Consumerism: Today's Pursuit of Healthcare's Unicorn

Mark P. Herzog, FACHE

The feature articles in this issue of *Frontiers of Health Services Management* provide an excellent overview of consumerism efforts in healthcare and many of the facilitating and resisting factors that affect its deeper adoption. The ways EvergreenHealth and Christiana Care Health System use consumerism to drive organizational strategy, design, and resource allocation represent best practices of learning organizations. They are making the pivot from a provider-centric view of the world to a consumer-centric one, even as today's healthcare business models make consumerism a challenging sell. Regardless of where you are starting from, the road to consumerism has more than a few twists and turns.

Healthcare Consumerism Defined

A quick literature scan yields dozens of definitions of *consumerism*. The one I prefer reads: "The concept of consumerism is generally understood to mean people proactively using trustworthy, relevant information and appropriate technology to make better-informed decisions about their health care options in the broadest sense, both within and outside the clinical setting" (Carman, Lawrence, and Siegel 2019). Note that this definition does not explicitly look to doctors or hospitals as core resources. In fact, thought leaders differ on the appropriateness of providers serving as the ideal consumer guide. The discordant introduction of the concept of value—and its widely varying definitions, depending on whether you are a hospital leader, doctor, acute or chronic care patient, healthy person, employer, or payer—has a profound impact on your enthusiasm for consumer-centric practices. The segment of the sector your organization is in and the consumer categories you serve are important factors in your approach to consumerism.

Consumerism for Healthcare Organizations

Consumerism is nothing new in retail and personal services industries; in fact, it has long been transformative. For today's hospital and physician/provider sector, however, consumerism represents unique and complex challenges. These challenges relate primarily to the fixed-cost exoskeletons of delivery system organizations, their traditional cultures, and a financing system that continues to reward providers mostly for volume. It is unclear just who in this system should be empowering the patient to be a consumer by controlling personal experiences and costs. Industrywide disruption

Mark P. Herzog, FACHE, *is president of Herzog Advisory Group in Manitowoc, Wisconsin.*

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stemming from the potential repeal of the Affordable Care Act and the healthcare rhetoric of the 2020 presidential election mean that leading transformation from within the sector will require courageous and visionary leadership now more than ever.

Successfully navigating the path to consumer-centric service delivery is especially daunting for complex legacy organizations such as hospitals. In introducing his book *The Innovator's Prescription*, Clayton Christensen (2009, xxiii) observes, "The lack of business model innovation in the health-care industry—in many cases because regulators have not permitted it—is the reason health care is unaffordable."

Among Christensen's "prescriptions" is that "health care systems will need to integrate so they can wrap their arms around all the pieces of the system that must be interdependently reconfigured" to produce the highest quality, the lowest cost, and, by extension, the clearest focus on consumerism (Christensen 2009, xxx). Furthermore, "disruptive innovations are simpler and more affordable" (Christensen 2009, 5). By almost every definition, this should be the core of every organization's consumer strategy. However, making healthcare both simpler and more affordable is presently, for most providers, like chasing a unicorn through the woods.

Health system leadership in consumerism, of course, depends directly on the mission and vision of who is doing the integrating, and why. At present, most integration energy is directed toward market accretion and consolidation. Perhaps the future will bring an emphasis on leveraging consolidation to improve consumerism attributes and to lower the personal cost of care. Christensen (2009) cites Kaiser Permanente as an example of one such organization doing that today.

A quip of health economist Uwe Reinhardt (2015, 27) seems appropriate to this discussion: "If I believed in reincarnation, I would think that American hospital CEOs must have done something wicked in an earlier life to be condemned to their current role in this life." Reinhardt's remark is applicable to the task that many leaders face in struggling to maintain, if not transform, their hospitals as consumer-focused organizations. Fortunately, as the feature articles in this issue of *Frontiers* demonstrate, the leadership of EvergreenHealth and Christiana Care have done outstanding work to help us understand the context for consumerism in healthcare. Their organizations are clearly pioneers that are showing a way forward, sharing successes and failures, and addressing the complex dynamics of change.

Defining Healthcare Consumers

To develop a consumerism strategy, one must first understand who healthcare consumers are and what investments are required to meet their needs.

The simple term *consumer* covers an exceedingly diverse universe of participants. In healthcare, the variety is evident in the different approaches to care based on different patients' needs. This situation presents a confounding challenge for hospitals and physicians as they try to meet anything more than narrow slices of consumer expectations in one or more categories. To illustrate this point, I suggest the following four major consumerism categories, the applicability of "consumer" tools, and the likelihood of provider effectiveness in solving needs in and across the categories:

1. **Living large.** Some people highly desire and are willing to personally pay for certain retail services or products that are not medically necessary. Examples

include cosmetic procedures, Lasik surgery, and the like. The full consumerism toolkit of experience shopping and comparing choices, prices, service, and quality is directly applicable to people in this category.

2. **Living well.** Others seek preventive maintenance and lifestyle coaching to maintain age-specific health status with evidence-based diagnostic testing and procedures. These consumers desire minimal interaction with healthcare providers; when they do interact, they have already accessed health information resources on their own. This category may use the full consumerism toolkit to compare choices, prices, service, quality, and experience, but if comorbidities or other complexities emerge, consumerism and choices quickly become limited.
3. **Living hurt.** Consumers in need of emergent care or diagnosis usually do not conduct online research or use an insurer or employer comparison app, and the space for objective consumer behavior is constrained. Choosing a physician, hospital, or alternative provider relies less on typical consumerism toolkit behaviors, and accessing comparison data is problematic.
4. **Living sick.** The vast majority of healthcare dollars and resources are spent by people on chronic disease management of known illnesses and comorbidities. This category represents the greatest challenges for consumer-focused provider tactics. Consumers in this category have well-established provider relationships, behaviors, and healthcare consumption patterns. Strong provider relationships may lessen the influence of comparison tools, but the market for consumer-focused monitoring and treatment technologies can significantly influence compliance and outcomes. Consumerism is important but is not always primary in driving care decisions.

To put this all in perspective, the Health Care Cost Institute (HCCI) has determined that shoppable care accounts for only 7 percent of all spending for privately insured patients (Frost and Newman 2016). HCCI president Niall Brennan adds, "If you want to hold down prices, if you want to use prices and quality to get people to buy value, 93% of the dollars are elsewhere" (Kaufman 2019).

A Midwestern Perspective: Holy Family Memorial

Holy Family Memorial (HFM) is a single-market, integrated community healthcare provider in Manitowoc, Wisconsin, that combines a 68-bed hospital with a multispecialty group practice of 90 employed providers who have a deep community presence and commitment. I retired from HFM in March 2018 after serving as president and CEO since 2001. I currently teach and conduct research on change management. HFM and its leadership have been named to many national lists over the years, including *Becker's Hospital Review*'s Top 100 Community Hospitals, and achieved Medicare five-star ratings in 2017 and 2018. Most relevant to the theme of consumerism, HFM has shown leadership in innovation, transformation, and resiliency in implementing a consumer strategy, which we named "Right Care."

From 2001 to 2008, we focused on integrating recently acquired practices into a cohesive relationship with the hospital, increasing days cash on hand from 100 to 200 and initiating an improvement system based on Lean methodology. Concurrently,

we devoted significant energy to board and leadership education and development. By 2008, we realized that a traditional community hospital vision and culture would neither guide effective achievement of our updated mission nor sustain a viable organization in competition against regional networks. Therefore, HFM initiated a transformation process in 2009 similar to the more recent work of EvergreenHealth and Christiana Care. Although we achieved many great things on our own, our early efforts would have benefited greatly from their wisdom, knowledge, and experience as a guide.

Pivotal in our transformation was the decision to update the emphasis of our mission statement from "providing services to all who seek our care" to "helping individuals and communities achieve healthier lives." For us, this meant reframing our community as consumers of healthcare who need access and education. It changed our role by adding coach, catalyst, and guide to the established, more traditional role of compassionate caregiver.

At first glance, this change may appear insignificant. Nearly every hospital has embraced community or population health in some fashion. What stood out for HFM was its historically strong identity in the eyes of its sponsor, board, staff, providers, and community as a hospital rather than a consumer-focused health system and catalyst for health. Edmondo Robinson of Christiana Care Health System notes in his article that "the long-term sustainability of a consumerism strategy requires a culture that not only tolerates but also actively celebrates innovation and transformation." For HFM, this meant reimagining our culture and business model to deliver today's services when and where consumers want them, as well as identifying, trialing, and adopting consumer-focused innovations ahead of the competition—and, hopefully, not too far ahead of our consumers.

Holy Family Memorial's Approach to Consumerism: Right Care

To describe and communicate this process to insurers, businesses, and the community, HFM developed Right Care. The initiative formalized a commitment to open innovation, financial stewardship, and relationships that are valued from a long-term, holistic perspective rather than as mere transactions. This approach was the right thing to do for consumers because it took into account their concerns about the personal and financial risks of care. In providing evidence-based care in the most cost-effective manner, HFM initiated the shift from a production-based model to a value-based one.

Implementing Right Care meant openly questioning our existing delivery model and everything that went with it. We pioneered a change process that integrated key tools from Lean to ideate a care and wellness model from the customer's perspective. An intentional culture-shaping process began in 2009 so that we could establish the environment necessary for innovation and transformation. Our cultural success was reinforced in 2013 when we were asked to deliver a keynote address at the 12th Annual International Conference on Co-Development and Open Innovation in La Jolla, California.

We sharpened our consumer focus by creating two idealized customer models representative of our community to anchor our delivery system ideation. "Harold," a retiree in his 70s, embodied our current customer base, and "Emily," a woman in her 30s seeking to start a family, represented a prospective customer. We used these consumer archetypes to personalize and anticipate their needs in a healthcare relationship and to look beyond the first

row of available innovations to add contextual richness.

This exercise spurred several innovations. First, to connect with "Harold" and his peers, the HFM Lakefront campus was created in 2017 to unite internal and family medicine, behavioral health, telemedicine, rehabilitation, and community wellness in a facility designed from the customer's perspective. We also relocated several primary care clinics to the campuses of senior living communities in the area to maintain trusted patient relationships across life's journey. Second, to deliver inspired caring to "Emily" and her peers, we developed the HFM Right Now suite of services. These focused on access channels outside of the office setting, such as electronic visits, work-site clinics, direct-access (no referral needed) lab testing and rehabilitation care, online scheduling, and mobile/text messaging. Common to each of these innovations was the idea of bringing our services to our consumers and delivering services to them in ways that they help direct.

Provider organizations must address several critical questions. Why pursue consumerism? Is it a values-driven process to improve service, experience, and outcome? Is the intention to grow or maintain market share? In markets favoring value, consumerism has a better chance of influencing market share, and because it might have a return on investment, it may find favor with finance leadership. Yet, across the nation, variations of the discounted fee-for-service model still predominate, and narrow networks are increasingly common. For providers, a narrow network strategy is often a much more efficient way to pursue market share than other delivery and experience-focused approaches are.

Lacking scale to leverage care innovations to gain market, HFM partnered in 2017 with a regional clinically integrated network that possessed expertise in connecting consumer-oriented care with economic rewards to the provider. We then faced the inescapable impact of our large competitor's narrow networks driven by pricing, with other consumer-facing factors such as quality, service, and experience taking lesser positions. Narrow networks reduce consumer choice and put insurers and network providers in the driver's seat of making decisions for the customer. Our relatively small market presence, compared to that of the competition, meant that a local focus on consumers, efficiency, and value was insignificant to large insurers and competing systems.

Knowing the Markets

Returning to the definition of consumerism stated earlier, a full realization of healthcare consumerism can only happen in open markets where consumers can proactively make choices "using trustworthy, relevant information and appropriate technology to make better-informed decisions about their health care options in the broadest sense, both within and outside the clinical setting" (Carman, Lawrence, and Siegel 2019). Today, few if any such market categories exist other than the "living large" cohort who access cosmetic or lifestyle-enhancing care. The "living well" people have the opportunity to act as informed consumers but may not choose to do so because they lack an urgent need to shop for tests or procedures, which are most amenable to comparison tools. The time pressure on the "living hurt" group limits patience and accessibility to comparison tools. Finally, the "living sick" are increasingly limited by the choices they or their employer make regarding insurer and benefit design and perhaps have a narrow network. The "living hurt" and "living sick" groups often find it difficult to

make reasonably informed decisions in all the ways consumerism would indicate they should.

Given these market limitations, providers need to carefully consider how receptive the consumer categories are to their consumerism tactics when making investment decisions. Kay Taylor's EvergreenHealth astutely organized a consumer strategy around two discrete markets: wholesale and retail. The retail market's sensitivity to experience should drive every provider's strategy, and EvergreenHealth has embedded repeating cycles of innovation in its process to continually improve experience. However, its robust wholesale market focus on clinical integration and market consolidation will likely be more important to long-term business model success. Consumerism is the *right* thing to do—but for now, market share is the *must* thing to do.

This commentary views consumerism primarily from the perspective of legacy providers. As Christensen notes, legacy organizations face daunting regulatory and financial headwinds in making the transformation to do what is right for consumers. In this spirit, providers should work to adopt the appropriate digital technologies and service enhancements they can afford, conceding that the greatest leaps forward mostly will come from for-profit entrepreneurs. One Medical, for example, employs a concierge primary care model to solve nearly all of the pain points for the "living well" and "living hurt" consumer groups and does so by selling directly to patients and employers. It is worth noting that One Medical, like most consumer-facing innovators, targets the wealthy and employed markets that make up perhaps a third of the US market. Other geographic markets with a different composition may benefit from subsequent waves of consumer innovation. The social policy aspect of this impact of consumer innovation merits further consideration.

Both feature articles refer to the rapid growth in out-of-pocket costs for insured individuals as an essential stimulant of consumer behavior among patients. This is common wisdom in national literature and health plan design. As a note of caution, however, Reinhardt observes that "people just do not behave as the theory predicts. Few employees of a large firm actually use the tools their employer provided to shop around for cost-effective health care. High deductibles simply induce them to forgo both high-value and low-value health services.... In effect, they enter that market like blindfolded shoppers pushed into a department store" (Reinhardt 2019, 52). The industry has a long way to go to provide patients with trustworthy, relevant information and appropriate technology to make better-informed decisions. My experience strongly affirms Reinhardt's conclusions.

Robinson observes that health system leaders need to zero in on consumerism strategies and view the process through two lenses. At Christiana Care, he writes, innovation is seen as "something that is new to us and has an uncertain outcome. The idea of 'newness' is important because it helps lay the cultural groundwork necessary for change." Innovation clearly deals with the "new," but it need not be new to the universe, just new to the organization. Second, Robinson notes that transformation is "a complementary concept to innovation, leveraging innovation in conjunction with implementation to drive lasting change.... Healthcare transformation requires a deep understanding of the organization's current state combined with a healthy skepticism of the status quo." For healthcare executives

leading large-scale change, these distinctions can be very important.

Conclusion

Tremendous entrepreneurial energy is being devoted to disrupting today's healthcare system. Some of this energy emanates from legacy organizations inside the sector, such as those represented by Robinson and Taylor, but the most vigorous and disruptive changes are coming from outside. Nevertheless, for traditional healthcare providers, embracing consumerism gets at *why* we do our work—inspiring our work and, as such, an easy sell if individual employees do not need to change! On the other hand, *how* traditional providers will need to evolve or transform to embrace consumerism is an open question.

Consumerism clearly holds tremendous potential for every stakeholder in healthcare. Many twists and turns will complicate the realization of this potential. Healthcare leaders will benefit from a deeper understanding of consumerism, the nature of facilitating and resisting factors, adopting an open approach to learning and innovation, and wisely leading forward.

The experiences of Christiana Care Health System, EvergreenHealth, and HFM yield insights on how healthcare can approach consumerism. They affirm my optimism that future approaches and models will lead to solutions that can improve our service to our customers through innovation, integration, and transformation. Certainly, a healthy skepticism of the status quo and an open approach to innovation will be among the keys to realizing consumerism in healthcare and fulfilling our organizations' potential to serve our communities in new and better ways.

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