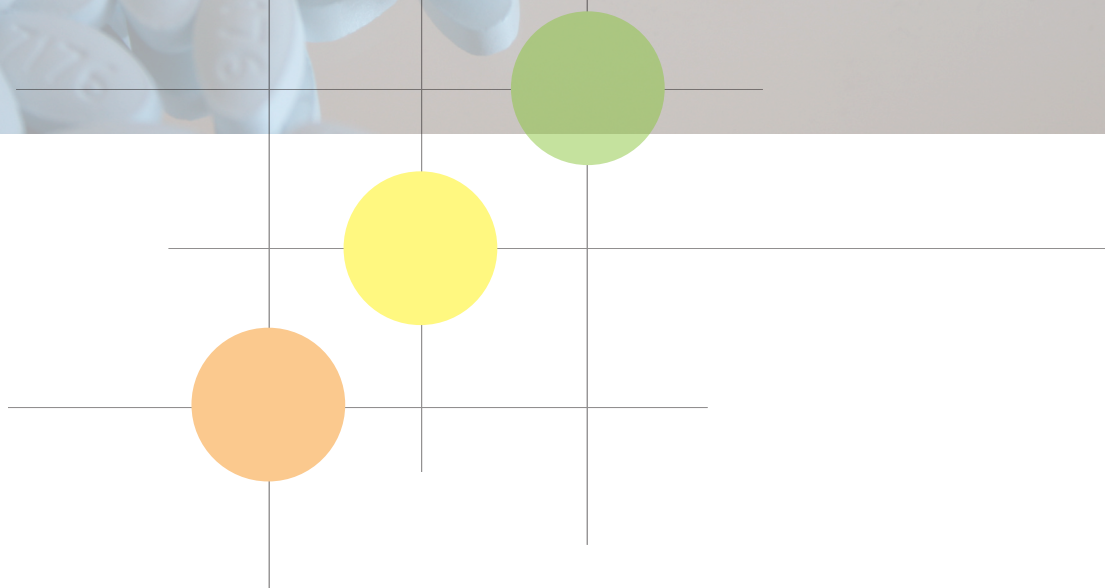




ECONOMIC DEVELOPMENT and VALUE DRIVEN-HEALTHCARE:

Embracing Local Delivery System Performance as
an Engine for Economic Growth



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JUNE 2009

EXECUTIVE SUMMARY

This paper suggests how economic developers might rethink their healthcare-driven strategies to better reflect today's push for health care reform. Per capita, the United States spends double the amount on health care than other developed countries. In response, the era of excessive health care spending is moving towards a delivery system model focused on increased efficiency and patient value. This value-driven movement to improve efficiency and quality will have significant impacts on local economies as interregional and intraregional competition intensifies. The impact to local economies will be greatest in high-cost regions as government, consumers, employers, and insurers seek out opportunities for cost savings. In response, economic developers should utilize their connections across government and industry to access the impacts of the value-driven movement, and to seek out new opportunities for local wealth creation in a value-driven model of health care.

INTRODUCTION

It is no secret that the United States pays too much for health care. Over 15 percent of total GDP is spent on keeping Americans healthy – approximately 2.2 trillion dollars per year. This cost burden is said to threaten U.S. global economic competitiveness, undermine federal and state fiscal stability, and still leave millions of Americans without access to proper care. If nothing is done to change the current system, the federal Medicare program is in danger of going bankrupt within 20 years. In short, the system is unsustainable from an economic, qualitative, and fiscal standpoint.

Nevertheless, health care continues to be a backbone for most local economies. While other industries shed jobs, employment gains in health care have averaged 17,000 new jobs per month in 2009 (Bureau of Labor Statistics). Hospitals and treatment centers employ over 18 million people directly, with many more jobs created in construction, manufacturing, and research. These jobs serve local markets and drive local economies. So, while the nation struggles to cope with the high cost of health care, local economies continue to see the direct benefits of high health care spending.

As the health care cost debate moves forward at the national level, economic developers should be equally mindful of the impacts broader reform could have on *local* economies and *local* delivery systems. In response, this paper looks at how economic developers might realign their healthcare-driven strategies to reflect today's market and political realities. It asks how their efforts might contribute to ensuring the sustainability of local delivery systems, both as crucial service providers and as engines for economic growth. It also looks at new possibilities for local economic growth arising from the rapid transformations through which the health care industry is undergoing.

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VALUE-DRIVEN INITIATIVES IN HEALTH CARE REFORM

The value-driven health care (VDHC) movement summarizes the prevailing reform trends now taking place in government as well as the private sector. VDHC centers on the idea that care can be delivered more efficiently, cheaper, and with even better results in health outcomes than in the current system. Reform policy around VDHC includes four main strategies aimed at lowering costs and improving quality: Healthcare information technology, comparative effectiveness, coordination of care, and consumerism.

1. Healthcare IT will reduce unnecessary paperwork and redundant tests by facilitating patient information sharing across sights. The Obama administration has pledged \$50 billion dollars for investment in healthcare IT over the next ten years.
2. Comparative effectiveness addresses regional variations in treatments, costs, and health outcomes. Part of the Obama plan is to implement a comparative effectiveness council that would oversee the implementation of standards in treating conditions as a way of lowering costs in high-cost regions. Comparative effectiveness would provide the basis for payment system reform to one that is focused increasingly on results instead of quantity of care.
3. Coordination of care is a renewed focus on primary care away from a reactive episodic acute care model to a proactive continuous care model. It is often referred to as the “medical home” model which addresses the fragmentation of care. The medical home model could be viewed as the end result of continued investment in healthcare IT
4. Consumerism focuses on empowering the health care consumer to take part in the decision-making process. Americans spend more time choosing their cars than choosing their doctors when in actuality there is a significant variation in quality and cost.

These and other cost-cutting measures are gaining momentum as experts increasingly agree that the current system is riddled with inefficiencies, excessive administrative expenses, inflated prices, poor management, inappropriate care, waste, and fraud (National Coalition on Health Care, 2009). The cost for enacting these systemic reforms has been estimated at over \$220 billion over three years, with the potential for achieving \$530 billion over the next ten years (Deloitte Center for Health Solutions, 2009).

If these measures are enacted, local economies and delivery systems should expect additional government funding in the short-run and greater accountability for cost reductions in the long-run. While the immediate focus in Washington is to extend coverage to the uninsured, VDHC will help to cover the heavy price tag of a universal plan.

LOCAL ECONOMIES AND LOCAL DELIVERY SYSTEMS

The impact of health care on local economies could be evaluated on three levels: Short-run, mid-run, and long-run impacts. Short-run impacts have already surfaced nationwide as a result of job cuts caused by the global recession. While health care continues to see positive growth, the average monthly rate has dropped from 30,000 new jobs in 2008, to 17,000 in 2009 (BLS, 2009).

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This slowdown is caused by lower demand for care as people lose their employer-sponsored coverage, lower overall reimbursements from public and private insurers, and cuts in investment capital available for hospital expansion projects (Thompson Reuters Report, 2009). Historically, job growth in health care has slowed during periods of recession. Whether the current economic situation is unique and will lead to mass layoffs is yet unknown.

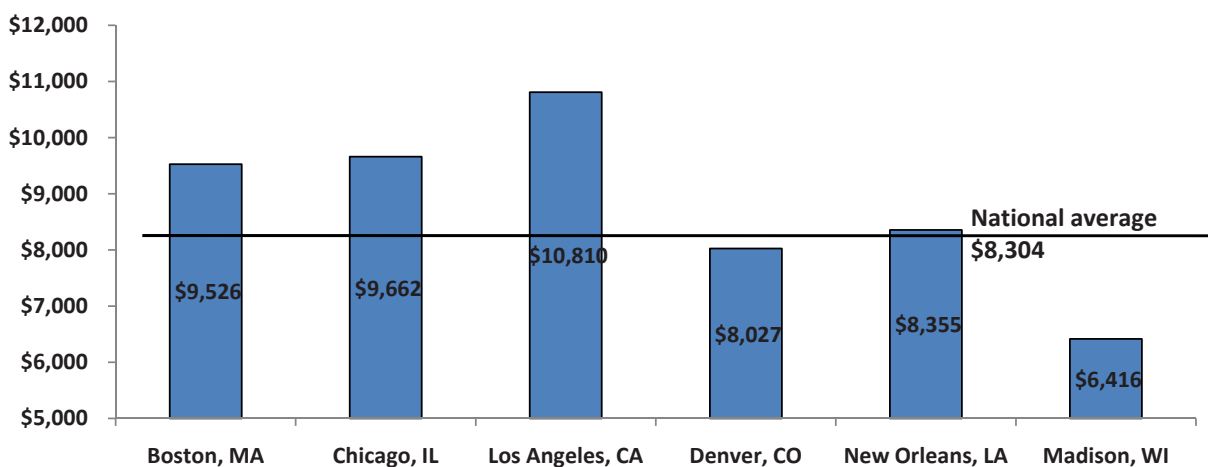
The mid-run impacts on local economies will come in the wake of national health reform and will largely depend on geographic location and the efficiency of local delivery systems. Hospitals and treatment centers will need to compete more aggressively as they are forced to become more accountable for controlling costs. Competition between and within local delivery systems is already intensifying around cost and quality considerations. Published quality measures such as infection rates, nurse staffing ratios, and other disparities in quality are helping to structure payment system reform away from the fee-for-service model to one that rewards quality instead of volume (Obama Plan, 2008).

Winners and losers in the mid-run will be determined by the efficiency of local delivery systems. Greater job cuts in health care should be expected in higher-cost regions as public funding for these communities is curtailed to increase competition. More and more, policymakers are looking to geography and regional variations in health spending to support efficiency measures. Researchers at the Dartmouth Institute for Health Policy have studied disparities in medical resources and spending across regions for more than twenty years (see figure I). Such cost and quality comparisons of local delivery systems will put added pressure on high-cost regions to improve on efficiency.

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FIGURE I - Total Medicare reimbursements

Per enrollee by hospital referral region, 2006*



* The Dartmouth Atlas on Health Care aggregates 306 hospital referral regions based on Medicare hospital service areas.

Data source: The Dartmouth Atlas on Health Care

The long-run impacts of health reform will influence cross-sector economic growth or decline. Stronger economic growth will occur in those regions that successfully manage to curb health care spending. Lower overall health care costs will make these regions more attractive for firms and individuals to invest and locate in. Higher-cost regions will increasingly view their delivery systems as a burden rather than an asset, and will struggle to compete not only nationally but globally. Today's low-cost regions already have an advantage over high-cost regions in at least two ways: First, the short and mid-run impacts will probably be less severe in lower-cost regions. Second, these regions will have the advantage of leading the national movement to restructure health care. Some unique dynamics of local delivery systems include the availability of medical resources, linkages between health care institutions and the broader life sciences industry, reputation of health care institutions, and the size and demographics of the population served by a given delivery system.

Each delivery system has its own set of systemic problems and requires a different set of solutions. For low and high-cost regions alike, there will be a pressing urgency from government and other stakeholders to adopt value-driven initiatives at the local level. Particularly for high-cost regions, differences in spending and quality will put into question widely accepted medical best practices and the overall effectiveness of their local delivery systems.

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WEALTH CREATION AS THE NEW FOCUS FOR HEALTHCARE-DRIVEN STRATEGIES IN ECONOMIC DEVELOPMENT

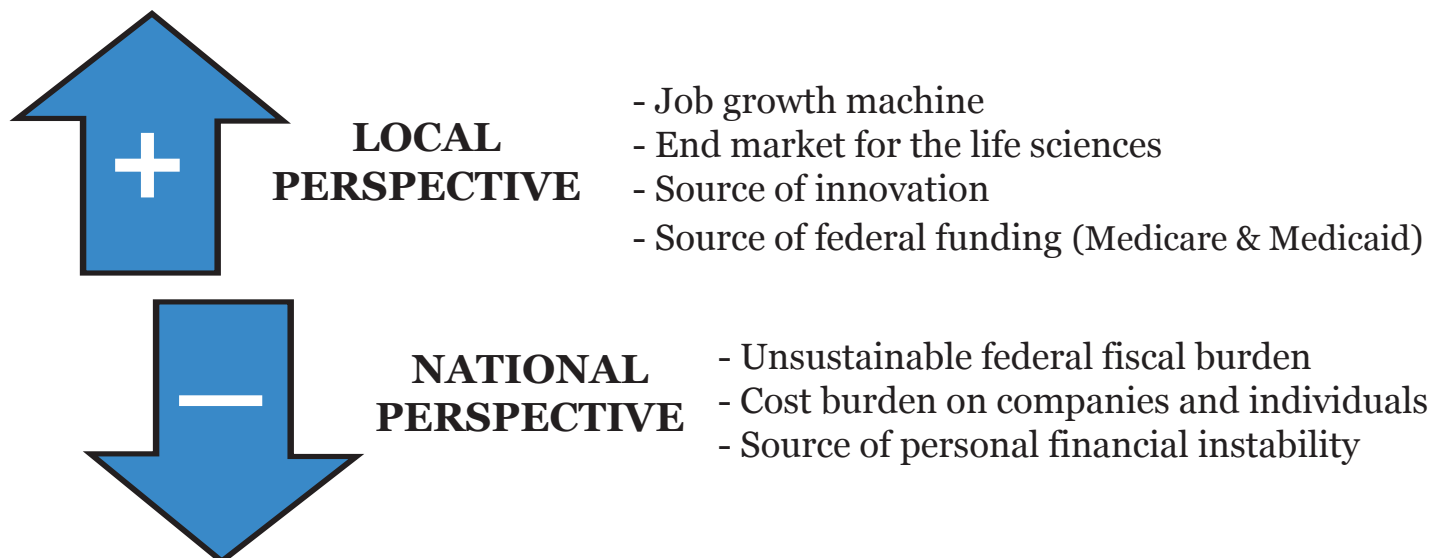
Traditionally, healthcare-driven strategies in economic development have focused on local job creation rather than improving delivery system performance. Two more common strategies are workforce development programs and regional marketing around medical assets. Workforce development attempts to meet local demand for nurses, x-ray technicians, and other health professionals, while creating employment opportunities for residents. Local governments will typically participate in public-private partnerships with educational institutions and local employers to support these programs. Regional marketing strategies are coordinated directly by economic development offices or industry associations and use health care assets as a selling point for business attraction and retention campaigns. Hospitals and other treatment centers are typically showcased individually as world class, or as part of a larger life sciences industry cluster to attract current and future investors (Lendel, 2006). While these methods have most likely been successful, the underlying goal is the same in that they focus on direct job creation in health care rather than improving delivery system performance.

Value-driven initiatives, on the other hand, would focus more on *wealth* creation rather than job creation (Evans/Stoddart, 1993, pg. 31). The objective is to move away from high spending on health care so that the economy can be more competitive in other industries, to safeguard personal financial stability, and to ensure government fiscal sustainability. Herein lays a major distinction between the federal and local development perspective on health care. Local development initiatives tend to focus more on direct job creation in health care, while the national perspective focuses more on wealth creation by attempting to relieve the economy from the burden of high health care costs.

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FIGURE II: Opposing local and national perspectives on healthcare and the economy



There are at least four reasons why local development efforts in health care have favored job creation over value-driven strategies. First, health care jobs are relatively easy to generate compared to other declining and competitive sectors such as manufacturing and financial services. Until recently, hospitals have been well-financed and have been generously extended lines of credit for expansion projects.

Second, much of health care spending is not done by those within a particular community or region. Federal programs including Medicare and Medicaid often subsidize a large portion of the local health care bill. This has left communities less accountable for controlling health care costs since local tax payers are not solely responsible for payment.

Third, inflation in health care spending and demand for health care jobs is still poorly understood. Rising costs in health care have primarily been explained as a result of an aging demographic and advancing technology. Consequently, both of these cost drivers suggest that job growth in health care is constant and that demand must be met through workforce development initiatives. However, researchers and policymakers are now increasingly pointing to other factors leading to higher spending including improper care, inefficiency waste and fraud.

Fourth, during prosperous economic times the country as a whole is less concerned with high levels of spending in health care, as long as other sectors of the economy are prospering.

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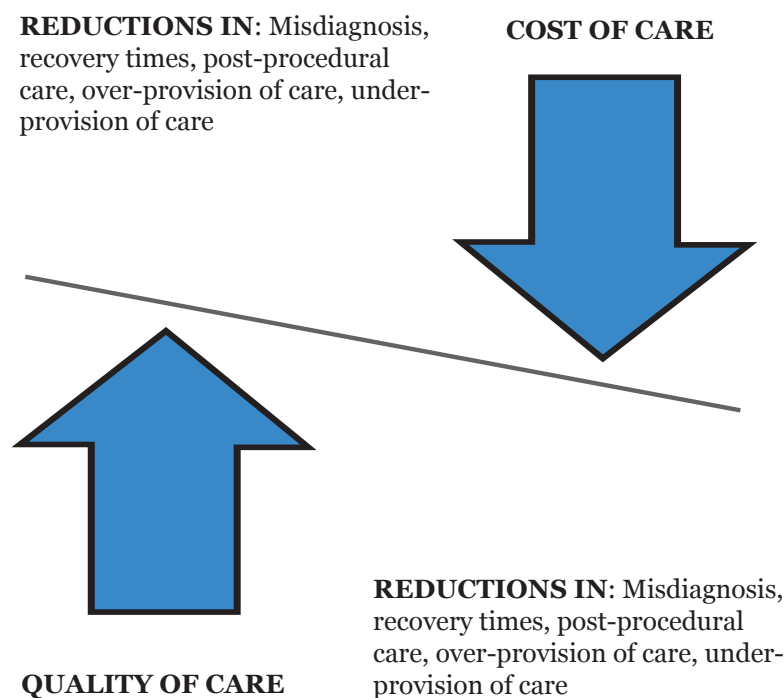
POLICY RECOMMENDATIONS FOR ECONOMIC DEVELOPERS

Recommendation One: *Advocate for greater price and quality transparency at the provider level*

In his co-authored book entitled *Redefining Health Care*, Harvard Business School professor Michael Porter lays out a new framework for competition in health care. He argues that the wrong type of competition between providers, health plans, and other participants is largely to blame for rising costs (Porter/Teisburg, 2006). One missing ingredient is said to be a lack of transparency in price and quality data at the provider level, and the inability for consumers to make informed decisions.

For health reform advocates, the most attractive aspect of value-based competition is the promise of lowering costs while simultaneously improving quality. The argument states that through value-based competition, providers continuously strive to reduce costly practices such as defensive medicine, misdiagnosis, lengthy recovery times, and post-care complications, since competition would take place on results rather than cost-shifting. Working with local participants to encourage health care institutions to publish price and quality data, and to build local support for value-driven health care could be a strategy for local economic developers.

FIGURE III: Relationship between cost and quality of care



[Economic Developers] could also incorporate value-based competition into regional marketing campaigns to demonstrate a region's commitment to lowering health care costs.

In the past, hospitals have not published this information but transparency in health is gaining momentum with groups such as the Wisconsin Collaborative for Health Care Quality and the Utah Partnership for Value-Driven Health Care. These organizations are working with providers, employers and other purchasers of health care in promoting quality and price transparency. Support for transparency is also growing in well-established health care institutions. In March of 2009 Blue Cross and Blue Shield of Minnesota released an online tool called Care Comparison. Care Comparison allows nearly two million members to evaluate total treatment costs as well as quality, safety and accessibility information.

Economic developers might think about supporting these efforts by working closely with local providers, employers and government to advocate for greater transparency. Local delivery systems that embrace transparency early on will be respected as leaders in local performance-based initiatives and will set the rules of the game. Economic developers could contribute to this movement by presenting a convincing, economic argument in favor of value-based competition. They could also incorporate value-based competition into regional marketing campaigns to demonstrate a region's commitment to lowering health care costs.

Recommendation Two: Use value chain analysis to identify and unite local stakeholders

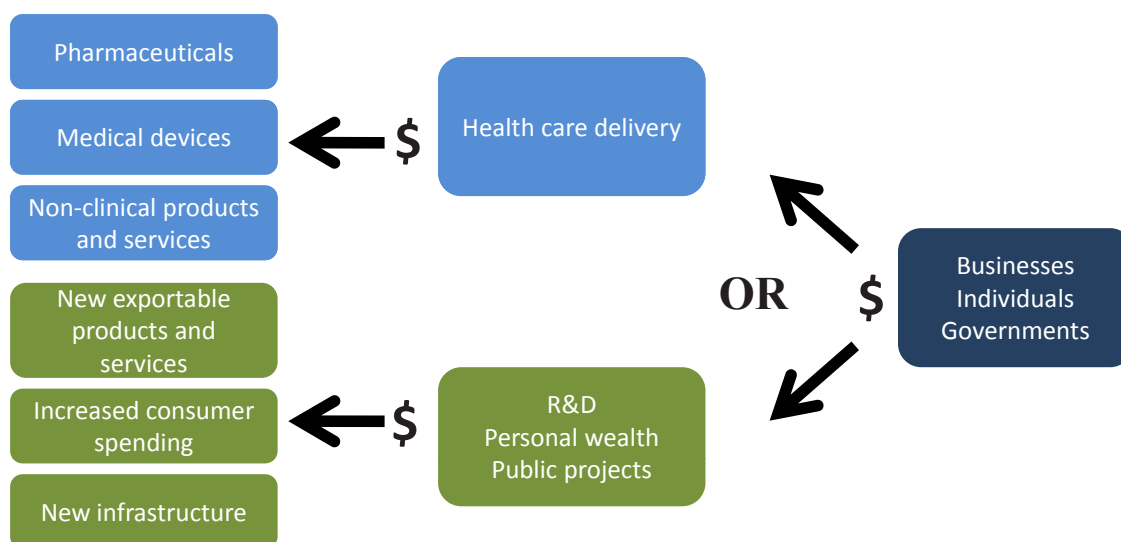
The methods used by economic developers to conduct inter-industry analysis could also be useful in uniting local stakeholders behind a coordinated, value-driven health care strategy. Health services sit at one end of a complex value chain of buyers, direct suppliers, and intermediaries (Burns, 2002). These include pharmaceutical companies, medical supplies and device manufacturers, and non-clinical products and services such as furniture, office supplies, and catering services. Since each delivery system has a unique mix of health services and supporting industries, communities should also have a unique strategy to understand cost drivers and to improve local delivery system performance.

As a planning tool, economic developers can use a formal economic model in health care. One such framework is a set of 378 disaggregated value chain benchmarks developed by Edward Feser at the University of Illinois (Feser, 2009). A value chain framework could be used to map the backward (buyer) and forward (seller) linkages across the health services value chain in a given community. This could be useful in at least three ways: First, value chain analysis could be used as a tool to better illustrate the unique qualities of a regional delivery system and its relationship with the local economy (see figure VI). Second, it could be used as an exploratory tool to benchmark local delivery systems to others. High-cost regions and their respective value-chains could be benchmarked to low-cost regions. From there, conclusions might be drawn on the distinct market dynamics that may cause these variations in costs. Third, value chain analysis could be used to assess the local impacts of health care reform across the three levels discussed in the previous section – short-run, mid-run, and long-run impacts. Value chain analysis in combination with logic models and scenario planning could be used to bridge common interests between local stakeholders.

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FIGURE IV: Modeling local delivery systems by using inter-industry value chain analysis



Recommendation Three: *Partner with HHS-recognized community leaders and chartered value exchanges*

The Department of Health and Human Services officially supports value-based competition through its Value-Driven Health Care program. Among the four cornerstones of VDHC are quality and price transparency, support of health care IT and incentives to promote quality and efficiency of care (Department of Health and Human Services). The HHS reaches out to local delivery systems by sponsoring what they call Community Leaders and Chartered Value Exchanges (CVEs). These organizations are local or statewide, and are typically a public-private mix of health care industry leaders, major employers, and governmental agencies. In total, the program has 122 official Community Leader groups and 25 Chartered Value Exchanges. Economic development offices should strengthen partnerships with these organizations in support of value-driven health care. Some agenda items might include:

- Mobilizing firms, government, and other major purchasers to demand greater transparency.
- Creating a regional marketing strategy based on a commitment to creating patient value.
- Using multi-stakeholder expertise and connections to refocus ED retention/attraction efforts around value-driven health care.

If your community does not have an official HHS sponsorship, then a dialog should be opened with major health organizations, governmental agencies, and health plan purchasing groups to designate a sponsor.

Recommendation Four: *Focus business attraction efforts on health service companies dedicated to value enhancement*

The national movement for health care reform will change the dynamic of how health care is delivered. A greater focus will be put on better coordination of care through health IT, greater transparency in quality and price transparency, and other services focused on improving the efficiency of local health systems. According to Porter, there is a growing service industry building around value-creating initiatives. These firms include information, software, and decision-support companies all trying to “seek out and disseminate the best available results information to assist providers, health plans, employers, and consumers” (Porter/Teisberg, 2006). One example is a firm called Data Advantage located in Nashville Tennessee. Specifically, their Value Index product measures the relative value of care that hospitals provide to patients. In their business attraction efforts, economic developers should research, court, and support the growth of these firms as part of their value-driven strategy in health care.

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Recommendation Five: *Encourage an export-driven culture in health care delivery*

Although health care delivery is still largely a local-serving industry, the geography of how and where patients seek care is quickly changing. The development of health information technology, personal health records, telemedicine, noninvasive medicine, flexible health plans, and alternative business models of health care delivery signify a big shift away from a centralized model of health care to a smarter, more decentralized approach centered around the patient (The Economist, 2009). Medicine will increasingly go where the patients are, instead of patients going to where the doctors are. More importantly for local economies, these trends in medicine are transforming health care into an increasingly export-driven industry.

Economic developers have traditionally paid more attention to the export-driven industries in the life sciences such as medical supplies and pharmaceuticals, but less on delivery. This local mindset in economic development research is reflected in the Harvard Cluster Mapping Project headed by Michael Porter. Porter classifies health care services as a local-serving industry cluster that primarily sells locally. Economic developers should change this local-serving mindset and work with health care providers to establish their regions as net exporters of health services, rather than net consumers.

A colorful example of export-driven health care is the booming medical tourism industry. More and more, people are traveling to foreign locations to receive sophisticated medical procedures including heart valve replacements, spinal fusion, hysterectomy, angioplasty, and hip replacement surgery (Deloitte, 2008). A recent study by Deloitte forecasted medical tourism to grow to six million Americans traveling for care abroad by 2010. Another example is the growth of hospital-sponsored retail clinics. While still a small player in the health care arena, the number of retail-based clinics is growing rapidly with approximately 1,000 sites across 37 states (Laws/Scott, 2008). The Cleveland Clinic is working with CVS to set up clinics in pharmacies in Ohio and the Mayo Clinic is operating two clinics in Rochester, MN supermarkets. Wal-Mart has also partnered with hospitals such as Aurora Health System in Wisconsin and CoxHealth in Missouri, as well as the Christus Medical Group, to open 26 retail clinics inside their stores to date.

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Another consideration should be the international market for US providers which remains largely untapped. Many of the major teaching hospitals are expanding their presence overseas through partnerships, schools, as well as treatment centers. For example, Harvard Medical International has a total of 23 outfits in foreign locations (Deloitte,2008). The University of Pittsburg has three hospitals abroad and Cornell has at least one medical school abroad. Also, the international market for U.S. health services will become more feasible if the franchise model – such seen with hospital-backed retail clinics – takes root.

The economic development community should work with stakeholders in promoting an export-oriented culture around health care through conferences, forums, and multi-stakeholder trade missions in collaboration with foreign markets. An export culture could also help foster greater efficiencies and innovation *within* local delivery systems, as providers and other participants learn about best practices and new business models from around the world. The Apollo hospital system in India, for example, has gained recent attention in the quality and cost effectiveness of their services (Barak/Krishna 2008). Economic developers should also encourage local providers to work with their foreign counterparts in sharing ideas on these and other global trends in health care.

CONCLUSIONS

The national reform agenda has focused increasingly on driving delivery system efficiency as a way to strengthen U.S. economic competitiveness. Communities and their health care institutions should also formulate a well-defined, multi-stakeholder strategy aimed at reducing costs and improving the quality of *local* health care delivery systems. Lower health care spending will help strengthen regional economies by retaining business and attracting new talent and investment. Furthermore, by planning around these national objectives, communities will help secure sustainable health care jobs as interregional and intraregional competition intensifies. Those regions that successfully adopt value-driven measures early will be better prepared for the impacts of health care reform and will strengthen their global economic competitiveness in the long-run. In response, economic developers should develop more sophisticated strategies centered around maximizing the efficiency of health care delivery. Instead of direct job creation, the focus should fall more on reducing the burden of high health care costs set on local government, business, and individuals.

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The economic development community should work with stakeholders to build an export-oriented culture around health care.

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ACKNOWLEDGEMENTS

Special thanks to Edward Feser from the University of Illinois at Urbana Champaign; Krzysztof Bujarski from Dartmouth Hitchcock Medical Center; Hunter Heath III from Indiana University; Mike Brooks from the Indiana Health Industry Forum and Sonal Gandhi from the Boston Redevelopment Authority for their invaluable input and help with revisions.