

# LOCAL CURES FOR A GLOBAL CRISIS

Many nations, both developed and developing, are looking for answers to their healthcare budget crises. A roundtable of experts weighs in on these initiatives.

PHOTOGRAPHS BY MATTHEW STUART

healthcare spending and performance, differences in culture, lifestyle, professional training, reimbursement and regulation render country-to-country comparisons of questionable value. Regional differences within countries further complicate the quest for useful generalizations and actionable conclusions.

Even if the perfect system could be divined by selecting the best from everywhere, implementing it anywhere would range from painful to impossible. The large number of stakeholders in any country's healthcare system — patients, providers, government, insurers, regulators — plus the fact that healthcare is an emotionally charged issue means that change is never easy.

The challenge of providing high-quality healthcare that is affordable for both governments and patients plagues developed and developing countries alike. But that may be one of the few characteristics different countries share with regard to healthcare. While many countries have reasonable to good data on their

Seven corporate leaders and policy experts explored real-world solutions for providing high-quality healthcare to all.



But there are some lessons that each country can learn from others, including what developed countries can learn from developing ones about the necessary role of government and the pivotal role of local communities. To focus on some of these lessons, FTI Consulting convened a roundtable of healthcare experts chaired by Mark Malloch-Brown, FTI Consulting's Chairman, Europe, Middle East and Africa.

In conversation with him were Michael W. Cropp, M.D., President/CEO, Independent Health; Anne-Toni Rodgers, Payer Capability, Regional Lead — Europe, AstraZeneca; Meg Guerin-Calvert, Vice Chairman and

*"I will press you to not forget the 2 billion people at the bottom of the economic ladder in our solutions for healthcare coverage worldwide."*

Senior Managing Director, Compass Lexecon; Vicky Pryce, Senior Managing Director of FTI Consulting's Economic Consulting practice; Liz Shanahan, Senior Managing Director, Health & Life Sciences, Strategic Communications, FTI Consulting; and Dan Corry, Director, Economic Consulting, FTI Consulting.

**MARK MALLOCH-BROWN:** I feel I perhaps know less about this subject than anyone else here today. But I was involved in running large international public-development organizations for a

decade at a time when communicable diseases and the absence of healthcare investments in developing countries were as salient a pair of development issues as you could find. So I will press you during this discussion to not forget the 2 billion people at the bottom of the economic ladder in our solutions for healthcare coverage worldwide.

**Meg, what are the underlying drivers for change in healthcare?**

**MEG GUERIN-CALVERT:** The single greatest challenge for developed economies is the proportion of GDP going for healthcare expenditures in virtually every country. In general, for major Organisation for Economic Co-operation and Development countries it's somewhere between 8% and 16%.

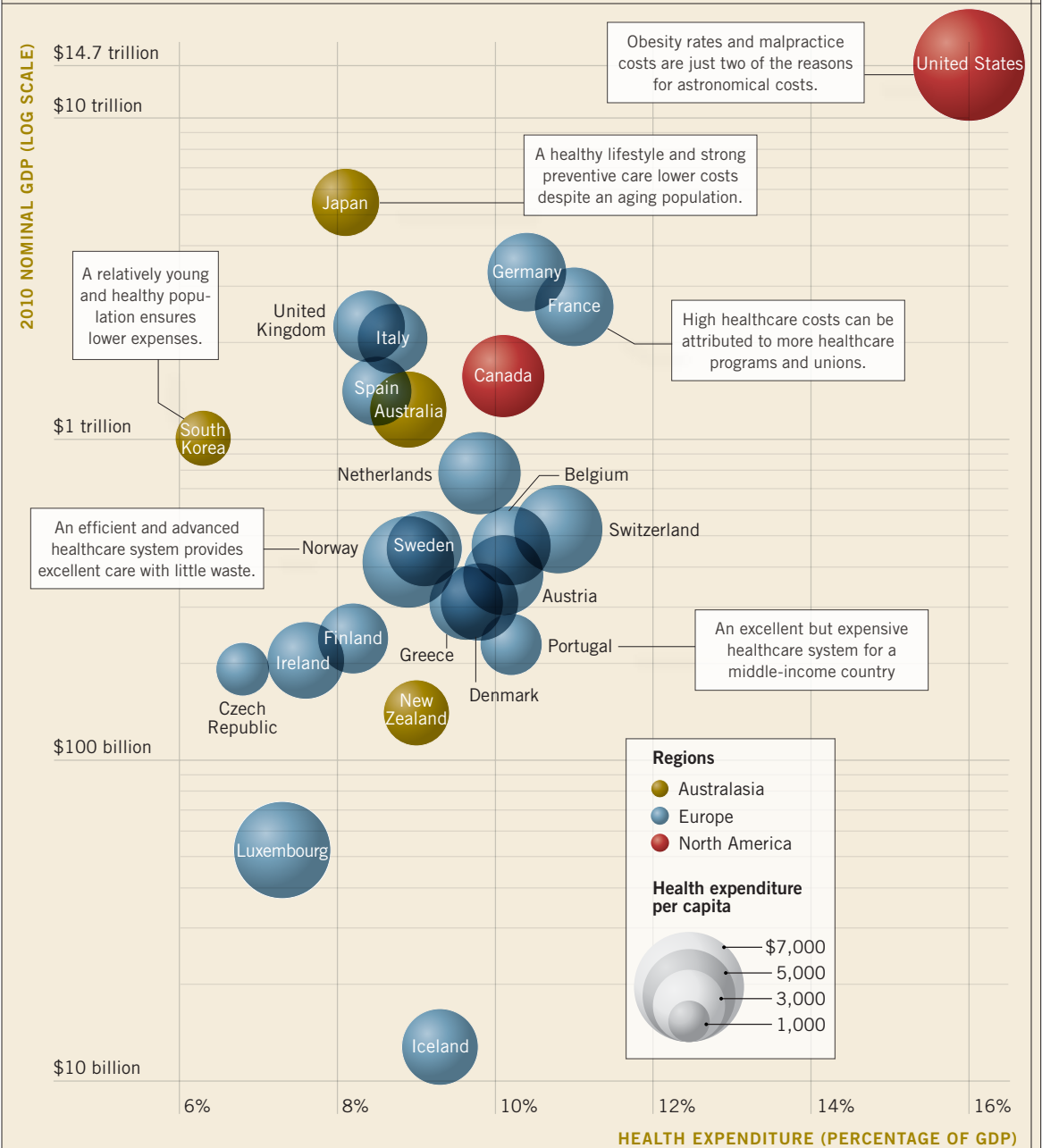
As we have moved through the financial crisis, the rate of economic growth in many countries has slowed or stalled, yet the rate of healthcare expenditure has not. As a result, the proportion of overall GDP consumed by healthcare in many countries is increasing. Depending on the importance of public sector funding, a very high proportion of government budget is allocated to healthcare. And despite that level of spending, certain countries, such as the United States, believe that quality and access achieved do not meet expectations. Those are substantial challenges.

**VICKY PRYCE:** The developing world, where population growth is high, faces huge pressures to provide any kind of



## HEALTH EXPENDITURES AROUND THE GLOBE

*Among many developed countries, the United States is an outlier in healthcare spending.*



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sensible healthcare system. At the same time, in some of those countries the emerging middle classes are looking for much more than just the basics.

**MICHAEL W. CROPP, M.D.:** The cost of care relative to the value created is an increasing challenge that is emerging in every country. Everyone is or should be grappling with how we can afford to provide care for the entire population and get the maximum value. It is quite simply the cost of doing business as a nation, and it has huge economic implications.

**MALLOCH-BROWN:** Since this is a global challenge, what lessons can we learn from each other? China, for instance, has made good progress against

**smoking through social marketing. It didn't have fully developed healthcare options available. Can other countries learn from such successes?**

**CROPP:** I think so. I just visited France, where government statistics show the country spends 11% of its GDP on healthcare. France has compelling statistics to suggest the results are worthwhile. For example, I was struck by the percentage of money spent on the physician component of healthcare overall, and that pharmaceutical spending is overrepresented relative to the United States; hospital expenditures are too. But smoking-related cancers aside, France stacks up exceedingly well on most of the



LIZ SHANAHAN

Senior Managing Director, Health & Life Sciences, Strategic Communications, FTI Consulting



MICHAEL W. CROPP, M.D.

President/CEO, Independent Health

mortality measures, such as deaths related to diabetes and heart disease.

**ANNE-TONI RODGERS:** Many people are taking note of what's being done by the United Kingdom's NICE [National Institute for Health and Clinical Excellence]. But while most of the focus is on technology appraisals of drugs and devices, the way they developed clinical guidelines was quite clever. NICE funded the Royal Colleges and the professional associations to produce the guidelines, so the guidelines were being produced for the professionals by the professionals. That has made the guidelines much more likely to be widely adopted. Therefore they are likely to have a greater impact on healthcare overall.

**MALLOCH-BROWN:** How transferable are practices? Can you easily take them from one country and implement them in another?

**DAN CORRY:** It is very difficult to make sound cross-country comparisons on health expenditure; even if we did have the right figures, would that persuade us that if something worked for France or the United States or wherever, we should change our system to match? I think that's very questionable. Each system has evolved over a long period of time, which creates significant inertia that makes it very tricky to completely change it. And there may be reasons that it works in one country and not in another.

Another challenge for policymakers is that it's very hard to say what the

right answer really is. As economists, we like to know we've done our analyses and econometrics so we can tell you the right answer. But in healthcare there are so many complications that make it very, very hard to model well. But progress is being made. So you're seeing proposals in the United Kingdom for changes in health that some people are convinced would work. Yet there's another set

*"Analytics and metrics are not sufficient on their own to drive change. The way the learnings are communicated will also be pivotal to their success."*

of people — just as genuine, just as clever — who don't think they will work. And the public is sitting there thinking, "What's the right answer?"

**GUERIN-CALVERT:** Looking behind the successes to understand the sources of improvement is critical. I would agree with your sense that sound analytics are important tools. In addition, there needs to be a way to measure and track on a common basis.

**LIZ SHANAHAN:** I agree that healthcare systems can learn from each other, but analytics and metrics are not sufficient on their own to drive change. The way the learnings are communicated, cognizant of cultural differences, will also be pivotal to their success.



*When you trace the underlying drivers of healthcare statistics, they often relate back to chronic diseases and to exercise, eating and smoking.*

**RODGERS:** There are structural issues in the way, too. In Europe, technology that's been around for 30 years could enable patients to be treated at home. But they're not given the choice because the system rewards physicians for providing care at a medical office or hospital. For example, there is hardly any home-care dialysis in Germany, as compared to the rest of Europe, possibly because German physicians are rewarded for owning and running the treatment centers.

**MALLOCH-BROWN:** France is a fascinating example to me because I believe that French health statistics are entirely driven by red wine consumption. And let me add that most of the FTI Consulting leadership would agree. But joking aside, there's a serious point here: Many French policy leaders argue that there are broad lifestyle issues involved. This is, after all, a country that has championed a kind of quality-of-life index where work-lifestyle balance is a key issue.

**RODGERS:** I think lifestyle issues are very relevant, and you don't only see differences between countries. There's actually strong regionalization within France, and you see incredibly different statistics across the regions, as indeed you do in other countries.

**CROPP:** That is a very important point. We see tremendous variations in the United States as well. Even though Buffalo might have a culture very similar

to those in Pittsburgh and Cleveland, the differences in health statistics are dramatic. When you trace the underlying drivers, they often relate back to chronic diseases and simple personal choices about exercise, eating and smoking.

**GUERIN-CALVERT:** In the United States there has been extensive study of the drivers of spending on Medicare [the U.S. government health insurance program covering everyone age 65 and older], looking at not just cost but also utilization — for example, the use of inpatient services vs. preventive care or the rate of readmissions. As an economist, what I find intriguing are the large variances in the utilization of services such as diabetes care, cardiac care, testing and so on across geographies. There are many factors that account for these differences, and demographics play an important role.

**MALLOCH-BROWN:** How important are local structures and incentives?

**CROPP:** As we've mentioned, local conditions are very different, so there has to be local ownership and accountability to make things happen effectively. Whatever works in Buffalo may or may not work in the next community. So I'm a strong believer that local solutions must emerge in every country we're talking about. But sometimes it's going to require support at the state or federal level to facilitate the right dialogue.

Key to effective local implementation is balanced metrics.

It can't just all be about cost and affordability. Only now is the United States beginning to go from a robust set of economic data — which is mostly complete for the Medicare population — to an almost equally robust set of quality data and a less robust data set on patients' experience. Pulling all of that together is essential to being able to say, "Hey, they've figured something out in Cleveland that's worth replicating." And to understand what it was that made Cleveland a success.

You can see from the data, for instance, that La Crosse, Wisconsin, is a very efficient area where the annual costs per Medicare enrollee are about \$5,000. That's at the bottom of the national range, which is \$5,000 to \$25,000. Plus, the quality of care and the patient experience are good. If you ask people from La Crosse what's going on, they'll tell you that as a community — of physicians, patients, faith-based institutions and others — they've tackled end-of-life issues. So if you live in the La Crosse area and you're over 65, you have a 95% chance of being enrolled in hospice and only a 5% chance of dying in a facility, which is the opposite of the rest of the country. And that's a local solution.

**GUERIN-CALVERT:** We can learn a great deal from cross-community comparisons as to what types of structures, incentives and metrics worked well to achieve desired cost, quality and access goals.

**SHANAHAN:** In the United Kingdom, general practitioners have been heavily incentivized to achieve improvements in screening and managing high-risk patient groups such as those with diabetes. The GPs have hit almost all of the relevant targets, capitalizing on the many exclusion criteria, and have

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been generously reimbursed for doing so. Still, it's hard to know the true benefit, and we have yet to see the improvements in outcomes promised by these incentives.

**MALLOCH-BROWN:** For healthcare systems being built in the developing world, how much of this is relevant? What would be your top lessons for someone in Chengdu, China, or wherever, which he might or might not learn from Buffalo as he starts to build a healthcare system?

**PRYCE:** The first thing to note is the huge differences between countries in the developing world, as well as between them and developed countries. You can't just take what works in the developed world and superimpose it on developing countries; it's not going to work.

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*In China, wealthy Chinese are spending on plastic surgery and the diseases of wealth, making plastic surgery an attractive specialty.*

**RODGERS:** These developing markets often trust the industry more than the Western markets do, and they are keener to have partnerships. They will often accept that the industry is investing in infrastructure because they want the right medicine to go to the right patient at the right time, and they want that inward investment.

In India, for example, some device manufacturers have worked with local communities to figure out how to get dialysis to a population that doesn't have refrigerators or electricity. They've come up with entirely different products and solutions, because that's what the community needs — for example, a box that delivers clean water to do the dialysis. They don't really need to know how it does it, and they just

easily provide and what things you might need to do to encourage new or different sources of funding to make that happen. By encourage, I mean new kinds of coordination, organizations coming together to exchange data and practices. Critical elements are the availability and use of data on quality, cost and other metrics.

**RODGERS:** If you look at what's happened in China, you'll see that wealthy Chinese are spending on plastic surgery and the diseases of wealth, and therefore it's more attractive for clinicians to go into plastic surgery, cardiology, etc. For the health of the country as a whole, China needs hematologists, pediatricians and mental health physicians — specializations that perhaps aren't as appealing. How you regulate and how you reward the clinicians in those markets will have a big impact on how the healthcare system develops.

**MALLOCH-BROWN:** We've talked a lot about how national and local variations make it difficult to transfer learnings from one place to another. What are some other impediments to change?

**GUERIN-CALVERT:** I have seen many industries go through transformative change, from regulation to deregulation, and in my experience healthcare is the most challenging. To make change possible will require a complex balancing of competition, government and consumer choice, combined with

accept that it does it. So my biggest recommendation is to capitalize on the level of trust and not start to over-regulate, because the minute you do, you stifle innovation and increase cost.

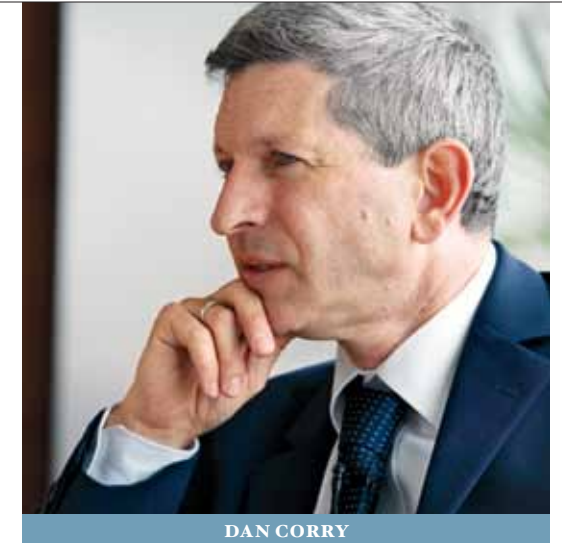
**GUERIN-CALVERT:** I agree completely; you do not want overregulation. You want to rely on the market as much as possible. But you need to take a realistic look at what the market can

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**MEG GUERIN-CALVERT**

Vice Chairman and Senior Managing Director, Compass Lexecon



**DAN CORRY**

Director, Economic Consulting, FTI Consulting

development of new organizations and increased coordination.

**CORRY:** As Meg says, there are some very complicated economics, very complicated stakeholder issues in all countries, and an awful lot of emotion. People care about nothing more than health. You only have to see how every newspaper in every country wants to have a health story high up every day. So it's a very interesting but very difficult area of policy.

**SHANAHAN:** Very few market sectors are as emotive as healthcare, and this makes it very challenging. There are clear tensions between physicians, management, insurers, pharmaceutical companies and providers. Balancing the needs and biases of each group demands a good understanding of the commitment phases individuals and groups go through, where they move from self-concern to

exploration to adoption, and finally where the changes become institutionalized. This can take many years.

**CORRY:** In addition, in most industries we think that competition is a good thing and it'll drive down costs, but in healthcare that may not be the case. In fact, for various reasons — asymmetrical information among them — we think it may be the opposite: that more competition might lead to higher costs.

**SHANAHAN:** Dan is right. Competition vis-à-vis health is viewed differently in some countries, though not universally. There is mixed evidence of benefit, with some recent data from the United Kingdom showing that local competition has raised standards and improved patient outcomes.

**CROPP:** Physicians are generally smart. They want to do good, and they want to do



right. But they haven't had the right kind of accountability structure to deliver a value proposition for a defined population. So if we sit down with physicians and say, "Let's talk about what excellent care looks like," they'll describe it, they'll be consistent about it, and they'll think they're doing it all the time. But they don't know what they don't know.

**SHANAHAN:** Inertia and entrenched habits play a role here too. I've done a lot of work in psychiatry, where the clinical community has recognized that there is a serious problem of obesity and diabetes in the patient population. To address this, they galvanized the support of their relevant cardiology and diabetology colleagues at a European

level to develop pan-European guidance. However, four years down the line patients have yet to see any tangible benefit. Wanting to do the right thing and then actually doing it require huge investments in time and education, which often don't follow from the original well-intentioned concept.

**RODGERS:** As spending on pharmaceuticals moves increasingly toward prevention or lifestyle conditions, such as vaccines or even obesity, a challenge I see is the length of time to payback. The budget may go up now, but the real economic benefit is in 30 or 40 years. So people see the budget going up, and they may object to their money being spent on antiobesity

therapies, even though in 30 years the benefit to the public balance sheet may be substantial.

**MALLOCH-BROWN:** We've talked already about the importance of local structures and incentives to making implementation successful. Are there any other things that can help overcome those barriers?

**RODGERS:** Education is critical. The original purpose of NICE was to drive innovation because U.K. doctors were some of the slowest to adopt new technology, and access to treatment varied by postal code. As I recall, when NICE looked at taxanes for breast cancer, only two out of 10 women who could benefit got access to the medication. Within eight weeks of NICE saying these women should have access, it had gone up to eight out of 10.

It's also important to educate young people. All the evidence shows that educating the young drives change. Recycling was a good example. And it's as true of doctors. When you've introduced change in clinical guidelines, for example, you might find that the consultant who's been in practice for 30 years isn't following them, but the junior doctors are all trained to work within guidelines now and are doing so.

There's also a role here for pharmaceutical companies to communicate directly with patients, which is one of the things the European Union has been trying to effect for about four or five years now. Patients

want to communicate with the people who have data on their products. But it's been continually blocked by member states who are afraid "communication" is going to turn into advertising prescription drugs on TV.

**CROPP:** Key for me is that we think beyond organizational boundaries and figure out how to bring various organizations and parties together to collaborate. I've started two nonprofit organizations in our community.

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One brings different parties together to create a culture of health in the community by looking at behaviors and helping individuals make choices and reinforce those choices across the community. The other is a regional health information organization through which all the health information in our community flows. We need competition to spur innovation, but I am sure we also need more collaboration in order to affect the cost/benefit ratio for healthcare.

**SHANAHAN:** Patients and consumers can be major drivers of change, and the growth in social media has removed many barriers. New data show that



**VICKY PRYCE**

Senior Managing Director, Economic Consulting, FTI Consulting



**ANNE-TONI RODGERS**

Payer Capability, Regional Lead — Europe, AstraZeneca

*French government statistics show that the country spends*

**11%**

*of its GDP on healthcare. Statistics suggest positive results.*

70% of consumers now get their health information online, and doing so has increasingly become an interactive experience, with consumers asking each other for advice and guidance on their treatments/interventions. Given that their patients are armed with this knowledge, physicians often have little choice but to change.

**MALLOCH-BROWN: What do you all think is the role of innovation in helping us make progress?**

**SHANAHAN:** I think a major challenge for innovation, particularly for the pharmaceutical industry, is the relentless pressure on costs, reducing medicines to no more than a cost base rather than an investment in patient health. Almost every new medicine

*“Some of the most interesting broader public health interventions are learned from developing countries that couldn’t rely on fully developed hospital systems.”*

or health technology has been developed by the commercial sector. If governments and healthcare providers continue to drive down reimbursement and undervalue these innovations, where will the hundreds of millions of euros that are required to develop new medicines and technologies to treat or prevent conditions such as Alzheimer’s come from?

**CROPP:** There’s another challenge too. According to the Institute of Medicine, it takes 17 years from the time when something’s proven to be effective to its finding its way into everyday use. With the profusion of new technology has come an implementation/innovation gap that could be better managed. So while there might be an innovation gap at the front end [in developing new therapies], you could argue that there is a bigger gap when it comes to getting proven technology to reach and have an impact on the broader population.

**MALLOCH-BROWN: To wrap up, it’s clear that there’s value in this iterative global knowledge exchange around what works, which is not just one approach. The point was made that some of the most interesting broader public health interventions are learned from developing countries that couldn’t rely on fully developed hospital systems.**

Second, we should not defer to markets alone, but also have a kind of strategic hidden hand. A 20-year view of where the shortages are is key. An example of that is the World Health Organization’s big push this year on noncommunicable diseases. It is an astonishing fact that obesity is now a bigger global problem than famine. So I think there is a sense that we’ve started to create a little bit of a global public policy health debate, which helps set some priorities.

Finally, we’ve seen that structures, incentives and collaboration locally are essential to effective implementation. ■