

By S. Harvey Price



S. Harvey Price is editor of For Your Advantage. A health care industry strategist based in Boca Raton, Fla., Mr. Price has worked as an independent consultant since 1971. His clients are community hospitals, hospital systems and major corporations.

About FYA

FYA - For Your Advantage, is a free twice - monthly newsletter published by TrendLeader Connections.

With every issue, FYA provides insights into the topics that concern healthcare leaders today and the challenges that will be faced in the near future.

The newsletter is provided free to healthcare CEOs only. CEOs may use the material in any way they wish—except for the editorial content that is copyrighted by the author. You are welcome to print copies of FYA.

**TrendLeader Connections
406-586-8775
www.ForYourAdvantage.com**

**What Is Disruptive Innovation? - II
"When Trying Harder Is Not the Answer"**

The New Success Factor By John W. Kenagy, MD, MPA

The last *New Success Factor* ([FYA- September 19, 2005](#)) introduced Disruptive Innovation and an Einstein quote sent by Edward Gamache, administrator of Deckertown Community Hospital - "Insanity is repeating the same behaviors and expecting different results." For organizations, there are times when repeating the same behaviors are more than insane, they are not an effective, adaptive winning business strategy.¹

Harvard Business School professor Clayton Christensen developed Disruptive Innovation to solve a recurring business strategy problem - the inability of the world's greatest companies to adapt when faced with industry-transforming innovations. The demise of Digital Equipment illustrates the problem.

In the 1970's and 1980's, Digital Equipment Company (DEC) was one of the world's greatest companies. They made minicomputers; marvelous \$100,000 machines that did very complex tasks. DEC was the classic success story of the early Digital Age - the best of the best - until the mid-1980s when they started into a dizzying tailspin.

The standard business school explanation for DEC's fall was "bad management." But, Clay Christensen saw something else - he saw the graph shown on page 2.

This graph shows improvement of products or services over time. The dotted lines (1. on the graph) represent the performance that users of a product or service need or want - a range from low to high-end users. Using an automobile example, my little old Nebraska Grandmother only drove her ancient 1953 Oldsmobile to the store; clearly she was at the "low-end" of the market.

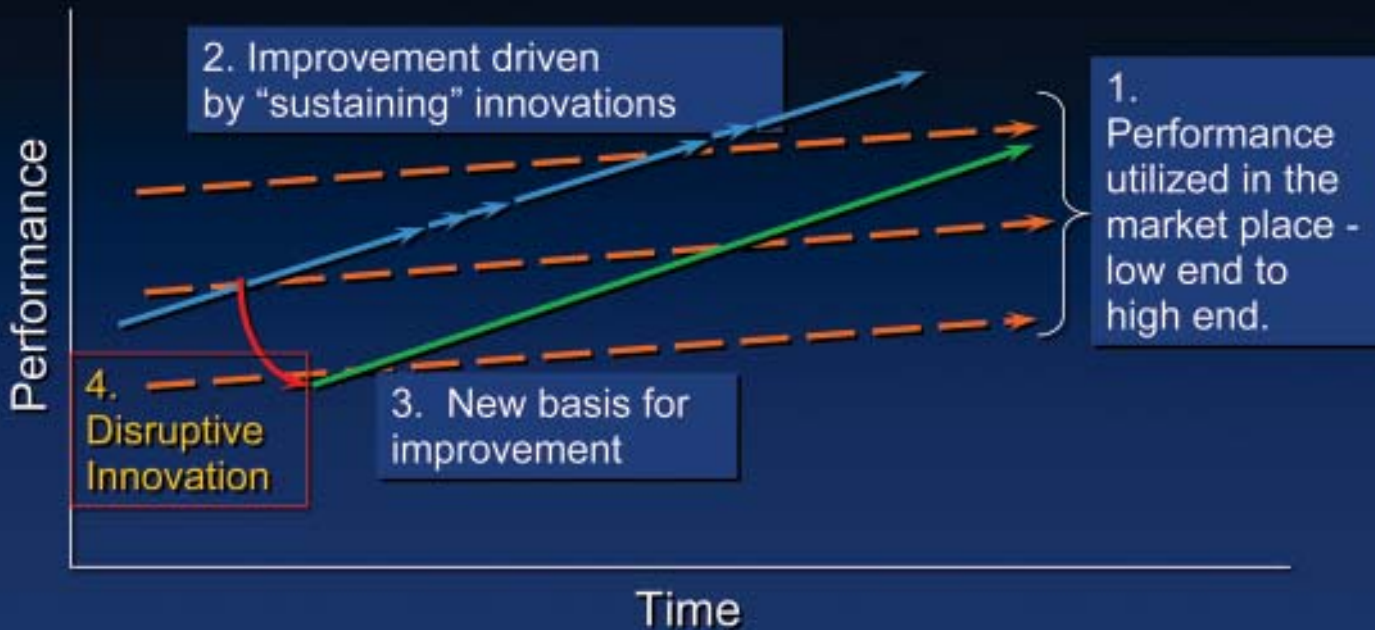
The middle and upper tiers represent users with increasing demands for higher performance - *e.g.*, bigger, faster cars; air conditioning; more cup holders, *etc.* - for which they are willing to pay more; much more than my Grandmother. Therefore, innovations (2. sustaining innovations) that meet the wants and needs of the profitable, high-end become the focus for the leading companies, not my Grandmother and her 1953 Olds.

Whether these innovations are incremental or tremendous breakthroughs, the best companies develop the processes, value systems and organizational structures to succeed at high-end innovation. And success attracts money and the best, most talented people. Moving up-market with higher performance products and services builds increasing returns...until success creates the opportunity for Disruptive Innovation.

The problem is that moving progressively up-market leaves more than just my Grandmother behind. In their quest for increased functionality, the leaders overshoot the needs of not just the low-end, but the middle of the market also. This happened to US carmakers in the 1960's and 1970's when they ignored low-end Japanese cars, particularly Toyota, to make more big cars with fins. But eventually a Toyota began to make sense to more people, even my Grandmother. This is an example of a new

¹To see if your organization needs to change its behavior, take the Self-Assessment Test in the first New Success Factor column ([FYA Volume 4, Issue 16 - August 15, 2005](#)) and see the answer key in last month's column.

Disruptive Innovation - When trying harder is not the answer.....



©2005 John W. Kenagy

platform for improvement (3); simple products that uniquely meet low-end customer needs off the radar screen of the leaders. The innovation is "disruptive" (4.) because, in the hundreds of companies Clay has studied, the incumbent leader was never able to use their established organizational methods, structures and business models to successfully adapt and compete on the new platform.

So what did happen to Digital? The profitable high-end of the market (1. on the graph) was complex mainframe computer functionality. DEC made the world's best minicomputers, continually moving up-market into more profitable tiers (2). The Disruptive Innovation that unseated Digital was the personal computer (PC's). Developed initially as toys, Apple, IBM and others moved PC's up-market into more sophisticated functions (3), while DEC could never adapt and make the jump.

I joined Clay as a Harvard Business School Visiting Scholar in 1997; the same year that he presented this story at Intel describing PC's as the "disruptive technology" (4) that sunk DEC. Sitting in the front row was Andrew Grove, Intel's powerful CEO. During his presentation, Clay saw Andy become increasingly interested and engaged. Now this is

Heaven for a Harvard Business School Professor - presenting his new ideas to a Fortune 100 senior executive team and the CEO, sitting right in the front row, gets it!! It just doesn't get any better than this!

At the end of the presentation, the lights and Andy's hand came up simultaneously. Confidently, Clay called on him first. Grove's response, "Professor, I see the flaw in your theory."

So readers, what do you think? What was the flaw that Andy Grove spotted? Hint: why couldn't DEC adapt? E-mail me your diagnosis (and any questions) to jkenagy@kenagyassociates.com. I will announce those who were closest to Andy Grove's insight in the next month's New Success Factor - "Disruptive Innovation III - Identifying when Best Business Practice is the Wrong Business Practice." For background on the new skills organizations need to adapt, see Adaptive Design® on our website at www.kenagyassociates.com.

©2005 John W. Kenagy, MD, MPA, Director, Kenagy & Associates, LLC (K&A)



What's Broken - Our Healthcare System or Our Social Structure?

By: Rick Kneipper, Chief Administrative Officer and Co-Founder of PHNS

We're missing the point according to an avid FYA reader --- it's not our healthcare system that is broken, it is our social structure upon which the healthcare system is based. According to Roy White, President and CEO of Cloud County Health Center in Concordia, Kansas, prior FYA commentaries that have discussed our healthcare industry problems haven't focused on some of the following serious flaws in our U.S. social structure that need to be fixed before we can fix our healthcare system:

- o **On demand healthcare:** The expectation is that everyone in the U.S. (whether citizens or aliens, rich or poor, employed or unemployed, etc.) is supposed to get what they want in healthcare services, when they want it, and yet our healthcare system does not have a funding mechanism that will pay for the high cost of such an on-demand healthcare system. This leaves hospitals with operating costs that often exceed net revenues. Other countries have realized the futility of that and were forced financially to revert to various forms of socialized medicine in which treatments are allocated based on need, usually resulting in lengthy waiting times for non-emergency medical treatments. Even more difficult is the decision in some socialized medicine systems to ration healthcare services by not providing certain types of services to patients who are dying, beyond certain ages, etc. Would U.S. citizens accept socialized medicine as the Canadians and British have done? If not, would they be willing to allocate the major funding needed to sustain our currently unsustainable on demand healthcare system?
- o **Individual responsibility and accountability:** Not only do people want what they want when they want it, but also too many people want to do what they want when they want to with no personal accountability or taking responsibility for the consequences of their actions. Choosing unhealthy lifestyles, or exposure to harmful or potentially harmful situations, with a penchant to blaming others for the consequences of their actions leaves insurance companies, those who pay premiums, and healthcare providers absorbing costs and bad debt. Why should our insurance programs pay out large sums for things that could be avoided? Why should we absorb large increases in insurance premiums because of others' lack of responsibility?

Why should providers absorb significant bad debt? Perhaps there needs to be legislative relief for providers when they hold a person responsible for the consequences of their actions.

- o **Corporate greed:** Our industry is replete with corporate greed in which everyone (insurers, hospitals, physicians, pharmaceuticals, suppliers, manufacturers, etc.) is charging as much as the traffic will bear, which they can get away with since the ones using the services usually aren't the ones paying for the services and thus there is little accountability or responsibility.
- o **Corporate and personal ethics:** The level of ethics in the healthcare industry is surprisingly low, especially when such a large percentage of the industry consists of not-for-profit and government healthcare providers. Maybe Sarbanes-Oxley ought to be made mandatory for these types of providers.

I think that Roy may be right on target---what do you think?

I would like to hear your comments.

Send them to:

Richard.Kneipper@phns.com



About

TrendLeader Connections

FYA - For Your Advantage is brought to you by TrendLeader Connections. The function of TrendLeader Connections is producing educational materials and seminars that help healthcare executives differentiate between fads and trends; and making connections with "Trend Leaders" within the healthcare industry.

We are committed to delivering new perspectives and ideas, creative and innovative healthcare solutions, provocative concepts and quality educational materials to today's healthcare leaders. We want to concentrate on "what comes after what comes next."

Defined Contributions vs. Defined Benefits

By S. Harvey Prive

The concept of employers moving from purchasing healthcare insurance for employees to giving employees an allowance to buy their own healthcare insurance has been around for several years. The companies that pioneered the movement were non-unionized. Most experts predicted that the movement would not become a trend until a major unionized corporation adopted the practice.

We may be seeing the early signs of the trend with a recent announcement by General Motors. Tens of thousands of its white-collar employees and retirees will experience higher costs in their insurance participation in 2006. Their deductibles for medical care will increase 50 percent over this year. Their co-pay for doctor's visits and generic drugs at the company's HMO plan will also rise.

GM is offering some relief for next year. Workers will have access to new flexible spending accounts that allow them to pay for healthcare expenses on a pretax basis. The important message coming out of Detroit is that GM has started talks with the United Auto Workers about raising out-of-pocket healthcare costs and alternative coverage programs for its blue-collar workers. While the two sides do not renegotiate their contract until 2007, GM is pushing for immediate concessions.

GM is making it a priority to reduce its nearly \$6 billion-a-year healthcare expense to rebuild its North American auto business-which lost \$2.5 billion in the first half of 2005.

This comes at a time when a vast majority of the nation's commercial health insurers intend to offer a consumer-driven health plan within the next year, according to a survey by a national actuarial firm in Seattle.

Among HMOs and PPOs serving large and midsize group markets, 93 percent said they expect to offer employers a high-deductible insurance plan coupled with a personal spending account, such as a health savings or health reimbursement account. So far, few employers and employees have adopted these products; but survey respondents said they expect consumer-driven products to bring in 5.2 percent of their total commercial premium revenue in 2006, up from 2.5 percent this year. The survey also found that 44 percent of health insurers expect to offer a tiered provider network within the next year and more than half already provide members with price and quality information on hospitals and physicians or plan to do so within the next year.

As we know Health Savings Accounts, a sort of IRA for healthcare, let people set aside money tax-free to pay for medical expenses, both now and later. But the accounts have been controversial since their introduction in January last year.

For some they are a wonderful tool to help Americans become wiser, more price-conscious healthcare consumers. For others they are a way for employers to pass along more healthcare expenses to their workers. Critics also suggest that the accounts are basically a tax-shelter gimmick for people who are healthy and wealthy enough to invest in them but don't have to rely on them to cover their care costs. One consultant said that the biggest drawback to the accounts is that they can be very confusing.

Whatever the prevailing opinion is of the accounts and despite

continuing confusion and potential drawbacks some businesses and individuals are curious to try the ideas. Since they were established under the 2003 law that set up a prescription drug benefit for Medicare, more than 423,000 accounts have been established and more than 50,000 are being opened each month according to a Washington-based newsletter, Inside Consumer-Directed Care.

Among those interested in the consumer-driven accounts are hospitals and hospital systems to cover their own employees. If you are one of them, anticipate the questions your employees will ask. The New York Times recently offered some considerations for employees' when deciding to open a health savings account:

- Ask about set-up, monthly fees, as well as transaction or account closing charges.
- Make sure deductibles and out-of-pocket spending limits conform to the law.
- Check your investment options. Will your money be deposited into an interest-only account, or can you invest in stocks and mutual funds as well? Ask whether there are any minimum-balance requirements before you invest.
- Find out how you gain access to your money-whether through checks or a debit card, for example.
- Ask about customer service. Can you call a toll-free number at any hour if you have question? Is help available online? Are there other extras, like drug cost calculators?

Anticipating these answers will go a long way in making your employees more informed consumers of the new insurance coverage options, and make you a more responsible employer.

That's my opinion. What's Yours?

Send it to: hprice@foryouradvantage.com

About



PHNS is an innovative healthcare services company providing strategic outsourcing services in information technology, health information management and receivables management to approximately 160 hospitals. PHNS is not a consultant, vendor or software company but a partner, a solution. PHNS understands healthcare because our partners are healthcare and healthcare only. Unlike its competitors, PHNS strategically aligns itself with a hospital's clinical and financial goals and objectives. Through its unique business model, PHNS reduces costs by aggregating, consolidating and sharing resources among its participating hospital partners. PHNS helps hospitals manage information systems, computer technology, patient records, coding and patient billing to improve patient care, safety and efficiency and increase profitability and efficiency. For more information, visit www.phns.com.