TPG International Health Academy

CEO Trade/Study Mission

Beijing, China, April 20-26, 2013

EXECUTIVE SUMMARY

In April 2013, a delegation of 30 U.S. healthcare executives traveled with the TPG International Health Academy (TPG-IHA) to Beijing for a week of intensive study of the Chinese Healthcare System. The purpose of this educational mission was not only for attendees to gain an understanding of China's healthcare system, but to learn new and innovative ideas that can be transferred back to their own organizations.

Focusing upon the advances made by the Chinese in achieving universal healthcare, the delegation met with policy makers, ministry officials, providers and consumers. The group also examined the details of healthcare delivery across a continuum of diverse economic, social, ethnic and geographic variation. As the immersion in the didactic curriculum and group discussion proceeded, questions began to emerge about lessons that we could learn from this massive restructuring of healthcare. The knowledge gained became the basis for examination of the U.S. healthcare system and their enterprises' role in it.

TPG-IHA is pleased to share the highlights of this mission. In summary, we can use what we learned on the China Trade/Study Mission to re-frame important questions in our own organizations. There has never been seen such a large scale reform of healthcare in our professional life-times. There are many specific opportunities for applied learning, but the greatest lessons may be those resulting from the massive redefinition of healthcare goals; the redeployment of existing healthcare resources and targeted funding of new resources to meet specific social and geographic service commitments; and the consequences of massive influx of patients into a healthcare system from which they were previously excluded. All of these changes are occurring in an environment where the burden of communicable diseases has been replaced by the larger burden of chronic illness and longevity. There are now great and similar challenges in healthcare faced by both of the world's largest economies.

Lessons Learned

Group discussion at the end of the week-long mission identified areas where U.S. healthcare leaders could possibly apply lessons learned in China. Areas to be considered include:

1. Attempts to apply U.S. healthcare business practices in China: There are similarities to entries into new U.S. markets or segments, into new states, new SMSAs, and new products. Assumptions based upon current state of known markets and businesses are frequently of little use in new markets and can lead to executive decisions which must be revised at significant expense.

2. Physician Credentialing and Competency Assessment: Advances in population health management and outcomes improvement require higher levels of physician talent. Business leaders must understand upcoming changes in mandatory 2014 Maintenance of Certification (MOC) for all American Board of Medical Specialties (ABMS) certified physicians in the U.S. Preparation must be made to assure ongoing licensure of medical staffs once the changes in 2020 link ongoing licensure linkage to MOC. U.S. healthcare providers must act to document current Competency Assessment of physicians holding permanent board certificates.

3. There are ramifications from the Economic model (China) vs. Social Model (U.S.) for healthcare reform which are useful in the ongoing debate over healthcare reform in the U.S. There are useful precedents found in the Chinese approach to: information needs to document productivity and affordability; realignment of provider incentives to reward broad consumer access; creation of integrated delivery platforms designed to serve geographic area; supply and demand for talent pools of MDs at differing levels of sophistication; and deployment of mid-level practitioners in designated service areas rather than as independent practitioners.

4. Universal Coverage creates different behaviors in consumers once they are freed from fear of a medical spending catastrophe. This is a business case that is seldom heard in the U.S. healthcare debates, and should be added to industry political initiatives. These behaviors benefit consumers' personal finances and these behaviors can be used to increase their engagement in preventative care and risk reduction.

5. The pace and scale of reform in China is much more rapid than that seen in the U.S. and Canada. This model of goal directed change is based upon a small number of clearly articulated goals. We must do a better job of identifying and communicating goals with which consumers can identify.

6. Both Chinese and U.S. healthcare reform attempt to eliminate economic disparities in access to healthcare. This enhanced access threatens to overwhelm the Chinese system and there is similar risk in our businesses. We must prepare to meet a surge in demand accompanying healthcare reform. Failure to do so can result in social upheaval and punitive political consequences. Our situation is more complicated than that of the

Chinese because we must be held additionally accountable for elimination of disparities based upon ethnicity, gender, mental illness, and religious practices in our system.

7. Changes in National Health Policy in both countries have re-prioritized care delivery. In addition to the influx of healthy, previously uninsured consumers, our businesses must deal with new influxes of chronically ill patients with high burdens of non-communicable diseases. Under-treated chronic illnesses must now be treated using evidence-based protocols. We must make preparations to deliver value-based reimbursements with mandated lifestyle and wellness components.

8. Once universal coverage is accomplished, product innovation will again become important to healthcare companies. We must invest in the development and market testing of next-stage opportunities in wrap-around products, network enhancements, concierge options, comfort and convenience upgrades.

9. Chinese medicine accommodates and respects treatments which are non-allopathic. Our concept of medication alternatives, complementary treatments, and Eastern medicine will change dramatically with the influx of patients who, having been excluded from healthcare because of cultural and economic barriers have long embraced these methods. We must examine evidence for alternative treatments' role in NCD. There may be a role for these treatments in improving patients' self-scored wellness assessments.

10. Chinese healthcare prioritizes reform of physician prescribing practices. Prescribers in the U.S. have not yet fully incorporated advances in generic prescribing generally and in the $4.00 formulary revolution specifically. There are still opportunities to reduce income-incentivized prescribing in the U.S.

Curriculum Review

On Day 1, an overview of the healthcare landscape was presented that highlighted the key issues that would be addressed during the mission. These included:

- Experiences in translating American healthcare business models to China
- A macro-economic overview of Chinese healthcare reform during the past 15 years
- Reform of the public healthcare system directed by National and Provincial Ministries
- The introduction of universal healthcare in China

First hand reports of American healthcare executives working in China to implement an American business model show that new market entrants should expect major differences, such as:

- The credentials and licensing of providers is much less formal, spreading across a wider spectrum
- Payment models while familiar in concept are vastly different in scale and sophistication
- The scale of business needs dwarfs anything heretofore seen in Western healthcare

Delegates were reminded of current changes in physician credentialing and competency assessment in the U.S.

The Economic Model for Chinese reform of healthcare is predicated upon the creation of an enlarged consumer segment in the national economy as consumers seek to purchase "peace of mind" through medical insurance. Such purchases will reduce the "excess saving" by households to avert financial disaster brought about by medical illness. Factors slowing implementation include poor quality care and misdistribution of clinical resources within and across geographic regions. The original 5 Pillars goals for reform (proposed in the 1990s) have been recently simplified and refined to just 3 Priorities, which are:

- Insurance coverage for all citizens
- New policies for prescription medications
- Reform of the public system of hospitals and clinics

Political obstacles slowing the completion of the 3 Priorities include competition between the two national ministries with incomplete and overlapping responsibility for medical insurance: The Ministry of Health vs. The Social Security Administration. A conundrum exists; Communist China uses consumer choice in health care reform, while the U.S. healthcare reform relies upon consumer mandates.

Reform within the public system is required and key priorities include:

- The talent pool must be expanded with more and better credentialed physicians
- Hospitals must be assigned into tiers and equipped to provide care at four distinct levels of complexity

- Tertiary care is currently priced below cost and must be priced differentially so that consumers will steer themselves to the appropriate level of care. It is anticipated that when coinsurance costs reach 30% of higher-priced tertiary services, consumers will begin using cost effective basic care instead of travelling to urban tertiary centers for routine health needs.

The introduction of the Medical Security System has resulted in dramatic improvement in access to healthcare in rural regions. Important financial risk reductions in out-of-pocket spending for basic healthcare have been made. Rural programs have very specifically defined catastrophic coverage, but copayment for this coverage varies widely by region. Opportunity for commercially provided supplemental coverage exists in this segment.

On Day 2, the discussion moved into the more technical tactics necessary for implementation. Key topics discussed focused on the development of the policies and financing necessary to fund healthcare reform; the opportunities for private health insurance markets in China in both the current environment and in the emerging markets for ongoing care of chronic illnesses; current privately-insured products in China, with experiences in product development, marketing, and service; integration of Eastern and Western medicine in patient care; economic and geographic disparities in access to quality health care; and finally, the perspective of a surgical subspecialist in the premier academic medical center.

With universal access now nearly achieved and most of the communicable diseases contained, new challenges emerge in Non Communicable Diseases (NCD) categories. The greatest need is prevention of cardiovascular disease related to diet, lifestyle, and tobacco use. There are extensive and expensive consequences from the imbedded practices of physician income supplementation through prescribing and dispensing medications. The analogous situation in the U.S. is that of oncologist dispensing of high margin biologics in their practices. Optimism for dramatic savings from reform of prescribing practices may be disappointed because there is not yet an accepted strategy for replacement of the income that physicians will lose. The faster growing expense is diagnostic imaging. Across all specialties and treatment modalities there are profound obstacles preventing use of performance data, both cost and quality, to improve care. There is, in many provinces, a hole in medical coverage from mandatory retirement age of 55 to the age of 70 for eligibility for national social security medical coverage.

The market share for private medical insurance is one of small and slow growth: 1.3% in 2008 and more recently 1.5% in 2011. The national goal for private coverage is the 35% out of pocket spend under public plans. The health risk profile of the population is high, with a Vitality age ® of plus 8.2 years, the comparable profile for US population was not available. The risk of a financially catastrophic health care event is 10% in rural groups and 4-6% in urban settings. The largest market for commercial insurance (57%) is “Critical Illness” coverage which is “not

the same as health insurance". It covers only 25 medical conditions and has a low likelihood of payout of benefits: only 5% of inpatient admissions and 13% of those expenses are covered. This misperception of benefits coverage may be a major cause of violence against providers by disgruntled families and patients who believed that they had purchased comprehensive coverage and are surprised to discover that major medical expenses are not covered by their Critical Illness policies. The better market for growth is the business of Supplemental Policies. New high-premium Comprehensive Coverage policies with modular benefit design administered in small select networks is being introduced. This market exists primarily for expatriate employees, but new mid-marked products are being developed that wrap around the public coverage, much like Medicare Part D in the U.S. Health Ministry approval of wellness products in private insurance policies was issued at year end 2012.

China's lack of integrated healthcare delivery platforms will continue to consume excessive amounts of public resources. Only diagnostic coding, ICD-10, is used, no CPT or treatment codes are in use. Public Health goals exist and are articulated as "Healthy China 2020". Government healthcare infrastructure has advanced and become more proactive following experience of each of the pandemics of the last decade.

Eastern and Western medicine treatments exist side-by-side in most healthcare settings. Traditional Chinese Medicine (TCM) is used in all but the most serious illnesses, such as those requiring intensive care in western-style ICU or surgical theatres. The western style of evidence-based statistical reviews in Chinese medical literature is limited. Such evidence does exist for treatment of hypertension and the nausea secondary to chemotherapy. There may be, however, additional evidence of efficacy of TCM practices found in Western medical literature. TCM is widely regarded as useful in "psychosomatic" conditions using herbals, therapeutic massage, and acupuncture.

Discussion of disparities in healthcare was limited to economic disparities which occur principally non-resident urban and in rural populations. Official census figures place rural population at 708 million and urban at 637 million people. Rural healthcare costs less, is more outpatient in character, inpatient lengths of stay (LOS) are shorter, and there are more frequent follow-up visits. Rural care uses fewer credentialed physicians, fewer trained nurses, and fewer inpatient beds compared to care delivered in urban settings.

On the third day of the trade/study mission, the group made visits to four healthcare delivery sites for first-hand exposure to a range of urban hospitals and clinics. Four different types of facilities were toured: a TCM facility, a University Medical Center with western-style practices, a private western-style hospital, and an integrated-care facility offering both TCM and western medicine. Following the on-site tours, group presentations and discussion allowed for comparisons and highlights of the various facilities.

The following day, the delegation reassembled to review pharmacy practices and policies and practices for chronic diseases. It was evident that western-style pharmacy management practices are commonly in place and widely used in inpatient facilities. Chronic disease profiles and disease management programs are emerging, but are often at only conceptual levels. These programs are prioritized for rapid expansion.

Antibiotic stewardship reviews for broad spectrum agents are now widely used in inpatient settings. Outpatient pharmacy, both for western pharmaceuticals and TCM agents has adapted a customer service focus. In all facilities where pharmaceuticals are dispensed there is attention being given to the problem of physician prescribing practices that are rewarded by the supplemental income it creates for them. A number of options to transition from incentive-compensation based physician prescribing were reviewed.

Ministries responsible for health policies are sensitive to World Health Organization (WHO) standard indicators of population health. China is concerned with its ranking internationally in key indicators and especially upon the chronic disease categories of hypertension (3 fold increase), and type II diabetes mellitus (4 fold increase). The National government has directed that there will be a unified Chinese response to the United Nations summit on NCD recommendations. This means that 15 different agencies will be working in a coordinated manner to address chronic diseases. Since deaths from infectious diseases have plummeted by 90%, the health of China's aging population has become a national priority. In Beijing alone there are 5 million people older than 65 years of age. Much attention is now given to prevention and population performance metrics on diabetes. The current delivery system does not accommodate the time necessary for providers to educate patients on risk and primary preventative measures, however. It is important to note that tobacco use is not currently identified as a public health priority "it is too big of an issue".

At the end of the week, the delegation reflected on what they had learned and looked forward to sharing their ideas and strategies among themselves and with their colleagues.

Written by:
W. Allen Schaffer, MD, Brilant Advisors, LLC

TPG-IHA (www.tpg-iha.com) develops and conducts educational programs in countries outside the United States for senior healthcare executives.