



THE WHARTON HEALTHCARE QUARTERLY

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EDITOR'S LETTER

Well, it looks as if we are on the right track. 93% of respondents to the survey sent out after the inaugural edition indicated that they would recommend the *Wharton Health Quarterly* be continued. The survey also provided lots of positive feedback and specifics regarding what resonated, what you found engaging, and enhancements to be made moving forward. Thank you for taking the time to let us know what you think.

Readers indicated they particularly enjoyed:

- the variety of topics and formats
- the number and length of the articles
- alumni news
- the opportunity for retired and overseas alumni to stay connected

Special thanks go to Sylvia Tara, who will be stepping down from co-editorship duties due to new work and other demands, to Jeff Voigt for his continued Board “executive sponsorship” of the e-magazine, Gabriela Sanchez for pulling everything together into the e-magazine template and providing other administrative and project management duties, and Vicki Campbell for the enhanced look of the publication.

Z. Colette Edwards, WG’84, MD’85

Managing Editor

To learn more about Colette,
[click here.](#)

THE PRESIDENT'S DESK

Fellow Alumni, Friends and Colleagues:

One of my favorite industry events of the winter season is the annual Wharton Health Care Business Conference. Despite the frequent travel challenges created by inclement weather conditions, it's always worth the extra effort to get back to Philadelphia for this exceptional conference. I'm continually impressed by how the student organizers can pull off a world-class event and make it all look so easy! For me personally, I look forward to seeing old friends, classmates and business colleagues and sharing in the success of our Alumni Achievement Award winner ([see article in this issue](#)) at our Alumni Dinner. We all make this annual trek based on our passion for Wharton and the Health Care Management Program!



Column Editor: Jay Mohr, WG '91,
Managing Director and Co-Founder,
[Locust Walk Partners](#)
To learn more about Jay, [click here](#).

This year's theme, "**Innovation in a Changing Health Care Environment**," resonated particularly well with me. Having spent the majority of my professional career in the biopharmaceutical industry, including leadership roles in start-up biotech companies, I have been surrounded by passionate researchers and business people who strive to bring novel medicines to patients. This year's biopharma panel drove the point home in a very convincing, if not sobering, manner.

The speakers emphasized that innovation will continue to be the province of emerging enterprises, but the payor community will need to be brought into the development equation much earlier in the product lifecycle than ever before in order to ensure new treatments will ultimately be reimbursed by insurers. Taking this key step increases the likelihood the right questions are answered in studies, helps shorten the cycle for gaining reimbursement and, ultimately can save on scarce resources that entrepreneurs will need to move forward with their development efforts.

I have great respect for the significant number of our fellow WHCM alumni and program faculty who have pursued innovative ventures in the face of, if not in response to, uncertainty in our industry. Many of us have started medical device, biopharma, healthcare/provider services, and consultative businesses that have the ability to address the impact of health policy changes on all segments of healthcare. Some of these ventures include AdvancePCS, Genoceia, Health Evolution Partners, Integral Molecular, Locust Walk Partners, Managed Health Care Associates, Vanda and countless others.

We have showcased many of our fellow alumni's accomplishments in our webinar series and at local events. **Please join us and share your story.**

Warm regards,

Jay Mohr (WG'91)
President, WHCMAA

OPEN WIDE: THE ACA, EHBs, AND DENTAL HEALTH

With the broad provisions of the Affordable Care Act (ACA) having been laid out, attention now centers upon the actual implementation of the law. Part of that implementation entails determining “essential health benefits” (EHBs), a central tenet of the ACA that must be part of insurance plans offered to individuals and small groups through state-based exchanges and in the marketplace. Yet the ACA itself provides only broad and sometimes ambiguous and contradictory definitions of the term. As a start, the act specifies, in Section 1302, ten categories of health services to be included as essential – such as ambulatory services, hospitalization, and maternal and newborn care – only one of which has explicit mention of oral health, the category of pediatric services.



Column Editor: Harris Contos, DMD,
WG'80, Asclepius Consulting
To learn more about Harris, [click here](#).

The Secretary of HHS asked the Institute of Medicine (IOM) to define further components and provide recommendations on the updating of EHBs, which resulted in the recently released report titled “[Essential Health Benefits: Balancing Coverage and Costs](#).”

In undertaking its task, the IOM committee considered four “policy domains” for guiding what should be included in an EHBs package – (1) economics, (2) ethics, (3) population-based health, and (4) evidence-based practice. It also used as a reference – in a somewhat circular argument – the benefits and design provided in a typical small employer health plan. As of this writing, only pediatric (those 21 and under) oral health care is included in EHBs.

Federal health policy under the ACA encompasses a fairly comprehensive level of services and financing. However, at this stage of implementation, the adult population must rely on either some form of private, employer-based dental insurance, self-pay for insurance or dental services, or depend upon state Medicaid coverage. And unlike for children, Medicaid dental benefits for adults are optional at the individual state level and are especially vulnerable to harsh economic times. These benefits are often among the first items that state legislatures turn to in making reductions in Medicaid budgets. Indeed, in FY 2011, some 34 states either reduced or eliminated Medicaid coverage, including adult dental. And for those eligible for Medicare, dental insurance is not an offering under traditional coverage plans.

In 2008, among approximately 172 million persons under age 65 years with private health insurance, the majority (73%) had some type of dental coverage. Conversely, that also meant that approximately 45 million individuals with private health insurance had no dental coverage. Overall, three times as many people are without dental insurance as are without medical insurance.

In the inaugural edition of this column I made reference to the Surgeon General’s report in 2000, the central theme of which was “Oral health is integral to overall health.” I raised questions as to whether the existing organization, financing, and management of dental care were capable of integration with (1) overall health and (2) addressing issues of cost, access, quality, and accountability, as they are in medical care more generally. To the extent that an inability to integrate and to address these critical issues exists, then, indeed, the aforementioned dividing line will characterize dental care in this society, and oral health becomes orphaned from the rest of medical care.

This “orphan status” of oral health is also illustrated by an example in Massachusetts. The governor has submitted Bill H.1849, “An Act to Improve the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments,” to encourage “integrated care through accountable care organizations operating under a global budget.” Curiously, the 53-page bill makes no reference to oral health at all. The Massachusetts Secretary of Health and Human Services suggested one explanation for this omission: “Health insurance and dental insurance are separate arrangements among patients, payors, and employers, and that represents a complication for integrating care and having the entity be ‘accountable’ for the care.” (Personal correspondence with Judy Ann Bigby, Secretary, Massachusetts Department of Health and Human Services.)

Adult oral health coverage continues to be regarded as separate from medical coverage (unless a rider is available in the health plan) and thus not as an “essential benefit.” There are a number of implications to be drawn, one of the more apparent being that dental care over the age of 21 can become a matter of “haves and have-nots” (the latter being those without employer-based insurance or the means to pay directly for dental care).

In microcosm, the oft-heard “rationing of health care” is fully in view. In somewhat different, less stark terms, Dr. Jonathan Gruber, an economist member of the “Perspectives on Essential Benefits” committee of the IOM, stated that the list of the essential health benefits in Section 1302 is

“... a fundamental change in the nature of insurance coverage in America. Never before have we mandated such a comprehensive set of insurance benefits... [This] committee can expect to hear from advocates, all with compelling arguments about important things to include. Such benefits are not part of typical employer plans. The issue is how much further do you want to go?”

For certain, given “no society can afford all the health care it is capable of consuming,” questions such as “How much further do you want to go, can you afford to go?” are not mere abstractions. A line needs to be drawn somewhere, preferably an explicit one. Must the pediatric/adult, well off/not-well off divisions necessarily be the dividing line in oral health, or can we do better?

It is clear the perceptual and policy hurdles for “oral health to be integral to overall health” and to be considered an “essential health benefit” remain high.

THE PHILOSOPHER'S CORNER

Welcome to this eclectic standing column which will feature insightful musings, words of wisdom, life lessons, and stepping stones to business success. We'd love to hear from you, so [click here](#) to participate in future editions.

Life Lessons:

If I knew then what I know now, I would get operational experience before going into consulting.

If I knew then what I know now, I would not act like the boss in places where I was not the boss.

Favorite Quotes:

"It's alright, every once in a while, for a man he should feel a little pain."
- Daniela Simon

"Integrity is one of several paths. It distinguishes itself from the others because it is the right path, and the only one upon which you will never get lost."
- M.H. McKee

"Be the change that you wish to see in the world."
- Mahatma Gandhi

"Life is not measured by the number of breaths we take, but by the moments that take our breath away."
- Maya Angelou

"No one can make you feel inferior without your consent."
- Eleanor Roosevelt

Recommended Reading:

- *Million Dollar Consulting* by Alan Weiss, 1992.
- *You Just Don't Understand* by Deborah Tannen, Ph.D., 1990.
- *Outliers* by Malcolm Gladwell, 2008.



This month's philosopher is Michael Rovinsky BA'81, WG'86, President of Integrity Consulting Group, Inc. To learn more about Michael, [click here](#).

Column Editor:
Z. Colette Edwards, WG'84, MD'85
To learn more about Colette,
[click here](#).

ALUMNI NEWS

Bruno Valle WG'08

Bruno Valle, C'08, is working at Bain & Company in Sao Paulo, Brazil, having done projects in healthcare/health insurance, financial services and consumer goods. He has been at Bain for 1.5 years, after working in mergers and acquisitions for his first 2 years after graduation. Bruno recently attended the first Wharton Healthcare breakfast in Sao Paulo, and eagerly awaits its next installment!

Barbara Troupin, M95, WG95

Barbara Troupin has been working with a small Bay Area pharmaceutical company, Vivus, for the last 6 years. Vivus has 2 compounds currently under review at the FDA – Qnexa for weight loss and avanafil for erectile dysfunction. Recently, she was promoted to Vice President of Global Medical Affairs and will be building a medical affairs department at Vivus in anticipation of the approval of Qnexa. She welcomes interested candidates to apply for positions in commercial/marketing or medical affairs. Please see www.vivus.com for listings of available positions.

Lauren Green Weisenfeld, WG' 93 and Andy Weisenfeld, WG'93

Lauren Green Weisenfeld (WG'93) and her husband Andy Weisenfeld (WG'93) are still living in New York City with their ten year old son and eight year old daughter, so much of their free time is spent going to their kids hockey, baseball and soccer games. Lauren has been a Program Officer at the Samuels Foundation for eleven years. She focuses on funding healthcare and social service projects focused on the older adult population in New York City. Andy is a Senior Managing Director at MTS Health Partners, where he leads the life sciences and medical technology practice.

Edward J. James, MD'91 WG'91

Several years ago, Ed struggled with obesity and prediabetes, and his LDL cholesterol (bad cholesterol) was elevated. Rather than immediately prescribing medication, his doctor fortunately suggested that he read "The China Study" by T. Colin Campbell, PhD. He also read *The Spectrum* by Dean Ornish, MD. These books prompted him to eat more fruits, vegetables, and whole grains, and to include exercise, as well as yoga/meditation in his daily routine. He was soon "cured."

He drew inspiration from his personal experiences with healthy lifestyle changes, and in 2011 founded Heal2BFree, LLC where he serves as President. Heal2BFree focuses on helping individuals, organizations and businesses to develop and implement action plans for healthy lifestyles, and is committed to closing the health disparities gap.

Dr. Ed James is the Healthy Lifestyle Expert for BlackDoctor.org and is certified in plant-based nutrition through Cornell University. Dr. James has given many presentations on this topic, including the 2011 National Medical Association Colloquium. He has hosted healthy lifestyle potluck dinners and regularly writes preventive health-related articles.

He currently lives in Northern Virginia with his wife and two boys.

His email address is dredjames@heal2bfree.com, and he would like very much to connect with other Wharton alumni who support healthy lifestyle changes as an important means to address our nation's current health care challenges.

ALUMNI NEWS

continued

Bob Yayac, WG'89

Bob Yayac, Managing Partner of DecisionSimulation was recently included in a media article on Fierce Health IT and Government Health IT for its recent contract award with the Veterans Health Administration.

Read more:

[DecisionSimulation Press Release](#)

[VHA tests virtual patient platform to hone clinical skills](#)

[VHA picks vendor for virtual patient pilot](#)

Z. Colette Edwards WG'84, MD'85

In addition to leading Insight MD, a healthcare business consultancy, Colette will be launching in-person capability as an addition to telephonic services already being provided by PeopleTweaker, her health, wellness, and life coaching practice. The PeopleTweaker service line offers confidential, customized coaching for individuals and companies as well as training for healthcare professionals and their staff in coaching techniques to enhance patient health outcomes.

"We are now at a point where the benefits of a holistic, whole-person view are being recognized with regard to health and wellness, dealing with stress, living with a chronic disease, or 'simply' living your best life and reaching your full potential, whatever your career/life/health goals may be. Coaching can have a tremendous impact by helping a client to make changes and by providing support, focus, and the extra boost needed to move forward."

Read more:

<http://healthprofs.com/cam/531198>

<http://abcnews.go.com/video/playerIndex?id=9493792>

TIME FOR EVIDENCE-BASED MEDICINE: COMMUNITY ONCOLOGY SHOULD LEAD THE WAY

Over the past several years, a national debate has rekindled over who should have access to and who should pay for health care in this country. Although there are many disputes, and many rational but passionate parties have agreed to disagree, most participants have confirmed a desire for better health outcomes at lower costs. From our perspective in oncology, the widespread adoption of evidence-based care pathways should be able to achieve these concurrent aims in a high-cost and high-stakes environment. While this seems like a common sense aspiration, unfortunately our health care financing system is not currently enabled to encourage this result. But what if it could?

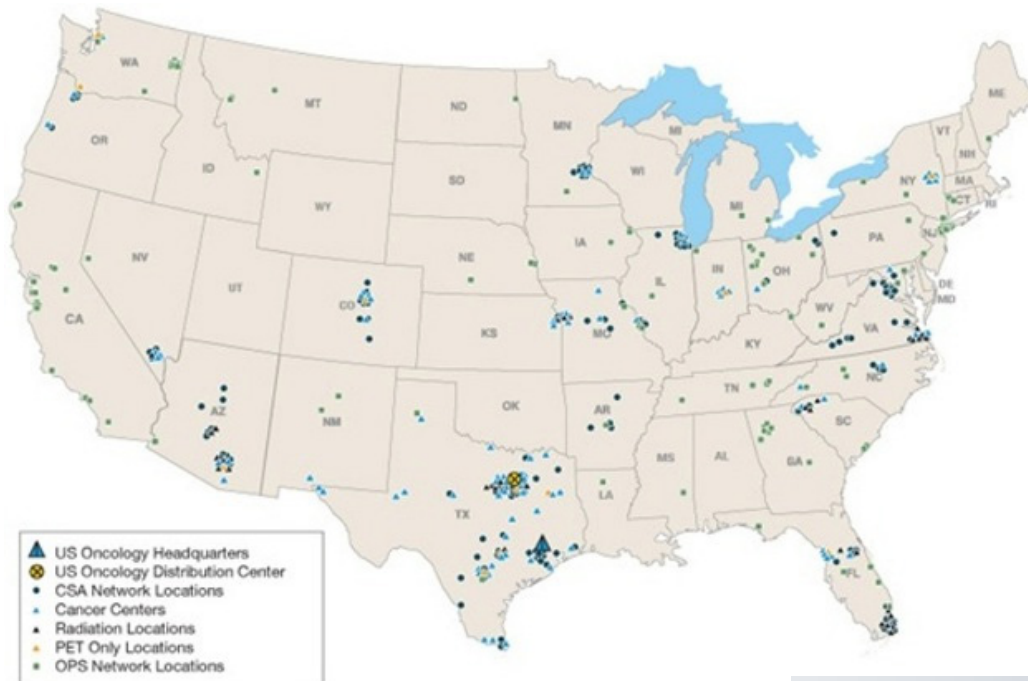
In a 2011 *New England Journal of Medicine* commentary¹, Smith and Hillner tackled the issue of the cost of cancer care and offered 10 suggestions for bending the cost curve, with a focus on oncologist behavior (i.e., treatment choices), attitudes and practices. Much of their prescription revolves around the importance of evidence-based medicine (EBM), the reliance on peer-reviewed, published studies to guide clinical care. The remainder of their recommendations largely can be characterized as a need to change the cultural mores that have historically militated against the consideration of cost and value in the treatment of deadly disease. We could not agree more.

Cancer Costs

In oncology, the current state is one of very high and rapidly increasing costs.

[\[Read More\]](#)

The US Oncology Network is one of the nation's largest networks of community-based oncology physicians, with over 1,000 oncologists in 450 sites of service.



Contributors:

Matt Brow, VP, Communications,
Government Relations & Public
Policy

Roy Beveridge, MD, Chief Medical
Officer, McKesson Specialty Health

To learn more about Matt and Roy,
[click here.](#)

TIME FOR EVIDENCE-BASED MEDICINE: COMMUNITY ONCOLOGY SHOULD LEAD THE WAY

continued

The Network has been ahead of the game in being an “early adopter” of evidence-based medicine in the oncology arena. Nearly a decade ago, physicians in The Network decided to develop Level I Pathways², which are evidence-based guidelines that re-direct the wide range of treatments driving tremendous disparities in oncology care into more precise, clinically proven treatment options. Level I Pathways refine potential choices to those with proven clinical effectiveness and the least possible toxicity by moving beyond broad label indications and public domain guidelines. When Level I evidence points to a superior treatment regimen, in terms of efficacy and safety, that course of therapy is the one selected. If there is no clear evidence of clinical superiority (i.e., if efficacy and safety are equal), then and only then are costs factored into the Pathway.



The value of Level I Pathways has been proven - lower costs while maintaining equivalent health outcomes. A joint study³ with Aetna published in the January 2010 *Journal of Oncology Practice* evaluated the cost-effectiveness of Level I Pathways for patients with non-small cell lung cancer in the community setting. The study found that certain outpatient costs were 35% lower for those patients treated according to Level I Pathways while maintaining equivalent health outcomes.

TIME FOR EVIDENCE-BASED MEDICINE: COMMUNITY ONCOLOGY SHOULD LEAD THE WAY

continued

Summary of Study Results*

- 35% reduction in total medical oncology costs
- 37% reduction in chemotherapy costs
- Total Savings: On- vs. Off-Pathway = \$9,695

	On-Pathway Treatment (N=1,095)	Off-Pathway Treatment (N=314)	Average Cost Savings per Patient (On vs. Off)
Total Med Oncology Cost	\$18,042	\$27,737	\$9,695
Chemotherapy	\$11,839	\$18,762	\$6,923
Oncology-related Outpatient visits	\$1,124	\$1,060	\$64
Supportive Care Medications	\$4,374	\$7,198	\$2,824

*Neubauer et al, Cost Effectiveness of Evidence-Based Treatment Guidelines for the Treatment of Non Small Cell Lung Cancer in the Community Setting, JOP 2010;6:1

12-Month Cumulative Cost by Pathway Status*

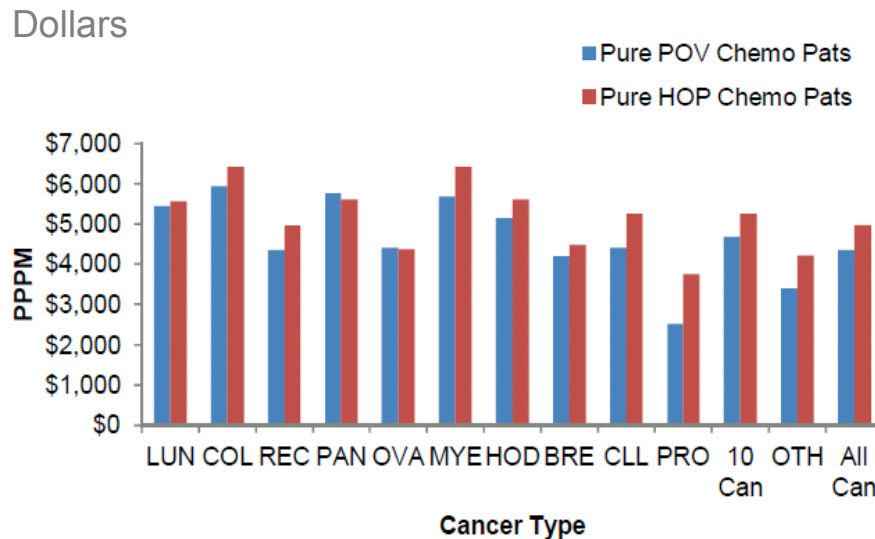


*Neubauer et al, Cost Effectiveness of Evidence-Based Treatment Guidelines for the Treatment of Non Small Cell Lung Cancer in the Community Setting, JOP 2010;6:4

In a similar study⁴ published in a special joint issue between the peer-reviewed *Journal of Oncology Practice* and the *American Journal of Managed Care* in May 2011, a joint study with Milliman found that evidence-based care for patients with colon cancer resulted in significant cost savings with equivalent health outcomes. There was a total cost savings of more than 30%, \$53,000 for the treatment of adjuvant (after the detectable disease has been removed, typically by surgery) colon cancer and \$60,000 for the treatment of metastatic (after the disease has spread beyond its initial site to a non-adjacent organ) colon cancer.

We know the setting in which care is delivered can have implications for its cost. A recent Milliman study⁵ found that per-patient-per-month (PPPM) chemotherapy costs and patient copay amounts for Medicare beneficiaries were significantly lower in community-based care settings. The study details the cost and utilization differences for nearly 80,000 Medicare patients receiving chemotherapy by the site in which service was provided. Total PPPM allowed costs for physician office-based care were approximately \$600 per patient per month less than other settings, amounting to a difference in cost of just under \$6,500 per cancer patient annually. Additionally, patient copay amounts were found to be approximately 10 percent lower, which totaled more than \$650 per patient per year.

TIME FOR EVIDENCE-BASED MEDICINE: COMMUNITY ONCOLOGY SHOULD LEAD THE WAY

continued

In the high cost area of cancer care, the data seem clear: *evidence-based medicine in the community setting is the most cost-effective way to give patients the best chance to fight cancer and win.* Not only is quality not jeopardized, such an approach actually increases quality and reduces variation. Yet government and private payer policies frequently seem to handicap community cancer care to the benefit of institutional care. Hundreds of community oncology practices have closed their doors in recent years, and hundreds more are struggling financially⁶. And regardless of setting, fee-for-service reimbursement structures used by both Medicare and private payers often disadvantage evidence-based care and incentivize the highest cost treatments regardless of the evidence.

In response to these distortions in the market, throughout the industry, participants are developing and testing oncology medical home demonstrations, episode-of-care payments, bundled payments, shared savings plans, etc., all intended to better integrate the full spectrum of cancer care, and to do so in a way which improves quality, value and the patient experience.

One such example is a pilot between Aetna and The US Oncology Network. The goal of the project, which began almost two years ago, is to deliver progressive, comprehensive cancer care for Aetna members and participating oncologists. The program expands the use of evidence-based guidelines and expert nurse support to deliver proven quality care that helps patients beat cancer with fewer side effects, less time in treatment, and less financial strain. The collaborators will be coalescing initial results for publication in coming months and hope to lead the way by demonstrating the synergistic impact of high-quality, cost-effective care in the community setting and the adoption of value-based reimbursement and evidenced-based medicine.

Regardless of the specific approach to achieve these goals, community oncologists and payers – both private and government – must work together in the coming years to drive improvements in the quality and cost of cancer care to create a sustainable future. Consumers also have a role to play in an increasingly patient-centric care model which requires active engagement and accountability.

With the rise of consumer power and the unrelenting increase in costs of care, the successful cancer care provider must focus on evidence-based quality care, lowering the overall costs of care (optimizing value) and improving the patient experience. At the same time, payers and the government must recognize and reward high-quality, cost-effective care if they wish for it to flourish. This focus must include a deep understanding of the cost and quality differences dependent on site of service and the reasons providers switch between settings.

TIME FOR EVIDENCE-BASED MEDICINE: COMMUNITY ONCOLOGY SHOULD LEAD THE WAY

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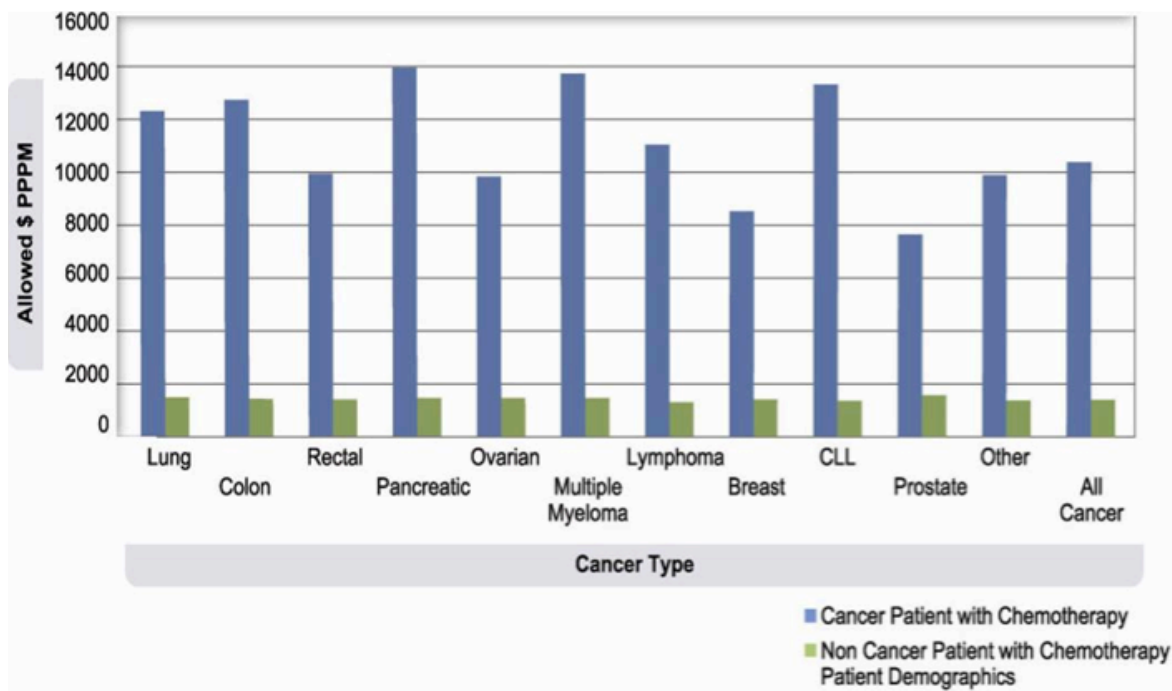
In all of these endeavors, the physician who manages the care of a patient population and oversees the care experience will be a key lever point for success. Precisely because no one else can do what they do, forward-thinking oncologists will need to shape the future of oncology by defining what it means to provide high-quality, cost-effective care and by insisting on payment which is aligned with the delivery of the care each patient deserves. And patients and payers (including taxpayers) must support these changes to build a sustainable cancer care delivery system to care for those fighting cancer.

Statistics

Cancer Costs

In oncology, the current state is one of very high and rapidly increasing costs.

In a 2010 study⁷ performed for US Oncology, the global actuarial firm Milliman reported that in 2007 a cancer patient receiving chemotherapy incurred, on average, allowed costs of approximately \$111,000, almost four times the cost of a cancer patient not receiving chemotherapy, three times the cost of a coronary artery disease patient, and six times the cost of a diabetes patient.



TIME FOR EVIDENCE-BASED MEDICINE: COMMUNITY ONCOLOGY SHOULD LEAD THE WAY

continued

In 2011, the National Cancer Institute released projections⁸ of the cost of cancer care in the United States, finding the total cost of cancer care in 2020 is expected to be \$173 billion, up 39% from 2010; these projections were based on 2006 data which predates many of the recent and expensive advancement in cancer therapies.

And what impact do rapidly increasing costs have on physician and patient choices to fight debilitating disease? A recent *Health Affairs* article indicates that 84 percent of oncologists say patients' out-of-pocket spending influences treatment recommendations, and many reports suggest that over the course of the recent recession, patients across various diseases have deferred care or chosen cheaper care more often due to cost concerns.

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IMPROVING HEALTHCARE BY REDUCING THE FUD FACTOR: AN INSIDE LOOK AT 'KNOWSUMERS'

Healthcare professionals have an essential mission and key responsibilities. One indicator that nothing is more important to people than their health can be found in every place of worship, where 80-90% of the prayers offered up are for health-related matters.

Public attention these days is focused on healthcare reform, where most discussion addresses macro-level issues, such as access, cost, and financing alternatives. And for good reason. Rapidly rising healthcare costs are increasingly unaffordable for individuals, undermine the global competitiveness of America's private enterprises, and create huge deficits for governments at every level.

However, it is essential from time-to-time to shift the attention from the macro-level systems perspective that dominates policy reform debates to focus on the patient, where the micro-level individual perspective is too often overlooked.

I practiced for over 30 years in a community that has one of the nation's most advanced community hospitals and a wider community of physicians and clinics, some of which are regional or national centers of excellence. Sometimes it takes a jolt to awaken you.

The first was Mrs. Abbott, who fired me because she had an unpleasant hospital experience. She was what I would later call a "knowsumer."¹ Knowsumers are the new wave of patients who won't accept the current healthcare experience. The second was a patient of mine who wrote me the following letter:

Dr. Steele,

I am not a happy camper. I am certainly not a satisfied consumer of medical and healthcare services in this town — even though the community healthcare complex has a tightly-designed but accessible campus, a highly-rated medical staff, the latest medical technologies, and clinical spaces designed with special attention to the ergonomics of my caregivers and their tools of the trade.

Why am I unhappy? Here it is: All the smart people who designed the systems and processes that drive the management of the clinics and the doctors' offices that I encountered over the past three months forgot about me "as the customer." I often wonder if the word "patient" is what they expect me to be.

I would have to say that the good work that you and your colleagues do is undermined by a culture that is indifferent to many of the ancillary needs of a patient – especially the need for information, education, understanding and navigation assistance. Attention to each of these areas is required to overcome the fear, uncertainty, and doubt (FUD) that come with "going to the doctor." The FUD factor plays an especially large role in healthcare because it is unfamiliar territory where my experience is limited.

I am not alone. People fear pain, and you really get their attention when issues of mortality or loss of quality of life might be involved. Fears and doubts grow as we are bounced from specialist to specialist or to a hospital. We feel "processed" by healthcare workers who often treat us like a number, not a human being. If this were to happen in any other business, that business would fail.

It seems as if medicine is organized primarily to deal with episodic healthcare events, i.e., with diseases or impairments, and not with people. Office management – especially patient intake and specialist navigation – is typically jury-rigged, left to the patient, or farmed out as a "support function" disconnected from

Contributors:

Marshall Steele, MD and
Phil Burgess, PhD

To learn more about Marshall,
[click here.](#)

To learn more about Phil,
[click here.](#)

IMPROVING HEALTHCARE BY REDUCING THE FUD FACTOR: AN INSIDE LOOK AT 'KNOWSUMERS'

continued

the “real work.” If you have more than one problem, seeking healthcare is akin to the life of a little silver ball in a pinball machine. You get launched up the ramp into the healthcare maze by your family physician and then propelled back and forth between the spinners and the bumpers, thrust here and there and then jolted by a flipper back through the maze. The game is over when you end up in what they call the “drain” or when the machine goes “tilt.” In my case, it often is a “tilt.”

Good healthcare outcomes require a high level of trust between me and my physicians and other providers, and that requires reducing the FUD factor as much as possible. An amplified FUD factor keeps people like me from seeking care, makes us less compliant, and increases costs. It becomes a serious barrier to solving our healthcare problems.

The health care paradigm needs to change. Yes, medicine needs to be more efficient and less costly, but you also need to adopt a customer-centric approach. You need a new paradigm that views the “patient” as a “customer,” develops and applies metrics of “customer satisfaction,” and uses “customer satisfaction” measures as a primary indicator of success.

Thanks,

Phil Burgess

Wow. Phil is right. We haven't created a service-oriented business despite being in the service industry.

It is clear that **we in the health care profession give enormous attention to medical talent.** We have an incredibly educated workforce. But talent can only take you so far. When healthcare services were compared to other industries in a study performed by The Advisory Board, healthcare as an industry scored the worst on the quality vs. productivity/efficiency scale in a group which included hotels, airlines, telecommunications, retail banking, food services, the United States Postal Service, and auto manufacturing.

Despite the enormous talent in healthcare, our current approach has underachieved. It is a system that relies on individual performance and gives scant attention to ancillary services and how they are managed. This is undermining the delivery of quality care – because it is inefficient and customer satisfaction is lacking.

Clearly, having highly-trained physicians, staff, and administrators does not achieve consistent and sustained excellence as measured by productivity and customer satisfaction. How can we provide the customer experience that Phil and Mrs. Abbot expect and deserve? When will we no longer accept HCHAPS (Hospital Consumer Assessment of Healthcare Providers and Systems - the first national, standardized, publicly reported survey of patients' perspectives of hospital care) scores showing that only 7 out of 10 patients would recommend us to their family and friends?

I realized **too little attention is given to “operations,”** i.e., the structures, systems, policies and practices, including performance and outcome measures, used to make things work for the customer and the providers of care. As a result, I sought out a completely different structure and delivery system for patient, families, and healthcare providers modeled after LEAN thinking and processes.

IMPROVING HEALTHCARE BY REDUCING THE FUD FACTOR: AN INSIDE LOOK AT ‘KNOWSUMERS’

continued

Using the tools of successful industries outside of healthcare, including outcome measurements, Marshall I Steele created the “Destination Center of Superior Performance.” Marshall | Steele is a physician-led healthcare services firm focused on transforming traditional hospital services into Destination Centers of Superior Performance. This model has been implemented in hundreds of hospitals worldwide with great success. Though the focus has been in the area of orthopedics, the concepts are just as relevant to service lines outside of that specialty arena. One very important concept - **reducing the FUD factor**.

Even if we do everything right, **the FUD factor will always loom large in health care**. However, we can reduce it if we make sure our patients are well informed and create a consistent experience which helps them know and understand what to expect. Thanks, Mrs. Abbot and Phil, for pointing this out.

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- 1 Marshall Steele, “Knowsumerism, Healthcare Reform and Chicken Farming: Five Lessons to Help You Thrive” *Orthopreneur*, July 2010.

THE WHARTON HEALTHCARE QUARTERLY INTERVIEWS GARY PHILLIPS, HEAD OF HEALTHCARE INDUSTRIES, WORLD ECONOMIC FORUM

Gary Phillips, M.D. recently joined the World Economic Forum in Geneva as Head of Healthcare Industries where he leads initiatives to improve the state of global healthcare through partnership with leading industry, government, NGO, and academic institutions around the world. He is a University of Pennsylvania “trifecta” - college, business school, and medical school! Read on to learn about Gary’s path to Geneva and his perspectives on the healthcare arena.



To learn more about Gary,
[click here.](#)

Wharton Healthcare Quarterly (WHQ): Gary, thanks so much for your time today. You have had a very rich and varied career. Can you tell us a bit about how things evolved?

Gary: *Well, I would say that my career resulted from a mix of intent and serendipity. I originally thought I might become chief of a medical department or CEO of a hospital. However, after my time at Wharton, I realized I was much more interested in the supplier side of the business, and that neither managed care nor the hospital provider side held the same appeal for me. The cost of medical school was covered by the Navy, so I had a time debt to repay, which I spent at Naval Hospital San Diego as a medical officer on a ship and in a primary care clinic.*

After my naval service, I moved to consulting because it provided an opportunity to learn a lot in a compressed timeframe and to meet many people - colleagues and friends - who have been invaluable throughout my career. After a few years, I spent time in “big pharma” at companies like Wyeth and Novartis. I moved into specialty pharma and medical devices at Bausch & Lomb, where I worked on strategy, R&D, business development, global marketing, and commercial operations over the next six years.

I then returned to Switzerland, with Merck Serono, but then transferred back to the U.S. as President of Reckitt Benckiser, Inc. Most recently, I have been “lucky” to return once more to Switzerland with the World Economic Forum. I am quite excited to be a part of this great organization.

WHQ: How would you compare each healthcare sector in which you have operated, and what lessons did you learn that will serve you well in your new position?

Gary: *Clinical practice served as the foundation and matured me from being an MD to being “a doc.” I came to understand what it was like to be an operator in the healthcare system and the thinking of a primary care physician. This experience has enabled me to put the “doc” hat back on when I am working with the medical community, developing strategy, or launching a product. It was a good experience, and it was also a lot of fun!*

From consulting I learned the sales process, project management, and the importance of human networks. I also learned something about myself in that I liked the sales arena much more than I thought I would.

On the supplier side, I gained knowledge regarding the strategy process, how to think about ROI, innovation, and regulatory constraints, and, most importantly, how to take a concept from the initial idea all the way through to a market launch.

Contributor:
Z. Colette Edwards, WG’84, MD’85
To learn more about Colette,
[click here.](#)

**THE WHARTON HEALTHCARE QUARTERLY INTERVIEWS GARY PHILLIPS,
HEAD OF HEALTHCARE INDUSTRIES, WORLD ECONOMIC FORUM**

continued

As a result of all these experiences, I believe I have gained a broad view, a strong network, and an understanding of the critical problems in healthcare, all of which helps in collaborating with a community of partners, which is at the heart of my work at the World Economic Forum.

WHQ: What differences have you observed in the manner in which pending healthcare crises are addressed in other parts of the world compared with the U.S.?

Gary: *In many parts of the world, particularly in Europe, where the government is paying the bill, there is rationing of care and pressure on suppliers and providers as a means to control cost. The focus is on squeezing cost and utilization.*

The U.S. takes a free market, capitalistic approach, and there is much more flexibility and opportunity for innovation, competition, and placing a greater focus on the potential value of technology.

Given both the percent of GDP which healthcare represents in the U.S. and its health outcome rankings compared with other parts of the world, some wonder if the U.S. is achieving the ROI that it should demand. Additionally, given the continually escalating cost of healthcare in the U.S., there is ample evidence of some degree of rationing of care and unit cost pressure on providers. However, things are moving at a different speed and with a different degree of force than that demonstrated in countries which take an approach much more heavily weighted with mandates as a strategy.

WHQ: Where do you see things headed with the U.S. healthcare system, and how do you “win” in business and as a patient in the midst of the swirling?

Gary: *I think there are a few key principles which emerge. Companies and individuals who focus on adding value to the system and placing the patient at the center of decision-making seem to be the ones who succeed in a sustainable way. Businesses whose main driver is solely on profit and revenue growth tend to lose focus and perspective over time, and there is a much higher rate of failure in the long-term.*

For patients, I think it is “caveat emptor.” Patients will need to become much more proactive about being informed consumers and truly take charge of their health and well-being. Optimizing interactions and negotiating through the system will require self-accountability and a partnering approach with healthcare practitioners rather than being a passive party.

WHQ: Gary, thanks again for taking the time today to share your insights. We look forward to more great things from you and hope that you will perhaps be a contributor to the WHQ from time to time as you settle in at the World Economic Forum.

WHCMAA ALUMNI DINNER IN PHILADELPHIA HONORS GARY PHILLIPS, HEAD OF HEALTHCARE INDUSTRIES, WORLD ECONOMIC FORUM

The Wharton Healthcare Alumni Association (WHCMAA) held its annual Alumni Achievement Award event on February 16, 2012 at Estia Restaurant in Philadelphia, PA. The award recipient, Gary Phillips, MD, WG'91 flew in from Geneva, Switzerland for the award. Gary's new position in Geneva is as the Head of Healthcare Industries at the World Economic Forum. He has been an active member of the Alumni Association and the Wharton Healthcare Program since graduating and has mentored several MBA students from the program.

A common thread mentioned by all award recipients has been a desire to "pay it forward" because of the influence of others (especially from the Wharton program) in the development of their careers. Gary was no exception, and upon receiving the award, he thanked a number of other graduates of the Wharton Healthcare Program who were responsible for mentoring and guiding him early in his career.

There were several speeches given prior to Gary's: From Jay Mohr, WG'91, and President of the WHCMAA, June Kinney, Associate Director, MBA Program in Health Care Management, and Jamie Richter, WG'95, a board member of WHCMAA and Chair of the Alumni Achievement Award Committee. Jay mentioned the long line of recipients who had received the award and their contributions both to the healthcare field as well as to the Wharton healthcare community. To say the least, Gary has had a very impressive career - and it is not even close to being over. June also talked about how Gary has contributed to the development of the MBA students (through mentoring and class involvement) and how much the Healthcare Program has appreciated Gary's involvement. Jamie followed up with Gary's commitment to the Wharton Healthcare alumni community. It was a great evening of toasting, reminiscing, networking, and enjoying each other's company and a wonderful example of the Wharton Healthcare community coming together to celebrate the accomplishments of its members.



Gary is married with 2 young boys and lives in Geneva. His wife, Eleni (also a graduate of the University of Pennsylvania and a citizen of Greece), was the main impetus for his living in Geneva. She fell in love with the city and the surrounding area (who wouldn't) in a prior stint in Gary's career with Merck Serono SA.

For those interested, Gary has been invited back (and accepted the invitation) for the annual alumni conference (to be held at Wharton October 27, 2012) to provide an update on his position and the state of healthcare globally. He no doubt will provide an interesting perspective



The February 16, 2012 Wharton Healthcare Alumni Association dinner feting the annual Alumni Achievement Award recipient – Gary Phillips, MD, Wharton Healthcare MBA 1991 – Estia Restaurant, Philadelphia, PA

Contributor:

Jeff Voigt, WG'85

To learn more about Jeff,
[click here.](#)