Universal principles for health care reform

A health care system’s fundamental problems can be addressed if the decision makers recognize the interlocking nature of its elements.

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Health care systems around the world struggle to reconcile three competing objectives: equitable access, high quality, and low cost. The trade-offs among these goals are inherently political. Should governments, for example, ration capacity in order to lower costs, even if doing so creates longer waiting times for care? Should they provide coverage to all citizens? Mandate quality standards?

As political and local as such choices may seem, many of the challenges reformers face are common to almost every health care system: for instance, increased supply creates additional demand for care and often fails to generate commensurately better outcomes, such as longer life expectancy. In many countries, higher spending does not correlate with higher-quality health care as perceived by consumers.

A comprehensive approach

The universal features of health care systems across the developed world suggest that today’s reformers, who tend to be piecemeal in their interventions, would benefit from a more holistic approach: one that recognizes the strong interdependency of seemingly autonomous actions. Reformers need a comprehensive perspective lest their remedies for one aspect of a health care system generate unintended—and potentially
negative and costly—implications for another part.

Developing a comprehensive perspective for such a complex challenge requires a framework to help guide decision making. To create an overview of the complicated relationship between the competing goals common to all health systems, we identified and unbundled the primary elements of supply and demand. In so doing, we formulated six principles that apply to a broad spectrum of health care systems. Two of these principles relate to demand, three to supply, and one to intermediation between supply and demand. In so doing, we formulated six principles that apply to a broad spectrum of health care systems. Two of these principles relate to demand, three to supply, and one to intermediation between supply and demand. We then derived a seventh principle, concerning the organizational and operational framework necessary to implement these concepts (Exhibit 1). Despite the unique characteristics of health care, our findings should refute the notion that it is fundamentally beyond the possibility of structured, logical, economically rational reform.

Seven principles to guide health care reform

While these principles are not necessarily new, they provide a systematic basis for aligning supply with demand and thus for characterizing the levers available to a health system’s policy makers. The framework of the seven principles will give policy makers an additional tool for comparing a health system’s performance with others and, when necessary, for reprioritizing areas of reform—to optimize performance and to reconcile the inherent conflicts among the objectives of access, quality, and cost.

1. Prevent illness and injury

Most health care systems focus on care for those already ill or injured. Yet policies aimed at promoting health and reducing the amount of sickness and

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1 The full report, *A Framework to Guide Health Care System Reform*, was published in January 2007 and is available free of charge online at [www.mckinsey.com/mgi](http://www.mckinsey.com/mgi).
Injury decrease the demand for medical services and may produce better health outcomes at lower cost. Obvious as this opportunity might seem, many reformers prefer to deal with more complicated matters before addressing it, perhaps in part because they believe that health and wellness are personal matters, while access to care and its financing are more political ones. We have identified four levers that help prevent illness.

Build an infrastructure to support basic levels of hygiene. Proper sanitation, clean drinking water, and safe, reliable energy all have an impact on health. Inner cities, remote areas of developed countries, and developing economies typically fall short in these areas.

Reduce environmental hazards. The link between pollution and illness is now well accepted. Despite the improvements some nations have made, large variations in pollution levels and environmental standards persist around the world—the United States emits nearly five times more carbon monoxide per capita than the United Kingdom, Germany, or Japan, for instance. In national debates, health system leaders must illustrate the link between environment and health more forcefully.

Establish effective and comprehensive immunization programs. Even in some developed countries, immunization programs fall short of reaching

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**Seven principles**

Framework to guide reform of health care systems

<table>
<thead>
<tr>
<th>Principles</th>
<th>Description</th>
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<tr>
<td>1</td>
<td>Prevent illness, injury</td>
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<tr>
<td>2</td>
<td>Ensure value-conscious consumption of services, treatments</td>
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<tr>
<td>3</td>
<td>Promote efficient creation of capacity for labor, infrastructure, innovation</td>
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<tr>
<td>4</td>
<td>Safeguard the delivery of quality by providers</td>
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<tr>
<td>5</td>
<td>Promote cost competitiveness</td>
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<tr>
<td>6</td>
<td>Promote sustainable financing mechanisms to collect and distribute funds</td>
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<tr>
<td>7</td>
<td>Build and organize capabilities of intermediaries to enable them to effectively manage the system</td>
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*By improving clinical outcomes through adherence to standards in screening, treatment, education, and accreditation; promoting evidence-based medicine; carrying out risk-based monitoring and performance review.

Source: McKinsey Global Institute analysis
100 percent of the population. In developed countries, the vaccination rates of one-year-olds for measles and hepatitis B, for example, vary from 80 to 99 percent and from 0 to 92 percent, respectively. Even allowing for questions about the efficacy and possible side effects of some vaccines, we believe that immunization rates should be more uniform.

Encourage healthy lifestyles. It is widely acknowledged that an increased risk of diabetes, heart disease, and cancer, for instance, is linked with poor diet, sedentary lifestyles, and smoking. Public-education campaigns can be effective—since the 1980s, for instance, the United Kingdom and the United States have reduced tobacco consumption per capita by approximately 50 percent. But unhealthy lifestyles remain pervasive in most developed Western economies, and the health of the overall population continues to deteriorate.

2. Promote value-conscious consumption

The quality and efficiency of any health care system can be improved through value-conscious consumption, but that is difficult to achieve when customers don’t know what constitutes superior quality and what that quality costs and don’t have financial accountability for their decisions. Health system leaders should act on two fronts to ensure that decisions about health care consumption are made in the same way as other decisions involving discretionary economic trade-offs.

Provide information and flexibility to support rational choice. At present, the level of transparency along the dimensions of price, quality, and service isn’t enough to support economically efficient decision making. But there has been some progress. In the United States, for example, the Centers for Medicare & Medicaid Services (CMS) now publishes statistics on the complication and mortality rates at hospitals. However, more information should be made available, and consumers should have the ability to select providers freely.

Foster consumer accountability. Transparency is a prerequisite for rational choice but won’t fully bring it about unless financial benefits and consequences are attached to the resulting decisions. Health care consumption has been isolated from nearly all economic trade-offs through the introduction of third-party intermediaries, yet different providers and treatments often involve vastly different levels of resource consumption—without a corresponding difference in benefits. In other words, consumer accountability is lacking.

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2 The Centers for Medicare & Medicaid Services is part of the US Department of Health and Human Services.
3. Analyze under- and overcapacity

We found evidence of both under- and overcapacity in different areas of all the health care systems we examined. The most glaring cases of undersupply are in African countries, where hardly any national health care systems have the resources to purchase adequate supplies of drugs, equipment, and devices. An example of overcapacity, in contrast, is the large number of MRI scanners per capita in Japan—more than six times as many as in Germany or the United Kingdom. While policy makers should try to limit their influence on capacity issues—poor investment decisions and regulation too easily lead to over- or undersupply—they should still aim to avoid extreme undercapacity in four areas.

Physical capital and capacity. Adequate health care coverage depends on a sufficient supply of hospitals and related physical resources, but even developed economies sometimes have trouble meeting these requirements. In Britain’s National Health Service (NHS), for example, some 41 percent of patients requiring elective surgery have to wait longer than four months for their operations, an indication of undercapacity or of inefficient use of available capacity.

Demand assessments and sustainable capacity. Traditional metrics may be misleading. In the United States, for example, simply counting the number of beds per capita suggests undercapacity. However, actual statistics for admissions and for the duration of hospital stays show that the country has too many hospital beds.

Labor. The failure to match labor supply with demand is a key factor limiting the provision of health care services. It is not easy, even in developed economies, to ensure an adequate labor supply—the training of doctors and nurses involves long lead times and can be made more difficult by professional associations that exercise a large degree of control over the number of educational and training positions in some countries. Many nations have resorted to importing health care workers—although this practice is proving increasingly controversial as it often takes those workers from the developing countries that educated and trained them.
Technology. The right quantity and mix of technology is necessary to secure an adequate supply of the most efficacious drugs and the most effective equipment. Innovation must be actively promoted to ensure that technology continually improves, but technology must be targeted to meet the health needs of the population in question. The newest and most expensive machines or devices are not always the most appropriate; technology, like physical resources, labor, and IT, may be in under- or oversupply.

4. Safeguard the quality of suppliers
Efforts to improve the quality of health care, which varies considerably among systems and even more strikingly within them, face two major challenges. First, the lack of reliable data on quality, safety, and service can hinder the development and monitoring of the most effective treatments. Second, quality and service problems often stem from system-level issues, such as a lack of adequate funding, so they have to be examined along with the other supply factors. Policy makers should focus their attention on three areas of importance.

Clinical practices. We define clinical practices as adherence to relevant national or local standards, not only in the screening and treatment of patients, but also in the education and accreditation of the labor pool, as well as the accreditation of facilities. These safeguards aim to improve diagnoses, increase adherence to well-documented practices, and reduce the incidence of harmful errors.

Medical literature provides growing evidence of the efficacy of particular diagnostic and therapeutic protocols that reduce morbidity and mortality. Health care facilities that follow established protocols get higher-quality outcomes. Hospitals with the highest adherence to evidence-based protocols for the treatment of pneumonia, for example, have 20 percent fewer complications and 25 percent fewer readmissions than hospitals with the lowest adherence. However, we found that health care providers in the countries we studied fail routinely to use the available protocols properly. In Germany, for instance, 35 percent of diabetes patients in one survey reported that their annual checkup didn’t include an examination for foot ulcers, one of the normal complications of chronic diabetes.
The availability of information. Health systems can promote evidence-based medicine by making real-time information on key outcomes and practices freely available to policy makers, insurers, providers, and the public. Studies in the United States have shown differences in quality between health care organizations that issue reports publicly and those that don’t. The mortality rates of cardiac departments in the United Kingdom improved markedly once these rates were published.

Risk-based monitoring and audits. Safeguarding quality also requires a comprehensive system to assess the delivery of health care and to recommend intervention for failure or underperformance. National inspection and intervention regimes work best when they allow for both risk-based monitoring (for example, more detailed monitoring of higher-risk organizations) and proportional intervention (no action below specific thresholds, for instance, and heavy intervention in cases of significant concern for the safety of patients). Nonetheless, the most important inspection processes are those of the providers themselves. Leading hospitals build performance reviews into operating meetings, put these reviews on the agendas of key committees, and integrate the reviews into employee assessments.

5. Promote cost competitiveness
Providers must have the right incentives to optimize costs in both the delivery of services (or goods) and the acquisition and management of inputs—in other words, the productivity of processes must be improved. Health care system leaders must thoroughly explore the implications of proposed changes to inputs and the delivery of care and seek to eliminate barriers to innovation that exist simply for the sake of protecting entitlements and job security—all while continuing to promote safety.

Enhance the productivity of processes. Higher productivity in health care can be measured by reductions in service times (including average lengths of stay and emergency room\(^1\) waiting times) and by increased capital productivity (for example, the number of surgical operations per

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\(^1\)Emergency rooms in the United States are the equivalent of accident and emergency facilities in the United Kingdom.
theater per day). Health care systems should strive to optimize costs by making better investments in assets and then using them productively rather than by creating excess capacity and overusing it.

Minimize factor input costs. Health care leaders can reduce the cost of labor or goods by purchasing them more effectively. Governments, which are often the single largest purchasers of health care services, frequently don’t implement proven techniques to manage purchasing and supply chains.

6. Improve finance mechanisms
Sustainable, equitable health care systems require efficient financing mechanisms to match supply and demand. Health care intermediaries should examine alternative sources of finance and match them to the needs and economic characteristics of populations in a way that helps to control overall prices.

Shifts sources of financing for health care. Health care systems around the world have largely used private or public insurance plans to finance care that does not lend itself well to insurance products. As demographics and lifestyles increase the incidence of medical conditions brought on by longer lives and unhealthy habits, respectively, the overall balance of funding needs to shift away from insurance and much more toward savings. Single-payer insurance coverage, for instance, tends to be excessive for the young and healthy but insufficient for the chronically ill.

A more graduated coverage structure could improve the system’s overall efficiency, reduce costs, and increase the amount that consumers save for their health care by encouraging them to understand the economic trade-offs between health care and alternative uses of these funds. In end-of-life care, for example, savings may be a better mechanism: late in life, individuals often own assets (such as life insurance benefits and retirement savings) they can use to hedge the risk of their end-of-life medical costs. Consumers already use their own savings for deductibles, co-payments, and elective procedures such as laser eye surgery.

*Co-payments, or co-pays, require the covered person to pay part of the cost of a treatment.*
Align reimbursement mechanisms with providers. Health systems around the globe will benefit by better aligning reimbursement mechanisms with the providers that best manage risk. In the past, providers were generally paid on a fee-for-service basis. The flaw in this approach is that costs rise whenever providers increase their fees, provide more services, or substitute more expensive services for less expensive ones—and providers have the incentive to do all three.

Three alternative-reimbursement mechanisms are in play. Diagnosis-related groups categorize illnesses according to their diagnoses and treatments and pay providers a predetermined amount, based on that category, for treatment. Capitation fees are specified amounts paid to the provider for each person in a given group, regardless of the actual number or nature of the services delivered over a set period. Per diem rates are flat, all-inclusive daily fees for a specific service or outcome, regardless of cost. Diagnosis-related groups have been clearly effective only in the United States, where they have produced the shortest average hospital stays in the OECD countries and catalyzed the development of subacute care providers.

Health care systems should explore novel structures, such as payment for performance, more intensively. In the United States, for example, CMS is pursuing a plan to improve the quality of care that Medicare beneficiaries receive by differentiating payments across the top and bottom decile of providers (calculated by a provider’s composite performance across four to six quality indicators per disease). Private payers in the United States are adopting similar programs, which use a combination of variable co-payments to nudge patients toward higher-quality and lower-cost facilities and reward high-performing providers with incremental increases in patient volumes and higher reimbursements.

7. Ensure successful implementation

To implement these reforms successfully, leaders of health care systems must work within a robust organizational framework at every level. Health care organizations need to have effective leaders who can push through change; to build institutional skills (notably in IT, which tends

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5 Organisation for Economic Co-operation and Development.
to be poor across most health systems); to develop greater accountability, which is often diluted by the public, nonprofit aspect of health care; to coordinate the stakeholders’ interests in order to avoid a backlash against change and any unintended, negative consequences; and to deploy the three main approaches to implementation (Exhibit 2).

Build awareness. Creating awareness of the need for change—in other words, providing the required contextual information—involves gathering data (through surveys, for example), compiling data sets, and disseminating information, along with any other tools that could increase knowledge of the health care system’s shortcomings and lead to action. Reform efforts are most effective when the interests of consumers and suppliers are aligned with the system’s goals.

Provide appropriate financial incentives. If the interests of individual players are not perfectly aligned with the system’s goals, financial—or indirect—incentives can play a significant role. The most widely used financial incentives are tax breaks, capital subsidies, or bonus payments. Tax breaks, for example, induce US employers to provide health care benefits to their employees. A public subsidy could be used to persuade health care providers to invest in more specialized staff and to raise the

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### Exhibit 2

#### Three main approaches

**Implementation approaches to shape demand and supply**

<table>
<thead>
<tr>
<th>Awareness (contextual)</th>
<th>Incentives (indirect)</th>
<th>Mandates (direct)</th>
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<tbody>
<tr>
<td><strong>Prevention</strong></td>
<td>Contribute to health savings accounts</td>
<td>Require vaccinations for children before they start kindergarten</td>
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<tr>
<td><strong>Value consciousness</strong></td>
<td>Design benefit packages to encourage use of specific providers</td>
<td>Exclude coverage for high-cost providers or procedures</td>
</tr>
<tr>
<td><strong>Capacity</strong></td>
<td>Forgive loans for physicians practicing in underserved areas</td>
<td>Require regulatory approval based on demonstration of need</td>
</tr>
<tr>
<td><strong>Quality, safety, and service</strong></td>
<td>Pay bonuses to providers for implementing evidence-based medicine</td>
<td>License/credential providers based on minimum standards</td>
</tr>
<tr>
<td><strong>Cost competitiveness</strong></td>
<td>Negotiate preferred vendor agreements with low-cost providers</td>
<td>Impose standard pricing for all doctors, set at low level to drive cost reductions</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>Offer tax subsidy for purchase of employer-sponsored coverage</td>
<td>Mandate insurance coverage for all not covered by public-entitlement program</td>
</tr>
</tbody>
</table>

Source: McKinsey Global Institute analysis
quality of care when the market would not reward them. Providing bonuses to physicians and nurses is one way to accelerate increases in capacity.

**Impose mandates.** If efforts to build awareness or to offer incentives have failed—or when the costs of external factors are not fully borne by their creators (such as restaurants that permit customers to smoke, thus exposing other customers to the fumes)—the more direct approach of mandates may be necessary to reinforce desirable behavior or prohibit bad practice.

By rooting the necessary analysis in a comprehensive framework, policy makers will find that local differences in health care systems need not preclude a structured, systematic approach to reform based on enduring, universal principles.