Chapter 6
Breakthrough: Letting Prevention and Self-Management Work

How Do We Create Incentives and Reward Systems for Demonstrable Health Benefits?

If we look for the ambitions in the triple-aim to make populations more healthy and improve treatments for lower costs per capita, prevention and self-management are key elements to solve the puzzle. We would like health to take over care and not the other way around! The needed medical treatments and medicine should be reduced because people live a regular healthy life. There is a lot of value in preventing someone from becoming ill. It is at the same time difficult to earn back investments based on illnesses that have not taken place and reimbursement of all healthy daily living is not the ultimate answer. There are however business models that make money by making people healthier:

- ***Discovery has built a vitality company besides its insurance activities which focuses on promoting a healthy lifestyle by combining incentives, fast-moving consumer goods marketing, and superior actuarial number crunching of big data.***
- ***Healthways has built a business model in which employers, insurance companies, and people themselves pay them for proven improvement of the health of populations with multiple chronical diseases.***
- ***Kaiser Permanente originated from an employer who wanted to provide care and from that perspective not only originated own healthcare but also prevention to keep employees healthy and productive.***
- ***PatientsLikeMe links people with rare diseases in online communities to share experiences on their medical conditions but also to exchange experiences to cope and improve daily life.***

If we end up with medical advice and reimbursement for riding the bike and eating tomatoes, the costs will rise and healthy living will not become something people enjoy and choose for themselves but an obligation which the doctor prescribes. This way of thinking is in line with a new dynamic approach to the concept of health in which this is defined as "the ability to adapt and to self-manage, in the face of social, mental and physical challenges of life." Compared to the traditional WHO

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approach the emphasis shifts from "complete well-being" to the "individual's potential to be or become healthy, even when affected by disease, as well as the potential of personal growth and development towards fulfillment of personal aims in life."[1] What's extra interesting in this perspective is that it not only takes an holistic view on health. It also opens up the possibility to take the own perception of the person and patient on life as factual input and goal for improvement to assess the quality of healthcare and lifestyle interventions.

Ensuring that people become and remain healthy is a collective interest of the individual, the employer, the insurer, the government and society as a whole. There is a great need to feel mentally and physically healthy, to prevent illnesses and to learn how to live with chronic diseases. That raises the question why there are so few successful companies who make money by making people more healthy? Healthcare practitioners are in abundance, but a "healthy lifestyle provider" is not (yet) a professional group. An important crux of the problem is that prevention and reintegration entail significant investment costs especially for the people who need it most. At the same time, the effects of interventions are difficult to demonstrate and attribute and it is often questionable who should pay. Avoiding a (new) medical treatment requires a real change in daily patterns, such as adopting a healthy diet, quiting cigarettes and exercising more. These behavioral changes are difficult to achieve and have more to do with daily life then with medicine. Those who focus least on leading a healthy life logically have the greatest health risks and challenges. The required change is most profound among this group of people and they appear difficult to reach and motivate. That is why altering people's behavior to ensure they lead healthier lives entails considerable and (continuous) hard work. It is also a very costly matter if it is paid according to the number of hours worked by health providers. Actually most of the work should be done for free by people themselves supported and jointly with their own social networks. An additional complication is that prevention often only produces a result in the long term and appears to be far vaguer and holistic than treatments that usually yield an instantaneous result. It is also difficult to demonstrate and declare outcomes if it is purely analyzed on medical terms; can a health provider prove that the incurred healthcare costs are lower compared to what they would have been without prevention? Many illnesses develop slowly, and inhibiting or even reversing them often necessitates a long-term approach. It is difficult to demonstrate who was behind the behavioral change and when, which also makes it more difficult to receive payment in return. Such causes make it difficult to find approaches and revenue models where prevention-related investments are earned back. The comment "Charity is not scalable" is applicable to a large extent here. Within the context of prevention, numerous appealing charity initiatives exist with a high degree of willingness to participate, but there are considerably fewer business models that are sustainable and successful. Yet there is light at the end of the tunnel here, and it does not appear to be an approaching train.

[1] See for an in-depth study and the full proposal for the new definition of health the dissertation of Huber (2014).

What developments bring about a breakthrough involving prevention and self-management? The problem is growing, which creates momentum. Meanwhile the possibilities increase as well: Information technology and big data will help, the interests of stakeholders can be united and medical knowledge is growing. From the consumer marketing perspective the good news is that a healthy lifestyle is becoming more popular as a way of living to look and feel good. An increasing number of senior citizens and people with one or more chronic illnesses are adopting and increasing self-management and prevention. At the same time, it is also clear that merely fighting and repairing symptoms is no longer sufficient to organize healthcare effectively. Not only individuals desire this. Other relevant stakeholders in the field, such as the government, healthcare practitioners, and insurers, are also encouraging this movement. Producers and service providers in foods, sports and recreation are challenged to their responsibility but also see market opportunities. Additionally, the application of information technology on big health data can clarify the effect of prevention more effectively, even if this is in the long term and involves a range of interconnecting variables. This allows a better understanding of what works and what does not, making it easier to align stakeholders with an interest in healthy employees, insured people and citizens. It also gives sources for mirror-information to stimulate and advise people with health apps. In addition to a common agenda, mutually reinforcing activities, constant communication and a joint organization, this also requires performance-related measurement.[2] This measurement in particular is a key factor behind failure or success. Data pooling and analysis is essential in order to identify those prevention-related investments that will yield cost-savings. Facts and feedback provide guidance and facilitate the better integration of prevention and self-management with health conditions, medical knowledge, and treatments. Essentially, prevention is about the interaction between one's body and potential or existing illnesses. That quickly becomes somewhat vaguer. In the past, when no proper evidence could be obtained (via randomized trials), this sometimes remained in the realm of complementary medicine. Sound, in-depth data analysis makes the effect clear and more factual. The wheat can be separated from the chaff in esoteric theories about energy channels and weak areas in the body. It demonstrates, for example, that using your immune system and your body's self-healing ability can be of real benefit. This is attractive since it results in a stable healthy condition. The life-long use of devices and medication is costly and appears to disturb the balance which creates side-effects that require additional treatments. This poses challenges for the twenty-first century, such as the extent to which illnesses that have changed from fatal to chronic also can be reversed or even cured. In Diabetes type II, for example, there is convincing scientific evidence that a lot of people in an early stage of the disease can even get better again by exercising and following a proper diet consisting of more plants with fibers and fewer carbohydrates[3]. At the same time, it also becomes clear that prevention and the self-management of

[2] Kania and Kramer (2011).

[3] See for instance Lindström et al. (2006), Redmon et al. (2010) and Kumar et al. (2012).

one's personal health and illness with lifestyle interventions in exercise, relaxation and food can be logically combined with regular treatment and/or cutting.

Diagnoses can be expanded with health-related advice and automated, and therefore personalized in an affordable manner with the ambition to realize precision medicine. Where this is being discussed as an individual medicine cocktail, the term *precision medication* would often be more apt as the initial target since a lot of treatments and pharmaceuticals are prescribed without having the picture on the mix as a whole, but some forms of personalization are definitely present. Where lifestyle is concerned, tailor-made advice is further away. Nutrition and exercise instructions are still very black and white in terms of what is good and bad for everyone. In addition, promoted food categories in Western diets often change. Dairy was good and is now bad, but is still advised by the government of Thailand. Eggs are now healthy, unless you suffer from high cholesterol. Carbohydrates are now bad. Fat is not always harmful or even perceived as healthy, provided you eat the right type. Such commonplaces are turning healthy eating into more of a religion than a science, and therefore into fodder for cynics, something that does not help promote healthy behavior. On the contrary it sometimes can be dangerous to exclude full segments of nutrition from the diet drastically because a body adepts to that as well. The same is also increasingly applicable to sport. Many people jog even though they dislike this physical activity. It is a matter of time before the discussion centers on whether running does not harm or age the bodies of many people too much, and whether the focus for those above the age of 50 should shift increasingly from cardio exercise to muscle strengthening. Information technology and personal advice can help people to eat and exercise in a manner that is demonstrably more healthy and not harmful. This will undoubtedly depend on personal characteristics, weaknesses and strengths, condition and age. Prominent information technology partners such as Microsoft, Google, Apple, Philips and Samsung also view health-related data and platforms as major pillars for their future strategy. It is interesting to note that this to a large extend does not concern medical and reimbursed applications and files but personal lifestyle apps and data which are integrated in consumer products such a tablets, smart-phones, sport wearables, watches, and home-equipment. In addition, more and more people are active in the movement called "quantified self" and are compiling all kinds of personal health data. They do this to understand and improve their body as some sort of machine using precision food, precision sport and an overall precision lifestyle. Prevention will be aided by the fact that people will also focus more on following a healthy life and lifestyle. The social healthy movement has already been set in motion. The aim is not always to grow older in a healthy manner, but to also simply look good and feel content with oneself. Even the number of man who want to look like Homer Simpson appears to be declining. That is also important as it helps broaden the appeal of a healthy lifestyle via popular role models from sport and entertainment and prevents adoption by only a small, well-educated elite (where intervention is probably the least needed). It supports the desirable movement in which healthy living takes over healthcare instead of the other way around in which daily living is made medical.

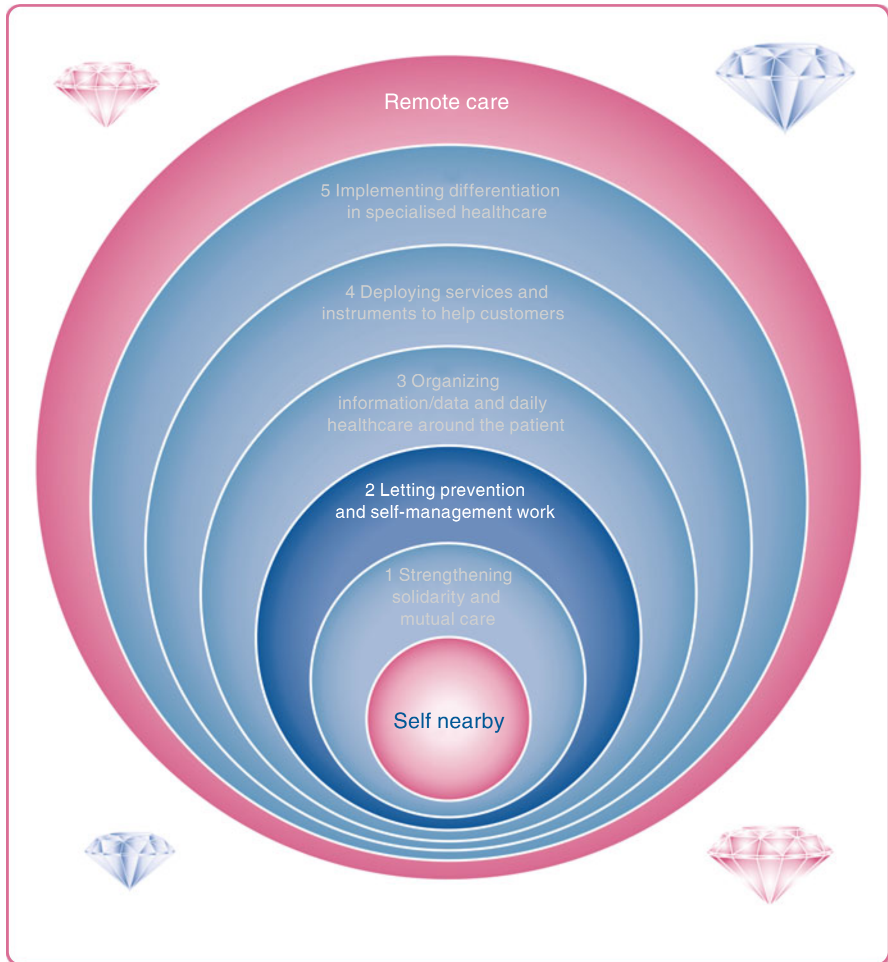

Figure 6.0.1 Breakthrough letting prevention and self management work

Business Models Like Discovery Health and Discovery Vitality Commencing with the interested party or parties is critical for feasible and scalable prevention. It is initially in the interest of people themselves and their family members to stay healthy. It starts with healthy people and those subject to additional risks but who do not yet have an illness. This does not yet involve prevention that is really part of recovering from medical treatment or learning to live with an illness. The challenge therefore lies in also making prevention fun, appealing and accessible for many people. In the healthy group without serious medical issues, the relationship between greater prevention and lower healthcare costs is more indirect. It is a long-term process. The expected healthcare costs per person are lower, and less can be saved. This applies to people with an elevated risk, but particularly to those who feel

thoroughly healthy at the moment. The challenge is to ensure prevention at the lowest possible cost, and in particular allowing people to undertake this themselves, together with others. The brilliant business model selected here to exemplify this is Discovery, an insurance company in South Africa that sells healthcare insurance under the name of Discovery Health. The company naturally has an interest in ensuring that people fall ill as infrequently as possible. If people live healthier, healthcare costs are lower, enabling Discovery to offer a competitive premium. Customers are also happier. At the same time, the costs of this prevention must be kept to a minimum. Discovery Vitality was established to this end alongside the insurance company Discovery Health. It offers preventive programs, gives customers discounts on healthy products and rewards them for healthy behavior via a reward system. For customers, the vitality and insurance activities feel like an integrated whole, but prevention-related activities are financed by suppliers in combination with a small membership fee. This highly successful approach has allowed Discovery to become the largest health insurer in South Africa. The company has a unique business model.

There are many individual providers of health programs offering an integrated package of exercise in a fitness center and dietary advice. Health insurance companies, which may or may not have been inspired by Discovery, also offer health-related activities integrated with healthcare insurance policies to a greater or lesser extent. These also involve joint ventures with Discovery, such as PruHealth (with Prudential) in the UK. In the Netherlands, Achmea is a pioneer in this area with Zilveren Kruis. Another example is Central in Germany, which focuses on employers. An example of a new fresh initiative which supports and rewards healthy behavior is Oscar health insurance which started in New York. There are also insurers such as CSS and Helsana in Switzerland that combine prevention programs with managed care as well. This is described in greater detail in the Kaiser Permanente model.

Business Models Like Healthways The individual is the first stakeholder and self-supporting “labor force” in prevention and self-management. The individual is possibly but not necessarily also the financier. Are there others with an interest in making someone healthier who are willing to contribute and/or pay? There are stakeholders among employers, healthcare insurers, and society with an interest in making people healthy. If people run a greater risk or suffer from a chronic illness, the extent of the potential “damage” can be such that it justifies actual investment. It seems logical to seek business models that allow stakeholders to pay (part of) the bill. The selected example involves the American company Healthways, which has a completely pure approach: it allows itself to be paid by sharing the benefits attained by making major risk groups and chronically ill people healthier. The interests among stakeholders are aligned in this way. Healthways does this for individuals and at the request of employers, insurers and authorities. These stakeholders also have similar interests. Employers have traditionally played a crucial role in providing care and prevention for their staff and family members. This is also apparent in the stories shared by many healthcare practitioners and insurers concerning the establishment of the organizations, which often involves employers in many countries. It is visible in the number of people insured via employers or

working on prevention in this manner. Employers have an interest in the health and care of their employees for various reasons. A large part of one's salary goes towards healthcare costs, which is why it is essential that this is kept affordable. Healthy employees are more productive and have a more positive effect on the atmosphere at work. Unhealthy and sick employees, on the other hand, are often responsible for additional costs. Employers have therefore also developed their own health programs and engage parties that provide assistance with reintegration. Healthcare insurers have an interest in ensuring that people stay or become healthy, given the high cost of medical treatment. It also helps if a long-term relationship exists between the insurer and the policyholder so that the common interest is greater. As discussed above in the Discovery example and below in the Kaiser Permanente example, various insurers are also actively involved in health programs to a greater or lesser extent. Finally, the social aspect has an enormous impact on the economy if people who are no longer fit for work can become productive once again. Consequently, it is often also in the government's interest to invest in prevention and a healthy lifestyle. This is also apparent, for example, in supporting and coaching vulnerable groups such as the unemployed, the homeless and vulnerable families. It is also reflected in programs aimed at increasing the quality of life in neighborhoods.

Business Models Like Kaiser Permanente "Perverse incentives" and rewards exist that would stimulate healthcare practitioners to focus more on treating instead of preventing disorders. Remuneration according to the number of interventions is seen as a major reason behind inefficiency within the care sector, incorrect treatments, treatment variation, overtreatment, and a lack of effective prevention.[4] This is not only about financial remuneration, but just as much about appreciation, attention, and professional honor. It also concerns detailed process instruction on the way a treatment should and should not be conducted, which impedes improvement and innovation. It would already solve a lot of issues if all financial and procedural barriers to give the right treatment were removed and people would be purely motivated based on their professional integrity. Healthcare practitioners should in principal have the responsibility to provide a group with the best possible care for a specified budget which is in line with the health conditions of the population. It helps if they are further focused and a little bit extra rewarded on the triple aim to increase the health of a population, improve the experience of care and reduce the cost per capita.[5] Decisions whether or not to provide treatment and the type of treatment involved must be taken in consultation with the patient. Understanding the patient perspective and goals is part of a good medical diagnosis. The best outcome can be to reflect for a while or to decide not to provide treatment at all. Additional remuneration, substantive appreciation and feedback for improvement must occur on the basis of health-related results

[4] For "perverse" incentives, overtreatment, personal responsibility, and self-management, see the arguments of Van der Gaag, Meerdink, Monissen, Florijn, and Rutgers in the publication *Financierbaarheid van de Zorg van Coincide*. See: Gruijters (2013).

[5] See Berwich et al. (2008) and Institute for Healthcare Improvement (2012).

for the entire population and a comparison with exchanged equivalent data on results in relation to others. As shown by analysis from BCG implementing such mechanisms can yield demonstrable improvements in the quality of care and also reduce healthcare costs by between 15 % and 20 %.[6] This is demonstrated by insurers and healthcare practitioners that implement managed care in an integrated or collaborative manner. The providers concerned render the insured care in kind. The most well-known international example of managed care is Kaiser Permanente from the USA, whose brilliant business model is also detailed here. Kaiser Permanente employs its own doctors and also owns hospitals in California, where it was founded. From an integrated care focus, it has taken the lead in health programs and the development of electronic patient records. The narrow definition of managed care relates only to truly integrated care in Health Management Organizations where insurance and the provision of care are integrated completely within a single organization. The broader definition involves intensive supply chain collaboration between the insurer and healthcare practitioners such as doctors. This with the focus, information, appreciation and/or remuneration geared towards actual and demonstrable health benefits. A distinction can be made between different types of managed care. The three most commonly used are the Health Maintenance Organization (HMO), Point Of Service (POS), and Preferred Provider Organization (PPO). With an HMO, healthcare practitioners receive a fixed amount for the patient's entire care. With a POS, customers receive a combination of an HMO with options to consult doctors outside the network. The customer has a doctor who acts as a supervisor and is employed or exclusively contracted by the insurer. Insured people can make use of the provided care at no additional cost within a hospital that is part of the insurer's network. If the insured person wishes to receive care outside the network, only part of the associated cost is reimbursed by the insurer while the remaining costs are borne by the policyholder. A PPO is the most pure form of managed care, whereby the insurer purchases care at a reduced price from hospitals that are a preferred supplier. Managed care does not always include a compulsory doctor and/or referral. The manner in which managed care is structured depends on the infrastructure existing within the country from the outset. At a regional level, there are various experiments involving managed care, such as in the Overvecht district in the Netherlands and in three municipalities in Kinzigtal in Germany. The USA has different examples of managed care, such as the Veterans Health Administration, Via Christi Health Systems in Kansas, and Intermountain Healthcare in Utah. Blue Cross/Blue Shield, just like Kaiser Permanente, has its roots in the Great Depression in the 1930s and focuses on employers and employees.[7] In Switzerland, for example, insurers have been obliged since 2004 to also offer managed care propositions, with this system now accounting for roughly 50 % of the market thanks in part to discounts. Doctors and hospitals were already here, of course. Some insured people also had existing insurance policies that excluded aspects of managed care. Managed care is then shaped firstly by regional

[6] Figures based on analysis by Boston Consulting Group with Zilveren Kruis Achmea of international best practises.

[7] For the examples from the USA, see Christensen et al. (2009).

group contracts with doctors and secondly by selected healthcare practitioners on the basis of telephone referrals. Examples here include the market leaders CSS and Helsana, and parties such as Sanitas, Swica, and Concordia, with a managed care proposition available to two-thirds of policyholders.[8]

Business Models Like PatientsLikeMe When people with an illness are involved, patients themselves are still the first and most important stakeholder. If people who do not suffer from too many complications can live with their illness, they are more productive for themselves and society, and high healthcare costs can be (at least partly) avoided. If people are really ill, they have to rely increasingly on society for their livelihood, accommodation, care and healthcare. Those who do relatively more themselves and improve their health again reduce this dependency and increase the feeling of control and self-reliance. Self-management is called self-management for good reason. The patient ultimately always has a decisive role in the personal prevention program. In the end, people will have to restructure their lives themselves and play a leading role in the process to learn how to live with an illness and to become healthier again, if possible. Patients and those closest to them account for 99 % of the time spent on their illness since they have to live with this on a permanent basis. The patient is therefore the first expert and treatment provider. Thanks to programs in which people with elevated risks or chronic illnesses support one another, they know what to do and how to deal with their personal situation. These are of course more affordable than programs where most of the work is done by or with healthcare practitioners. An inspirational example is described in the business model of PatientsLikeMe (patientslikeme.com). This is an online platform where communities of people with similar illnesses can interact with each other. It is unique in that it has been established based on the insight that the Internet allows people to find fellow sufferers and stay in contact with them regarding extremely rare illnesses. The information is shared not only amongst patients themselves but also with the pharmaceutical industry, which sponsors the platform. While this involvement of a commercial player may sound somewhat strange, a sustainable form of financing has been found and the information is also used to develop more effective medicines and treatments. PatientsLikeMe is merely one example of the many online patient communities in the USA.[9] A large community for diabetics, dLife.com, has its own newsletters, recipes, TV shows, radio channel, courses and interaction resources. Crohns.org in the USA is another example. While the Internet offers unique opportunities for intensive mutual interaction from the comfort of one's home, the underlying phenomenon is not new of course. The group processes and mutual support in prevention appear very similar to the methods employed by Weight Watchers and Alcoholic Anonymous. From an even broader perspective, it entails forms of mutual caring and sharing and support within a group as described in Chap. 5, but for patients in this case.

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[8] For the information on managed care in Switzerland, the authors thank Jan Willem Kuenen, Wouter van Leeuwen and their Swiss colleagues of Boston Consulting Group (BCG).

[9] See for instance: Christensen et al. (2009).

6.1 Discovery

It's not about winning but about playing the game

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Prelude *Lindi, a working mother in South Africa, has just turned forty and is now in a phase of her life where she is conscious about her health. She has been insured with Discovery Health for a number of years and decides to join Vitality, Discovery's health program. During the registration procedure Lindi immediately completes an online vitality check featuring questions about various topics, including her lifestyle. Her Vitality age, which indicates how rapidly her body is ageing, is apparently forty-seven years. Seven years older than her actual age! She is now even more motivated to work on her health and get back into shape. The test also identifies areas she can focus on best, namely her physical condition and cholesterol level. Fortunately, Vitality helps her improve these areas by providing a personalized pathway with intermediate goals, for example. For every goal Lindi attains, she earns points that she can then redeem for attractive rewards. Her goals and results appear in her personal profile on the Living Vitality platform.*

As Lindi desires quick results, she wants to know how she can achieve these. She takes two more Vitality tests: the fitness test and the nutrition test. These reveal that she can improve her condition to an acceptable level very quickly if she adjusts her diet slightly and participates in sport a few times a week. She enrolls at a sports school. She is entitled to a discounted subscription as a participant in the Vitality program. She also receives Vitality points each time she visits the sports school. A good outfit is also essential, of course. Her Vitality card gives her a discount on Adidas clothing and she buys herself a fine new pair of running shoes.

Some of Lindi's regular running friends are also active on the Living Vitality platform. The great thing about this platform is that it allows them to challenge each other. Her friend Susan, for example, organized a fun run recently. Lindi won by a

whisker and earned 150 Vitality Points once again. She wanted to celebrate this by doing something fun with her daughter and therefore decided to use the Vitality points she had saved to go the cinema one evening with her daughter An, who is mad about movies.

Introduction Discovery Health has 2.6 million members with healthcare insurance in South Africa. With around seven million customers, it is the leader in this private market.[10] Discovery started off in 1992 as a healthcare insurer and pioneered new concepts such as Vitality. This platform—aimed at promoting health—was launched by Discovery Health in 1997. Vitality is a fully fledged subsidiary of the organization. It was deliberately set up in addition to and separate from the insurance organization from a financial and organizational perspective. Today, Discovery is a fully integrated financial service provider that operates in various markets, including non-life and life insurance. Discovery Holdings is a listed international financial service provider that also operates in the UK, China, and the USA via partnerships.

Healthcare insurance accounts for 57.4 % of Discovery's turnover and 41.7 % of its profits.[11] The company is renowned for its activities in the fields of care and health, the focal points of this case. Discovery is convinced that involving consumers in their health and encouraging them to lead a healthy life is best for them, the insurer and society. It is crucial that risks are assessed properly and reduced since Discovery personally bears all the risks of the insured person as a private insurer.

The cornerstone of insurance is providing customers with security and protection during adversity. Many insurers opt to do this by paying for the required care. Discovery goes further and helps customers avoid having to use their insurance. Prevention has a twofold effect: it is better for the patient and cheaper for the insurer. This is not rocket science. It is nevertheless difficult to identify ways in which prevention-related investments can also provide a demonstrable return on investment, or better yet: finance itself. So how does Discovery do this? The most important solution for the insurer is to create the conditions but entrust the responsibility and investment to buyers and providers of healthy products and services. To this end, Discovery offers a health program in addition to health insurance.

6.1.1 The Cornerstone: Permanently Healthier

Discovery offers the health insurance scheme Discovery Health and the health program Discovery Vitality. The latter encourages people to lead a healthy life and rewards them for doing so.[12] The Vitality programs compile a vast amount of data about the (un)healthy behavior of participants and immediately determine whether

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[10] Floor (2012).

[11] Annual results presentation 2013.pdf Discovery.

[12] Discovery (2013a, b, c, d, e, f, g).

interventions have yielded the desired effect.[13] Adrian Gore, the founder and CEO of Discovery, started the company in 1992.[14] Remarkably, he found investors without showing them a detailed business plan or financial perspectives, but by offering them a concrete vision about how Discovery would create value by limiting risks. He knew a great deal about risks due to his actuarial background. He came up with the idea of offering a health program combined with health insurance that would help assess risks more effectively while reducing them in turn.[15] Adrian Gore's philosophy is that companies should not only focus on direct profit, but also on changing the market on a permanent basis. The organization's audacious goal is to be not only dependent upon South Africa but to become one of the best insurers in the world by shaking up markets with innovations. The concept has already proven to be highly successful in South Africa, and Discovery is focusing on expanding its business to other countries.

Within this context, being "one of the best insurers" means being a market leader which is dedicated to obtain the best for its customers. Discovery also has another goal: make people healthier and enhance and protect their lives. The company has various challenges: offering an appealing product, giving insured people access to a good network of hospitals, and compiling sufficient data to ensure risks remain manageable. Discovery has done precisely that over the past two decades and built a sustainable business that creates value for all stakeholders.

Discovery embraces two values that are deeply rooted in its vision, strategy, and business operation: integrity and honesty. These come before everything else, including financial gain. Discovery assumes that people who are treated fairly and honestly will in turn act with integrity and do the right thing. All activities within Discovery are furthermore based on the three principles of drive, perseverance and urgency. Discovery believes it can achieve great things and looks beyond (organizational) boundaries. This mentality can be characterized as a "can do" one, with the company doing its utmost to make things happen. Making it happen is equally important as promising it, which is why measurements are carried out constantly to ensure continued learning and improvement. Discovery changes the rules of the game through innovation and optimism. It can then use these rules to innovate the market and do things differently and better in particular compared to competitors. According to Discovery, at least 250 care-related innovations have been realized between 2004 and 2014, 48 of which are in the Vitality program.

The company has several core qualities that distinguish it from its competitors, such as the ability and courage to be different. Discovery has the ability to devise innovative ideas and the courage to make them happen, even against the tide. This yields new products and services, and allows Discovery to retain its distinctive character.

[13] Nossel (2011).

[14] Economist (2013a, b).

[15] Gore (2012).

The manner in which Discovery studies its customers closely, is unique for an insurer. It can assess behavior thanks to the Vitality program. The company also examines customer behavior, and even established a separate institute in 2013 that focuses specifically on understanding well-being and prevention.[16] Discovery does business in an intelligent and sensible way and endeavors to operate as optimally as possible so that all its ideas also dovetail with its ambition to do good business. This means it does not gamble, but calculates and manages risks properly. An organization is only as good as the people who work there. Discovery is committed to hiring, retaining and developing the best people. Positive people who are in a position to create an environment that is encouraging, fun and challenging. It is also important for people to be aware that everything is possible: trying and failing is better than not trying at all!

The strongest proof of Discovery Vitality's success is that members who actively participate in the Vitality program enjoy a lifespan demonstrably longer than that of non-active insured members. In addition to a health benefit of 8 years for the most active participants, this yields a win–win situation for Discovery, because healthcare costs decrease while customer loyalty increases. The same also applies to other product groups: active Vitality participants are involved in fewer traffic accidents thanks to Vitality Drive, and are also more loyal when it comes to repayments. The brilliant part is that the relative positive effect on healthcare costs is always applicable, regardless of age, gender, or chronic condition. This result is based on programs that demonstrably succeed in helping people to positively and permanently change complex habits such as unhealthy eating behavior and a lack of physical exercise.[17] Data from online health risk assessments reveal that participants in the Healthy Food program have a healthier eating pattern: they eat more vegetables and fruit, and consume less sugar, salt and processed foods.[18] This yields health benefits and also provides people with enjoyment. Participants give Discovery Health a score of 8.9.[19]

Discovery has grown organically to its current size without making any acquisitions. Expanding to other countries on its own turned out to be more difficult than anticipated, which is why it opted for partnering as the basis for its international expansion. It has forged partnerships with Humana (the number four in the USA), Ping An (the number two in China) and through PruHealth with Prudential (the largest insurer in the UK). It should be noted that these markets have not achieved the same success as in South Africa. Why? To be truly successful, the product, the organization and the country have to be in complete harmony. Perhaps that is more difficult with joint ventures in a less familiar market. But this does not in any way detract from the brilliance of the model in South Africa!

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[16] Vitality Institute (2013).

[17] Polard (2008).

[18] An et al. (2013).

[19] Discovery (2012).

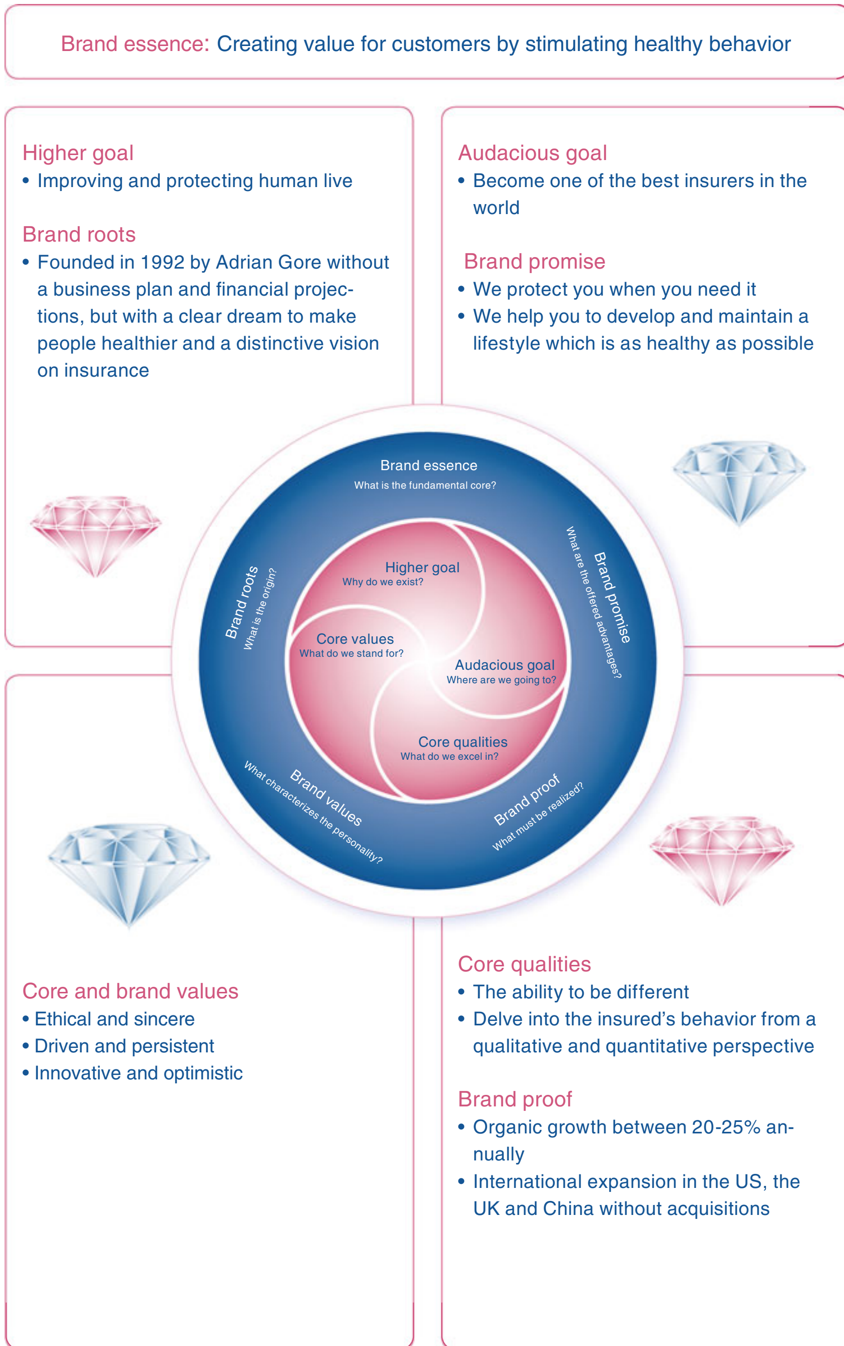

Figure 6.1.1 Vision and positioning of Discovery

6.1.2 The Business Model: Prevention as Well as Insurance

Both prevention and insurance are the cornerstones of Discovery's business model. In this case, the focus is placed on care and health, but the principle is also used in combination with other products, such as the car insurance scheme to which Vitalitydrive is affiliated.

Market Segments: Large Country, Limited Market Africa is currently the continent experiencing the fastest economic growth. While the economic development has not been very positive in the last years, South Africa has grown from a GDP of USD 115 billion in 2002 towards USD 313 billion in 2015. South Africa still leads the way with a GDP growth of 3.5 % annually.[20] The effect of this is a growing middle class.[21] The number of people with "lifestyle diseases" has grown exponentially. Many South Africans are dying because of obesity, diabetes, cardiovascular diseases, heart attacks, and lifestyle related types of cancer.[22] Leading a healthier lifestyle can help prevent a substantial number of these cases.

Discovery Health focuses on employer group contracts and private individuals. The number of group-insured members is by far the greatest: 2.3 million policyholders from over 800,000 SMEs and large companies. Some 300,000 people are privately insured. With 2.6 million insured people, Discovery Health is the largest insurer in South Africa.[23]

The success of the combination between the healthcare insurance of Discovery Health and the health program of Discovery Vitality has not escaped the attention of competitors. The health program has 1.3 million members, making it the largest in South Africa. Four other healthcare insurers currently offer a health program in the South African market, but use it primarily as a marketing and loyalty program and are considerably smaller. The insurer Multiply, with just over 100,000 members in its health program (Momentum Health), is the second largest player in this market. The following are Own Your Life (Liberty Health), Reality (Sanlam), and Zurreal 4Life (Resolution).

Context: The South African Healthcare System in a Nutshell South Africa has a broad selection of healthcare options, ranging from very basic primary care to highly specialized care. The differences between public and private care are profound. Public institutions have had to contend with poor management, insufficient funding and an obsolete infrastructure. Numerous examples exist of patients who were dependent on public care and died because hospitals could no longer care for them.[24] The private healthcare sector is run by commercial parties and often better equipped. Their customers

[20] World Bank (2016).

[21] Reuters (2013).

[22] South African Medical Research Council (2013).

[23] Preez (2013).

[24] World Health Organization (2013).

are middle- and higher-income people. Around 79 % of doctors work in private healthcare.[25]

The income gap among ethnic groups is huge. A black South African family has an annual income of ZAR 69,632 (around USD 6000 or EUR 5100), an Asian family ZAR 252,724 (USD 22,000 or EUR 18,600), and a white family ZAR 387,011 (USD 33,600 or EUR 28,600). The current government is busy implementing a new insurance scheme called the National Health Insurance (NHI) in the hope it will ensure greater equality in care between the different socioeconomic groups. A strong correlation still exists between the use of private or public care and ethnic background. In 2011, 81 % of black South Africans and 63 % of colored South Africans used mostly public healthcare facilities. With regard to white South Africans, 88 % use private facilities, like 64 % of Asian South Africans.

These differences are also reflected in healthcare insurance. Almost 70 % of the white population has private healthcare insurance compared to 41 % of the Asian population, 20 % of the colored population and 9 % of the black South African population.[26] The number of insured people differs from region to region. The wealthiest provinces, namely the Western Cape (25 %) and Gauteng (24 %), have significantly higher percentages of insured people compared to poor regions such as the Limpopo (7 %).[27] Your annual income determines what you do and do not pay for each treatment in the public healthcare sector. People earning more than ZAR 72,000 (USD 6200 or EUR 5300) pay the costs in full. The group that earns less receives a supplement. People who are unemployed or dependent on the state receive free care, as do children under the age of six, people with disabilities, and pregnant women. Out in the countryside, the lack of people and resources sometimes hinders the provision of good local care. Many South Africans simply cannot afford to travel to a hospital.[28] Consequently, even free care is inaccessible to many poor South Africans.[29]

Customer Value: Reward Is Better Than Cure With the addition of Discovery Vitality, the customer value that Discovery Health provides extends far beyond insurance against healthcare costs. Discovery Vitality encourages VIPs (Vitality Insured Persons) to develop and maintain a healthy lifestyle. These VIPs use test results to set themselves multiple goals, such as attaining a healthy weight, remaining physically active and undergoing annual preventive care. The aforementioned care involves screening, testing, and preventive treatment at a healthcare practitioner within the Discovery network. Special protocols exist for customers with a specific illness to

[25] Ataguba (2010).

[26] Statistics South Africa (2012a, b).

[27] Davis (2013).

[28] Chuma et al. (2006), Russel and Abdella (2002), and Goudge et al. (2012).

[29] Stassen (2012).

keep their health at an optimal level. VIPs are motivated by rewarding healthy activities with Vitality points that yield the widest possible range of benefits.

Discovery wishes to make insured persons aware of the important role they play in protecting their own health and reducing healthcare costs. Besides the Vitality program, Discovery does this via a personal Medical Savings Account for insured persons.[30] Discovery deposits a sum of money into this account at the beginning of the year. It is then paid off using part of the customer's monthly contribution. Day-to-day care-related costs such as a visit to a doctor and the purchase of a pair of glasses are paid from this account. The personal “control” over how money is spent on everyday care makes members more aware of costs and challenges them to make conscious choices. The money left over at the end of the year is carried over to the following one. The combination with Vitality is ingenious. Customers who lead a healthier life thanks to Vitality notice that they have more money in their Medical Savings Account at the end of the year.

Discovery: Packages and Products Discovery Health offers six different insurance packages, each of which includes an optional health program. Which private hospitals are covered depends on the package. The Keycare packages offer the least cover. The cheapest insurance costs ZAR 450 (USD 40 or EUR 34) per month. Customers must pay many day-to-day medical costs themselves. The KeyFit health program costs ZAR 33 (USD 3 or EUR 2.50) per month and offers basic tools and facilities for keeping fit.

Besides Keycare, Discovery offers five packages with increasing cover and contributions: Core, Saver, Priority, Comprehensive and Executive. The Saver packages, for example, offer an insurance with a Medical Savings Account and start from ZAR 980 (USD 87 or EUR 74) per month. The insurance also includes screenings and prevention. Daily medical costs are paid from the Savings Account. Priority, Comprehensive and Executive provide the most cover. The cheapest package costs ZAR 1778 (USD 157 or EUR 134) per month. Besides more extensive cover, a Medical Savings Account, and a larger network of hospitals you can visit, the excess is also limited. All of these packages allow you to purchase the Vitality health program, which costs ZAR 155 (USD 13 or EUR 11) per month. The additional costs for the Vitality program are perceived as a bargain. It gives customers access to a wealth of health-related tools, and they can recover these costs in no time thanks to numerous discounts that often total up to 25 %.

Delivery: Every Day, Step by Step Like most insurers, Discovery sells its products via financial advisors and directly over the telephone and the Internet. The delivery is unique if you are going to use both the Health and Vitality products which are, technically speaking, two separate products. This split is essential in the business model because preventive measures do not have to be financed from

[30] Discovery (2013a, b, c, d, e, f, g).

insurance money earmarked for care. In terms of perception the combination is of key importance and they are exceptionally well integrated.

Most customers belong to a collective health insurance scheme, which means they fall under a joint scheme from their employer or another party. Such a "collectivity" has its own board, website, and insurance policy.[31] All administration and services are provided by Discovery. A collective partner such as an employer has an interest in ensuring the health of employees. They value a health program and therefore often help to actively participate with own employees. Discovery Vitality is also able to identify the health benefits over a specific period. One of the initiatives to encourage companies to operate in a healthy manner is the "most healthy company list," which is drawn up using a health scan of individual employees and the company as a whole. This maps out, amongst other things, the (likelihood of) chronic illnesses in each department and the Vitality age of people in relation to their actual age.

The introduction of Discovery Health in combination with Vitality was a major social innovation and therefore highly complex too. It initially required considerable time and money to familiarize customers and intermediaries with the concept and the benefits thereof for insured persons. Discovery learned that customers were very focused on obtaining as many options as possible, but were not entirely sure how to use these. The insurer has since devoted additional energy to educating people with the help of instructional videos. It is important for Discovery that people use the Vitality program properly, otherwise they will not enhance their lifestyle and health.

Discovery Vitality motivates people through a combination of loyalty initiatives and game mechanisms. Vitality is an enticing program that complies with all rules of marketing and brand management in the fast moving consumer goods sector. At the same time, it is much more than a loyalty program. It has a scientific basis and is strongly connected to and organized with communities. Experiments with golf players, for example, have revealed that people are more strongly motivated when they stand to lose something (require more strokes than the objective) compared to when they stand to win something (require fewer strokes than the objective). Such insights play a key role in defining the program more sharply.

The personal pathway is person-dependent and starts with a comprehensive sports program, or assisting someone to quit smoking, for example. VIPs are motivated by allowing them to earn Vitality Points if they participate in activities. Participants start off as members and can become gold members if they follow the program properly and score points. A higher status offers new benefits, such as a better interest rate on your Medical Savings Account and greater discounts with partners.

Vitality gives access to a physical network of parties that can help members attain the goals on their pathway. Customers can enjoy a discount of up to 80 % at a fitness partner, for example. They also receive redeemable points each time they participate in a sport. The VitalityCard plays a key role in delivery as it gives access to benefits. Another card also entitles the bearer to various benefits. The HealthyGear Card, for example, must be presented when paying at Adidas and Totalsports partner stores. The discount is then deposited into the customer's account. The same principle applies to HealthyFood. If customers use multiple benefits, the DiscoveryCard is the

[31] Altron Medical Aid (2013a, b).

most convenient option because everything is included on a single card. At the same time, Discovery is physically visible in numerous places, such as in Woolworths and Pick n Pay supermarkets where all Discovery customers receive a 25 % discount on healthy (Vitality) products. The same applies if you pay the "Discovery price" for hotel reservations or flights, with the level of the discount depending on your membership status. Dual branding is also carried out with other top brands such as Nike and Adidas. All of this has a profound effect on branding and positioning of the brand. That is why Discovery is also an absolute top brand in South Africa.

An interesting mechanism is the discount percentage that can be increased by performing additional checks. New members who have not yet undergone any checks are entitled to a 10 % discount. This discount rises to 15 % once the Vitality Health Check has been carried out. In this way, Discovery ensures that people actively provide information and helps customers overcome the hurdle of starting the program.

Everyone can use the website and app of the Living Vitality platform, including nonmembers. It offers customers advice and tools to start looking after their personal health as well as an online community. It also integrates input from various health platforms and wearables such as miCoach from Adidas, your Polar heart-rate monitor, your JawBone, Garmin, or Nike+. Customers receive Vitality points for every workout they do. The platform is important because it integrates all information relating to the health program.

Operation: Big Health Data The customer experience and health programs are mostly online. Integrated information is an essential part of Discovery Health and Vitality. Apps have to be developed and blogs and experts must be available. The large-scale setup of a personal pathway for every VIP is also impossible without the help of ICT. The platforms and systems are the drivers behind Discovery. All Discovery health customers, for example, have their own electronic patient file that merges their healthcare use, medical data, and health-related data.

The combination of Discovery Health and Vitality is an important source of information for ensuring continuous improvement. A vast amount of "big health data" is compiled that relates to the health of VIPs who participate in Vitality. Discovery is a world leader in this field. Around five million people around the world are currently participating in this program.[32] Besides facilitating better risk assessment, it also yields new insights into the effects of health and care-related interventions. Working together with leading research institutes enables the stimulation and selection of more effective treatments, which in turn results in better care and lower healthcare costs. The results of studies are shared with universities and research institutes. Discovery's data is a veritable goldmine for them. Privacy naturally plays an important role here. Personalized data will never be shared. The partnerships deliver interesting results. The Vitality Age, for example, is based on a meta-analysis of more than 5000 international studies containing data on over 75 million years of peoples' lives. The annual international Discovery Vitality Summit gives people the opportunity to share their care-related knowledge.[33]

[32] Vitality Group (2013).

[33] Vitality Summit (2013).

Providers and partners play a crucial role in the Discovery Vitality concept. It is also important for Discovery to select the best partners without granting exclusivity. Partners can be divided into three categories:

- *Health and Fitness Partners*, where VIPs can use sports facilities for a reduced fee;
- *Reward Partners*, where VIPs can redeem their collected points for rewards;
- *DiscoveryCard Partners*, where VIPs can receive additional discounts and other benefits by using the VitalityCard.

To change behavior, it is important to strike a good balance between what VIPs should do and what they gain from doing so. The value of the reward for the customer and the frequency with which it is used are important aspects. Discounts on the purchase of healthy food at a supermarket, for example, have a low value, but are commonplace and used frequently. It is also healthy for everyone so all members receive the same discount. The other extreme is a ticket to a holiday destination, which has immense value but is used sporadically and differs in terms of membership status. Since VIPs can use small and frequent rewards and save for less frequent, large rewards, they are motivated to maintain their behavior. Discovery has compiled a sophisticated portfolio of rewards to help VIPs remain motivated. The types of participants and their motivation are also taken into consideration. Altruistic VIPs, for example, can redeem their points by giving these to a good cause.

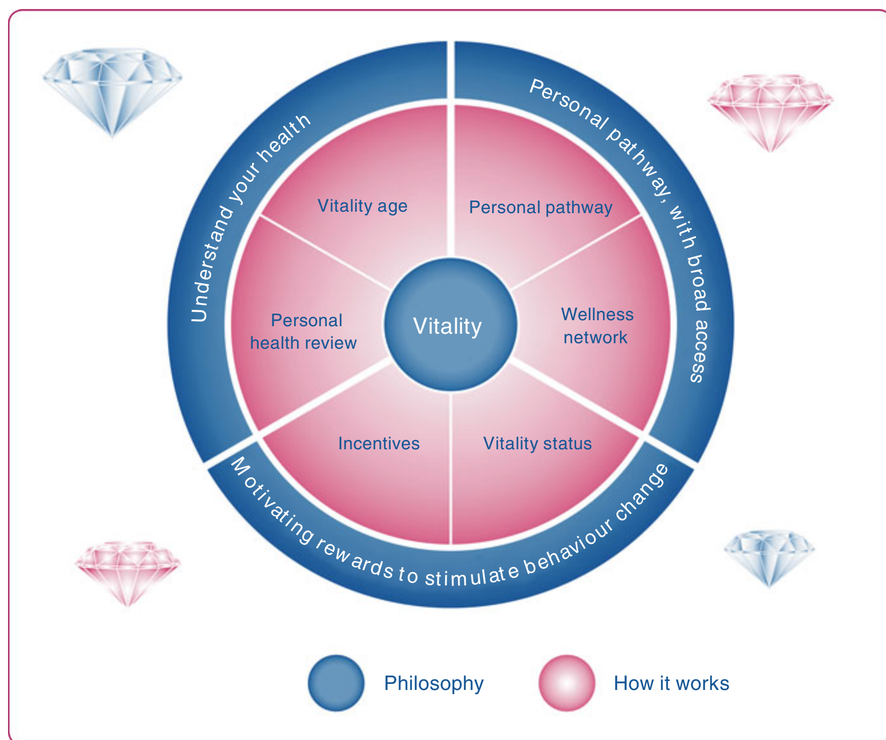

Figure 6.1.2 Vitality model

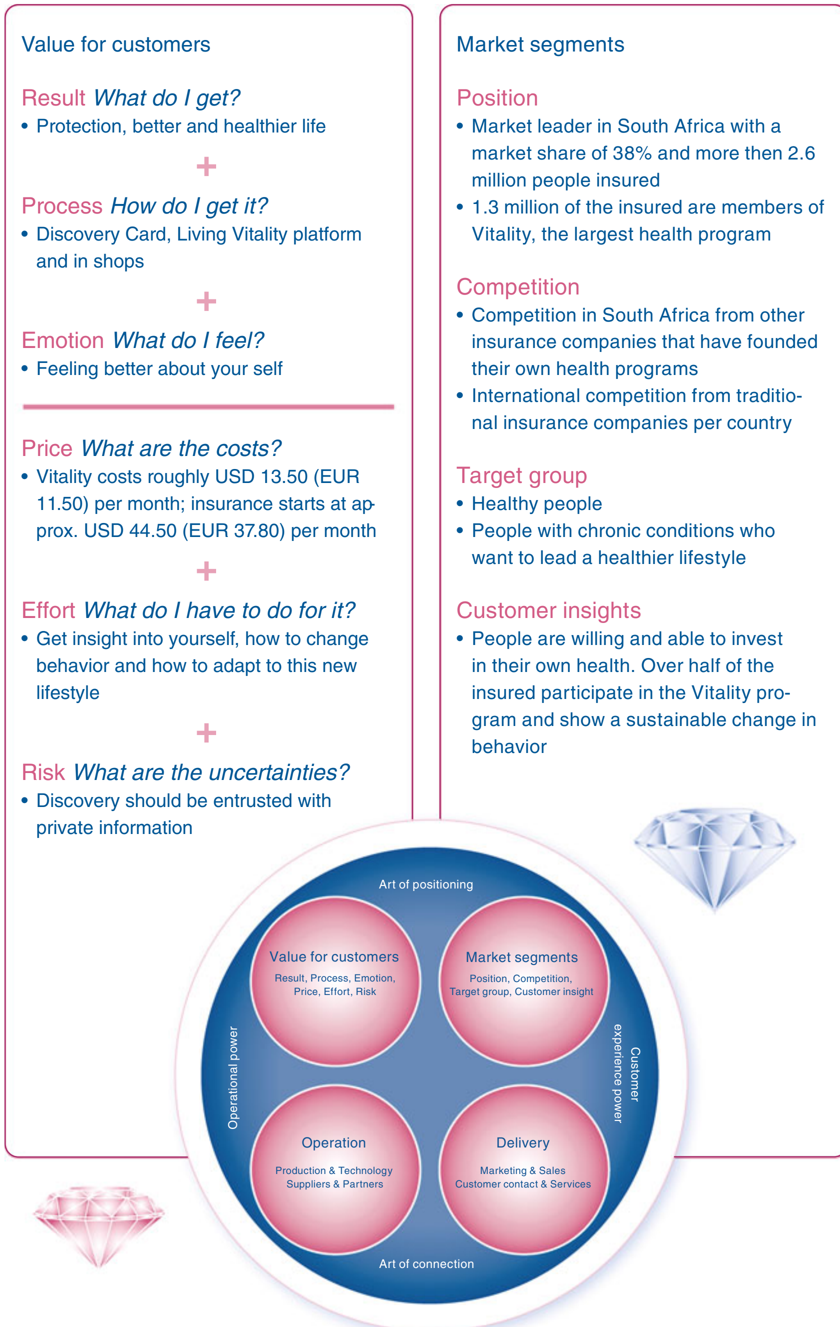

Figure 6.1.3 Value for customers and market segments of Discovery

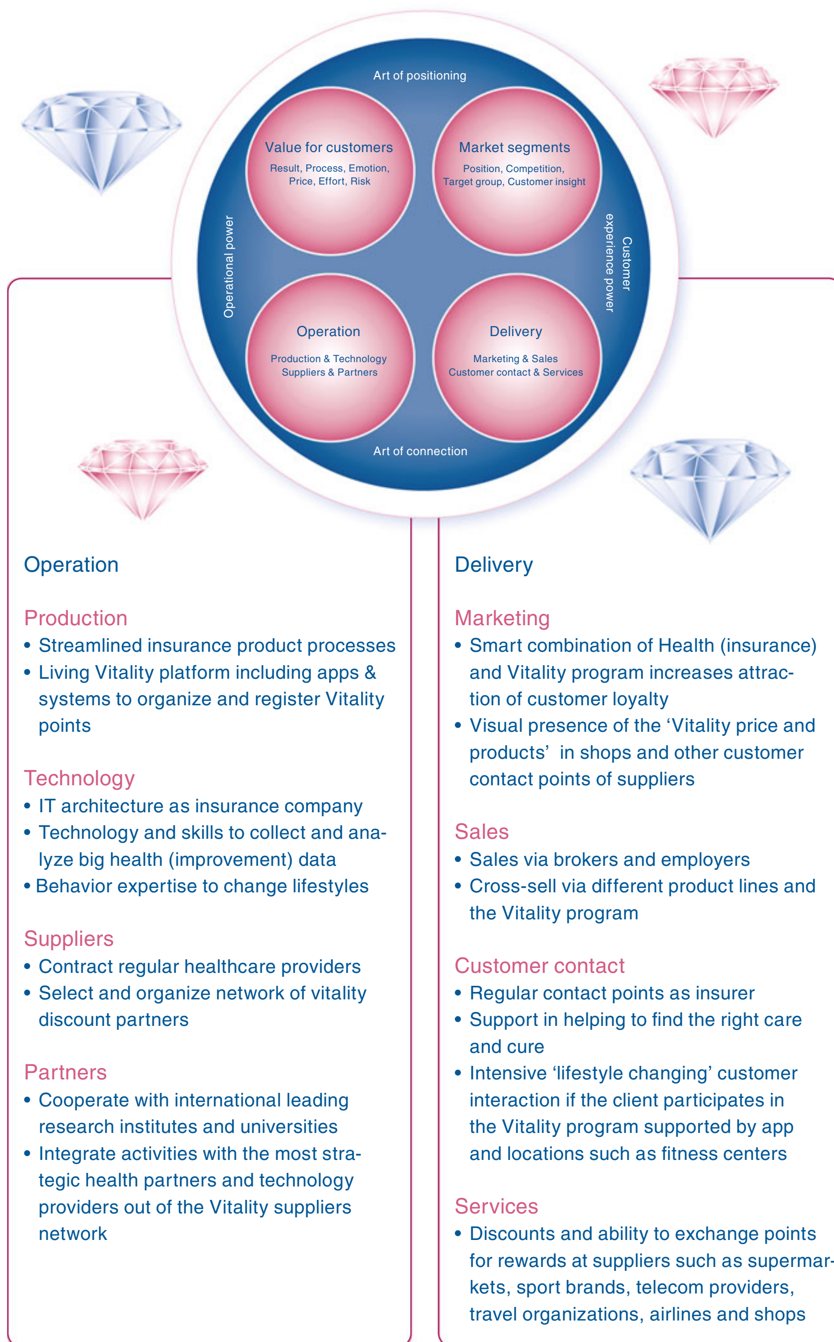

Figure 6.1.4 Operation and delivery of Discovery

6.1.3 The Result: Healthier Participants and Lower Costs

Vitality studies reveal that participants become healthier: that is valuable for customers as well as for Discovery. That applies to truly fit people, but couch potatoes can also earn Vitality points by carrying out tests and giving up smoking. The results for active Vitality participants are astonishing: the most active participants live 8 years longer than nonparticipants on average! The number of hospital treatments and the length of stay for each treatment are significantly lower, resulting in lower healthcare costs as well, as depicted in the table below. This table has been adjusted according to age, gender, chronic conditions, and the number of admissions to avoid bias.

Table 6.1 Results of VIP study[34]

		Vitality participant		
	Not registered	No involvement	Average involvement	High involvement
Percentage of insured persons	37.7 %			
Days in hospital per patient	6.10	6.12	5.62	4.77
Costs per patient in rands (dollars/euros)	30,420 (2,641/2,165)	31,332 (2,721/2,230)	31,078 (3,698/2,212)	27,538 (2,391/1,961)
Costs per incident in rands (dollars/euros)	18,494 (1,684/1,317)	19,044 (1,653/1,356)	19,189 (1,666/1,367)	18,011 (1,564/1,283)
Number of days' stay in hospital per treatment	3.61	3.60	3.32	2.97

In addition to the impact on healthcare costs, the Vitality program also plays a pivotal role in binding and retaining customers of Discovery Health. On average, customers are rewarded with a 15.2 % lower premium. A customer who has invested in all the activities required to become a bronze or silver member and receives all accompanying benefits will not go elsewhere quickly. A Discovery study involving Vitality members indicates that the number of these active and therefore more loyal customers has grown from 38 % to 48 % over a 5-year period.

Medical costs for highly involved insured persons are 10 % lower on average than those for insured persons who do not use Vitality. While the program finances itself it meanwhile also saves healthcare costs such as in the event of hospitalization. Average daily costs per patient in a hospital amount to USD 665 (EUR 492).[35] In 2012, insured persons were hospitalized a total of 547,705 times (roughly 30 % of overall claim costs). Without Vitality, hospital admissions could be estimated at over USD 1.31 billion (EUR 970 million) annually. With Vitality, this totaled USD 1.25 billion (EUR 930 million) annually. A difference of USD 58 million (EUR 40 million) annually (i.e., a saving of almost 4.1 % on the entire population).

[34] Discovery Vitality Journal (2013).

[35] International Federation of Health Plans (2012).

Discovery's business model is very attractive to shareholders. The positioning makes Discovery more appealing to people who consider health important, the compilation of data provides input for the proper estimation and selection of risks, and healthcare costs are lower because people are made healthier. The overall result is 18.8 % lower claims per insured person.[36] The Vitality program, which is responsible for this decrease, is paid for by participants and providers and not by the insurance premium itself. The program itself is profitable to a degree, but the real benefit and significance for the organization naturally stems from the health advantages and high loyalty among its customers. The selection also attracts numerous customers, resulting in rapid organic growth. Over the past 11 years, profits rose from ZAR 122 million (over USD 10 million or EUR 8.5 million) in 2000 to ZAR 2838 million (USD 237 million or EUR 202 million) in 2011. Profits grew by 50 % over the past 5 years, mainly due to new business (40 %). Discovery's equity fund is one of the top five on the South African Stock Exchange. A dividend of 90 cents per share was paid in 2011, compared to 69 cents in 2010 and 48.5 cents in 2008.

Discovery aims to work with smart people who perform optimally and can connect with the company's vision. The company therefore pays close attention to the career prospects, motivation, encouragement, and retention of employees. During "stay interviews," for example, employees are asked why they continue working at Discovery and given the opportunity to provide feedback on how the company is doing. New employees complete a 3-month program first that familiarizes them with the company, its history, raison d'être, and core values. They are then interviewed to determine whether the company meets their expectations. This allows Discovery to use the fresh perspective of employees to ascertain whether the link between what is said and what is happening in practice actually corresponds.

The results achieved in enhancing the health of people are Discovery's most important contribution to society. Healthy people also create greater value for society because they earn money for their family and need to use collective resources less often. In addition to its primary activities in private healthcare, Discovery also helps improve public healthcare. It does so not only to unburden the public sector, but also to create capacity in the future healthcare system of South Africa. Infrastructure-related investments are made, for example, by training people and providing resources. The provision of primary care delivery is supplemented by counseling, tests, and home care for HIV/AIDS sufferers. Investments are also made in projects aimed at children and young people.

6.1.4 The Brilliant Lessons of Discovery

What can we learn from Discovery?

- Start with a clear vision, lay down a new concept and continue embracing that dream, even if it is against the tide. This approach has permitted Discovery to realize one of the few international examples of preventive care that really does

[36] Stassen (2012).

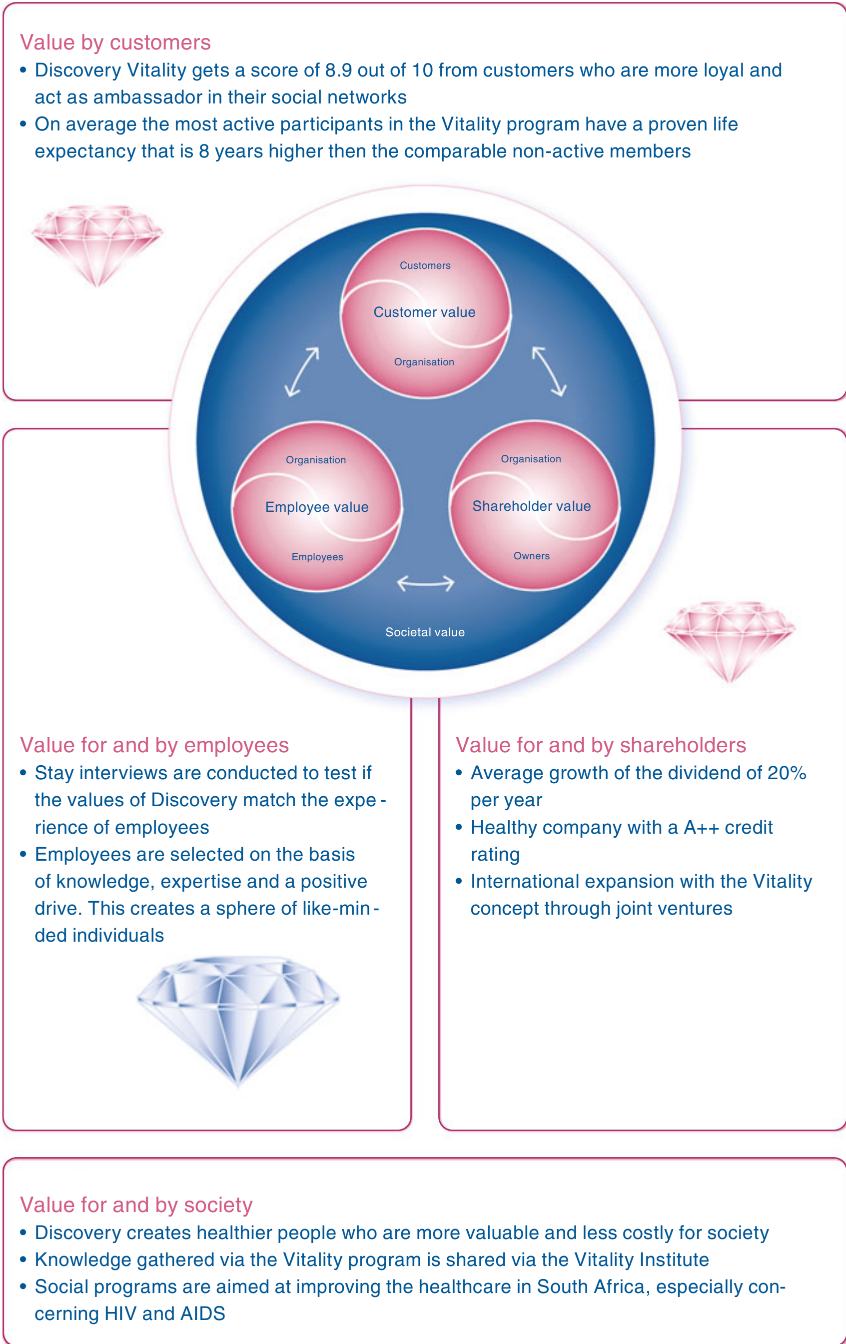

Figure 6.1.5 Value for and by stakeholders of Discovery

make people healthier, and which is self-financing and therefore scalable. The inspirational solution that this insurer has found entails organizing prevention and insurances into two separate companies that are self-reinforcing from a customer's perspective.

- Make a virtue out of necessity and let customers personally compile the information relevant to you and them. It is difficult for every insurer to obtain and compile sufficient information for assessing risks as effectively as possible. The Vitality program not only collects data relating to insured persons, but also creates direct value by raising the awareness of insured persons and motivating them to lead healthier lives by making this information available as a dashboard for personal health benefits.
- Focus on your customers and their motives sincerely and profoundly if you wish to change their behavior. Discovery has combined and experimented with the theories of behavioral change and the mechanisms of game theory and loyalty program in order to bring about actual behavioral change among customers.

6.2 Healthways

Create a healthier world, person for person

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Prelude *Jim Johnson's 80th birthday was some time ago. He has recently spent eleven days in hospital after undergoing heart surgery. His cardiologist told him he had to start exercising if he wanted to continue living for a while longer. He heeded this advice and joined Healthways' SilverSneakers program. This program, which he discovered via his health insurer, is aimed specifically at senior citizens with chronic illnesses. An exercise and nutrition program is created based on the personal data of participants. Jim now walks five miles on a treadmill every day and trains with weights. He firmly believes that he would not be alive today without this program. Besides exercising, he has also shed 46 pounds while at the same time gaining muscles. Currently he weighs 194 pounds, the same weight he had when he played football at high school! The program has made him healthier and also allowed him to get his life back on track.*[37]

Introduction The predecessor of Healthways starts in 1981 and focuses primarily on hospitals, addiction clinics and diabetes centers. In 1984, the management team sees a consolidation battle occurring within hospitals in the USA. They feel that they are at a crossroad and wonder whether they wish to continue taking over hospitals in order to grow even bigger in this rat race. They opt for a different path and start to move away from hospital-related activities. Instead of focusing on hospitals themselves, they shift their attention to disease management within hospitals. In 1989, they begin promoting good health for people with specific complaints, such as diabetes.

In 1993, American Healthcorp introduces the health program Diabetes Healthways, and in 1996, the first disease management contract is concluded. While this is a challenging new field, the shift in focus still causes sales to decline. This is logical since traditional sales focusing on healing in hospitals are being reduced, but it is also scary.[38] Overall sales consequently fell from USD 41 million to USD 30 million (EUR 44 and EUR 25 million respectively) in 1998. The strategy did however work out in the long run. The market positioning was such that profitability improved and growth could be achieved again in the long term. In 1999, 10 years after the start with the promotion of good health, American Healthcorp changes its name to American Healthways (and to just Healthways in 2006 in order to compete more effectively outside the USA).

American Healthways initiates more activities outside the domain of diabetes programs and introduces a comprehensive disease management program to tackle heart failure (Cardiac Healthways), followed by one for dealing with respiratory illnesses (Healthways Respiratory). Up until the turn of the century, Healthways sells disease management programs geared to a specific condition. They discover that this is restrictive and relatively costly. In 2000, Healthways offers disease management contracts for multiple diseases for the first time, which marks an important step forwards. Most people with a chronic illness also suffer from other disorders. Patients who participate in disease management programs often have more than one condition. It is expensive and not always effective to constantly use individual and specialized

[37] See Jim Johnson et al. explain this themselves in a video about Silversneakers (1 October 2013):95 http://www.silversneakers.com/TellMeEverything/WhatisSilverSneakers.aspx.

[38] http://www.fundinguniverse.com/company-histories/american-healthways-inc-history/.

nurses for illnesses who can intervene together. Preventive measures such as more exercise and a healthier diet are often similar for various disorders. Moreover, you want to know when various disorders impose conflicting requirements for interventions. This integrated approach to disease management appears to work well. During that period, Healthways is the first to publish standards that make the approach to disease management transparent: measurable and verifiable. This is ground-breaking. At the time, many programs are still being used primarily as a marketing tool or on the basis of faith, hope and love. Healthways is able to prove that its approach actually works. The patients feel healthier and happier, but the approach itself has developed into one that clearly pays for itself through savings on healthcare and/or greater labor productivity. Healthways demonstrates with this enhancement programs that its approach is not a hype, like many other cost-saving initiatives that cannot be verified. The publications and the approach enable Healthways to secure major contracts in 2001. The 10-year contract with Blue Cross Blue Shield of Minnesota is a resounding success from a commercial and reputational perspective.

Healthways proves its ability to obtain verifiable results and is a reliable partner within the medical world. This image is reinforced in an evaluation carried out by the Johns Hopkins University. Blue Cross Blue Shield and Healthways ask the university to study the effectiveness of the enhancement program, the results of which are positive. The Johns Hopkins University approves the results of the cardiac and diabetes care enhancement programs. This marks the first time that such investigations are carried out in the USA. In June 2002, Healthways is the first organization to receive the stamp of approval from the Disease Management Accreditation program, an institution managed by the National Committee for Quality Assurance (NCQA). Healthways is subsequently certified by the largest healthcare accreditation bodies in the USA, and is the first company to implement disease management programs.

These programs enable Healthways to offer demonstrably good care while saving money simultaneously. They let themselves increasingly be rewarded on a "no-cure-no-pay" basis in which they share the financial benefits they have realized with employers, insurers, and/or government. That is a unique and highly distinctive business model, but is not always the easiest way. From a business perspective, a boom period commences after 2002. The contract with Blue Cross Blue Shield of Minnesota, however, remains the key revenue generator. It is not renewed in 2008, and Blue Cross Blue Shield operates the purchased services itself from that moment onwards. The telephone services, staffed by 200 people and previously acquired from Healthways, are transferred in-house in order to expand them further.[39] Additionally, Healthways and seven other companies had participated in a large disease management experiment (the Medicare experiment), and at that time the positive results of this are challenged by Medicare.[40] These two events affect Healthways financial results and since the start of the economic crisis in 2008, the organization's growth has slowed compared to the preceding period. Nevertheless, Healthways is generally recognized as being at the forefront of proven and self-

[39] http://www.startribune.com/business/18787234.html.

[40] http://www.nytimes.com/2008/04/07/business/07medside.html.

financing disease management programs. At the same time, this business model also continues to be a challenging one for Healthways. What can we learn from this pioneer in the field of prevention?

The Medical Expenses System in the USA The medical expenses system in the USA is a key factor that helps with the commercial development of the disease management market. There is a large difference between healthy people who earn money and people unable to work because of their health. The best care in the USA immediately translates into the best care in the world. However, such care is unaffordable for many people. Due to the prohibitive cost of care, it is logically also worth more if you can avoid it.

Prosperity in the USA has its corresponding problems. Many people suffer from obesity- and lifestyle-related chronic illnesses such as diabetes. The average life expectancy is no longer increasing nowadays, but actually appears to be decreasing. Healthcare in the USA is provided by a myriad of organizations. Healthcare institutions are owned and operated largely by private organizations. Health insurance for workers in the public sector is provided primarily by the government. Employers contribute significantly to their employees' healthcare premiums. For them, disease management is a tool for boosting labor productivity as well as for curbing medical costs.

Insurers have contracts with certain healthcare practitioners (organized and non-organized). If insured people visit a healthcare practitioner with whom they do not have a contract, they will pay a higher percentage themselves.

Most of the population under the age of 65 is insured via their own employer or that of a family member. Some people insure themselves. A large percentage of people in the USA are not insured, namely 49 million inhabitants or 16.3 % of the population. ObamaCare has made basic healthcare more widely accessible, but this is significantly less than the broad level of care available to everyone in the strip between Scandinavia and Switzerland.

According to the World Health Organization (WHO), the USA spent the most on healthcare per capita (USD 8608/EUR 6336) and more on healthcare as a percentage of GDP (17.9 %) than any other country in 2011.

6.2.1 The Cornerstone: A Healthier World, One Person at a Time

Healthways wants to create a healthier world and does so one person at a time.[41] The well-being of people is improved through specific and resulted-oriented programs. Investments made in Healthways' programs are recouped because the care costs of

[41] www.healthways.com.

participants decrease while productivity increases. The approach taken by Healthways unites several aspects. Key ones include a personalized approach that focuses on behavior, prevention, and lifestyle. At the same time, the approach must be backed up with scientific proof as is customary within the medical world. These elements are also evident in Healthways' roots.

The organization is founded by five hospital administrators: Thomas G. Cigarran, James A. Deal, Henry D. Herr, Robert E. Steen, and David A. Sidlowe. The primary activities Healthways concentrates on at that moment include hospitals, addiction clinics, and diabetes centers. The combination between the medical physical side of health and the behavioral side is already present at that very beginning. The disease management approach commences within healthcare facilities. Healthways' focus on proving and demonstrating results is therefore a logical extension of its own medical background.

The introduction of the health program Diabetes Healthways in 1993 reveals the eventual cornerstone of Healthways: focus on a population's risk groups and on well-being. It launches a population-oriented approach to diabetes based on customer needs and self-management. The medical world has never seen such an approach before. Up until then, healthcare practitioners opt for a traditional approach, with hospitals playing a pivotal role in the provision of a diabetes program. The shift is now made from a hospital-based diabetes approach to a population-based diabetes approach. The focus is placed on the population instead of the illness, resulting in a different perspective on the result. It becomes far more logical to view this in an integrated manner and focus on the integrated perspective of general well-being, life, and overall healthcare costs. In addition to the approach based on the perspective of people instead of that of healthcare practitioners, a personal approach is also chosen that is still an important feature of the way Healthways operates. It is no coincidence that an American company is playing a pioneering role with such an approach. Additional labor productivity is of the greatest value here, and healthcare costs are the highest. A personalized program within a collective approach appears to be a good cultural fit, and the USA has the dubious honor of leading the way with respect to lifestyle-related diseases.

Healthways wants to take the lead in making the world healthier, one person at a time. To this end, it makes promises to different groups of customers that are both simple and revolutionary. Healthways promises people that it will increase their well-being and help them lead a longer and healthier life by making them healthier thanks to a customized approach. The organization has the self-confidence to make payments to Healthways increasingly dependent upon the realization of this promise. The organization approaches employers, governments, insurers and other collective groups with a financial interest in ensuring more productive and healthier people while lowering healthcare costs. Healthways offers to make a selected "unhealthy" part of "their" population demonstrably healthier on a no cure, no pay basis.[42]

[42] Healthways 2012 Annual Report (2013).

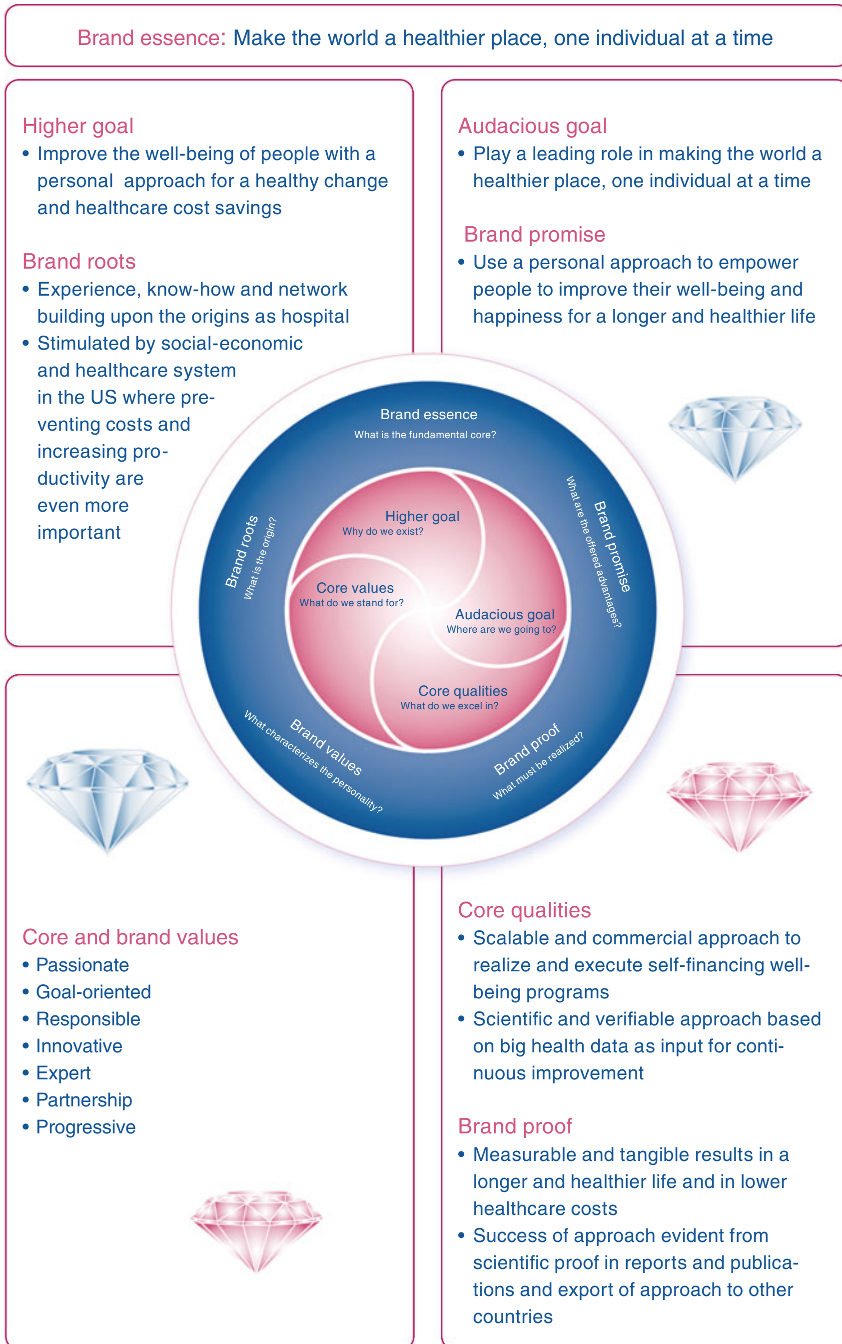

Figure 6.2.1 Vision and Positioning of Healthways

To deliver on these promises, Healthways works according to the following values[43]:

- passionate: inspiring, optimistic, and motivated with an everything-is-possible attitude;
- deliberate: solutions correspond to the mission and yield measurable results;
- responsibility: promises are kept by a reliable partner judged on results;
- innovative: being creative, no problems exist that cannot be solved;
- expertise: 30 years of experience in the creation of workable solutions;
- partnership: be a partner in well-being and joint improvement-related initiatives;
- forward-looking: a desire to lead the quest for improvement in well-being.

The promises and values must be proven to the customer. Most important of all is that people have a greater sense of well-being and happiness, and a longer and healthier life, while healthcare costs are demonstrably lower. This is supported with a personalized approach powered by big health data. Such data not only helps to achieve a personal approach, but is also the source for recording within research reports and scientific publications, and is needed to get paid when work is conducted on a no-cure-no-pay basis. It stimulates Healthways to really help make the world a healthier place. Scalable commercial solutions arise when it becomes clear which type of prevention works in such a way that this can be financed from productivity gains and savings on healthcare costs. These can be exported and copied.

6.2.2 The Business Model: A Longer and Healthier Life

Market Segments: Unhealthy People In 2013, over 40 million people had access to the Healthways' programs through collective contracts. The focal point still lies in the USA, but contracts and activities are also prevalent in countries such as Australia, Germany, France, and Brazil. Healthways reaches the end users of its services through these "collectivities," namely the social groups in which they find themselves. This can be done through the employer, insurance company or hospital, but also via government health programs. The underlying reason for these parties to invest in Healthways' services stems from the insight that people with a higher well-being also perform better, live a longer and healthier life and require less care.[44] Healthways therefore assists in doing something good for people, but also boosts productivity and reduces costs at the same time. Within the collectivities, Healthways focuses on groups in which the greatest health gains can be attained. These are the

[43] Healthways Brand Guidelines V.02.2011, Healthways.

[44] Healthways 2012 Annual Report (2013).

people who truly find themselves in major risk groups or already suffer from one or more chronic illnesses. Few competitors go as far as Healthways when it comes to a personal approach judged according to measurable results. Healthways' competitors are primarily parties that help improve health or reintegration in another way. They are mostly parties with revenue streams greater and more important than disease management, such as healthcare practitioners that offer medical assistance to the chronically ill or reintegration assistance. However, they also provide services as part of an insurance program, internal corporate programs or consultancy. Competition also stems from businesses offering sports programs, fitness facilities, and nutritional advice to organizations and private individuals.[45] The greatest competitor in terms of volume and relevance falls within an entirely different category, however. The most commonly used alternative to Healthways is … no health program. The result is a shorter and unhealthier life, with less well-being and higher healthcare costs. This is of course the real reason why Healthways competes because it wants to make the world a healthier place. A significant share of the market is yet to be conquered, in other words.

Value for the Customer: A Longer, Healthier and More Productive Life The result for an individual is a longer and healthier life. The personalized services of Healthways give customers the feeling that they can work directly on their personal well-being and therefore on their happiness and social participation. The services, programs and advice it offers are based on specific health risks arising from the customer's personal profile. That increases the involvement and justifies the effort and time required to participate and transmit data.[46] Healthways embraces an integrated and holistic view on health and well-being, and also focuses on underlying mental factors. The value of Healthways for people in programs is significantly greater than that obtained from regular medical treatment. Its philosophy dovetails directly with a positive perspective on health but also with the traditional WHO's definition: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[47]

The investment in an individual's health is usually borne by the collectivity. The "hard" result for this organization is additional productivity and/or reduced healthcare costs. There is also the more 'soft' result, whereby it is valuable and useful to assist people with health risks and problems from an own group. This not only feels good but also projects a positive social image to other people in the group. Healthways' services may therefore also contribute to the distinctiveness to staff, patients, and/or citizens to do the right thing and care for people. Healthways partly still operates on a fee-per-participant basis, but is leaning increasingly towards a performance-linked remuneration approach, which also reduces the financial risk

[45] Idem.

[46] Effective Communications, Meaningful Incentives Help Customers Set New Bar For Biometric Screening Participation.

[47] http://www.who.int/about/definition/en/print.html.

for the customer. The price paid is based, in principle, on half the amount that is saved. The health benefits are shared, in other words.[48]

Delivery: Access via Collectivity and a Personal Approach in Programs Collectivities and decision-makers are the parties Healthways focuses on particularly with regard to sales and marketing. Hard evidence that the approach works helps bolster Healthways' reputation and position among these collectivities. It also provides direct contact persons with instruments to convince their colleagues. Once Healthways' services have been engaged, the collectivities "stamp" of approval helps ensure access to people, but also encourages people to actively participate in health programs. The diagnosis is the key element in the approach that is shaped person by person. This is achieved using information about present well-being, the health risks someone is facing, the medical background, and the limitations and possibilities. An analysis of this information is then used to create a tailor-made package of scientifically proven health and well-being interventions for the individual in question. In addition to the content of these services, an equally crucial element for success entails ensuring that they are offered to the end user in a manner that corresponds to the person. The philosophy that only a personal approach leads to a measurable positive result constitutes a key part of the entire process. Personal information is translated into appropriate strategies and means for communication and interaction.[49] In the end, the most important production factor for success is people themselves. These individuals will ultimately have to change their behavior to become healthier by exercising more and eating and drinking differently. Healthways assists in this regard by also offering related health services that complement the health programs. SilverSneakers, for example, is a large-scale fitness program dedicated entirely to older adults with health risks and mostly chronic illnesses.[50]

Operation: People and Data for Behavioral Change Healthways is a strong knowledge-driven service provider. People, systems and information are the main components in the operation. Staff undergo intensive training in the field of personal behavior. This approach is combined with the required technology that enables a personal approach to customers. The Healthways operation is based on making solid and accurate analyses that map an individual's health profile.[51] The Embrace Technology Platform combines the identified health and well-being risks with relevant personal characteristics in relation to behavioral change. The Healthways Well-Being Assessment combines validated questionnaires about health, work and well-being, with benchmark information from the Gallup-Healthways database. This database contains national data relating to the health and

[48] Healthways 2012 Annual Report (2013).

[49] http://www.healthways.com/approach/default.aspx?id=86.

[50] http://www.silversneakers.com/TellMeEverything/WhatisSilverSneakers.aspx.

[51] www.healthways.com.

well-being of reference groups within the USA. Specific health risks within a population are identified by finally complementing this information with demographic data, medical history and medical declaration information of individuals.[52] Healthways is constantly searching for the newest, scientifically substantiated and proven interventions relating to health and well-being in order to include these within its services portfolio. Healthways innovativeness in the application of information technology is demonstrated by the fact that it has been ranked among the top organizations of the InformationWeek 500 for six consecutive years. In 2013, Healthways was in thirteenth position, and was also included in the list of "20 great ideas to steal in 2013." The flexibility and innovativeness to continuously respond to the changing demands of customers is achieved in part through partnerships and acquisitions. Healthways has succeeded in binding parties to itself via a network strategy that delivers breakthrough results and insights in health management.

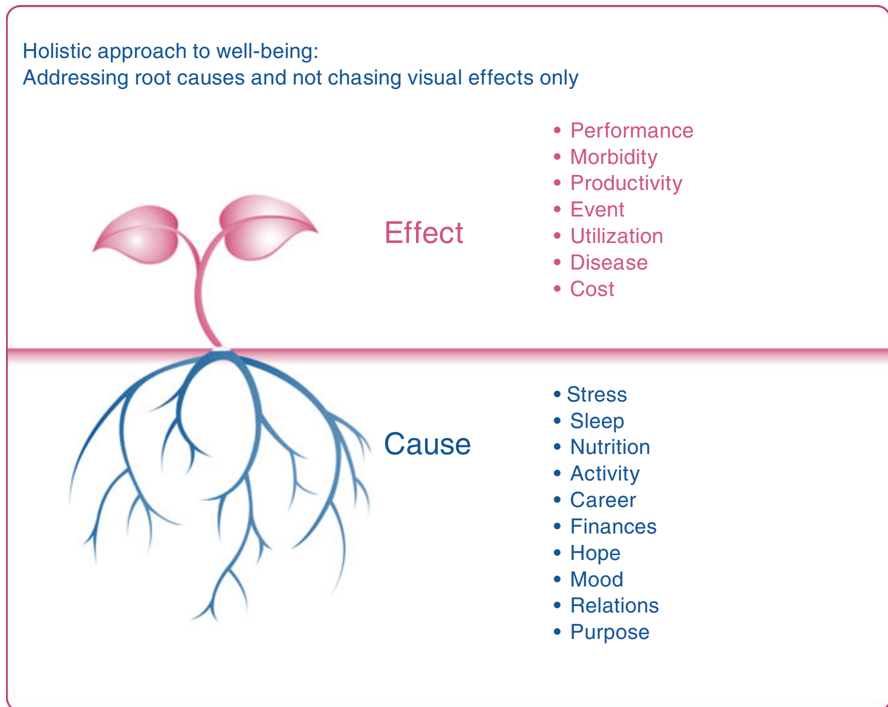

Figure 6.2.2 Holistic approach to well-being: Addressing root causes and not chasing visual effects only

[52] See also the video about the Healthways Gallup index: Video Feature: A Tale of Two Cities: Raleigh and Hickory NC Well-Being Differ Significantly.

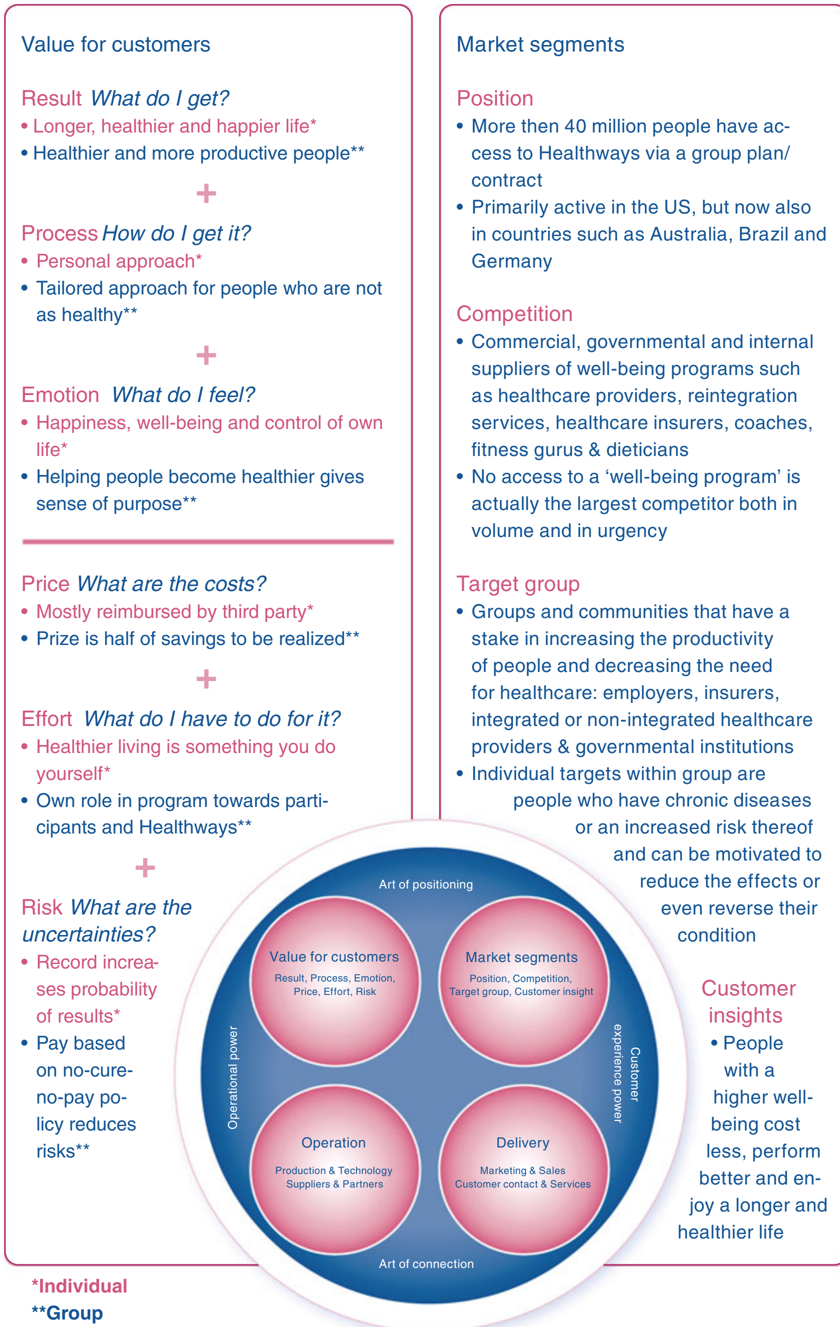

Figure 6.2.3 Value for customers and Market segments of Healthways

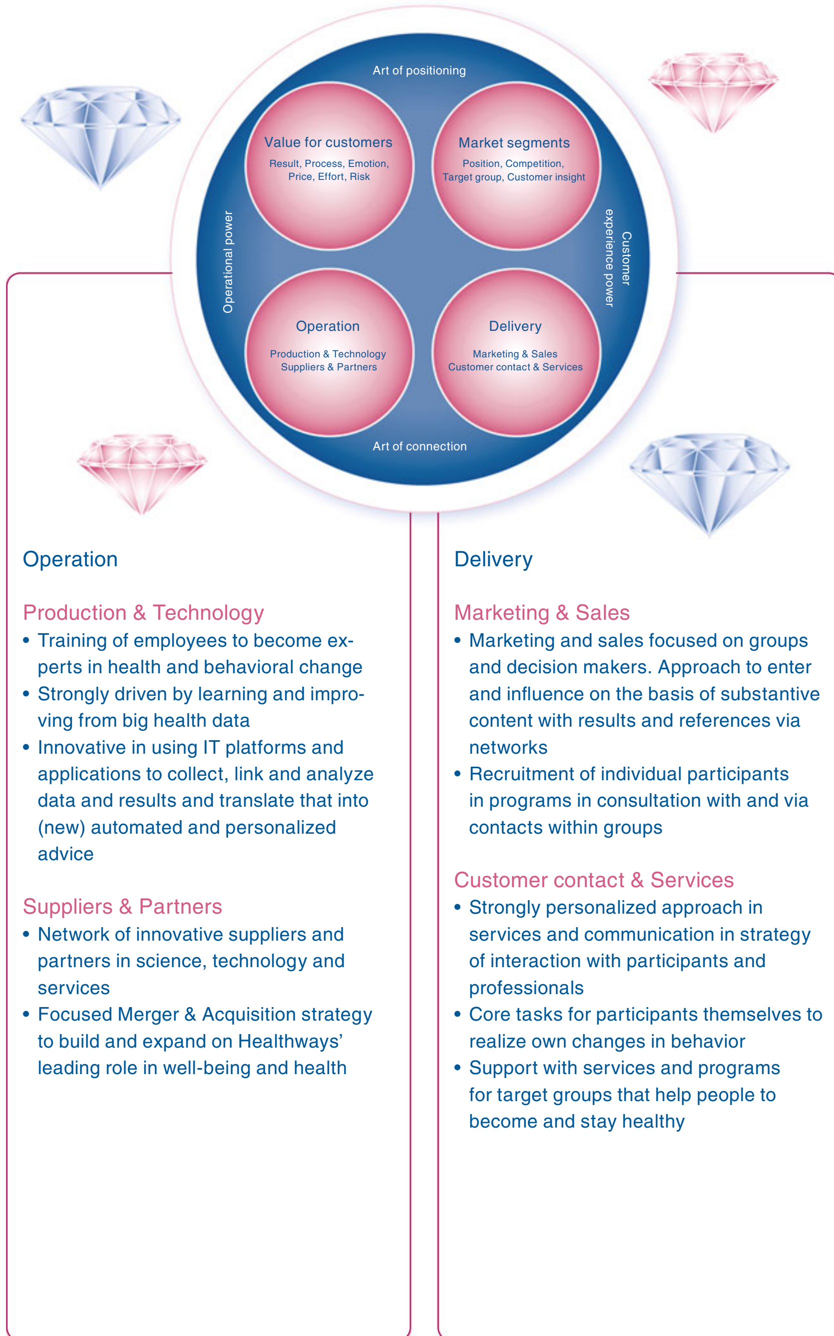

Figure 6.2.4 Operation and Delivery of Healthways

It also works closely with suppliers and partners by entering into academic, strategic and technical partnerships with companies that develop services or knowledge that match its health and well-being vision. The method of working via partners is complemented by an acquisition strategy focusing on companies that develop health-related interventions based on this knowledge.

6.2.3 The Result: Equal Interests Among All Stakeholders

A business model is often about giving and taking between stakeholders that have partly common and partly different interests. Healthways' business model is designed in such a way that all parties in the chain share the same motives. Benefits and risks are shared on the basis of common goals.

The causal value creation chain for individual and collective customers of Healthways works as follows: by improving welfare, medical costs decrease and performance increases, which creates economic value. This is relevant for those directly concerned, but also for society as a whole. After all, more people can actively participate in society and the collective resources of the government are burdened less. This is depicted in the figure 6.2.5.

Healthways uses a personal approach to help people lead longer and healthier lives. They must ultimately take responsibility for their own health. The intended result is that people fall ill less frequently and are more productive in society. Healthways looks for a party for whom this is of value and that is willing, in principle, to share 50 % of this benefit in the form of a fee to Healthways.[53] Learning, adjusting and demonstrating health benefits requires open and high-quality data from individual and collective customers. When people participate in Healthways' programs, they must therefore also commit to an intensive partnership and complete openness and transparency in data and knowledge.

A study was conducted on how involvement, healthy behavior and physical health influences the performance and absenteeism of employees.[54] To this end, analyses were carried out on 20,114 employees who completed the Healthways Well-Being Assessment 2008–2010. The results corroborate the approach of Healthways. They reveal the efforts to boost employee productivity require a

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[53] Healthways 2012 Annual Report (2013).

[54] Shi et. al. (2013).

[55] Healthways 2012 Annual Report (2013).

[56] http://performance.morningstar.com/stock/performance.

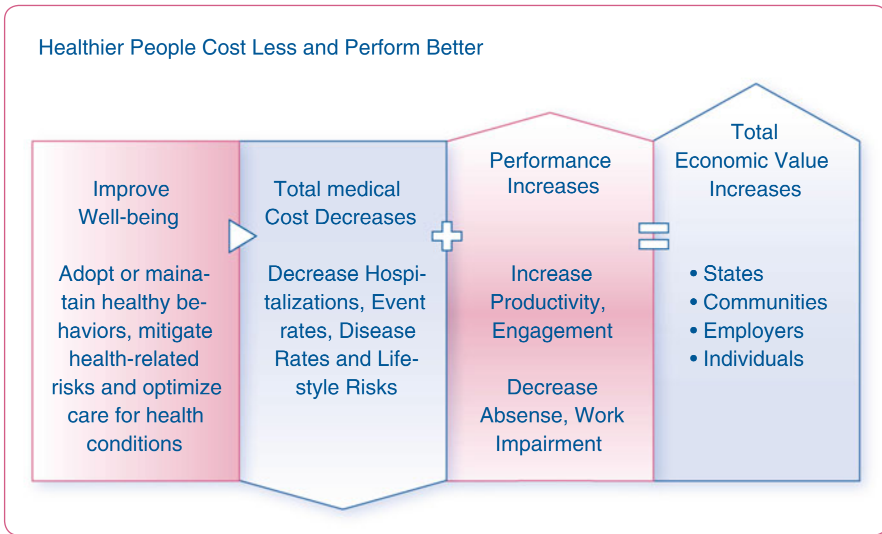

Figure 6.2.5 The chain of value creation for stakeholders and society via the improvement of well-being and health

holistic approach with strategies aimed at increasing the health and involvement of employees.

Healthways is primarily interesting as a leader that has found a revenue model where prevention benefits all parties involved. In the meantime, shareholders have not fared too badly either. Since its establishment in 1982, Healthways has developed into a company with a turnover of over USD 700 million (EUR 515 million).[55] From 1996 until 2008 in particular, Healthways grew strongly, but the last few years have been slower and growth, margins and contracts are under pressure.[56] Competition in the US home market has increased. Substantial investments have been made in technology and data, and this platform makes economies of scale possible and necessary. Healthways finds itself in a transitional phase and wants to return to the path of growth by expanding internationally.[57] It has a unique business model that makes it a leader in substantive terms, but simultaneously also requires people to simply work for the business.

[57] http://finance.yahoo.com/news/healthways-reiterated-neutral-220003700.html.

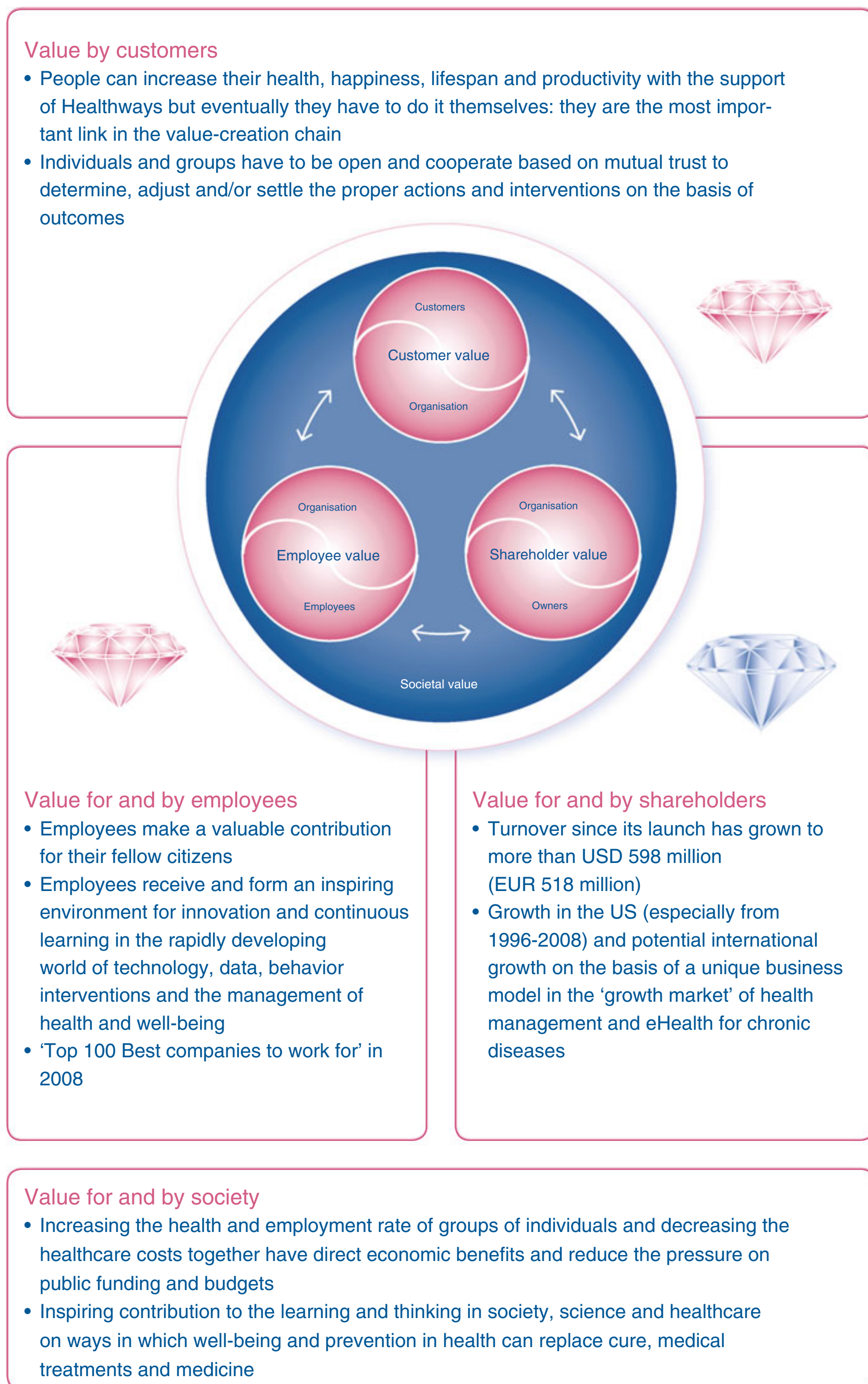

Figure 6.2.6 Value for and by stakeholders of Healthways

Healthways has 2,400 employees. In 2008, the organization was one of the Fortune 100 Best Companies to Work For. If offers the opportunity to perform valuable work for other people, which is even more appealing because it does this by leading the way in relation to technology, science, data and interventions in order to bring about actual behavioral change. This makes Healthways attractive to the best people in fields such as IT, analysis and behavioral change.

With the focus on improving health, reducing healthcare costs and increasing labor productivity, Healthways is working directly on socially relevant objectives. In addition to the result for the organization itself, it also offers policymakers, government, opinion leaders and investors an insight into methods for attaining these objectives and therefore has an additional leverage effect.

6.2.4 The Brilliant Lessons of Healthways

Healthways has a working business model based on prevention, which is unique. "Prevention is better than cure" is always emphasized at macro level and in public discussions. At the same time, the bulk of investments made in care and health are still not earmarked for prevention, but for recovery. Prevention is frequently difficult and stubborn in practice. Initiatives in this direction often remain as good intentions only. They have limited scalability and are the first to perish when cuts need to be made. Healthways provides a number of lessons that can help overcome this and ensure successful prevention and focus on health:

- Searching for a collective party interested in the health of a group of people is a good start. This can be an employer, but also an insurer, a healthcare practitioner or a government. That is a logical party with which to conclude agreements about objectives and benefits. The most elegant option is to work where possible on a no-cure-no-pay basis and link revenue to health benefits, just as Healthways does.
- Along with the business model and medical background, Healthways focuses on research and demonstrable results. This makes the organization a source from which others can also learn. Which interventions work and which do not? How should they be used and at what moment? Which target group should be focused on and in what manner in order to ensure promising health benefits that have an impact?
- The results and approach of Healthways demonstrate that many healthcare costs and productivity losses can be avoided through solutions that reinforce well-being and happiness. The hard evidence for the benefit of soft values can inspire people to earn money by making other people happy.

6.3 Kaiser Permanente

Boosting health and lowering costs together

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Prelude *Following a regular preventive mammogram, Lonny Catalan receives the bad news that cancer cells have been found in one of her breasts. While she is momentarily at a loss about what to do after this news, the doctors and staff of Kaiser Permanente ensure that they jointly will do anything they can to turn this bad news into a successful treatment story. Lonny praises her doctors not only because they take the time to explain the treatment process in detail, but also because she truly does feel she is undertaking this battle against cancer together with her doctors.*

Besides medical care, Lonny also receives tips that allow her to determine what she is capable of physically and mentally. Lonny decides to participate in a nutrition and exercise program for cancer patients, which also brings her into contact with fellow sufferers. The care process is supported with an online patients and insurance dossier that clarifies her medical data. This allows Lonny to read what doctors have discussed and decided in joint meetings, and to submit questions and schedule appointments online with her doctors. After a three-year battle, Lonny is told that her cancer has disappeared. She is advised to continue participating in prevention programs that can reduce the chance of recurrence. Her wholehearted response is: "Yes, I'll do that, otherwise I'll have to miss you and all the wonderful people I've got to know over the past few years."[58]

Introduction The business model of Dr. Sidney Garfield, founder of Kaiser Permanente, transformed traditional healthcare into real *health*care. To ensure care was affordable for workers, during the 1930s in the USA he combined his hospital with an insurance based on a prepaid contribution, or a premium in other words.

[58] Kaiser Permanente 2012 Annual Report (2013).

This combination of fixed income and integral care ensured a shift from focusing on providing care to ill people as cheaply as possible to keeping the population as healthy as possible and lowering the cost of care. Eighty years later, Kaiser Permanente has become one of the best insurers in the world, renowned for the high quality of care it offers and effective prevention programs at an affordable price. Kaiser Permanente customers purchase an integral insurance product with managed care. To put it simply, customers are insured for care provided by doctors and specialists who are mostly employed by the organization itself. Kaiser Permanente is the most famous and most frequently used example of managed care where the insurer and provided care are part of a single organization. Thanks to this care system, doctors can be rewarded for the quality and effectiveness of care, a healthy life, care and insurance can be linked via information dossiers, and the responsibility for health can be divided between the customer, doctor and insurer.

6.3.1 The Cornerstone: Prevention Is Better Than Cure

The guiding principle of Kaiser Permanente is joint responsibility as the cornerstone for affordable care. This has always been the case and is part of the very fabric of the organization. The roots of Kaiser Permanente can be traced back to the height of the Great Depression.

In the early 1930s, a recently graduated doctor called Sidney Garfield sees an opportunity to treat thousands of sick and injured workers involved in the construction of the Colorado River Aqueduct Project. He borrows money to build a small hospital in the vicinity of a little town called Desert Center. Finding structural funding for this care proves to be a difficult task, however. Insurers are late in paying bills for care that already been provided and many workers are not insured back then. Since Dr. Garfield refuses to turn away uninsured workers, he receives no financial remuneration whatsoever for some of his services. How can he solve this puzzle?

Harold Hatch, an engineer involved in the construction of the aqueduct, proposes a potential solution, namely the creation of a new financing system that will require workers to pay 5 cents a day upfront for health coverage to the healthcare practitioners. The hospital is guaranteed a steady income and assumes responsibility for the health and safety of insured workers. The business model shifts from *medical* care to *health*care. Fewer accidents and diseases mean less hospital costs and therefore less pressure on the prepaid contribution. Legend has it that Doctor Garfield is looking at that time for loose nails as these could injure a worker and require the appropriate care. Thousands of workers join the insurance scheme of Doctor Garfield and Harald Hatch, turning it into a resounding success. The aqueduct is completed a few years later and the workers leave. The hospital is no longer required. Shortly before Doctor Garfield closes it, he receives a surprising call from Henry J. Kaiser. This is an industrialist who owned various business including construction companies and shipyards. He asks Garfield to implement his healthcare

model for the 6500 workers and their families at the largest construction site in history, the Grand Coulee Dam on the Columbia River in Washington State. The story continues!

The dam is completed in 1941 and it appears once again that Dr. Garfield's work had come to an end. But a few months after the dam is completed, Japan attacks Pearl Harbor. The USA's involvement in the Second World War is now a fact. Tens of thousands of workers go to the Richmond shipyards to meet the demand for new naval vessels. The shipyard's owner—the same Henry J. Kaiser—has to provide good healthcare to this inexperienced, unhealthy group of workers. Convinced by the previous partnership, Kaiser engages the help of Dr. Garfield. Kaiser even writes to President Roosevelt, asking him to relieve Garfield of his military obligation. Once Roosevelt grants his approval, Garfield leaves for California and together with Henry J. Kaiser establishes a cooperative called the Permanent Foundation, which organizes healthcare for tens of thousands of workers. The cooperative is named after the Permanent stream that flowed past the first company founded by Kaiser. The war ends in 1945 and the number of workers employed in the shipyards drops. Convinced of the power of the healthcare system, Garfield and Kaiser jointly decide to make this system accessible to all individuals. After rapid growth with the support of a number of trade unions, Kaiser Permanente develops into the company it is today.

The organization's core values and higher goal have been forged in its history. Kaiser Permanente focuses not only on facilitating medical care, but also on improving the health of individuals and the community in which insured people are active. The organization also opts for a partnership with the customer, whereby both parties assume shared responsibility for the customer's health and therefore share the same interest. Kaiser Permanente wants to do this at a price that is affordable to the greatest group possible. The organization exists in order to provide affordable, high-quality healthcare aimed at improving the health of insured people and the community in which they live. A sense of responsibility, flexibility and innovation are the core qualities used to achieve this objective. The organization and services of Kaiser Permanente are set up in such a way that everyone feels responsible for the individual care of customers, from policymakers to doctors and patients themselves of course. The provided care focuses on the patient's individual needs, with a continuous quest for innovative ways to deliver better health at the lowest possible cost. During a period when the American care system is under pressure, Kaiser Permanente is trying to demonstrate that the provision of high-quality, patient-oriented healthcare is possible and even contributes to the system's affordability.

In its pursuit of the audacious goal, Kaiser Permanente promises a complete health experience tailored to personal needs and geared towards strengthening its members. This means that the organization is not only trying to make sick members healthier, but to also keep healthy people healthy. This is done at the individual level, but also for a group of employees, a family or community members. Kaiser Permanente has always devoted considerable attention to a healthy workplace. The social environment and residential area form a key element in health. The role that Kaiser Permanente assumes in this involves helping to make such an environment safer and healthier by modifying hazardous intersections or planting trees.

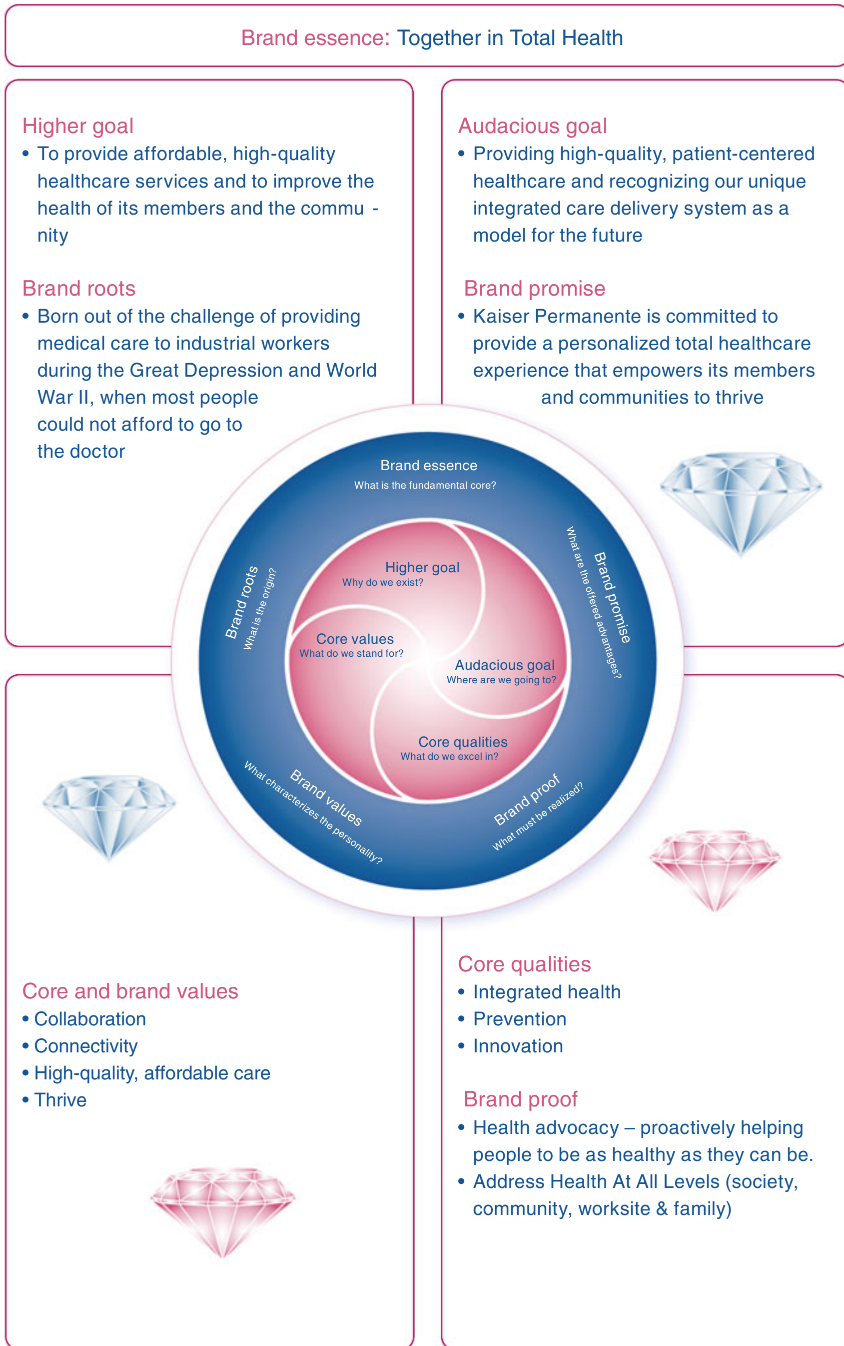

Figure 6.3.1 Vision and Positioning of Kaiser Permanente

6.3.2 The Business Model: From Medical Care to Healthcare

In 2010, the USA had 308 million inhabitants. In 2011, the country spent on average USD 8,266 (EUR 6,083) per person on healthcare. This boils down to 17.9 % of the gross national product; the highest healthcare expenditure per person worldwide.[59] The introduction of Obamacare will not provide universal cover with the best level of care for all, but will make more care accessible to many more people. The government has several collective insurance programs such as Tricare for (retired) soldiers and their families, and Medicaid Services (provides basic care) for low-income families. Disabled and elderly people (over 65 years of age) are eligible for Medicare, the social insurance program financed by the government. In addition to these insurance programs, the possibility also exists of course to take out health insurance with one of the private companies. From 2014 onwards, people are obliged to take out a health insurance, insurers have an acceptance obligation and price differences in premium may only be age- or gender-related. This only applies to an insurance that provides the necessary basic care. Due to the strict definition of "American" in the Patient Protection and Affordable Care Act, around 25 million people in the USA are not be insured in 2014.[60]

Market Segments: Not Being Insured as the Greatest Competitor Kaiser Permanente is the largest nonprofit health insurer in the USA. The organization is active in eight regions with over nine million customers in total. Kaiser Permanente is most represented in northern and southern California, with over 3.5 million customers in both regions. A traditional Health Maintenance Organization product (HMO product) is held by 78 % of "commercial" customers (who are not insured by a government program). An HMO product is an insurance with a closed care system that permits the insured person to receive care from a select number of doctors and hospitals. Doctors are often employed by Kaiser Permanente or work there (almost) exclusively. In California, where Kaiser Permanente started, the organization has built its own hospitals to which it refers members. This was also the logical thing to do since there were no hospitals. In places where it started later, such as in the eastern USA, existing hospitals have been selected for an intensive partnership. The specific model has therefore also been adapted to local conditions and the existing or absent infrastructure. The best way to organize integrated care is also dependent upon the available healthcare at the start and whether there is scarcity or overcapacity.

Customers pay a fixed monthly amount for health insurance , referred to as prepaid insurance. Some 21 % of customers have a different HMO product with additional, high personal payments, while 1 % have a specialist insurance. Kaiser Permanente has 36 hospitals and over 600 medical offices staffed by doctors and physiotherapists. These hospitals and medical offices have 16,658 doctors in the employ of Kaiser Permanente. Not everyone in the USA is insured. The greatest competitor, according

[59] Center for Medicare and Medicaid Services (2011).
[60] Smith & Medalia (2015).

to Kaiser Permanente, is therefore the option for people to be part of the group of uninsured Americans. Competition from insurance companies usually stems from healthcare insurance giants such as United (36 million policyholders), Anthem (33 million policyholders), and Aetna (18 million policyholders).[61] These healthcare insurers provide normal insurance products as well as insurance products with managed care. They are also active in areas covered by Kaiser Permanente.

Traditionally, Kaiser Permanente has targeted the working class. Since the system was opened to everyone (after the Second World War), this group has expanded to include employers intent on contributing to their employees' health. Since the 1950s, individuals have also been able to take out an insurance. In other words, Kaiser Permanente is there for employers, employees and individuals, and aimed at people who consider health important and are willing to assume joint responsibility for ensuring that they and their environment are as healthy as possible. However, there are regional limits for the target group. Unless it concerns emergency care policyholders can only use hospitals and healthcare facilities belonging to the organization, and people can therefore also only take out health insurance in areas where Kaiser Permanente operates.

According to the organization's philosophy, only 10 % of the demand for care originates from medical reasons, 30 % to family history, 40 % to behavior and 20 % to environmental and social factors. This reveals a completely different way of looking and thinking. A playing field is created as a result, involving the reduction of care consumption by improving behavioral and contextual factors such as the environment and social surroundings. In brief: by improving behavior and the environment, insured members remain healthy for longer healthy and make less use of care.

Customer Value: Personal, Affordable High-Quality Care and Insurance in One The healthcare insurance concept created by Garfield and Kaiser developed over the course of the twentieth century into what is referred to nowadays in the USA as a Health Maintenance Organization (HMO). Upon conclusion of the contract, the insured person chooses a doctor from the Kaiser Permanente list, who provides all basic services. If a customer requires specialist care, the doctor will refer the individual to a hospital or specialist. This role fulfilled by the doctor is common in many countries, but not in the USA. Only emergency care provided by a hospital or doctor not affiliated with Kaiser Permanente is reimbursed. This guarantees the patient-oriented treatment method of Kaiser Permanente, keeps care costs transparent and limits these as much as possible. Products are subject to standard, minimal excess fees and personal contributions so that costs are felt and borne collectively. A higher excess or personal payments result in lower monthly costs. Additional products are offered for the (non-urgent) use of doctors outside the Kaiser Permanente network.

Approximately 38 % of the American population (120 million)[62] are insured through their employer. This percentage is higher at Kaiser: 56 % of Kaiser Permanente customers were insured via an employer in 2011.[63] This corresponds to

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[61] Henry Kaiser Foundation (2012).

[62] RAND (2012).

[63] Henry Kaiser Foundation (2012).

its roots, but is also logical because employers share the importance of keeping people healthy and productive and are therefore even more pleased with Kaiser Permanente who is a partner in doing that. In terms of remuneration, the products for businesses are not that different to products for individuals. The distinction lies in the product range that matches the risk profile of employees. The larger the organization, the more specific the prevention program, and HMO package. Doctor Garfield helped uninsured workers even though he knew his bills would not be paid. Kaiser Permanente now also supports over 560,000 Americans who are not eligible for other insurance programs [64] via charitable coverage or charitable care programs.

The price of a health insurance policy depends on the policyholder's age and gender. Healthy customers pay less than people with a greater care need, and a risk selection is carried out. Kaiser Permanente customers receive high-quality care at an affordable price. In the event customers decide to change health insurers, they can switch to another doctor and hospital. Customers are expected to focus actively on their personal health to help reduce or prevent care costs.

Delivery: Thriving The main element in Kaiser Permanente campaigns and statements is thrive, or to allow people to thrive. The campaign focuses on prevention, a healthy lifestyle and well-being in every phase of life. Slogans such as "A car runs on money and makes you fat, a bike runs on fat and saves you money," are used to encourage people to exercise. A key element is that in addition to the group approach with companies, a community approach also exists whereby local programs are initiated to promote healthier cooking or jogging. This goes further than just a lifestyle approach and may for example also entail improving the quality of life in the neighborhood. At district and local community level, programs are organized to encourage sport and healthy living. Investments are also made in safety and mobility by lending financial support to parks, and making traffic intersections and cycle routes safer for young people. Contributions are also made to ensure safer schools and workplaces.

The insurance product can be purchased individually, online, via an insurance agent or the employer. Businesses can seek the advice of a consultant. The integrated healthcare system (care facilities as well as insurance) also enables an integrated customer contact system. An online platform (My Health Manager) allows customers to communicate via secure e-mails with doctors, make appointments (including a logistical function that minimizes waiting times between visits to multiple doctors). In addition, this online environment provides an insight into medical information and insurance products, and offers the opportunity to register for workshops, programs or training aimed at prevention or treatment. If the answer cannot be found online, customers can call or visit the doctor or hospital. Kaiser Permanente offers different programs for healthy eating, sports and community involvement. Activities for secondary prevention also exist in order to prevent the deterioration of care. For example, Kaiser Permanente has programs for avoiding lower back problems, managing a chronic condition and overcoming depression. Self-sufficiency is encouraged through training and providing support to people

[64] Kaiser Permanente 2012 Annual Report (2013)—by the numbers.

with a chronic illness such as diabetes. This prevention focuses where possible on the assistance and care needs of the individual. Besides medical issues, family history, behavior and social aspects are also considered in the diagnoses and action plans. In this way, the patient's actual needs are addressed and unnecessary investments are avoided where possible.

Operation: The Pinnacle of Efficiency Through Full Integration For the most part, Kaiser Permanente owns the care infrastructure such as hospitals, customer domains and IT infrastructure, and often employs the doctors, nurses and other care staff who work there. Each region is a separate legal entity, with each regional entity comprising Kaiser Foundation Health Plans (KFHPs) and Permanente Medical Groups. The organization's insurance branch falls under KFHPs, which take care of sales, policy-making and the administration of health plans. The KFHPs have no profit motive, but invest in the development of Kaiser Permanente hospitals and the organization's entire care infrastructure. The Medical Groups are the for-profit partnerships consisting of doctors, and they receive almost all of their income from the KFHP. Care financing occurs within a closed system, which allows funding to be organized in an optimal manner that facilitates the delivery of effective and efficient care. Besides a fixed salary, doctors are given the opportunity to earn some additional rewards by offering effective, high-quality care. This is significantly different to a large percentage of doctors and specialists around the world, including the USA, whose income depends in part on the volume of care they provide. This is referred to as the "perverse incentive" in which additional treatment is remunerated, leading to a risk of overtreatment. The Kaiser Permanente model also allows the organization and use of diagnostic technology to be managed more efficiently. It is possible, for example, to match the number of MRI scanners to the number of expected scans per year, centralize the location of the scan, and organize care logistics around the scan. Linking insurance and the overall provision of care helps simplify the organization of IT systems. Kaiser Permanente uses Health Connect, a single system in which doctors as well as insurers work. Doctors therefore have access to the information they require and are authorized to consult. The integrated IT system provides solid management information for making supply-related choices and selecting prevention-related investments, for example. Health Connect lets customers consult their medical files on Health Manager (an electronic patient dossier), along with information about their insurance and opportunities to schedule appointments with a doctor or insurance specialist.

Kaiser organizes its prevention program at different levels within society. The broadest level focuses on society by supporting health policy, research and lobbying the government for prevention and safety initiatives. In 2012, Kaiser Permanente invested USD 230.2 million (EUR 169.4 million) in clinical and policy research. Kaiser believes in measuring and financing care on the basis of the quality of results and is constantly looking for ways to measure the quality of results effectively and adapt the procedure accordingly.

Employers are an important customer since they act as a gateway to employees. They are also a natural partner for working together to ensure the health of personnel. Government authorities with support programs are also a key partner.

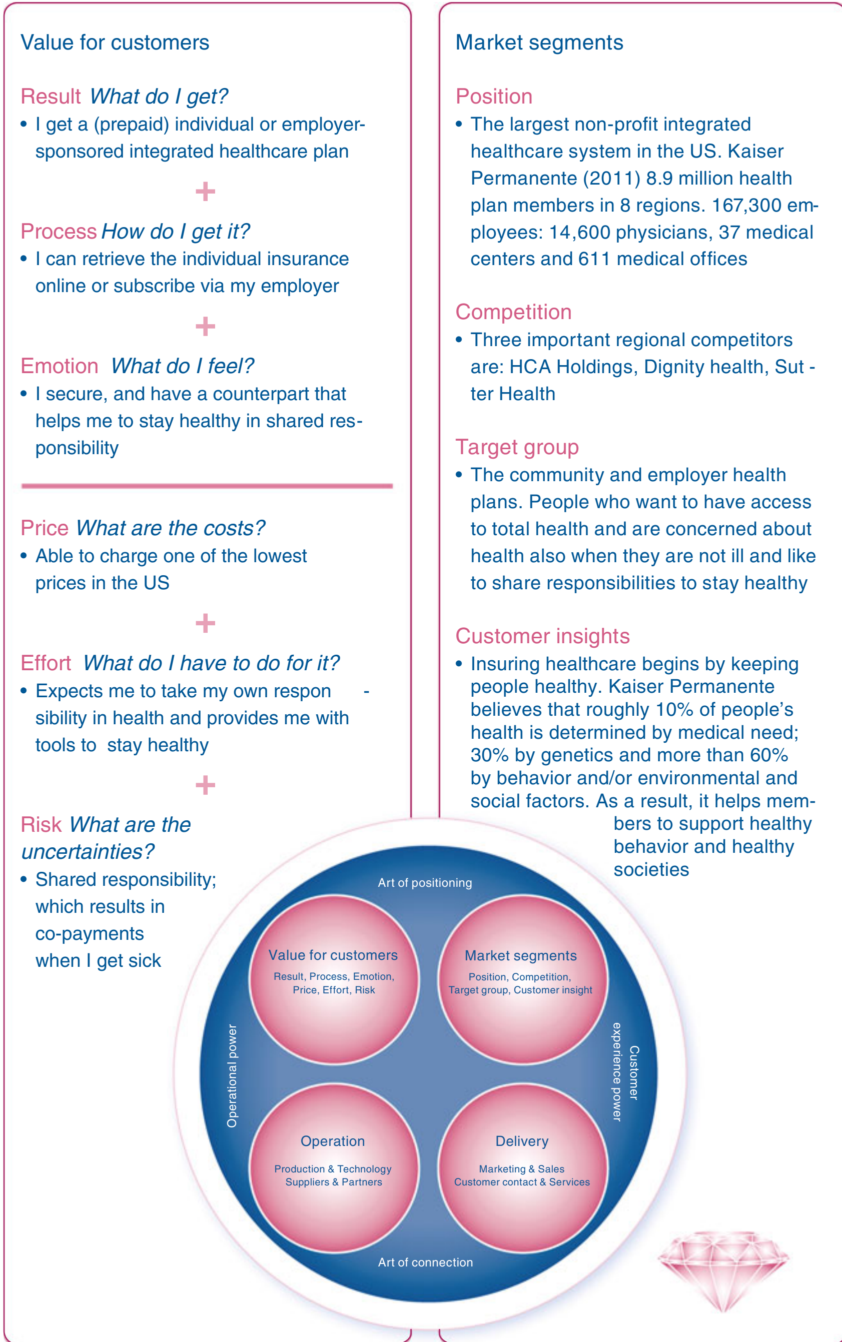

Figure 6.3.2 Value for customers and Market segments of Kaiser Permanente

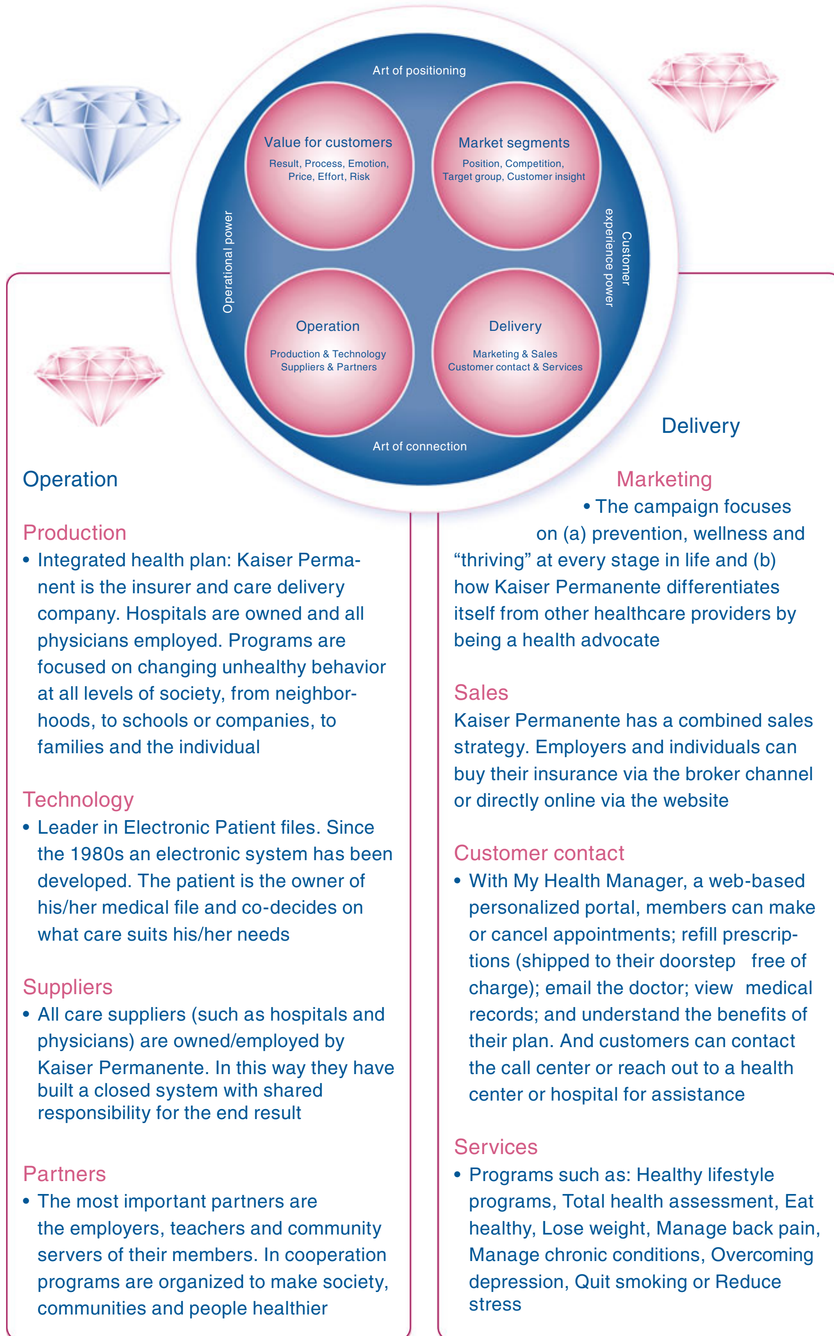

Figure 6.3.3 Operation and Delivery of Kaiser Permanente

6.3.3 *The Result: A Healthier Population with Lower Costs*

The deal that Kaiser Permanente concludes with customers involves working together to keep them healthier, which reduces the cost of care. Care consumption is relatively low because people are sought within the target group who wish to dedicate themselves to a healthy lifestyle. This means that more money is available to invest in health and safety (an upward spiral). Furthermore, the additional revenue is shared because customers are offered a lower insurance premium in addition to better quality and greater prevention. Customers view this procedure in a positive light. In 2012, Kaiser Permanente had the highest score of all healthcare insurers in the J.D. Power and Associates 2012 Health Insurance Plan Study.[65] This study examines patient satisfaction and the quality of the health plan. With a Net Promoter Score (NPS) of 33, Kaiser Permanente attained the highest score of all healthcare insurers in 2012. This is an astonishing 30 points higher than the average NPS in the entire healthcare insurance market.[66] According to NCQA's Health Insurance Plan Rankings 2011–2012, Kaiser Permanente is the best-rated healthcare insurance in California.[67]

Loyalty is an additional value that the customer has for Kaiser Permanente. Since Kaiser Permanente provides integrated care, customers tend to switch less to another provider. In the event customers wish to change, they do not only have to switch healthcare insurers, but also doctors and hospitals. Moreover, their premiums may become significantly more expensive. The hospitals of Kaiser Permanente are rated positively on the quality they deliver. Eight Kaiser Permanente hospitals feature in the top hospital rankings of the U.S. News and World Report, placing them among the very best in the country. In 2011, 2012, and 2013, the clinical quality of Kaiser Permanente hospitals, according to consultant Aon Hewitt, was around 30 % higher than the average of other HMO hospitals, and even 123 % higher than that of all hospitals.[68] The Leapfrog Group rated 900 hospitals, with only 53 receiving the label of top hospital, 18 of which were Kaiser Permanente hospitals.[69] In 2011 and 2012, the organization was one of the few healthcare companies to appear in the top 50 of the InformationWeek 500, a ranking that includes the most technically innovative businesses.[70] The Harvard Business Review also praised the organization's leading position in the innovation and improvement of care.[71] The electronic patient dossier developed by the organization ranks among the top 20 innovative IT ideas that are worth stealing.

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[65] J.D. Power and Associates Member Satisfaction Study (2012).

[66] Satmetrix Net Promoter® Benchmark Study 2012 (2012).

[67] *NCQA's Private Health Insurance Plan Rankings 2012–13,* National Committee for Quality Assurance, 2012; Kaiser Foundation Health Plan of Colorado—HMO, Kaiser Foundation.

[68] AON Hewitt Quality of HMO plans 2013.

[69] The Leapfrog Group's annual 'Top Hospital' designation 2012.

[70] InformationWeek (2012)—http://www.informationweek.com/iw500/2011/top250.

[71] Lew McCreary, 'Kaiser Permanente's Innovation on the Front Lines,' *Harvard Business Review,* September 2010.

Kaiser Permanente knows how to combine the delivery of quality with effectiveness and efficiency. For the eleventh year in a row, consulting firm Aon Hewitt has calculated the cost-effectiveness of healthcare insurances in the USA. After correction to make populations of insurers comparable, Kaiser Permanente was 17 % more cost effective than other insurers in 2012.[72] Thanks to the combination of cost effectiveness and high quality, Kaiser Permanente has managed to achieve an operational profit of USD 2 billion (EUR 1.5 billion) over the past few years. In 2012, the organization's turnover totaled USD 49.96 billion (EUR 36.77 billion) with a net profit of USD 2.57 billion (EUR 1.89 billion). Its profits are managed by a fund. In 2012, USD 1.97 billion (EUR 1.45 billion) of the USD 2.57 billion (EUR 1.89 billion) profit were invested in society and the development of Kaiser Permanente hospitals and the organization's entire healthcare infrastructure.[73]

The organization has 172,997 employees in total, including nursing staff, administrative staff and cleaners. Kaiser Permanente lives up to its own vision. In 2011, 2012 and 2013, Kaiser Permanente was proclaimed the healthiest employer in California in the San Francisco Business Times Survey.[74] The Workplace Wellness Program certainly contributed to this accolade, and was itself the recipient of a Top Honor Award from the National Business Group on Health in 2012.[75] The training program for new doctors is also greatly appreciated. With an immense training capacity and intensive supervision, Kaiser Permanente states that it is training the next generation of outstanding doctors.

The value and benefits of the integrated approach can be found on different levels within society. The first is the most prominent result of healthier and more productive people. Most revenues are invested directly in society to this end. This occurs on different levels in society (individual, community) and for various issues such as health and prevention, but also for broader themes such as mobility and safety. There are, of course, also investment and studies that foster a deeper insight into the treatment and prevention of diseases such as cancer and diabetes, and more tailored, outcome-based and demand-driven healthcare. This not only benefits own customers, but also society overall. In 2011, 22 Kaiser Permanente researchers received awards and USD 24.9 million (EUR 18.3 million) in research funds from the National Institute of Health. This money was used to support the largest-ever population study involving 500,000 participants and focusing on genes, the environment and health. In the belief

[72] Hewitt Health Value Initiative benchmarking study—Kaiser Foundation Health Plan, Inc., Aon Hewitt, April 3, 2013.

[73] Kaiser Permanente 2012 Annual Report (2013).

[74] Business Times Survey (2013).

[75] National Business Group on Health (2013).

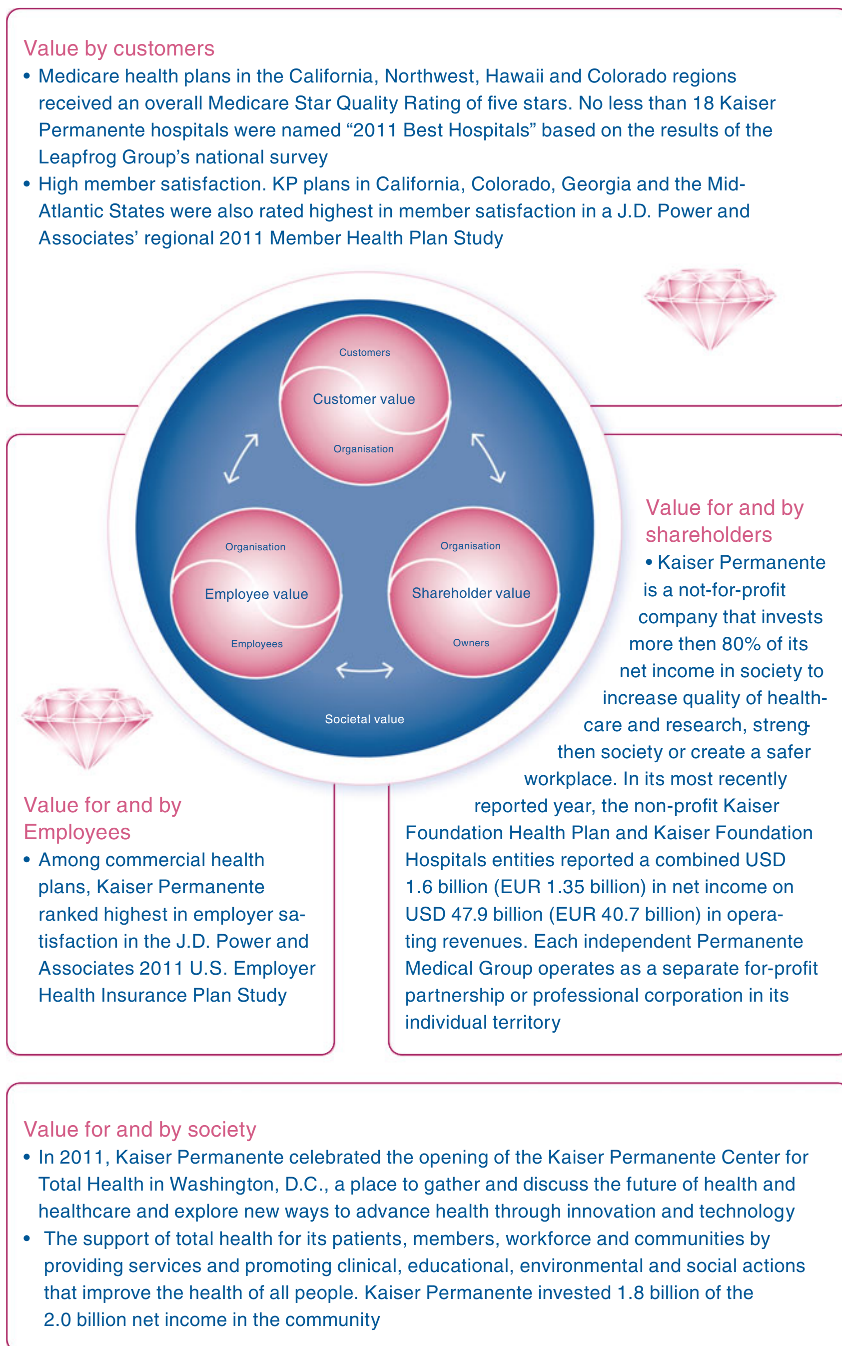

Figure 6.3.4 Value for and by stakeholders of Kaiser Permanente

that better data and communication contribute to improved care, Kaiser Permanente has made its self-developed software for medical terminology available to all professionals and hospitals in the USA for free. By doing so, it is endeavoring to help standardize the language and data used in medical records.

6.3.4 The brilliant lessons of Kaiser Permanente

- The focus on shared responsibility and cooperation at Kaiser Permanente ensures that a personal approach to healthcare is paramount. Care is not provided because a doctor says so, but because the patient wishes to lead a healthy and happy life. Such an approach means that ownership for improving one's health lies with the patient first.
- Kaiser Permanente has created a system of integrated care whereby all parties focus on attaining the best level of health and care. Doctors are rewarded for high-quality and effective care (and not for the number of treatments). Customers receive support to help them lead a healthy life and are partly responsible for their own healthcare costs via own contributions which remain at an affordable level. Employers and government authorities operate better and more efficiently when citizens/employees are productive and look after themselves well. The insurer earns more money if less care is needed because policyholders remain healthy.
- By integrating insurance and healthcare, Kaiser Permanente is responsible for health and not only for treatment. While hospital care can also be obtained via partnerships, employing primary healthcare practitioners yourself in particular makes a significance difference for Kaiser Permanente. This shifts the business model from *medical* care to *health*care. Every dollar that can be saved in healthcare costs is a profit, allowing the financing of prevention and resulting in high-quality care and reduced costs. The nonprofit organization reinforces this by not paying a dividend to shareholders; profits are invested in better care, research, and society.
- Thanks to shared responsibility and motives to improve care and health, the organization focuses continuously on enhancing and innovating its performance. It is also important to measure quality and results constantly in order to take the following improvement-related step. The continuous and joint compilation, enrichment, sharing and analysis of data for health records is a logical requirement and a necessary key.
- The integrated organization of care enables the development of the electronic patient dossier. Besides the fact that it is easier to link and secure IT services within the integrated healthcare system, it also helps that all stakeholders are part of the organization and agree on objectives amongst themselves. This results in a system that allows customers to view their dossier online and gives doctors access to the information they require at all times.

6.4 PatientsLikeMe

Using the Most Unutilized Resource in Healthcare

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patientslikeme™

Prelude *E-patient Dave, as he calls himself, has a story that describes precisely why PatientsLikeMe was established. Dave was diagnosed with stage IV kidney cancer and then read that the average survival period after the moment of diagnosis was only 24 weeks. Shortly thereafter, he joined a social network for cancer patients where he discovered a treatment involving Interleukin-2, a drug most kidney cancer patients had never heard of. Ultimately, this treatment even saved his life. Today, E-patient Dave is a healthy guy, but also an outspoken ambassador for many of the things PatientsLikeMe stands for. He believes that patients are "the most under-used resource in healthcare" and that they need access to their own medical data. He is of the opinion that patients can only crack the code of their own health situation and treatment with complete information.*[76]

In 1998 Stephen Heywood is diagnosed with ALS. As Stephen's situation deteriorated, he and his family repeatedly try to delay his illness and treat his symptoms. They experience the time-consuming and repetitive nature of this trial-and-error approach and become convinced that a better manner has to exist. Not only Stephen and his family but also millions of people around the world who live with life-changing and chronic illnesses have the same feeling. They often have specific questions about their treatment options and what awaits them. They wonder: "Is what I'm experiencing normal?" Or: "Is there someone else just like me?"[77] *PatientsLikeMe is created in 2004 by Stephen's brothers Jamie and Ben Heywood and family friend Jeff Cole, and provides answers to questions such as these.*

[76] PatientsLikeMe (2011).

[77] http://news.patientslikeme.com/about/background.

Introduction PatientsLikeMe is an online network where patients can find answers to their questions and are connected with other patients who know what they are going through. Today members share their experiences on more than 2000 medical conditions. These include rare illnesses such as ALS, but also more prevalent ones such as depression, fibromyalgia, multiple sclerosis and psoriasis.[78] Via a patient profile, members can monitor how they are doing between doctor and hospital visits. They can document the severity of their symptoms, identify triggers, note how they are responding to new treatments and keep track of side effects. Patients also learn from their respective experiences and support one another. This helps them improve their quality of life from day to day.[79] By sharing their practical experiences, members also help the rest of the world obtain a better understanding of various medical conditions and healthcare.

PatientsLikeMe has a philosophy of openness. Information from patients is compiled and analyzed. The information and results are shared with researchers and companies from the healthcare sector, and especially the pharmaceutical world, in order to expedite research into and the development of more effective treatments. Data and results are always made anonymously to ensure personal details cannot be traced back to the individual patient.[80] The value of this open, community-driven approach to research into healthcare was demonstrated for the first time in 2011, when PatientsLikeMe unveiled the results of an operational study initiated by patients. A publication from 2008 claiming that lithium carbonate can halt the progression of ALS was refuted.[81] Ben Heywood explains: “As the family of an ALS patient, we thought we already knew everything there was to know about ALS as we were closely involved. What is fascinating about the website is how much more we learned that we did not yet know when we started the online network for ALS patients. That is the power of PatientsLikeMe; you do not know how much you do not know yet.”[82]

6.4.1 The Cornerstone: “Live Better Together”

The brand essence of PatientsLikeMe is encapsulated in its motto “Live better together.” It is an online network that wants to help patients with a life-changing illness to obtain a better quality of life and thereby change how they cope with their illness. At the same time, the aim is to alter the manner in which the healthcare industry carries out research. By acting as a real-time research platform that focuses on patients, treatment options can be improved according to the patient's needs.[83]

[78] http://www.patientslikeme.com/conditions.

[79] http://news.patientslikeme.com/about/background.

[80] http://www.patientslikeme.com/about/openness.

[81] http://news.patientslikeme.com/about/background.

[82] Williams (2008).

[83] Draft Q&A with Jamie Heywood for UK Newsletter Aug. 2013.

The higher goal the company wishes to attain is more patient-oriented care. The online network gives patients a place where they can connect to one another, learn from each other, and learn how to deal with their illnesses.[84] The key phrase "Making healthcare better for everyone through sharing, support, and research"[85] articulates this noble pursuit. This philosophy is underpinned by the life experiences of Stephen Heywood from the prelude. His brother, Jamie Heywood, starts ALS TDI in 1999 shortly after Stephan is diagnosed with ALS in 1998. ALS TDI is at that time the first organization in the world to engage in nonprofit biotechnological research in order to accelerate the development of new treatment methods.[86] PatientsLikeMe is eventually established in December 2004 with the idea to share all acquired knowledge about ALS with other patients. The website is officially launched in 2006. Initially dedicated to ALS, the focus quickly expands after the launch to encompass other life-changing and chronic illnesses such as epilepsy and MS. Today, it provides a platform for over 2000 medical conditions.

The audacious goal is strongly linked to the company's higher goal. This audacious goal is to transform healthcare into a sector that implicates patients more, so that greater patient value is created. PatientsLikeMe represents the voice of patients around the globe.[87] One of the company's goals is to ultimately create an online community for every life-changing illness.[88] To truly transform the healthcare industry, the strategy of PatientsLikeMe is to develop itself into a real-time health educational system. The aim of this educational system is to make analyses of health conditions that can be of value to patients, but that can also simultaneously align medical research with patients' needs.[89] PatientsLikeMe can then be used for treatment methods, clinical trials and insurance payments, for example.[90]

To achieve this goal, PatientsLikeMe's brand promise is to encourage its members to actively participate in the opportunities provided by the online network and to inform patients as extensively as possible about their illnesses and conditions. The website gives patients a place where they can submit status updates about their health, share experiences, find other patients with similar complaints and learn from their respective experiences.[91] The provided services and tools allow patients to manage their health more effectively,[92] or in other words: it enables personalized discovery and management of the patient's health.[93]

[84] Interview, Sept. 2013.

[85] http://www.patientslikeme.com/.

[86] http://www.patientslikeme.com/members/view/jamie.

[87] Interview, Sept. 2013.

[88] http://www.patientslikeme.com/help/faq/Corporate.

[89] Idem.

[90] Gupta and Riis (2012).

[91] http://www.patientslikeme.com/.

[92] http://money.cnn.com/2013/04/15/technology/patientslikeme-heywood.pr.fortune/index.html.

[93] http://www.patientslikeme.com/help/faq/Corporate & TED Video Cambridge by Ben Heywood January 2012.

The above actually clearly reflects the company's core values. These values form the basis of the business model, but also appear to explain the success of PatientsLikeMe. The first and perhaps most important core value is "patients first." The patient is the focal point of all of the organization's core activities—this is a major driving force. The trust that the patient gives must not be undermined under any circumstances. The other core values cannot be ignored, however. Every decision is taken and measured using the complete set of values. Transparency, openness and ensuring a "wow" effect[94] correspond seamlessly with the first core value and with the business philosophy and vision as a whole. Openness among patients is stimulated intensively; it is only by sharing information, experiences and results that patients can learn from and support each other, and that healthcare can improve significantly on a large scale. It is obvious that PatientsLikeMe runs thanks to patients who are members of this network and the information they share upon it. The wow effect that PatientsLikeMe endeavors to create must occur when you look on the website. It is important that patients see and feel that they are not alone; people should actually feel they are receiving social support from each other. PatientsLikeMe also offers value such as education.[95] It goes without saying that transparency should be an important core value for the company. No surprises about what PatientsLikeMe does may arise, nor about what it does with the patient-related information it shares, where the money comes from or existing partnerships.[96]

The company's core qualities are closely linked to its core values. Following on from the creation of a wow effect, one of the qualities of PatientsLikeMe involves making patients feel connected; part of a family. This results in friendships and participatory members of the website. The company does a great deal to teach about health conditions in order to meet members' needs and therefore bind them to the community. Real life and ethnographic studies also form part of the qualities therefore. The accumulation of knowledge about health conditions but also about what the company does with data relating to its members forms part of its core qualities. This data is compiled and processed into structural results, symptoms and treatments, but is also used to create a learning system that can improve the healthcare industry. The research and insights become available in a language comprehensible to patients. Results that PatientsLikeMe shares with its partners are also shared with its members.

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[94] http://www.patientslikeme.com/help/faq/Corporate.

[95] Interview, Sept. 2013.

[96] http://www.patientslikeme.com/help/faq/Corporate.

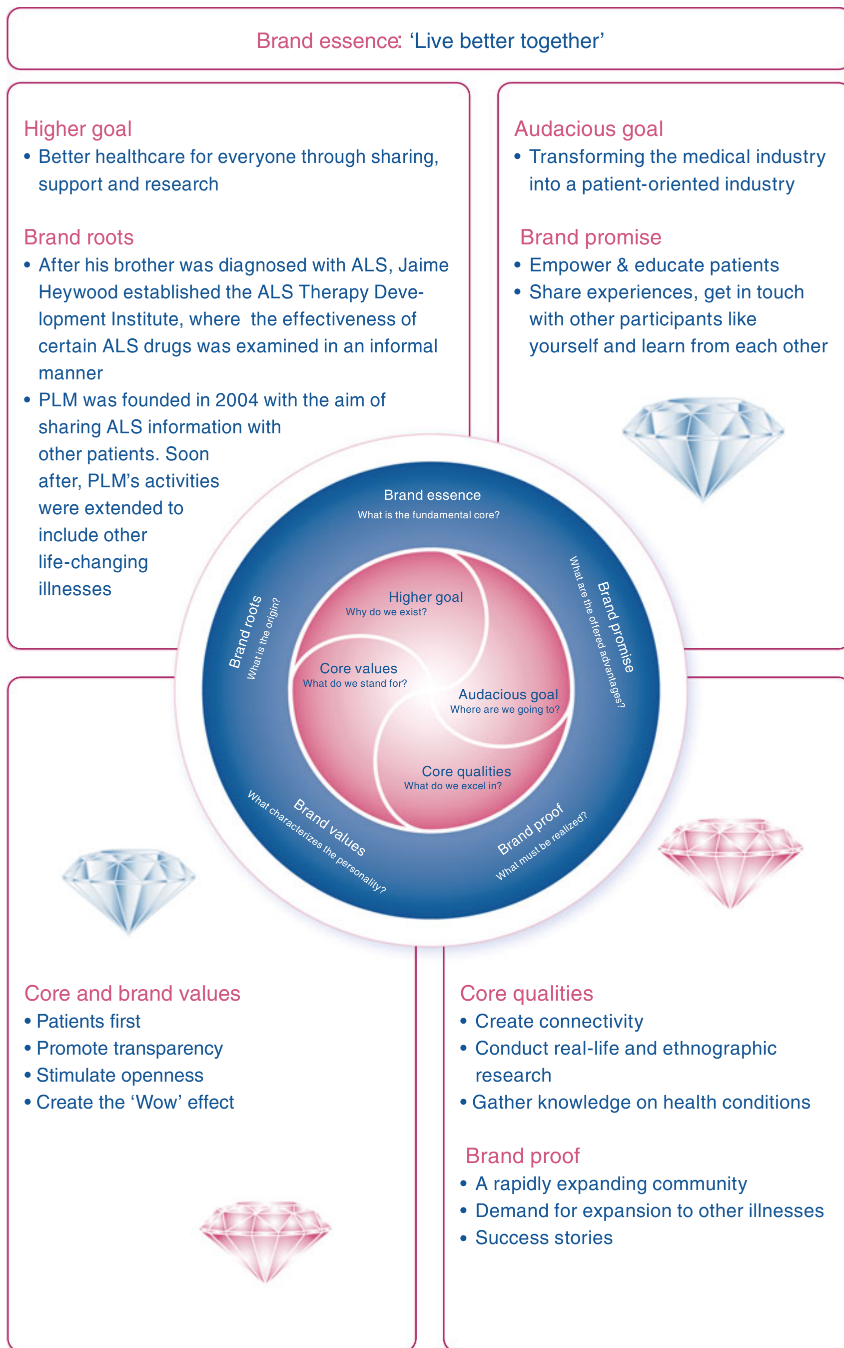

Figure 6.4.1 Vision and Positioning of PatientsLikeMe

6.4.2 *The Business Model: "To Get Paid for Making Patients Better"*[97]

PatientsLikeMe reaches many patients, who can enhance their quality of life through the online network, while simultaneously assisting healthcare and the pharmaceutical industry. But what precisely makes this business model so exceptional?

Market Segment: for Patient and Company What makes PatientsLikeMe so special is its unique position in the market. The concept works from patient to patient, but also from patient to professional at the same time. The company's target group therefore involves two parties: patients, on the one hand, and healthcare industry professionals on the other. In principle, all users of the illness community are encouraged to visit the website or participate in it. These can be caregivers, patients, doctors, and clinical and visiting researchers interested in learning more about different conditions and healthcare.[98] The members of the online network come primarily from the USA, in addition to 40 other countries. PatientsLikeMe is actively working to extend its network across American borders.[99] Patients find understanding and answers to questions to which doctors have no answer. The participation of patients also creates a dataset containing highly valuable real-time information on experiences and outcomes of treatments and medication by a range of patients. The pharmaceutical industry is eager to obtain this wealth of knowledge because it can help significantly improve treatments, medication and equipment. By integrating clinical and behavioral research, PatientsLikeMe acts like a data compiler, analyzer and intermediary of information for the medical industry.[100] Although the online network can distinguish itself in different ways, some competition does exist in other online information websites and forums for health and health-related conditions. Pharmaceutical companies can also act as competitors when they provide condition-specific information and set up patient networks but this often remains more in the field of clinical trials with test groups then learning from the data of real life.[101] There is not one explicit other company that offers full competition. While PatientsLikeMe focuses on over 2000 health-related conditions, the competition often focuses on single diseases or a few related illnesses. It is precisely one of the network's strengths that it bundles together so many diseases and conditions, because information and experience are brought together in this way. Symptom treatment, treatment experiences and daily tips in particular can be applied to multiple illnesses.

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[97] Gupta and Riis (2012).

[98] Idem.

[99] Williams (2008).

[100] http://vimeo.com/61429662.

[101] Gupta and Riis (2012).

Customer Value: Where Customers Strengthen One Another As has already been pointed out, both patients and professionals within the industry constitute the company's target group, thus allowing PatientsLikeMe to create customer value in two ways. Patients can become site members for free, learn a great deal about their condition and maintain their personal self-care model[102] online. In this way, members are connected to a community, and the severity of each condition and its impact on the patient is measured. This information should effectively help support patients' life choices, doctors' treatment choices, and researchers' knowledge about various conditions.[103] To obtain this information, pharmaceutical companies enter into partnerships with the company and pay for reports and surveys that are conducted within the online community.[104] The associated costs are borne by the professional partners of PatientsLikeMe. This can occur for a separate study, or pharmaceutical companies can take out a subscription for analyses and aggregated data from PatientsLikeMe, for which they pay an unspecified amount. "We have created a website where people can learn from each other, share experiences and at the same time contribute to knowledge about health data. We have removed traditional barriers between researchers and patients," says Michael Evers, Executive Vice President of Marketing and Patient Advocacy at PatientsLikeMe.[105] The company also develops tools such as the prediction tool, which creates a control group for individual patients with a predictable illness featuring ten others with the same illness progression. Merging the data of these patients makes it possible to predict the progression of the illness for the patient using the tool.[106] This knowledge can then be used not only by the patient but also by healthcare practitioners when taking decisions aimed at improving patient-focused care.[107] Another valuable aspect for the patient and pharmaceutical industry is that all the information is linked to the network for clinical studies. Patients who have registered are notified about clinical studies being carried out within a 40 km radius of their home for which they are eligible.[108] This enables patients to voluntarily participate in tests they are interested in and makes it easier for researchers at the same time to find enough test subjects to yield test results. An awareness of not being alone is created for members of the online network. It should be noted, however, that when personal data is shared online, there is a risk that people with malicious intentions may abuse this dossier knowledge. Although information that can allow members to be identified directly is not shared publicly, such a system is not watertight and members must be aware of this. Ben Heywood has the following to say on about this matter: "Patients understand that the value they provide by sharing information outweighs the potential privacy risks."[109] To date, PatientsLikeMe has never had to deal with any cases where

[102] http://vimeo.com/61429662.

[103] Idem.

[104] Gupta and Riis (2012).

[105] In Ventiv Health (2013).

[106] http://vimeo.com/61429662.

[107] Interview, Sept. 2013.

[108] Idem.

[109] Williams (2008).

medical information is misused and harms patients. Patients can also increase their anonymity by registering under a fake name and using an avatar.

Delivery: "Tell the World!" The marketing expressions focus firstly, of course, on new members and potential partners. But the company also uses other marketing approaches. One such example is the sponsorship program of PatientsLikeMe called "In Motion." Teams are sponsored to participate in local nonprofit walks and runs to raise awareness about specific illnesses. A wealth of online material (under the motto: "Tell the World!") can also be downloaded, and contains information about the initiative and results of PatientsLikeMe.[110] The "Value of Openness" blog keeps everyone abreast of the latest events, successes, experiences, and patient stories. Employees, researchers, and patients regularly post on this blog. In addition, the "PatientsLikeMeOnCall Podcast" broadcasts interviews with patients and companies about healthcare trends, patients' needs and much more.[111] Most importantly, patients who become members of the online network often act as ambassadors for the organization and its philosophy. Word-of-mouth advertising is therefore the most valuable tool in the end. PatientsLikeMe also has partnerships with nonprofit organizations, patients' associations, and other associations that can be potential members.

Operation: Customers Are the Key Player In this business model, patients are the goal and the means. They are the supplier of the organization's most important resource: real-time information about various illnesses and experiences. The primary task of PatientsLikeMe is to facilitate the online network and act as a mediator for the community. It conducts various analyses on all the information obtained through the website to ensure it can be used. One of the organization's other primary tasks is to engage in business-to-business networks so that partnerships can be concluded with authorities and companies that purchase the analyzed data. These partners include researchers and academics, nonprofit organizations and the medical industry, such as pharmaceutical companies and developers of medical equipment.[112] Customization is needed to meet these partners' changing demands. On average, contracts for community partnerships last 2–3 years, but many projects and partnerships also last around 3–9 months.[113] The Management Team is responsible for research; scientific and clinical are responsible for data analysis and generating knowledge. The Technology Team focuses on the product while Design and Engineering is responsible for implementing website functionality. The Patient Experience Team and the PatientsLikeMe Customer Service Team are responsible for moderating communities and forums. Finally, the Health & Data Integrity Team is responsible for the completeness and accuracy of data, while the Marketing and Business Development Team takes care of patient acquisition and engagement.

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[110] http://www.patientslikeme.com/about.

[111] https://itunes.apple.com/us/podcast/patientslikeme-oncall-mp3/id364055239.

[112] http://www.patientslikeme.com/about/partners.

[113] Interview, Sept. 2013.

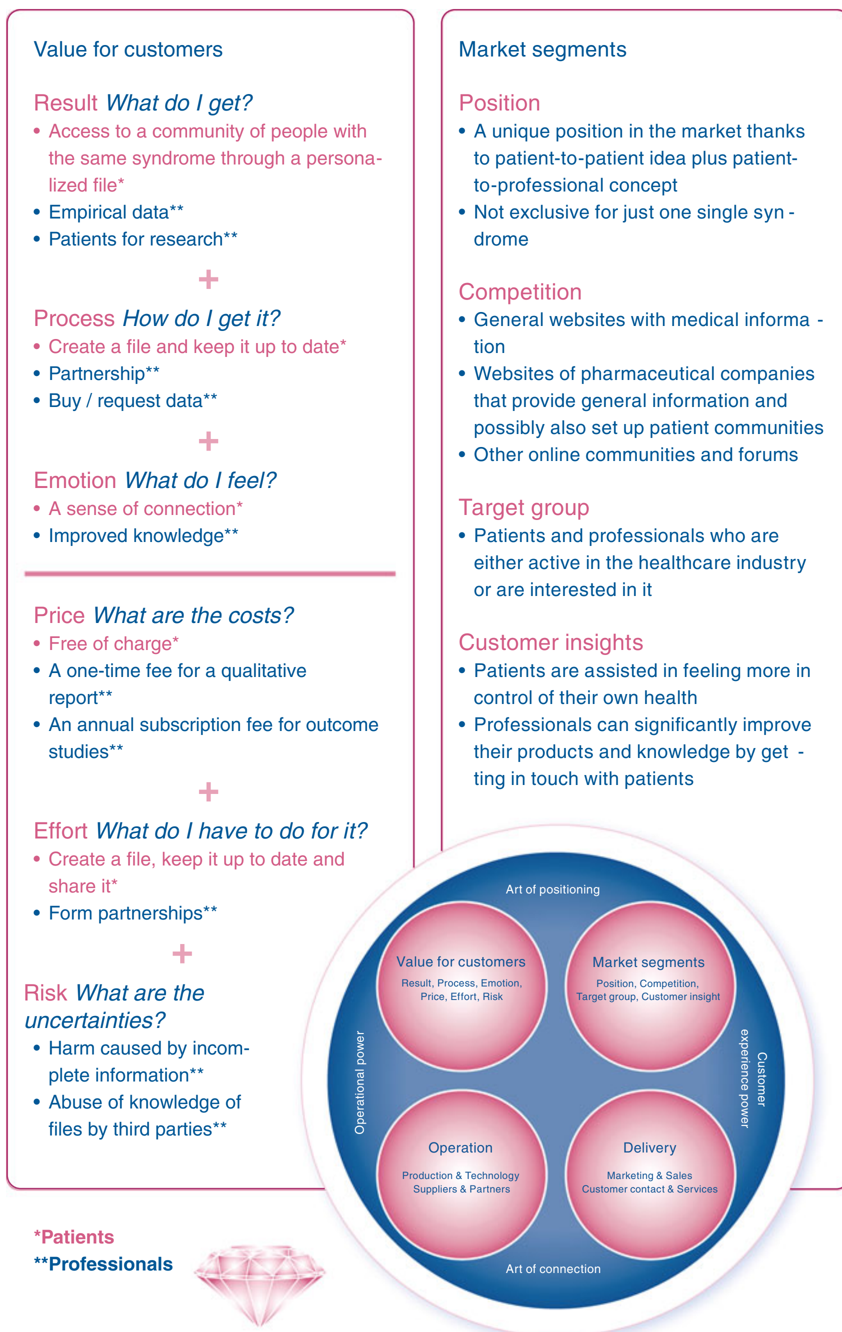

Figure 6.4.2 Value for customers and market segments of PatientsLikeMe

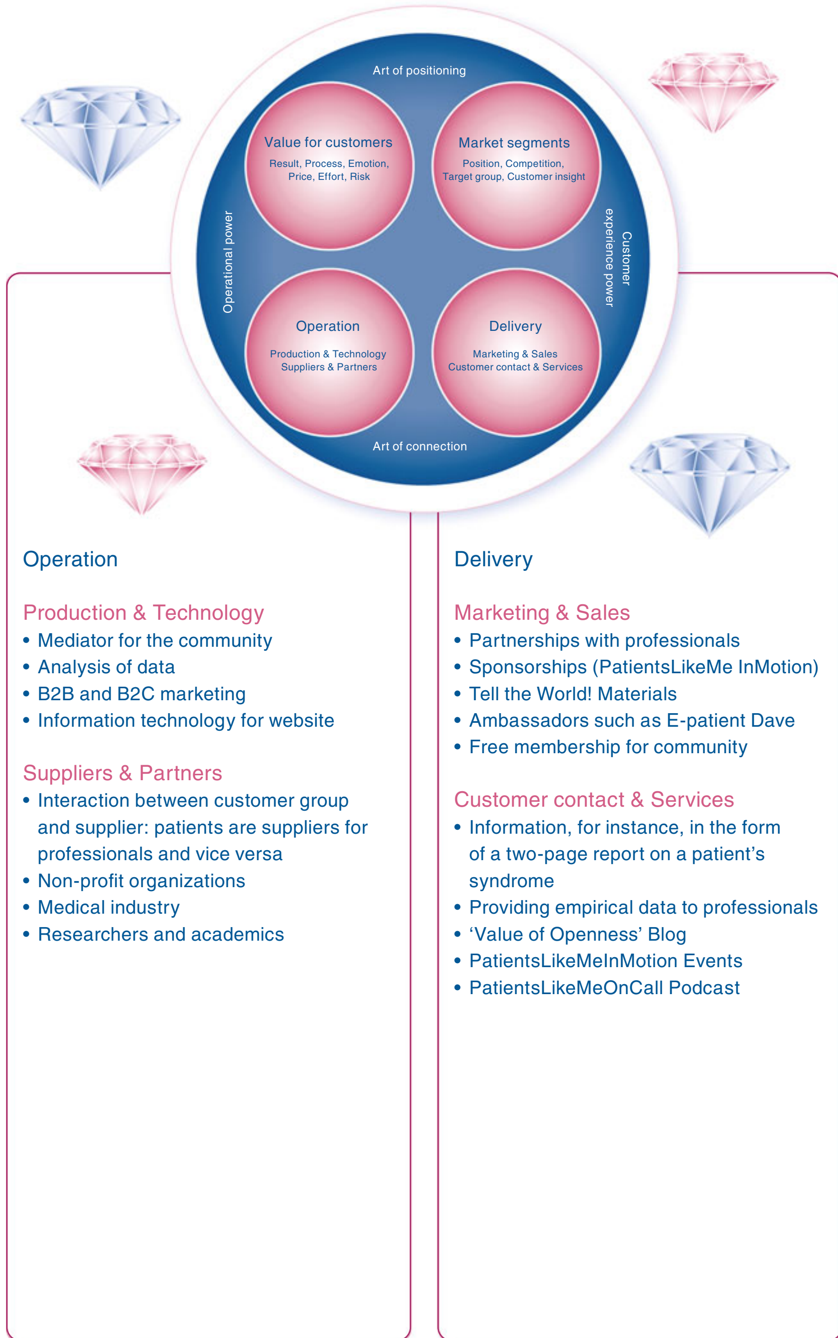

Figure 6.4.3 Operation and Delivery of PatientsLikeMe

6.4.3 The Result: Far-Reaching Value Creation

Value creation plays a pivotal role in this company. The creation of significant customer value is a major focal point in organizations that attach great importance to customers. PatientsLikeMe looks further than that, of course. On what other levels does the organization succeed in creating even more value?

PatientsLikeMe is able to generate considerable customer value. At the time of writing, the online network is enormous and growing rapidly with more than 220,000 members and 2000 illnesses. The fact that patients with a life-changing illness or condition feel connected and can learn about their health condition from each other is something they appreciate immensely; they can find a "patient like me." "Patients find emotional support and give each other tips on how to tackle small things, helping them deal with their illness and enabling the creation of a healthcare standard. Peer pressure also ensures greater pressure on patients amongst themselves, making it apparent that they follow prescribed treatments more carefully. Good information and education also foster a better understanding of the patient's treatment plan, which also has a positive effect on their compliance with therapy. For some illnesses on PatientsLikeMe, up to 45 % of patients become therapy compliant which is more than usual."[114] It is also immensely valuable for patients to acquire an insight into their future thanks to resources such as the prediction tool.

"An interesting aspect of members of the network is that there are many different patient expertises. Some patients simply know a great deal about the disease; others know a lot about how to best manage daily things; others in turn are very knowledgeable about studies; others offer great emotional support, all of which are equally important for our community."[115] In practical terms, this also has considerable added value for the professional help that patients receive. Doctors' and hospital visits can be far more efficient and effective thanks to enhanced knowledge and health monitoring. Patients can ask specific questions and doctors can respond accurately and quickly because their condition and any side-effects caused by medicines are tracked. Completely measurable improvements are for instance evident for epilepsy-suffering members; 59 % have a better understanding of attacks; 50 % have a better understanding of side-effects and there is even a 23 % decrease in emergency care visits.[116] The value of the clinical research network, which automatically notifies each patient about studies for which they are eligible, must not be underestimated either. According to the president of inVentiv Health, Raymond Hill: "inVentiv Health will be able to quickly recruit potential trial participants by tapping into one of the fastest growing and most active patient networks online, so that our customers can speed up the development of drugs, devices and treatments to improve patients' lives."[117]

[114] Interview, Sept. 2013.

[115] Williams (2008).

[116] Interview, Sept. 2013.

[117] In Ventiv Health (2013).

The fact that patients enrich the medical world with valuable knowledge is also considered very important by members. They do not only become better themselves thanks to the knowledge they acquire, but many (future) patients are also helped. PatientsLikeMe has developed into a reliable and valued source for empirical disease-related information as well as a clinical robust source that has published over 30 peer-reviewed studies.[118] The aggregated and depersonalized information members share on the website is analyzed and insights are sold to partners who develop products or sell to patients. By selling these insights and involving partners in discussions about patients' needs, PatientsLikeMe helps them better understand the actual medical value of their products so that they can improve these. Partners also receive help with expediting the development of new solutions and treatments for patients.[119] In short, value creation for professionals lies in improved knowledge and products.

PatientsLikeMe is a for-profit organization that benefits from the sale of patient information. However, it has no annual reports to consult and does not disclose turnover and profit details because it is a non-listed private company. Since professionals often have varying demands and are looking for specific information, reports, surveys and studies are customized. This makes it difficult to acquire a good insight into actual revenues stemming from PatientsLikeMe partnerships. A Harvard business case estimates potential revenues for the business if it expands its focus on market research towards insurance companies. If PatientsLikeMe can convincingly demonstrate that patients become more therapy compliant because they are engaged members of the site, a good value proposition can be created for both pharmaceutical and insurance companies.[120] Each partnership entered into with the organization must bring it closer towards its audacious goal. All partnerships must ensure that the interests of patients and the industry are more aligned. The ultimate goal is: better care and a better quality of life for the patient.[121]

The company's employees all share the same ideal; making better healthcare a reality. Contributing to this by working for PatientsLikeMe is considered the greatest added value of the job by more than 60 employees. According to an employee: "We are all dedicated to the creation of a meaningful experience for our patients and customers. It is wonderful to see that we are all happy to work on bringing about change within healthcare."[122] Greater employee value is also derived from the fact that the health and well-being of its employees is a priority for the company. PatientsLikeMe even ranks among the top 44 healthiest companies to work for.[123] It offers flexible working hours and encourages exercise by providing yoga classes and Nintendo Wii games. The company also offers major medical and dental benefits to its employees.[124]

[118] Idem.

[119] http://www.patientslikeme.com/help/faq/Corporate.

[120] Idem.

[121] http://www.patientslikeme.com/help/faq/Corporate.

[122] http://blog.patientslikeme.com/tag/patientslikeme-yoga-class/.

[123] http://greatist.com/health/healthiest-companies.

[124] http://www.patientslikeme.com/about/careers.

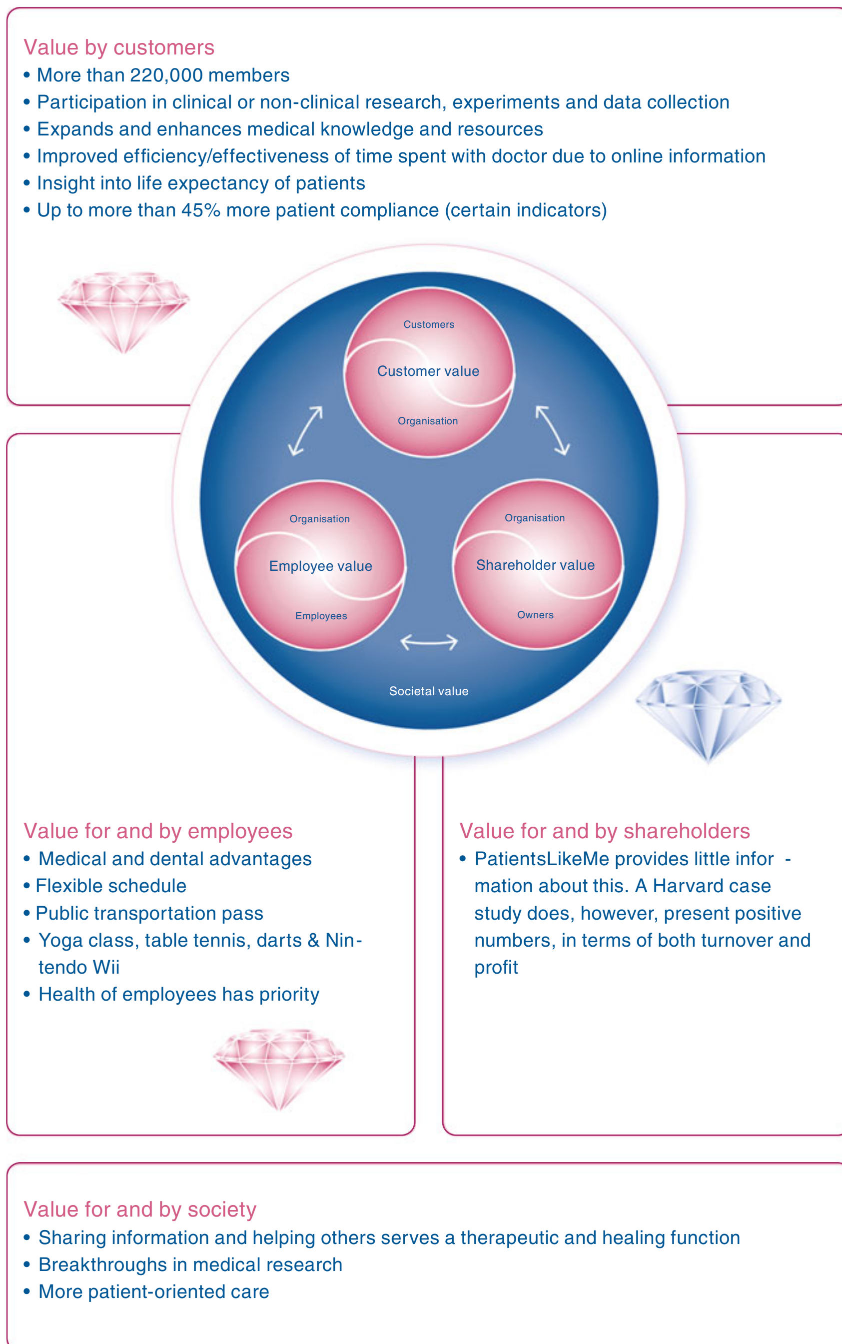

Figure 6.4.4 Value creation for and by stakeholders of PatientsLikeMe

In addition to customer, shareholder and employee value, PatientsLikeMe also creates immense social value. Research breakthroughs are achieved and even greater breakthroughs are expected in the medical world because of a business model that focuses on sharing patient information. Not only members of the online network and direct partners of the company benefit from the successes that are achieved; the medical world learns and improves as a result of this.

6.4.4 The Brilliant Lessons of PatientsLikeMe

Several lessons can be learned from this special and brilliant business model. It is worth taking a more in-depth look at the following six lessons.

- Allow your one customer to benefit from the input of the other. Patients fill in all kinds of data (for free). This provides value for patients because they come into contact with similar patients. This is very valuable data and this is then analyzed, aggregated and used for another customer group. In this way, the efforts and insights of one customer group also benefit the other, while PatientsLikeMe provides the intelligent platform. Patients pay for something which is very valuable for them bij giving their data which is very valuable for the industry.
- Connect your customers to one another. One of the strongest qualities of PatientsLikeMe is that customers are connected to each other. Patients are not only connected to each other, but also to researchers and medical professionals. On the first level, a strong sense of community arises and the connection between private and professional customers ensures an interaction that permits both parties to make desired improvements. The business model therefore has a self-reinforcing effect. PatientsLikeMe has attached the following goal to this: "*To get paid for making patients better*."[125]
- Connect your customers to your business philosophy and make your goals known. When customers are aware of the business philosophy and goals you wish to attain with it, they can be of a greater value compared to when they have no knowledge of this. The philosophy of openness resonates with customers and is linked to a robust audacious goal with which customers can identify. Privacy-related risks are even considered acceptable because the goal outweighs the risks. Customers can actively share and cooperate in the attainment of the company's audacious goal.
- Make your customers ambassadors of your company. Who else can sell your company better than a satisfied customer? Ensure therefore that your customers are satisfied, but also give them all the possibilities and information to actually act as ambassadors. By being open and transparent about the way you work and conveying your philosophy to your customers with conviction, they know what you stand for and can share this with others. Word-of-mouth advertising is one

[125] Gupta and Riis (2012).

of the most effective marketing tools, so invest in it and also express your appreciation for ambassadorship.
- Create value on various levels. A brilliant business model provides value creation for customers, shareholders, employees, and society. The value created on each of these levels has a reinforcing effect on the next level.
- Dare to create a social impact. The audacious goal of PatientsLikeMe is not only aimed at internal performance, but also endeavors to bring about change within the healthcare sector. By extending the audacious goal to achieve a social impact, all the parties concerned are stimulated to work together in achieving this objective.