

Controlling health-care costs

Another American way

The success of Kaiser Permanente, an integrated American health-care firm, offers lessons for insurers and hospitals at home and abroad

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ON A recent trip to America, Nicolas Sarkozy, France's president, could not resist the temptation to needle his hosts. Just before the visit his American counterpart, Barack Obama, had secured Congressional approval of a plan for a dramatic expansion of the country's health-insurance market. Observing that America is the only wealthy country to lack universal health coverage, Mr Sarkozy sniffed: "Welcome to the club of states who don't turn their back on the sick and the poor."

Europeans have long thumbed their noses at America's bloated health-care system. It is true that parts of it are convoluted, cruel and much too costly. But Sir Richard Feachem, a health expert and the former boss of the Global Fund to Fight AIDS, Tuberculosis and Malaria, argues that such a view ignores "nuggets of good practice". The best such nugget, he reckons, is Kaiser Permanente (KP), a not-for-profit health insurer and hospital chain which last year took in \$2 billion more than the \$40 billion it spent.

For the most part, the American health system is dominated by cream-skimming health insurers and the myriad "fee for service" providers they do business with, which drive up costs by charging high prices for piece work. KP's business model integrates fixed-price health insurance with treatment at its own hospitals and clinics. This has led to big efficiency gains, making KP one of the cheapest health-care providers in most of the regional markets in which it competes. Thanks to Mr Obama's reforms, over 30m Americans will enter the health-insurance market over the next few years—and KP's low prices should make it a big beneficiary.

Moreover, KP's medical results are as good as its financial ones. By many clinical measurements, it is the best-performing health-care outfit in the regions it covers. The firm's success obviously holds lessons for its American rivals, but given that KP serves some 8.6m patients—more than the population of Austria—and has come up with some world-beating innovations, Sir Richard believes that there is "much that Europe can learn too."

At KP's Oakland Medical Centre in northern California, Christina Ahlstrand, a lifelong customer, has come to see her doctor, Jennifer Slovis. Ms Ahlstrand had been feeling "very low energy", so she e-mailed to see if she should get any blood tests done. After reviewing her electronic medical records (which include all her lab tests, prescriptions, e-mail exchanges and notes from visits to all specialists), Dr Slovis e-mailed her back saying she needed to see her in person.

Many health systems, including Britain's National Health Service (NHS), have tried unsuccessfully to implement comprehensive computer systems; patients and doctors often hate them. But studies published in the journal *Health Affairs* and elsewhere show that KP's embrace of technology (its doctors conducted nearly 9m electronic consultations last year) has resulted in fewer frivolous visits, better medical outcomes and soaring patient satisfaction. Patients can even send doctors photos of worrisome moles or slow-healing wounds by e-mail for remote diagnosis.

Ms Ahlstrand, like many KP patients, loves this system. She also likes KP's personal-health website, which gives her tips and points her to classes on healthy living, or "wellness". Dr Slovis, for her part, is pleased that her work is "nearly paperless" and that she can easily track the specialists treating her patients, "so I know exactly what's going on."

The ease with which Dr Slovis tracks Ms Ahlstrand's interactions with specialists and any resultant test results is indicative of the sort of integration that is missing in most health systems. George Halvorson, KP's boss, argues that such co-ordination is all the more essential because of the dramatic rise of such lasting and expensive afflictions as metabolic syndrome, diabetes and heart disease.

Kaiser also aligns incentives both to promote parsimony and to improve the quality, rather than merely the quantity, of the care it gives. Patients like Ms Ahlstrand use e-mail because it is free and convenient, whereas a personal visit can involve hassle and an out-of-pocket payment. Dr Slovis and other KP doctors are on fixed salaries, unlike America's many self-employed physicians, so they have every incentive to share information with other specialists and no financial motive to order unnecessary procedures.

KP's third big advantage is that its integrated approach and incentive structure encourage investment in forms of long-term care such as the wellness classes that Ms Ahlstrand enjoys. The firm is in the midst of a ten-year, \$30 billion capital-investment plan. In March it completed the rollout of its computer system—the biggest one in the world for private health care.

Many other insurers and health systems avoid making such investments because of "churn": patients switch insurers frequently, so any spending on preventive medicine, aimed in particular at avoiding expensive hospital visits in future, ends up benefiting a rival company. KP says its churn rate is well below that of its rivals, so it can invest for the long haul. It funds an innovation centre that perfected the telemedicine systems its doctors are now using for remote dermatology consultations, for example.

Clayton Christensen of Harvard Business School applauds the firm's culture of innovation. He notes that KP's dentists routinely apply a coating to children's teeth that helps prevent cavities, a procedure that many other American dentists tend not to use. Why not? In an integrated system with incentives aligned properly, he argues, preventing future cavities saves the company money. In contrast, in a fee-for-service system, "future cavities represent future revenue."

If KP's approach is so successful, why is it not more widely copied? A number of health systems from around the world, including Britain's NHS, have sent emissaries to California to study KP's approach, but efforts to replicate it have met only with limited success. Within America, a handful of outfits—such as the Mayo Clinic—independently evolved into integrated systems, but the rest of the industry remains a fragmented mess.

The prevailing culture of health care in the country is difficult to overcome. Some American patients, used to having all the scans and consultations with exotic specialists they want, costs be damned, do not like KP's frugal ways. By the same token, some freewheeling American doctors do not like KP's rigid systems or fixed (albeit generous) salaries. Much the same applies in other countries: whether in politicised state-run systems or profiteering private ones, the incentives for doctors and patients are seldom as soundly aligned as they are at KP. "Most of its success is explained by culture," says Alain Enthoven, a health economist at Stanford University, "and that is simply not easy to replicate."