

Discovering - and Lowering - the Real Costs of Health Care

by Michael E. Porter



The rising costs of health care are a pressing issue in the United States and elsewhere, but we can't reform the system without better ways of understanding the relevant costs and how to measure them. To achieve that, I'm pursuing a new initiative with my colleague Robert S. Kaplan to bring modern cost accounting to health care delivery.

To be sure, the health care system does not lack for cost data. Ask about costs at any level of health care provision, and you will be deluged. But we actually know very little about costs from the perspective of examining the value delivered for patients. In particular, we do not know the total cost that health care providers incur to deliver care for patients' medical problems. There are two big puzzles to untangle: how costs are aggregated, and how they are allocated.

With the first, the problem is that health care organizations divide their expenses into buckets that are not very useful for cost analysis. Care providers account for expenses incurred by departments, by physician specialties, or for discrete services. It's easy to record the costs of running a hospital's emergency room, radiology lab, cardiology department, or physical therapy center. What's obscure is the full cost of treating the patient's problem.

It isn't surprising that costs are aggregated in this way: In the U.S., in particular, it reflects how care is organized and paid for. Reimbursement is based on fee for service, with separate bills for each physician specialty, procedure, test, and so on. That makes meaningful reform difficult, however, because efforts to reduce costs naturally proceed from known costs. Cost-reduction initiatives involve incremental steps such as bargaining down reimbursement rates for specific services and attempting to limit expensive services and drugs. This approach has yielded marginal savings at best.

If we truly want to understand costs and where they can be reduced without compromising outcomes, we need to aggregate costs around patient cases. What matters is the total cost of treating a patient's medical condition, such as renal failure or breast cancer, not the cost of running a dialysis center or a medical oncology department. If all the costs involved in a patient's care—inpatient, outpatient, rehabilitation, drugs, physicians, equipment, and facilities—are brought together, it is possible to compare the costs with the outcome achieved. Armed with this knowledge, we are in a position to reduce structural costs by reallocating spending across types of services, eliminating non-

value-adding services, better utilizing capacity, speeding up cycle time, performing services in the appropriate facilities, and so on.

This is the objective of pilot projects that Professor Kaplan and I are conducting with major health care delivery organizations. We are investigating total costs for a number of medical conditions, and also comparing total costs incurred to treat the same medical condition by two different providers, one in the U.S. and one in Germany. In Germany reimbursement for a total knee replacement is about \$8,500, whereas in the U.S. it ranges from about \$25,000 to \$40,000. These are the prices that payers are presented with. Are the underlying costs so wildly different, and if so, why? Using current cost accounting practices, such comparisons are difficult (sometimes virtually impossible) to make. With proper cost measurement, however, we can ask the \$30,000 question: How might the U.S. provider reduce the gap?

In addition to measuring costs around the patient, we need to address a cost allocation problem. Note that patient care involves not only the direct costs, such as a surgeon's time, drugs, or supplies, but the costs of utilizing shared resources. Indeed, shared personnel, facilities, and equipment account for much of the cost of health care delivery. Typically, these costs are charged out evenly across all patients, regardless of how much an individual patient actually draws on shared resources. The challenge, then, is to appropriately allocate shared resource costs to individual patients. It is a challenge tailor-made for the activity-based costing methods that Kaplan and his colleagues have pioneered.

Already our work is revealing opportunities for cost reduction. Much health care, we now see clearly, is delivered in overresourced facilities. Routine care, for example, is delivered in expensive hospital settings, where facilities are often idle and a lot of equipment is in place but rarely used. Skilled physicians and staff members spend considerable time on activities that don't depend on their expertise and training. The way care is currently organized leads to redundant administrative costs, unnecessary and expensive delays in diagnosis and treatment, and unproductive time for physicians.

All these observations make me optimistic that health care costs can be substantially reduced without sacrificing patient outcomes. In fact, cost reduction will often be associated with better outcomes. The introduction of modern cost accounting may turn out to be as much of a breakthrough in health care as it was in other industries decades ago.

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