



SEARCH

Strategy

TOPICS

[Business History](#)
[Career Effectiveness](#)
[Entrepreneurship](#)
[Finance](#)
[Globalization](#)
[Innovation](#)
[Leadership](#)
[Marketing](#)
[Operations](#)
[Organizations](#)
[Social Enterprise](#)

→ Strategy

[Technology](#)

TOPICS IN THE NEWS

[Corporate Governance](#)
[Managing Recovery](#)
[Moral Leadership](#)
[Negotiation](#)
[Outsourcing](#)

COLUMNS

[Alumni Insights](#)
[Research Notebook](#)
[What Do YOU Think?](#)

ALSO OF INTEREST

[HBS Conference Coverage](#)
[Faculty Q&As](#)
[Audio Conferences](#)

HARVARD BUSINESS SCHOOL LINKS

[Alumni](#)
[Baker Library](#)
[eBaker](#)
[Faculty & Research](#)
[Executive Education](#)
[HBS Interactive](#)
[HBS Publishing](#)

Michael Porter's Prescription For the High Cost of Health Care

July 12, 2004



The troubled U.S. health care system needs a brave, new kind of competition, say HBS professor Michael E. Porter and the University of Virginia's Elizabeth Olmsted Teisberg. A *Harvard Business Review* excerpt.

by Michael E. Porter and Elizabeth Olmsted Teisberg

We believe that competition is the root of the problem with U.S. health care performance. But this does not mean we advocate a state-controlled system or a single-payer system; those approaches would only make matters worse. On the contrary, competition is also the solution, but the nature of competition in health care must change. Our research shows that competition in the health care system occurs at the wrong level, over the wrong things, in the wrong geographic markets, and at the wrong time. Competition has actually been all but eliminated just where and when it is most important.

There is no villain here. Poor public-policy choices have contributed to the problem, but so have the bad choices made by health plans, hospitals, and the employers who buy their services. Decades of "reform" have failed, and attempts to reform will continue to fail until we finally get the right kind of competition working.

The health care system can achieve stunning gains in quality and efficiency. And employers, the major purchasers of health care services, could lead the transformation. [...]

Positive-sum competition

In a healthy system, competition at the level of diseases or treatments becomes the engine of progress and reform. Improvement feeds on itself. For that process to begin, however, the locus of competition has to shift from "Who pays?" to "Who provides the best value?" Getting there will require changes in the strategies of providers and payers and in the behaviors of employers purchasing health plans. In addition, some important system infrastructure needs to be put in place—rules and regulations that shift the incentives and create the right types of information. Let's look at each needed reform in turn.

Provider Strategies: Distinctiveness. Under positive-sum competition, providers would not attempt to match competitors' every move. Instead, they would develop clear strategies around unique expertise and tailored facilities in those areas where they can become distinctive. Most hospitals would retain a wide array of service areas, but they would not try to be all things to everyone. In most businesses, it is common sense to develop products and services that create unique value. For many hospitals, developing uniqueness is a significant change in mind-set and deciding what not to do is an even more radical idea.



Michael E. Porter

No Restrictions to Choice. Under positive-sum competition, all restrictions to choice at the

Jul. 12, 2004 Issue

[Enron's Lessons for Managers](#)[How Tide Cleaned up the Competition](#)

→ Michael Porter's Prescription For the High Cost of Health Care

[Readers Respond: Work-Life: Is Productivity in the Balance?](#)

disease or treatment level would disappear, including network restrictions and approvals of referrals. Reasonable co-pays and large deductibles combined with medical savings accounts would let patients take some financial responsibility for their choices. But co-pays would be the same inside and outside of the network. Antitrust authorities would scrutinize system participants so that one hospital system or health plan did not unfairly dominate an important market.

Transparent Pricing. Prices would be posted and readily available. Providers would charge the same price to any patient for addressing a given medical condition, regardless of the patient's group affiliation. Providers could and would set different prices from their competitors, but that pricing would not vary simply because one patient was insured by Aetna, another covered by Blue Cross, and another self-insured. Payers could negotiate, but price changes would have to benefit all patients, not just their own. The cost of treating a medical condition has nothing to do with who the patient's employer or insurance company is.

Price discrimination not related to costs imposes huge burdens on the system today. Having multiple prices drives up administrative costs. Patients covered by the public sector are subsidized by private-sector patients. And within the private sector, patients in large groups are subsidized by the uninsured, members of small groups, and out-of-network patients, who pay list prices. Artificially high list prices make more patients unable to pay, driving up uncompensated care expenses, which leads to ever higher list prices and bigger discounts for large groups. The price disincentives for care outside of the network stifle competition, which in turn slows quality and efficiency improvements that would otherwise benefit all patients. Without service-by-service competition, costs spiral ever higher while quality lags. The cost of dysfunctional competition far outweighs any short-term advantages system participants get from price discrimination—even for those firms that currently get the biggest discounts. [...]

Simplified Billing. A fundamental function of pricing is to convey information to consumers and competitors. Current billing practices obscure that information. Unnecessarily complex billing contributes to cost shifting, drives up administrative costs, and makes price and value comparisons virtually impossible. Under positive-sum competition, providers would have to issue a single bill for each service bundle, or for each time period in treating chronic conditions, rather than a myriad of bills for each discrete service. Many other industries have solved the problem of how to issue a single bill for customized services; among them aerospace, construction, auto repair, and consulting. A competitive health care industry could figure it out, too. Competing providers would also figure out how to give price estimates in advance of service. Such estimates would not only improve consumer choice but would also spur providers to learn about their real costs. [...]

Accessible Information. Under positive-sum competition, both the providers and the consumers of health care would get the information they need to make decisions about care. The government or a broad consortium of employers could jump-start the collection and dissemination process by agreeing on a standard set of information that would be collected nationally on a regular basis. Indeed, medical information is not unlike the corporate disclosures overseen by the SEC. The benefits of national comparisons are compelling and will unleash a tidal wave of improvements in quality and efficiency.

An obvious—and relatively uncontroversial—starting point would be to collect information on specific providers' experience with given diseases, treatments, and procedures. The data would be made publicly available after a waiting period during which providers could correct any errors. Over time, information about providers' risk-adjusted medical outcomes also would need to be collected and disseminated, allowing consumers to evaluate the providers' areas of expertise. This information would be specific to particular diseases or medical conditions, not aggregated across different areas of medical practice. A productive system would also collect or disseminate pricing information, enabling comparisons for specific treatments or procedures.

Nondiscriminatory Insurance Underwriting. Two anomalies mar the pricing of health plans. First, people who are included in large risk pools (such as those who work for big companies) can get a reasonably priced health plan even if someone in the family has medical risks. But those without access to such a pool (such as people who work for small firms or are self-employed) will pay very high prices if a family member has medical risks. Realistic reform efforts need to assume that health care coverage will continue to come mostly from employers. However, risk-pooling solutions need to be developed for those who are self-employed, employed by small firms, employed part-time, or unemployed. For example, smaller companies are joining consortia for health plan purchases. For high-risk people unable to buy health plans, assigned risk pools, like those used in automobile insurance, will need to be developed.

In addition, people in small groups or with individual insurance policies face the likelihood that their premiums will rise sharply if someone in the family actually develops an expensive medical condition, even if the family has paid premiums for years without making large claims. This practice, known as "re-underwriting," negates the purpose of health insurance and must be eliminated.

Fewer Lawsuits. Malpractice litigation and the associated defensive medical practices inflict huge costs on everyone, and they have done little to raise the quality of health care. Indeed, the threat of malpractice creates incentives for physicians and hospitals to hide their mistakes rather than own up to and eliminate them. Standards for malpractice litigation need to change. Lawsuits are appropriate only in cases of truly bad medical practice, such as negligence, the use of obsolete treatments, or carelessness, not when a patient had a bad outcome despite receiving appropriate, up-to-date treatment. With better information and no restrictions on choice, many lawsuits will be averted. The money spent on enabling information and choice is an investment in removing billions of dollars of administrative and legal costs from the system.

National List of Minimum Coverage. The current system of individual negotiation and litigation over coverage is expensive. A better system would mandate a minimum level of coverage with a national list (such as the one used in the Federal Employees Health Benefits Program). Health plans could choose to cover more services and treatments for competitive reasons, but they could not be forced to do so by lawsuits. This change would refocus health care expenditures from malpractice premiums to delivery of care for more people.

Payer Strategies: Choice and Efficiency. Positive-sum competition would induce payers to compete to create value, not just to minimize cost. They would simplify billing and administrative processes. They would serve subscribers by identifying treatment alternatives and providers with excellent outcomes. They would help subscribers to know when and where it is appropriate to travel outside of their immediate areas for quality care. (Some payers have begun to post information about treatments and providers on their Web sites, but the information is often only about those treatments and providers within a small radius around the subscriber's ZIP code.) The best payers would be able to recommend effective disease-management options for subscribers with chronic conditions. Competition would shift to providing information and excellent service. Attempts to limit patients' choices or to control physicians' behavior would end.



Excerpted with permission from "Redefining Competition in Health Care," **Harvard Business Review**, Vol. 82, No. 6, June 2004.

[[Buy the full article](#)]

Michael E. Porter is the Bishop William Lawrence University Professor at Harvard University. He is based at Harvard Business School.

Elizabeth Olmsted Teisberg is an associate professor of business at the University of Virginia's Darden Graduate School of Business Administration in Charlottesville, where she focuses on innovation and strategy.

RELATED STORIES IN *HBS WORKING KNOWLEDGE*:

[Using Technology to Change Healthcare](#)

[New Cluster Mapping Project Helps Companies Locate Facilities](#)

[Are Consumers the Cure for Broken Health Insurance?](#)

RELATED HBS CASES FOR PURCHASE:

[Bridges to Excellence: Bringing Quality Health Care to Life \(2004\)](#)

[BestDoctors, Inc. \(2002\)](#)

ABOUT FACULTY IN THIS ARTICLE:

[Michael E. Porter](#) is the Bishop William Lawrence University Professor, based at Harvard Business School.

BOOKS BY:

[Michael E. Porter](#)

HELP US IMPROVE THIS SITE

TELL US ABOUT YOURSELF »



[Easy Print](#)



[Send This to a Friend](#)



[Send Us an E-mail](#)



[HBSWK on Your PDA](#)



SIGN UP FOR THE FREE WORKING KNOWLEDGE NEWSLETTER

Enter E-mail Address:

Sign Up!

Copyright © 2004 President and Fellows of Harvard College