creative in designing inclusive events to accelerate the rate of personal connection between all employees. For example, instead of a baseball game or happy hour at the local bar, companies can enlist employees in an ongoing community service project like mentoring high school students weekly or helping a local non-profit raise money. Whatever activity a company chooses, the goal is to find a non-work activity where employees can engage with those in the company with whom they don’t already have a personal relationship. These events should be an inclusive alternative to networking events that tend be more favorable of men’s interests and schedules than women’s. These events must also work on a collective goal to foster rapport and equalize the playing field in hierarchical organizations.

Companies can also educate their senior women on the importance of sponsorship to help them navigate their careers. One study<sup>53</sup> found women value guidance less and would pay \$197 monthly for advice, versus men who would pay \$289. It takes an active experience with sponsorship to appreciate its impact. Companies should also require senior executives and C-suite leaders to assign accountable sponsors for high potential women.

## 2. DEVELOP A MORE EXPLICIT SET OF LEADERSHIP CRITERIA, COMPETENCIES, AND INTERNAL LEADERSHIP DEVELOPMENT.

Misinterpretation of what’s considered effective leadership plays a larger role than most executives recognize in evaluating a person’s potential. When we asked C-suite executives to define leadership, people said a leader must drive results and have a strategic, senior leadership presence.

Strategic skills, however, are either too narrowly defined and traditionally exclusive of women, or lack leadership acumen. For example, when we traced the backgrounds of 112 payer and provider chief executive officers, we found 86 percent had prior profit-and-loss experience, yet men are three times more likely to fill such positions.

Senior executives need to recognize this reality when comparing candidates and either consider a wider range of experiences or more explicitly place high potential candidates in these roles. The chief executive officers we interviewed from organizations where women held at least 40 percent of C-suite positions took the former path, prioritizing ability and potential above a perfect resume of past experiences.

In terms of what drives results, our interviews found men and women evaluate competency differently. For instance, we found women think job candidates should check all the boxes – but men disagree. This becomes an issue when women take themselves out of the running for roles their backgrounds don't perfectly align with. Here too, sponsors can make a huge difference. As one female senior vice president said, "Without sponsors, I would have fallen into the trap of, 'I don't know anything about medical plans,' and not have taken over the product area. Men think you just need to surround yourself with the right people and don't need to be an expert."

### 3. IDENTIFY HOW MEN AND WOMEN LEAD AND COMMUNICATE DIFFERENTLY.

Part of developing a common set of explicit leadership criteria involves uncovering the implicit ways different genders think teams should be led. In our research, we found senior women often favor a more collaborative approach, but that can lead to a lack of clarity about the leader's role in the results. As one senior director we interviewed explained, "A manager in a review told me, 'You need to find your leadership voice.' Had he not said that, I wouldn't be where I am today. I don't think women are aware leadership's an issue. They think they're doing right by letting the team present information."

In addition, our research showed many women initially build their credibility as problem solvers, but this then causes them to be pigeonholed and limits their ability to lead and develop a broad strategy. As one female vice president we interviewed put it, "It's not enough to just deliver. You need to bring ideas, insights and strategy. Execution alone does not get you there."

Leaders also need to be more purposeful developing the high number of women they already have in lower and middle ranks, particularly as companies in healthcare promote in such large numbers from within. In our research, 63 percent of the 112 payer-and-provider chief executive officers we analyzed were promoted from within. Yet since there are a limited number of senior executive positions in any given company, executives need to be more explicit about leadership criteria and plan ahead to develop high-potential female candidates so they are competitive for promotion opportunities. If companies look to hire from outside, it's more challenging to find female candidates. Healthcare is regional, so new talent comes from other geographies. Moving is more challenging for women because female executives are more often part of a dual-career household. A Harvard Business School study<sup>54</sup> found 60 percent of male executives' spouses did not work full-time outside of the home compared to 10 percent of female executives.

Not only do men and women build and evaluate leadership styles differently – they also communicate differently and react differently to leaders with contrasting communication styles. As research has shown,<sup>55</sup> women are more likely to interject with small acknowledgements to show active listening. Men tend to find this disruptive, whereas women think men aren't listening if they **don't** do this. By contrast, men are reportedly<sup>56</sup> twice as likely than women to interrupt a speaker, and three times more likely to interrupt a woman than a man.

The communication burden falls on women – it's commonly women who adapt their leadership and communication style to that of men, not the other way around. If companies want a better balance at the top, they need to help all employees get a better understanding of each other's leadership and communication styles and collectively understand destructive behaviors they are unaware of.

## THE PATH FORWARD

While the challenges are real, companies are increasingly committed to balancing the ranks of senior leadership in healthcare. But announcing your commitment is not enough, and simply adding women to leadership teams to meet a quota won't bring about real results. To change the composition of C-suites, companies should explicitly address misperceptions and hidden biases that impact promotion and embed diversity goals within the daily discussions of strategic objectives.

## KEY TAKEAWAYS

- Women make 80 percent of family healthcare decisions yet are only 13 percent of healthcare's CEOs.
- Hidden, subtle influences and implicit bias – “affinity” – affect senior-level leadership promotions.
- Many women initially build their credibility as problem solvers, which ultimately pigeonholes them.



# THE HEALTHCARE LEADER OF THE FUTURE

BUILDING FOUR DESIGN ZONES  
FOR COMPANY TRANSFORMATION

**Simon Holland**

Partner, Organizational Effectiveness, Oliver Wyman

**Helen Leis**

Partner, Health & Life Sciences, Oliver Wyman

Finding a show that my whole family enjoys is no easy feat. I love heartwarming tales where heroes overcome challenges (*Outlander*, minus the violence). My husband loves dark, ironic dramas (*Breaking Bad*, anyone?), and my kids love cartoons, mostly mindless ones. So, we were thrilled when we stumbled across *Grand Designs*, a British home renovation show featuring people who restore older buildings and transform them into the homes of their dreams. All of us love it. We especially love the “before” and “after” aspect, and seeing how people choose to protect or preserve certain elements of the original building, creating something new and purpose-built for their family. We suddenly fell in love with the idea of renovation. Then we lived through our own.

Both Simon and I independently undertook pretty ambitious home renovation projects over the past year, and in parallel worked closely with payer and provider clients striving to transform their businesses and create something purpose-built for a new set of needs – while protecting and preserving what was important from the legacy business. We were struck by the parallels.

It’s not easy to seamlessly incorporate new building materials, new plumbing, and new technology into old buildings. But this must be achieved if you want your dream home manifested.

We talk to many chief executive officers who have the same dilemma when trying to deliver their own “grand designs.” How do they make the very best use of what they have now while ensuring they’re up-to-date with the latest innovation? It’s easy for healthcare leaders to get caught between risk and return, often bounded by the need to deliver on operational metrics. Why risk changing the status quo – or, worse, spend already limited dollars on something unproven? The pace of disruption is hard to predict, and it’s difficult to extrapolate the future from the past when it comes to innovation. As a result, most organizations tend to avoid doing anything for a while, choosing to wait it out. Afterward, though, they may be forced to take big, risky actions that come too late.

To thrive during this volatility and create resilient organizations, healthcare leaders need to create new “grand designs.” Thinking about innovation like you’re building a home – which is both a challenging and opportunistic undertaking – can help leaders identify the new mindset, skills, and priorities needed to prepare an organization to seize tomorrow’s opportunities.

Consider the following four design zones, inspired by Geoffrey A. Moore’s book, *Zone to Win: Organizing to Compete in an Age of Disruption*.

# BLUEPRINT FOR LEADERSHIP SUCCESS

## FOUR DESIGN ZONES

The “grand design” for this new home has four major areas, which we’ll call zones:



### 1. Performance Zone

The focus here is on enhancing the current business. Improvements are targeted at driving revenue growth, consistent with how the business delivers services and operates today. Leaders are delivering revenue and margin commitments. They’re continually asking:

*“Are we onboarding capabilities quickly enough to neutralize evolving market and stakeholder demands?”*



### 2. Productivity Zone

The focus here is on the core business and how to make the organization more efficient today. Efforts are targeted at minimizing resources required to sustain today’s businesses or gracefully retire them to free up resources. Leaders are trying to optimize for efficiency, effectiveness, and compliance. They’re asking:

*“Are we liberating management attention and resources to fund the future?”*



### 3. Incubation Zone

Here, leaders are planting the seeds of change. And they’re spending time and money on experiments with significant risk that can potentially transform the types of services they provide to clients, how they provide them, and how the organization operates. Leaders are looking to accelerate and de-risk disruptive options. They’re continually asking:

*“Do we have a balanced portfolio of bets linked to our mission and ambition that’s in line with trends?”*



### 4. Transformation Zone

Leaders are reinventing and disrupting their core business and value proposition. Efforts in this zone have been de-risked, but not yet scaled. Leaders are introducing new ways of serving clients and fundamentally changing how organizations operate. Here they seek to scale disruptive options to materiality. They’re continually asking:

*“Have we set the right conditions for moving to materiality?”*

Source: Moore, Geoffrey A. “Zone to Win: Organizing to Compete in an Age of Disruption.” 2015.

## BUILDING INNOVATION FROM THE GROUND UP

Building on Geoffrey Moore's four-part framework, here are some targets of ways to allocate management time, attention, and energy, and some examples of successful healthcare initiatives within each zone.

1. **Performance Zone (Target: ~ 40 percent)** – Most leaders tackle performance management by focusing on profitability. It may be about protecting market share in key product areas like Medicare Advantage or clinical service lines, or improving medical cost management for specific populations. They're also addressing growth and positioning – to ensure the right consumers are targeted with the right message and the right product offering. Likewise, they want to optimize the credential and referral processes. In some cases, that involves monetizing services to the marketplace – for example, when medical directors who monitor the effectiveness of drugs use that capability to advise employers on formularies.
2. **Productivity Zone (Target: ~ 30 percent)** – Since efficacy and efficiency is the main play here, leaders in the immediate term use medical management to drive costs in a meaningful way. Longer term, they're using game-changing capabilities (like artificial intelligence) to reduce prior authorization or enhance throughput of radiology. Productivity enhancement requires a relentless eye on what's driving cost and how it can be brought down. At the same time, it means every player is performing the highest value tasks they're most qualified to do with an eye towards patients seeing the appropriate clinician in the most suitable medical facility at the right time.
3. **Incubation Zone (Target: ~ 20 percent)** – As an example of successful incubation, a regional health insurer partnered with a large media telecom company to launch a joint venture at the intersection of their industries. The new company connects consumers and providers on a specific care path. Imagine longitudinal care in the home where all members of the family and care team can communicate, where technology in the home monitors people's conditions and provides prompts when medical emergencies are imminent, and where patients are empowered and informed to manage their conditions at home.
4. **Transformation Zone (Target: ~ 10 percent)** – An example of companies embracing transformation includes payers who retool their network to focus on low-cost access. Another instance is a large regional health plan redefining its insurance product by contemplating multiyear subscriptions, freeing them to invest in population health programs that don't necessarily yield in-year returns.

When leaders face disruption on so many fronts, understandably many default to spending all their time and resources in the “performance” and “productivity” zones. These two zones are critically important because they make an organization better. But leaders who only spend time in those areas miss the vital innovation and potential new business opportunities found in the “incubation” and “transformation” zones.

To deliver their new “grand designs,” leaders need to rebalance and allocate the appropriate level of energy, attention, and financial investment to build a portfolio across all four zones and create a resilient organization that can nimbly respond to future challenges and opportunities.

Of course, with this all being a little new, healthcare executives must excel in multiple zones by developing different competencies and redesigning metrics to measure success.

**EXHIBIT 1: A ROADMAP FOR SUCCESS: BREAKING DOWN THE FOUR ZONES**

	"MAKE NEW"		"MAKE BETTER"	
	INCUBATION ZONE	TRANSFORMATION ZONE	PERFORMANCE ZONE	PRODUCTIVITY ZONE
<b>Leadership Style</b>	<ul style="list-style-type: none"> <li>Disciplined entrepreneur</li> <li>Innovator</li> </ul>	<ul style="list-style-type: none"> <li>Business-builder</li> <li>Deployer</li> </ul>	<ul style="list-style-type: none"> <li>General Manager</li> <li>Operator</li> </ul>	<ul style="list-style-type: none"> <li>Shared service leader</li> <li>Optimizer</li> </ul>
<b>Leadership "Superpowers"</b>	<ul style="list-style-type: none"> <li>Cross-functional players with a discipline "spike"</li> <li>High-risk and ambiguity tolerance</li> </ul>	<ul style="list-style-type: none"> <li>Flexible and focused</li> <li>Highly specialized with orientation to team success</li> </ul>	<ul style="list-style-type: none"> <li>Functional or product</li> <li>Low-risk propensity</li> </ul>	<ul style="list-style-type: none"> <li>High degree of service-level accountability</li> <li>Deep functional expertise</li> </ul>
<b>Workforce Models</b>	<ul style="list-style-type: none"> <li>"Pods"</li> <li>Open "studios"</li> </ul>	<ul style="list-style-type: none"> <li>Transformation hub for new capabilities; integrated business unit for new revenue</li> </ul>	<ul style="list-style-type: none"> <li>Organization tuned to "business as usual"</li> </ul>	<ul style="list-style-type: none"> <li>Organization tuned to fund the future</li> </ul>
<b>Metrics to Measure Success in this Zone</b>	<ul style="list-style-type: none"> <li>Learning-cycle time</li> <li>Customer and stakeholder validation</li> </ul>	<ul style="list-style-type: none"> <li>Time-to-impact</li> <li>Share of target segment; scalability of a future capability</li> </ul>	<ul style="list-style-type: none"> <li>Current stakeholder expectations (revenue, profit)</li> </ul>	<ul style="list-style-type: none"> <li>Cost reduction</li> <li>Cycle-time improvement</li> </ul>

Source: Moore, Geoffrey A. "Zone to Win: Organizing to Compete in an Age of Disruption." 2015.

## FIVE WAYS TO GET STARTED BUILDING YOUR OWN "GRAND DESIGN"

- 1. Start early and take small bites towards the future business.** To lead across the four zones and build the organizational muscles for this new mindset requires time and resources to change an organization’s operational model, behaviors, and ways of working. It’s a long journey, one that requires significant resources. Starting sooner in a small way is better than delaying completely because of cost.
- 2. Embrace leadership as a team sport.** Change, neither quick nor easy, involves thinking about leadership in completely new ways. This means letting go of the traditional command-and-control structure and shifting towards developing strategies for leading multidisciplinary teams that may include both company employees and a more dispersed workforce that contributes through crowdsourcing and other open platforms.
- 3. Rethink promotion and succession.** So many healthcare executives rise through the ranks as specialists. Actuaries become executive vice presidents of products or even chief executive officers of insurance companies because that specialty was critical to the success of the business. Other chief executive officers come from backgrounds in government regulations at companies where they need to woo regulators. In hospitals, chief executive officers are often medical doctors first. Healthcare leaders can take a page from other



industries like retail or consumer packaged goods, where the chief executive officer rotates through several functions from branding to marketing to manufacturing, then runs a profit-and-loss unit before ultimately leading a company. Leadership training in healthcare should become broader to develop skills across various functions. Design management teams to include a diverse array of executive backgrounds.

4. **Consider new C-suite roles.** A stand-alone chief data, analytics officer, or head of innovation can help companies think across our four zones as they drive technological advances, explore and implement new technologies, and upskill the workforce as technologies like artificial intelligence, robotic process automation, and virtual care become more prevalent.
5. **Incorporate empathy-based design thinking training throughout the organization.** Healthcare continues to become more consumer-centric as consumers increasingly make more decisions about their own healthcare, from choosing providers and health plans, to Googling their symptoms, to seeing a doctor at their local drugstore rather than at their primary care provider. Empathy-based, design thinking at all levels can help organizations embrace this consumer-first mentality.

With this roadmap in place, you're set to begin your company's transformation. As we both realized watching scores of *Grand Design* episodes, whenever a new home is complete, it looks and feels amazing (and, funny enough, the pain of getting there suddenly doesn't seem as vivid). Similarly, payers and providers who mindfully "renovate" their companies based on Moore's framework will have competitive advantage by being well prepared for emerging needs, while still safeguarding their most important legacy business aspects.

## KEY TAKEAWAYS

- Leaders must think about innovation like they're building a home from the ground up.
- Many leaders default to spending all their time and resources in the "performance" and "productivity" zones, missing the vital innovation and potential new business opportunities found in the "incubation" and "transformation" zones.
- Working across multiple zones requires leaders to develop different competencies and redesign metrics to measure success.

## CITATIONS

## NOW YOU SEE US, NOW YOU DON'T

- 1 <https://hbr.org/2017/11/the-cvs-aetna-merger-hinges-on-one-question-what-do-consumers-get-out-of-it>
- 2 <https://www.modernhealthcare.com/article/20190223/NEWS/190229970/ceo-power-panel-m-a-no-longer-health-systems-top-growth-strategy>

## FORTUNE FAVORS THE BOLD

- 3 <https://health.oliverwyman.com/2019/06/chenmed-podcast.html>
- 4 <https://health.oliverwyman.com/2018/11/podcast--niyum-gandhi.html>

## ARE SOCIAL DETERMINANTS OF HEALTH THE HOLY GRAIL?

- 5, 6 [http://publichealth.lacounty.gov/epi/docs/SocialD\\_Final\\_Web.pdf](http://publichealth.lacounty.gov/epi/docs/SocialD_Final_Web.pdf)
- 7 <https://eymanlaw.com/cms-approves-innovative-pilot-program-address-social-determinants-health-part-north-carolinas-new-medicaid-waiver/>
- 8 <https://www.geisinger.org/freshfoodfarmacy>
- 9 <http://www.hcsc.com/newsroom/news-releases/2019>
- 10 <https://www.upmc.com/services/behavioral-health/schizophrenia/our-services/homeless-continuum-program>
- 11 <https://populationhealth.humana.com/>
- 12 <https://www.healthaffairs.org/doi/10.1377/hblog20190627.482360/full/>
- 13 <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2671405>
- 14 [https://health.oliverwyman.com/2015/09/video\\_hiccup\\_chairm.html](https://health.oliverwyman.com/2015/09/video_hiccup_chairm.html)

## HOW AN INFUSION OF TECH WILL REVERSE THE WORKER CRISIS

- 15 <https://www.mercer.us/our-thinking/career/demand-for-healthcare-workers-will-outpace-supply-by-2025.html>
- 16 <http://reports.weforum.org/future-of-jobs-2018/>
- 17 <https://www.healthimaging.com/topics/practice-management/jama-uspends-most-healthcare-and-imaging-reason-why>
- 18 <https://www.forbes.com/sites/samshead/2018/08/20/facebook-aims-to-make-mri-scans-10x-faster-with-nyu/#66faf5ac7a04>
- 19 <https://www.aamc.org/data/workforce/reports/458498/1-5-chart.html>
- 20 <https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/surgical-specialty-report.pdf>
- 21 <https://www.tandfonline.com/eprint/7nRE2albZh2BAx94TZ5P/full>
- 22 <https://journals.sagepub.com/doi/full/10.1177/2010105819834569>
- 23 <https://www.healthaffairs.org/doi/10.1377/hblog20180914.711688/full/>
- 24 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160594/>
- 25 <https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf>
- 26 <https://nei.nih.gov/catalog/only-half-all-people-diabetes-get-annual-comprehensive-dilated-eye-exam>
- 27 [https://www.aoa.org/Documents/news/state\\_of\\_optometry.pdf](https://www.aoa.org/Documents/news/state_of_optometry.pdf)
- 28 <https://www.dashpredict.com/surgical-site-infection>

## MONETIZING HEALTHCARE'S C2B CONSUMER DATA EXPLOSION

- 29 <https://www.oliverwyman.com/content/dam/oliver-wyman/v2/publications/2018/october/Consumer-Survey-US-Healthcare.pdf>

## CEO BRIEFING ROOM

- 30 <https://www.businesswire.com/news/home/20181126005585/en/Seagate-Launches-New-Data-Readiness-Index-Revealing-Impact>
- 31 <https://www.pnas.org/content/115/50/12616>
- 32 <https://www.inc.com/marcel-schwantes/first-90-days-facebook-research-shows-why-people-quit-their-jobs.html>

## SPECIALTY DRUGS

- 33 <https://www.ajmc.com/payer-perspectives/0218/the-growing-cost-of-specialty-pharmacy-is-it-sustainable>
- 34 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2706163/>
- 35 <https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2015/11/specialty-drugs-and-health-care-costs>
- 36 <https://static1.squarespace.com/static/54d50ceee4b05797b34869cf/t/5cd765e5c49ce70001f3449a/1557620199759/medicine-use-and-spending-in-the-us---a-review-of-2018-outlook-to-2023.pdf>

## NOT YOUR GRANDMA'S MEDICARE

- 37 <https://www.aha.org/system/files/content/00-10/070508-boomerreport.pdf>
- 38 <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/1568518>
- 39 <https://www.aha.org/system/files/content/00-10/070508-boomerreport.pdf>
- 40 <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage/>
- 41 <https://www.cms.gov/newsroom/fact-sheets/2019-medicare-advantage-and-part-d-rate-announcement-and-call-letter>
- 42 <https://www.cms.gov/newsroom/fact-sheets/2020-medicare-advantage-and-part-d-rate-announcement-and-final-call-letter-fact-sheet>

## THREE WAYS COMPANIES CAN CLOSE THE GENDER GAP IN HEALTHCARE LEADERSHIP

- 43 <http://www.genderleadershipgroup.com/the-inclusionary-leadership-blog/210>
- 44 <https://www.bls.gov/cps/cpsaat18.pdf>
- 45 <https://www.forbes.com/sites/forbesmarketplace/2018/06/05/5-things-you-need-to-know-about-women-in-finance/#3b4ebe9e4e77>
- 46 <https://www.bls.gov/opub/mlr/2017/home.htm>
- 47 <https://www.oliverwyman.com/media-center/2019/jan/oliver-wyman-announces-inaugural-women-in-healthcare-leadership-.html>
- 48 <https://hbr.org/2018/07/the-other-diversity-dividend>
- 49 <https://hbr.org/2013/12/how-diversity-can-drive-innovation>
- 50 <https://hbr.org/2019/02/research-when-gender-diversity-makes-firms-more-productive>
- 51 <https://hbr.org/2016/09/diverse-teams-feel-less-comfortable-and-thats-why-they-perform-better>
- 52 [https://www.jstor.org/stable/258792?seq=1#metadata\\_info\\_tab\\_contents](https://www.jstor.org/stable/258792?seq=1#metadata_info_tab_contents)
- 53 <https://www.growthbusiness.co.uk/mind-the-mentoring-gap-why-men-are-more-likely-to-look-for-career-mentors-2552733/>
- 54 <https://hbr.org/2014/03/manage-your-work-manage-your-life>
- 55 <http://www.globallisteningcentre.org/sex-differences-in-listening/>
- 56 <https://womenintheworld.com/2015/03/19/google-chief-blasted-for-repeatedly-interrupting-female-government-official/>

## **ABOUT OLIVER WYMAN**

Oliver Wyman is a global leader in management consulting. With offices in 60 cities across 29 countries, Oliver Wyman combines deep industry knowledge with specialized expertise in strategy, operations, risk management, and organization transformation. The firm has more than 5,000 professionals around the world who work with clients to optimize their business, improve their operations and risk profile, and accelerate their organizational performance to seize the most attractive opportunities. Oliver Wyman is a wholly owned subsidiary of Marsh & McLennan Companies [NYSE: MMC]. For more information, visit [www.oliverwyman.com](http://www.oliverwyman.com). Follow Oliver Wyman on Twitter @OliverWyman.

## **OLIVER WYMAN HEALTH AND LIFE SCIENCES PRACTICE**

Oliver Wyman is a leader in value-based, consumer-centric health. Everything we do improves access, quality, and consumer experience. We serve clients in the pharmaceutical, biotechnology, medical devices, provider, and payer sectors through three global teams: Health Services, Provider, and Life Sciences. We rely on deep healthcare expertise and capabilities to deliver fact-based solutions and provide strategic, operational, and organizational advice. We help our clients bridge the gap between their business today and their vision for the future.

## **OLIVER WYMAN HEALTH INNOVATION CENTER**

Oliver Wyman Health Innovation Center In 2011, Oliver Wyman launched a Health Innovation Center (OWHIC) dedicated to promoting positive change in healthcare. OWHIC champions innovation by disseminating proven innovations; envisioning market-based solutions to today's and tomorrow's challenges; and establishing a cross-industry community of thought-leaders to share and shape ideas. To contact OWHIC, email us at [owhic@oliverwyman.com](mailto:owhic@oliverwyman.com).

Copyright © 2019 Oliver Wyman. All rights reserved.

HEALTH INFORMATION JOURNAL  
VOLUME 3 2019