

**By S. Harvey Price**



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**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.

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**Disruptive Innovation - "Making It Stick."**

***The New Success Factor***

*By John W. Kenagy, MD, MPA*

*This column is the fifth in a series on the "New Success Factor" for health care. Each is designed to use with your board and senior management team. If you have questions on how to use these columns, please contact me at [jkenagy@kenagyassocites.com](mailto:jkenagy@kenagyassocites.com).*

In last month's FYA ([Volume 4, Issue 22 - November 21, 2005](#)), Harvard Business School Professor Clayton Christensen had just presented to Intel his "Disruptive Technology" theory to explain the fall of the "world's greatest company," Digital Equipment. Digital excelled at making minicomputers but was "disrupted" by the personal computer (PC's). They, like almost every company Christensen has studied, failed to adapt and "make it stick" when challenged by a "disruptive technology."

Andrew Grove, Intel's powerful CEO was obviously interested. But, instead of complimenting Clay he said, "Professor, I see the flaw in your theory. You say personal computers were a 'disruptive technology.' But, PC's are trivial technology. The problem was Digital could not make PC's. They did not work that way."

What did Grove mean? Why couldn't Digital innovate and make it stick? The table below describes the facts. If you were directing strategy for Digital, what would you have done?

	DEC - Minicomputers	Personal Computers (PC's)
<b>Design</b>	"The world's best" integral design - complex, capital-intensive; needs expert driven, highly structured coordination and control capability.	Modular design - simple components made in many different places; needs flexible, low-cost design/assembly capability.
<b>Price</b>	\$100,000 and going up	\$3,500 and going down
<b>Profit Margins</b>	Must be high to fund big projects, expensive technology, facilities and more R&D.	Low and going lower
<b>Sales</b>	"The world's best" field sales force; close, valued relationships with loyal, long-term, Fortune 500 customers.	Retail sales to kids, gamers, techies and ??
<b>Service</b>	"The world's best." Highly developed and coordinated on-site service, part of the total package.	Unknown
<b>Customer Needs</b>	High end business computing functionality	Toys and typing

*(continued)*

## Disruptive Innovation - "Making It Stick." (...Continued)

What makes best business sense to you? Do you invest in a product that:

- You know how to make very well,
- Generates very high profit margins and
- Your best customers want?

Or do you invest in a product that:

- You do not know how to make,
- Generates low to no profit margins and
- Your best customers don't want?

Digital failed because, based on traditional thinking, they made the right business decision. I recently taught this case at a large medical center. The health care example I used was a strategy of funneling resources away from cardio-pulmonary to focus on primary care and psych. The managers and physicians laughed. Digital's management laughed too. It doesn't make sense. That's the problem.

What are the takeaways for health care leaders today?

1. Some innovations are "disruptive" because established institutions never compete successfully against them using their current business methods and thinking.
2. Why? - These innovations never make good business sense to the leaders until it's too late. "We don't work that way" becomes the death knell.
3. Are you at risk? - Take the self-assessment test in [For Your Advantage Volume 4, Issue 18 - September 19, 2005](#). If you score greater than 50, you are being disrupted. History says you need to adapt and make it stick.

4. Those few established organizations who successful compete do two things differently:

- a. They identify when they need more than "best business practice" and,
- b. They develop the new, adaptive skills to do it and make it stick.

And that is the New Success Factor for 21st Century Health Care - the ability to rapidly adapt when you need to and make it stick. In my experience, health care leaders want to leave a legacy. Future columns will help you with "leave a legacy" ideas that do one of three things:

- Introduce a new strategy tool,
- Outline a unique operational tactic, or
- Identify a simple innovation you can use now to adapt and make it stick.

As always, I am interested in your commentary or, if you have questions about how to use these ideas with your management team and Board, contact me at [jkenny@kenagyassociates.com](mailto:jkenny@kenagyassociates.com). For a preview of what's ahead, see our Web site at <http://kenagyassociates.com>. And, 'tis the season to be jolly," have a great Holiday.

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### About



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## Cost/Benefit Analysis Revisited

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

**M**y concerns about broaching the subject of healthcare "rationing" in my last column were unwarranted since many of you responded by saying it's time to get that subject out into the public debate over reform of our healthcare system (see "Time for a Cost/Benefit Analysis in Healthcare?" in our 12/5/05 FYA).

One response came from Gary Tiller, CEO of Kingman Community Hospital in Kingman, Kansas, who suggests that we consider rationing by changing our healthcare system to a defined contribution, not a defined benefit, system:

"I agree that the healthcare system can provide far more than we need to, especially when we are trying to meet the demands of people, and governments elected by those people. We may need to move to a defined contribution model, as we have done in some pension plans, insurances, etc., instead of a defined benefit model like we have. This would bring in rationing simply by design. Defined benefit typically seems, again by design, to cost more than we can anticipate and pay for. The drug plan was predicted to cost \$450 billion over 10 years. Soon they realized it would be over \$600 billion. I bet it will cost over \$1.5 trillion- that is if they can ever convince people to sign up."

Another response came from Roy White, President and CEO of Cloud County Health Center in Concordia, Kansas, who had previously commented that the principal problem with our "on demand" healthcare system is the rapidly escalating costs based on the expectation that everyone expects "to get what they want in healthcare services, when they want it" (see "What's Broken- Our Healthcare System or Our Social Structure" in our [10/17/05 FYA](#)). Consequently he says that there is no individual responsibility and accountability for the consequences of individual actions such as choosing unhealthy lifestyles and suggests that be a factor in a rationing system.

The same day my column came out there was a front page column in *The Wall Street Journal* about the transformation of the Chinese healthcare system over the past few decades from a "collective" network that covered everyone's healthcare needs to its current free market system

in which "hospitals were ordered to turn a profit." As a result, China now has a "pay-as-you-go system" in which the rule is "cash upfront, or no treatment." Patients are warned that they will not get treatment if they don't pay up front, even in life-threatening situations--- as one Chinese doctor told parents of a child with leukemia, "If you have the money the child will live. If not, he will die." That's rationing with a vengeance, and I'm not sure that the U.S. is willing to go that far, but we have to consider the Chinese model since it affects the healthcare of 1.29533 billion people or about 22 percent of the total population in the world.

Several other hospital executives told me that the reality is that we're already rationing healthcare in the U.S., mostly on the patient's ability to pay. They suggested that we need to develop a more equitable system of rationing based on the cost/benefits of treatments, much like the British system referred to in my prior column.

Any other suggestions?

**I would like to hear your comments.**

**Send them to:**

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### 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."

## END PIECE: Credit Cards from Hospitals

The *Los Angeles Times* recently reported that some hospitals and medical providers may have found a partial solution for Americans struggling to pay their medical bills. The answer may be credit cards that can be used only for healthcare expenses.

The *Times* article suggested that the cards can help patients meet their deductibles and other out-of-pocket expenses, obtain elective surgery, even help pay for care that might otherwise be off-limits.

Kaiser Permanente last year began offering credit cards with \$5,000 limits to customers in Hawaii and Colorado and is considering expanding the program to other states, including California. Hospital chains such as the Carolinas HealthCare System and Kansas-based Via Christi Health System are also signing up patients with cards. GE Capital has started offering credit cards to patients in several pilot programs around the country.

The primary benefit of the cards is that patients can more easily obtain procedures and tests when they're most needed. Federal law requires that hospitals treat patients for all emergency care, but many people without insurance or with high-deductible health plans skip other necessary treatments because they can't afford them.

Hospitals and providers hope to see a reduction in patients who do not pay their bills. When patients pay with specialty credit cards, hospitals or other providers still get paid. Usually the banks that issued the cards try to collect the debt.

The *Times* article stated that patient advocates worry that the cards may do more harm than good. A big complaint: The cards have interest rates as high as 23 percent. When patients set up payment plans with hospitals, they often pay nominal or no interest. Also, patients who are offered credit cards may be less inclined to pursue other payment alternatives, such as researching if they're eligible for charity care through the hospital. The majority of hospitals around the country are nonprofit institutions and are required to give a certain amount of discounts and free care to patients.

Many of the cards can only be used for health expenses, and hospitals typically offer them to patients after they have had medical treatment and report that they can't pay the full tab. Other patients can ask to sign up on their own or contact banks directly to apply. Cards obtained directly through a bank can be used with any provider; those

obtained through a hospital are for use there only.

Many experts within the healthcare industry believe medical credit cards and other types of creative financing will become more common as health costs continue to rise and the number of Americans living without health insurance grows.

Also fueling the growth in medical credit cards are new consumer-directed health plans. These plans typically combine high-deductible insurance with a savings account that consumers can use to keep cash for out-of-pocket expenses. But some people are likely to have a hard time paying their initial deductible, which can be \$2,000 a year or more.

The cards work in different ways. With Kaiser, for instance, patients pay 9.9 percent interest for the first year and then 23 percent on unpaid balances after that. In other programs, such as the Carolina HealthCare System, patients who agree to pay the bill off during the first year get charged no interest; otherwise the rate is about 13 percent. Some providers will deduct the estimated interest on the outstanding credit balance from the overall hospital bill.

Dr. Rusty Salton, president of AccessOne, a niche North Carolina-based medical credit card provider with 30,000 clients, said that people apparently perceive a greater obligation to pay a credit card bill than an outstanding hospital bill. His clients have paid about 80 percent of their bills, he said, more than twice the industry average. "This isn't about trying to make money off of people," said Salton. "The fact is most people want to pay their bills, and this just helps them do it a little more easily."

One concern is how credit card companies will try to collect from patients who don't pay them. After state lawmakers threatened to restrict hospitals from aggressive debt collections practices such as placing liens on people's homes and garnishing their wages, the California Hospital Association agreed last year to voluntary guidelines that bar hospitals from such practices.

*The source of this information was The Los Angeles Times. E-mail your comments to [hprice@foryouradvantage.com](mailto:hprice@foryouradvantage.com).*

**We wish you a joyous holiday season, a prosperous New Year and good health to enjoy both.**