



Rapidly shifting attitudes among physicians on critical issues such as managing costs, drug and device usage, and standardized care are transforming healthcare business models.

# The new cost-conscious doctor: Changing America's healthcare landscape

By Chuck Farkas and Tim van Biesen

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**Chuck Farkas is a partner with Bain & Company and a leader in the firm's Healthcare practice. Tim van Biesen is a partner with Bain & Company and leads Bain's Healthcare practice in the Americas.**

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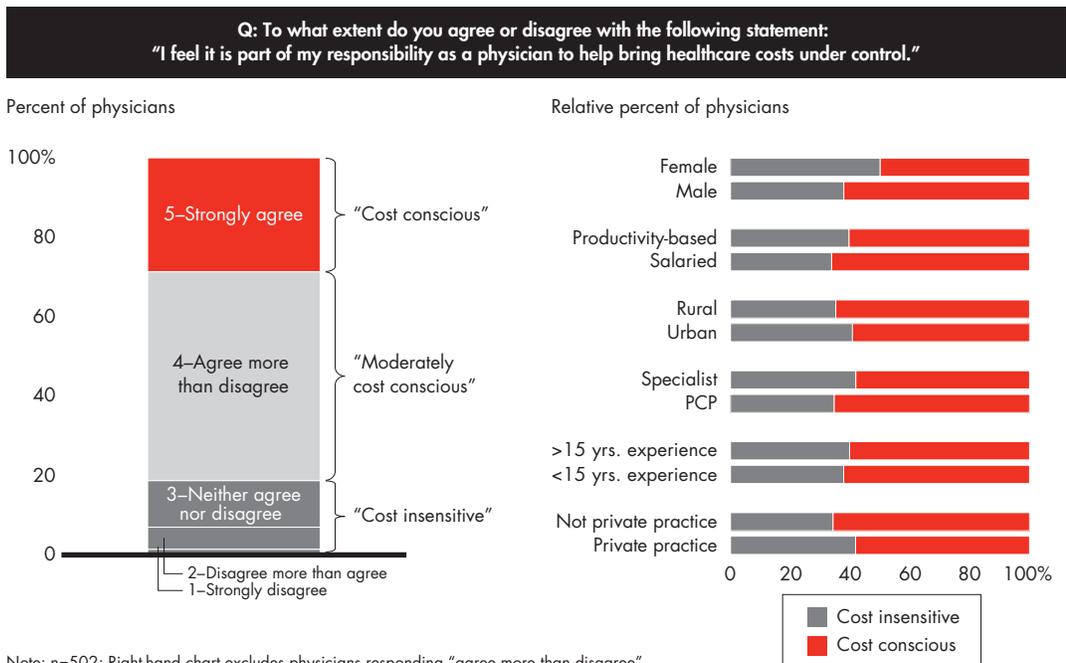
# Rapidly shifting attitudes among physicians are transforming healthcare business models.

For those who believe that America’s physicians contribute to the country’s spiraling healthcare costs by demanding more—more unnecessary tests, more expensive prescriptions, more complex treatment regimens—change is on the way. Increasingly aware and concerned about the growing cost of healthcare, for the first time a majority of physicians show an increased willingness to consider the cost implications of the products they use. They recognize a pressing need to adjust their clinical practices to accommodate healthcare cost considerations (see Figure 1). As the shift in attitude gathers momentum, it promises to have a profound impact on the approach to managing health-

care costs in the US. A Bain & Company survey captures the rising tide of change currently under way in physician behavior and highlights how these shifts will fundamentally transform the way healthcare companies conduct business.

Of all the changes sweeping across healthcare in the US, perhaps the least documented—but potentially most direct—factor likely to help reduce healthcare costs in the future is this shift in physician behavior. To capture the trend, we surveyed more than 500 physicians from across the nation, including primary care physicians, surgeons and other specialists. Respondents included physicians with varying years of experience, ranging from just five years to more than 40 years. The sample represented a balance in factors such as geography, practice type and physician payment method. The survey included diverse physicians’ organizations, including multi-specialty and single-specialty

Figure 1: Most physicians, regardless of demographics, believe their role includes controlling healthcare costs



**The new cost-conscious doctor: Changing America's healthcare landscape**

group practices, health systems and hospitals of all sizes and types—including physician-owned hospitals, academic medical centers, ambulatory surgery centers and specialty hospitals.

Regardless of demographics, physicians sent an unequivocal message: increasingly, America's doctors are ready to adjust their clinical practices to accommodate economic considerations. They display greater price sensitivity to the products they use and are aware of procedure costs to patients and providers. More likely to align with hospitals than ever before, physicians expect they will increasingly respond to rather than resist initiatives such as incentives to decrease utilization; measures to promote preventive care; limits on the practice of "defensive" medicine; and the application of generally accepted clinical treatment protocols. How quickly more physicians move down that path will depend on payers and hospital providers. They can set the pace, ideally with active and thoughtful engagement of physicians, by developing the right approaches that will align incentives to reduce the total cost of care.

**Significant changes in physician behavior**

Such fundamental shifts create both challenges and opportunities for the healthcare industry. They are also a wake-up call for those who cling to the belief that these changes are temporary and physician habits—for example, buying behavior for new drugs and devices—will revert to the old ways. Straddling nearly a decade of perceptions, the survey shows that physicians are not just reacting to the recession or months of recent debate on healthcare reform. These findings represent systemic change rather than a reactive distortion.

We believe these changes in physician behavior are so significant, they represent a tipping point. They will require stakeholders across the healthcare value chain to react in substantial

ways, perhaps, in many cases, redefining their business models. By identifying these emerging attitudes and understanding their implications, leaders can get ahead of the changes and create new sources of value in their respective sectors.

In this section, we take a detailed look at the survey findings and discuss the implications for stakeholders in the healthcare ecosystem. Next, we share some "no-regret" actions that can help healthcare companies tap into the opportunity—and calibrate their business models to get the most out of changing physician behavior.

**Physicians increasingly see controlling costs as part of their job**

Currently, the reimbursement system for products and procedures creates a barrier between the cost and efficacy of care. Physicians are thus able to focus on providing the most effective care for patients, but that is often done regardless of cost. In the past, physicians functioned with the entrenched belief that managing costs was the responsibility of payers. But in recent years, physicians have begun to consider the cost-effectiveness of a treatment in addition to its efficacy when making healthcare choices.

The Bain survey shows that more than 80 percent of physicians "agree" or "strongly agree" that they consider bringing healthcare costs under control as part of their responsibility. That was a consistent finding across the board, regardless of demographics such as age, practice type, geography or specialty. Driven in part by the highly visible national debate on healthcare costs and in part by physicians' increasing alignment with providers, the new attitude marks a significant shift from the past. Increasingly, America's doctors *want* to embrace the opportunity and play a leading role in reducing healthcare costs.

While some physicians are further along than others, even the least cost-conscious physicians

The new cost-conscious doctor: Changing America’s healthcare landscape

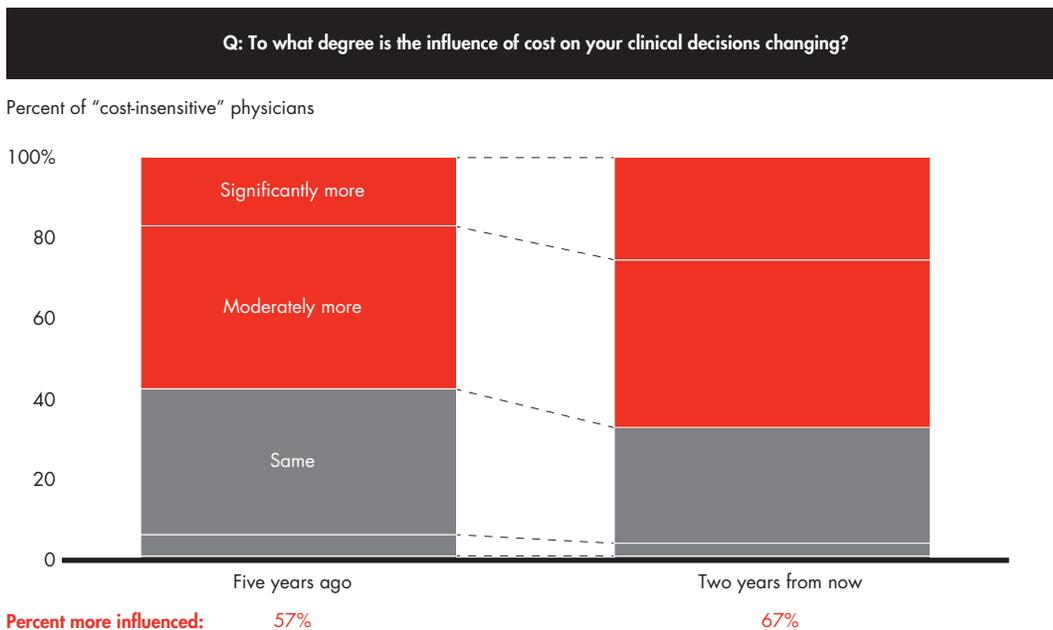
expect costs to wield a much greater influence on their actions over the next two years. Nearly 70 percent of these “cost-insensitive” physicians, already in the minority, respond that cost will have more influence on their decisions in two years’ time (see Figure 2). In addition, physicians who are already relatively cost conscious state they will be even *more* conscious about costs in the future.

The implications are significant. Pharma and medtech companies must develop and commercialize products with a focus on proving significant differentiation versus standard of care, keeping a keen eye on delivering products with clear health economic value. Payers and providers can expect more physicians to work in collaboration with them on initiatives that bring down the cost of care.

Helping these trends is the growing alignment of incentives. Today, physicians can directly

contribute to improved practice and hospital profitability by reducing the cost of consumables (medical devices and products) and decreasing inpatient lengths of stay (or using outpatient sites of care). Both approaches result in improved profitability for providers and can contribute to lower system costs overall. While the fee-for-service model has not provided physicians with incentives to drive preventive care, decrease system utilization, limit the practice of “defensive” medicine or curtail overuse of medical procedures, the changing attitudes, combined with the potential for payment reform, are priming the market for change. For example, much of today’s healthcare debate focuses on structural solutions such as accountable care organizations (ACOs), medical homes and integrated delivery networks. While these are early days in this “final frontier” of fully aligned incentives, our survey data reinforces that the physician community may respond more quickly to such approaches than ever before.

Figure 2: Even cost-insensitive physicians expect to be much more influenced by cost in the immediate future



Note: n=94

**The new cost-conscious doctor: Changing America's healthcare landscape**

For players in the healthcare industry, the message is clear: physicians may no longer be the barriers to change that they have been accused of being in the past. Each part of the healthcare value chain needs to reevaluate its value proposition and ensure long-term alignment with clinical innovation *and* cost management.

**Physicians demand more before trying new drugs or devices**

In the past, product improvement was synonymous with innovation. Physicians wholeheartedly embraced most new products with the belief that the more current a drug or device, the superior the product. Physicians focused on bringing the latest—and therefore, the greatest—drugs and devices to their patients.

In contrast, physicians are now looking at new products with increasing skepticism. More than 50 percent of physicians say the “burden of proof” for trying new products is now higher than ever. One private practice family doctor we interviewed admitted, “Physicians have become jaded with pharma companies and the new drugs they want us to use. There are a lot of me-too drugs out there that offer minimal benefits.” A pediatrician added, “The more experience you have, the more skeptical you are. Physicians are aware of the pressures of the industry where everyone is trying to push the newest product.”

In further support of this trend, our analysis points to a significant number of physicians who are less likely to try new products than in the past. Approximately 25 percent of physicians say that they are less likely to try new products as soon as they become available compared with five to 10 years ago.

This wariness about using new products has increased for several reasons. While physicians cite payer restrictions as one of several barriers

to using new products, importantly, a range of individual motivations are also at play. First, doctors express a high level of overall satisfaction with the drugs and devices currently available (see Figure 3). In fact, the biggest unmet need they perceive in both drugs and devices is cost-effectiveness. Second, physicians express concern about the long-term safety profile of new drugs and devices. Perhaps influenced by a number of recent high-profile product recalls and greater regulatory scrutiny overall, physicians no longer feel “new” axiomatically implies “improved.”

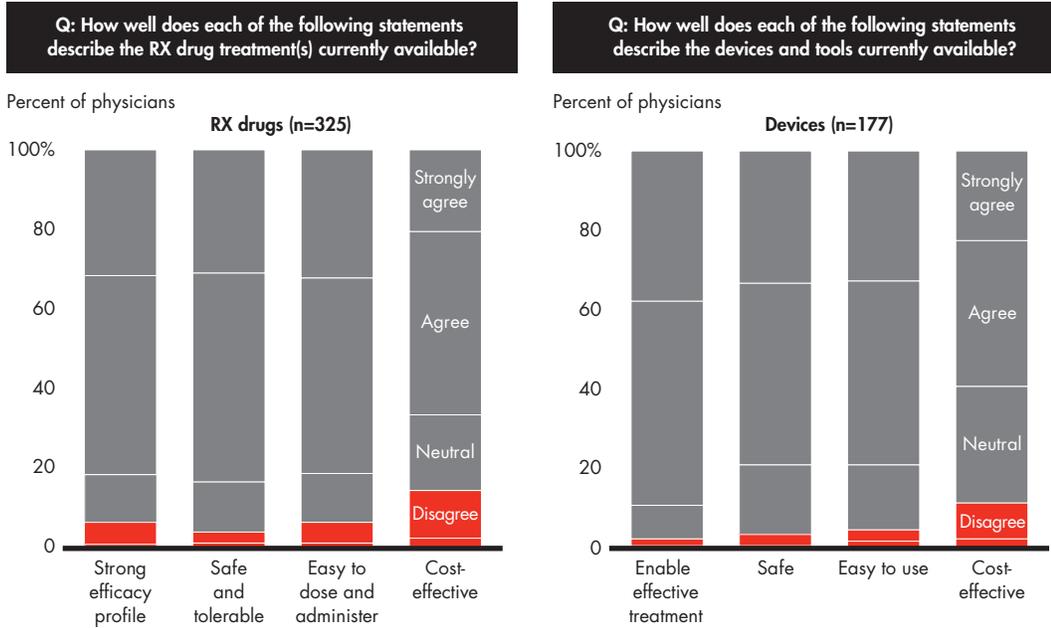
In addition, only 50 percent believe that new drugs generally offer valuable benefits and only 30 percent believe that they actually offer sufficient value. In the case of devices, the lack of differentiation between some brands further influences physicians' unwillingness to try newer products. In short, physicians are increasingly joining the calls of payers and demanding clear evidence of clinical differentiation and economic value before they use new drugs or devices.

**Physicians are comfortable with more standardized care**

The era of the fiercely independent physician is waning. Most physicians in our survey believe that care should be more standardized than it is today. Moreover, an interest in standardized care is correlated with a focus on cost management—suggesting that the two issues are increasingly linked in the minds of physicians. A number of recent studies<sup>1</sup> address this relationship in detail. Our data describe the underlying reason why physicians may now be predisposed to change their clinical practice to manage costs. Nearly 75 percent of “cost-conscious” physicians believe care should be more standardized versus less than 50 percent of “cost-insensitive” physicians (see Figure 4).

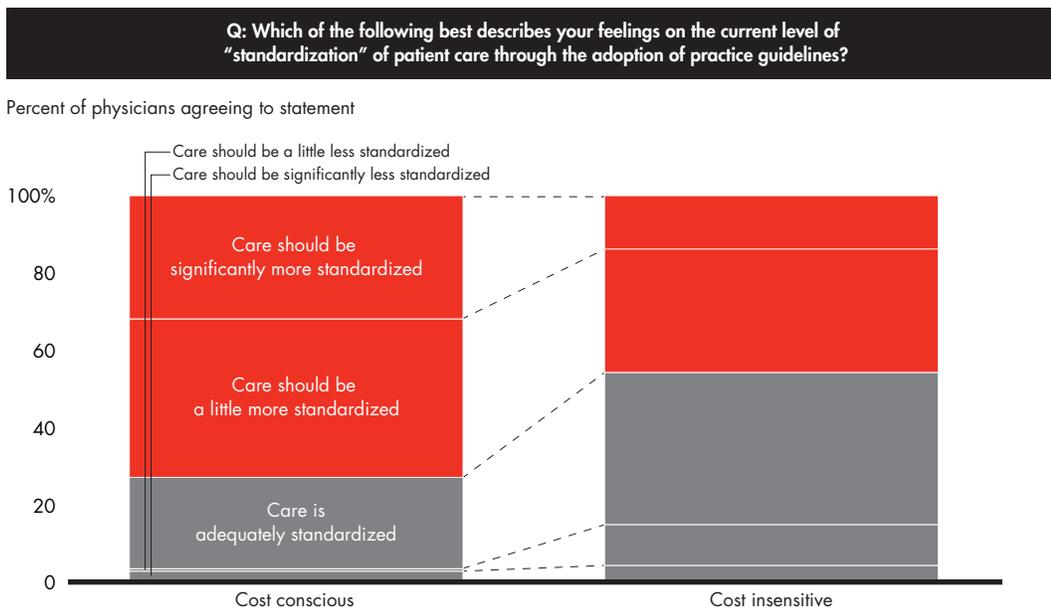
The new cost-conscious doctor: Changing America's healthcare landscape

Figure 3: Physicians show a high degree of satisfaction with existing drugs and devices



Note: Question asked in context of a condition the physician treats frequently

Figure 4: A majority of physicians believe care should be more standardized; this is especially true of the cost conscious



Note: Practice guidelines are defined as systematically developed statements to assist practitioners and patient decisions about appropriate healthcare for specific clinical circumstances; developed by physician organizations, government, insurers or other such groups. n=502

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It appears that those physicians who advocate most strongly for standardization see it as an effective way to address healthcare costs.

The survey also shows that physicians adhere to clinical guidelines more today than ever before. The average number of patients for whom guidelines were applied rose from a third five years ago to nearly half today, and that number is expected to increase further two years from now (see Figure 5). Younger hospital-employed specialists tend to apply guidelines the most: physicians with less than 15 years of experience say they refer to practice guidelines for more than 60 percent of their patients. The survey projects that across all physician segments, guideline usage will increase over the next two years. Says a primary care physician at a private practice: "There are so many treatments out there that are ineffective or downright harmful. By using treatment guidelines you feel more secure that you are doing something 'tried and true' and not responding to advertising."

The growing acceptance of more standardized care combined with enabling technology such as electronic access to guidelines promises to generate a virtuous cycle. Doctors visit online resources like UpToDate, ModernMedicine, MDLinx and Epocrates in large numbers. UpToDate currently reports more than 400,000 users. Hospitals are also pushing standardization, often by incorporating "checklists" into the software physicians are required to use. Our survey shows that while only a limited number of physicians worked with hospital-enforced checklists five years ago, by 2012, this number may exceed 50 percent.

**Physicians are giving up private practice—and decision rights—in greater numbers**

In response to declining practice economics and a growing administrative burden, private

practice physicians are increasingly turning to employment in hospitals or larger practices. When asked how likely they were to switch practice type, almost 25 percent of private practice physicians said they "are somewhat likely" or "extremely likely" to change practice types in the next five years. Nearly two-thirds of these physicians indicated they would be likely to move to a hospital or health system (see Figure 6).

In response to why they would switch practices, most respondents cite the drop in reimbursement rates coupled with rising costs. Three-quarters claim the autonomy of running their own practice would no longer be worth the associated economic pressures. These trends have had a dramatic impact on a number of specialties. For example, says a cardiologist, "Most cardiology practices have experienced dramatically reduced reimbursement rates and a vast majority of cardiologists have moved to hospital employment."

As physicians become employed or aligned with more integrated systems, we see a reallocation of decision roles in the healthcare landscape. In the US, increasingly, both clinicians and administrators will influence decisions on which guidelines to follow, which drugs to prescribe or which medical technology to use. Five years ago, almost 40 percent of the physicians surveyed felt they had complete discretion over all medical supply and device decisions; fewer than one in five feel they will have the same control two years from today (See Figure 7).

In recent years, this transition led to an "us-versus-them" mentality between clinicians and hospital administrators. But in reality, the most sophisticated buyers have developed truly collaborative approaches where both clinical and economic considerations are weighed and evaluated by value analysis teams (VATs) comprised of physicians and procurement

The new cost-conscious doctor: Changing America's healthcare landscape

Figure 5: Physicians report increasing use of practice guidelines in providing care

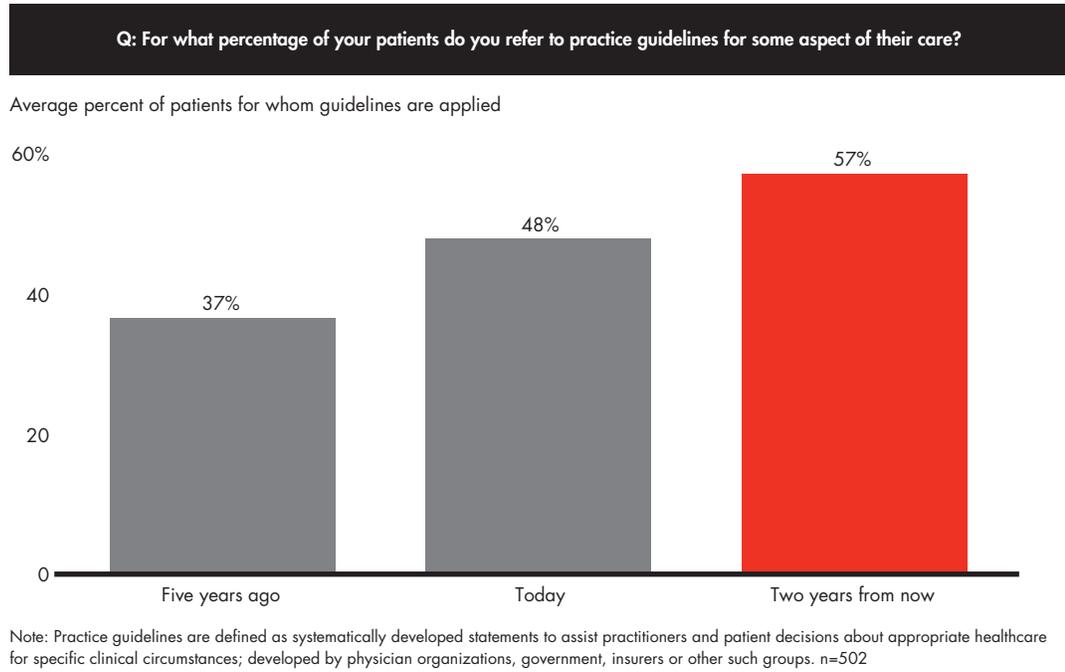
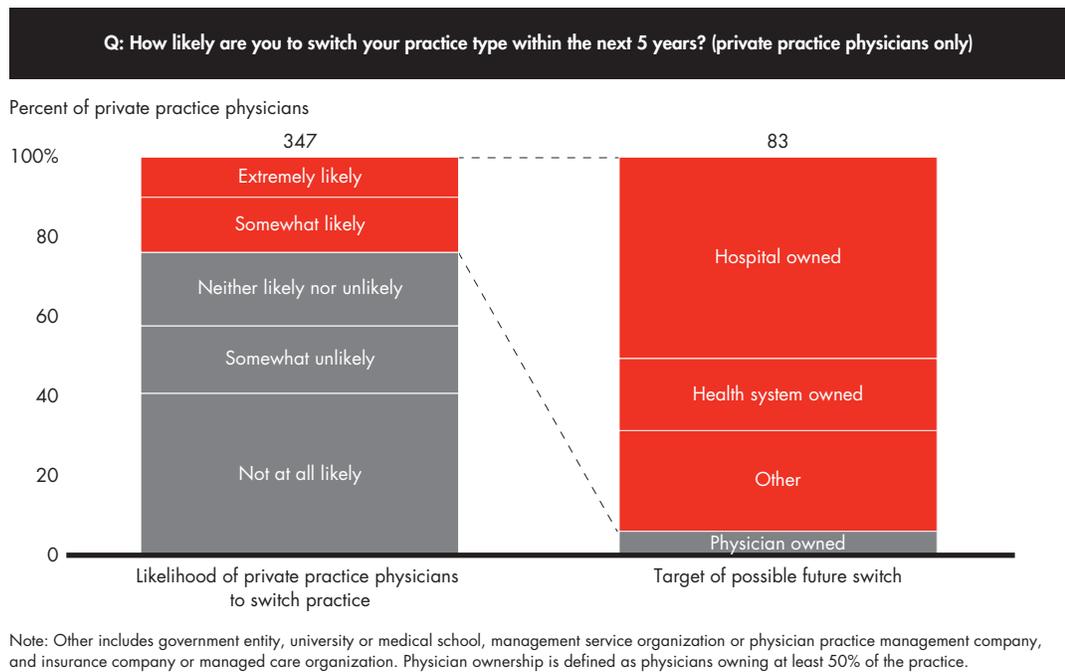
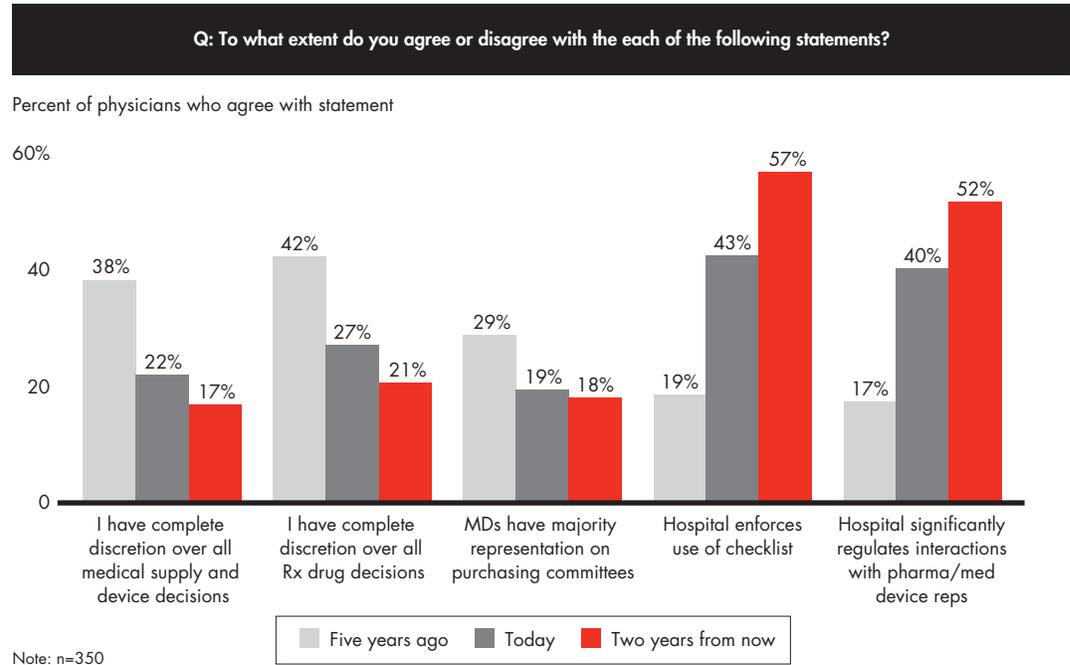


Figure 6: Private practice physicians will continue to shift toward employed models



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Figure 7: Physicians confirm their waning influence over decisions made in the hospital environment



professionals. When done well, this approach can lead to better informed health economic decisions, strong alignment between clinicians and administrators, and improved economics for all stakeholders.

**Taking “no-regret” actions**

Changes in physician behavior of this magnitude are likely to rearrange the healthcare landscape in significant ways. For pharma and medtech companies, the change in physician attitudes will require engagement with stakeholders—such as CFOs and procurement professionals—beyond their historical physician base. Manufacturers will need to focus increasingly on new product innovations that either offer true clinical differentiation or demonstrably improve the overall cost of care.

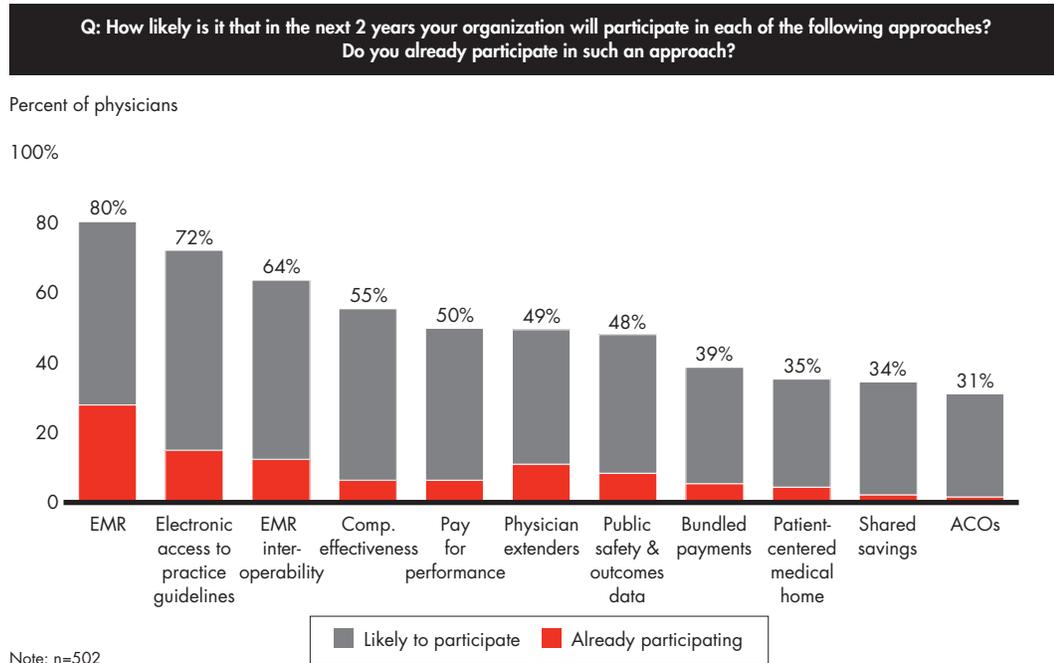
With a market primed with physicians more ready to accommodate change, payers and

providers must determine how best to align incentives and reduce overall system costs. Physicians must maintain sufficient independence to exercise appropriate clinical judgment while being rewarded for new models of care management and longer-term patient outcomes. This study demonstrates their willingness to adapt to approaches focused on cost management.

Over the next two years, physicians expect a fivefold increase in the prevalence of electronic access to clinical treatment guidelines, nearly an eightfold increase in pay-for-performance programs and approximately one-third expect they will participate in a medical home or ACO model. A majority of physicians endorse the need for comparative effectiveness research and believe electronic access to guidelines will improve the quality of healthcare (see Figure 8).

The new cost-conscious doctor: Changing America’s healthcare landscape

Figure 8: Physicians indicate a growing openness to new approaches for care delivery



Each such insight represents opportunity. Different stakeholders in healthcare will react differently based on how slowly or quickly they see these changes in attitude gather momentum. Let’s consider some concrete actions companies can take.

**Manufacturers (pharmaceuticals, diagnostics and medical technology)**

Selling products in this new environment will require a fundamentally different business model for manufacturers of pharmaceuticals, medical products, diagnostics and medical devices. Increasing recognition that “new” is not equivalent to “clinically differentiated” raises the bar for innovators. Next-generation products with incremental improvements will no longer command a premium in the market; instead, they will find themselves competing with prior-generation products or other low-cost substitutes. Given that the exist-

ing R&D pipelines of many manufacturers consist of products that don’t meet the “differentiated” hurdle, many pharma and medtech companies will need to cull such products from their portfolio to improve the returns on their investment in R&D.

For example, in surgical endo-mechanical instruments, an entire industry has sprung up to recycle single-use surgical instruments. These “reprocessors” such as Ascent (now owned by Stryker), SterilMed and others tap into the current market demand for “good enough” products, in which the latest features are often traded off for lower prices. Moreover, companies like GE find that “de-engineering” products such as ultrasound machines or ECG devices not only helps penetration in emerging markets but also opens up new opportunities for expansion in developed markets. In some product categories, medtech products stripped of little-used features can help defend share of

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**The new cost-conscious doctor: Changing America's healthcare landscape**


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wallet, serve a broader range of customers and sometimes even expand profit pools.

Due to these shifts, in some ways the definition of “innovation” is expanding. In addition to delivering true clinical differentiation and improved patient outcomes, innovation will increasingly include products that improve care economics: products that may not have differential clinical impact, but improve efficiency and reduce total costs. This new approach to innovation will require more collaborative engagement with both payers and providers. Manufacturers will need to understand their customer's processes and work flows better and deliver programs that focus on the metrics payers and providers deem most relevant. They will need to build product pipelines influenced by an increasingly broad range of inputs, including clinical, administrative and economic considerations. Ultimately, manufacturers will be compelled to self-fund comparative effectiveness studies to demonstrate the economic superiority of their products.

The commercialization of products will also depend on a broader set of skills beyond those in predominant use today. The ability to communicate both clinical and economic impact will only increase in significance and will involve engagement with physicians and administrators. Sales reps will continue to play a meaningful role, but they will be supplemented by account managers who understand their customers' profit and loss situation and can engage procurement professionals and service-line leaders in a more comprehensive discussion.

### **Payers**

Our research highlights an opportunity for payers to work in partnership with physicians to restructure the payment system and align incentives with high-quality, cost-effective care. Now, more than ever before, physicians

expect payment reform, and will become increasingly amenable to new incentive and risk arrangements.

For example, to arrest spiraling medical costs, Blue Cross Blue Shield of Massachusetts (BCBS-MA) developed the Alternative Quality Contract (AQC). Under the terms of the five-year contract, providers receive a global monthly budget per patient and are allowed to keep the savings if care costs less than this amount; they share the risk if care costs more. They can also earn substantial bonuses for exceeding process and outcome quality standards. Incentives encourage eliminating wasteful care while robust performance measures create accountability for quality and safety. Payers also provide individual physicians with information on their practice patterns relative to others, arming them with data that can help them rethink choices in the context of quality and cost and help successfully manage the risk.

In the future, expect more payers to invest in such change. A good starting point: developing tools and support that allow providers to deliver more cost-effective care and track their performance. These might include member-specific care alerts and the provision of care guidelines that are integrated into physicians' work flows.

The growing acceptance of guidelines by physicians allows physicians, providers and payers to press ahead on standardizing care based on evidence. By investing in comparative effectiveness research and partnering with providers in their network, payers can develop a strong set of guidelines with support from physicians who will use them. BCBSMA found that physicians became “passionate” frontline champions against clinical waste when they saw clinically and specialty-specific data on how practice patterns could vary. By transparently revealing the wide variations between doctors in treatment

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**The new cost-conscious doctor: Changing America's healthcare landscape**

components—lab tests, office visits, pharmacies—for a host of conditions like hypertension, arthritis, depression and skin inflammation, BCBSMA quickly and effectively proved its case for standardized guidelines.

Finally, as they rethink their business models, payers can consider opportunities that assume a more collaborative relationship with physicians. For example, payers can aspire to emerge as the trusted source for patients' clinical and lifestyle information needs. With physicians backing their efforts, payers can also provide better tools to patients to manage their health; create more sophisticated informatics and decision support systems for providers to improve care and reduce costs; and even create the infrastructure for provider teaming, ACOs and other coordinated care models.

### Providers

With more physicians giving up private practice to join hospitals and health systems, providers can build more captive referral networks and better align incentives, and at the same time redesign care in a coordinated way. A consortium of top medical centers in the US—including the Cleveland Clinic, Dartmouth-Hitchcock, Denver Health, Geisinger Health System, Intermountain Healthcare and Mayo Clinic—plan to share data with one another in an effort to lower costs and improve the delivery of care in specific areas of focus, such as knee replacement procedures. More than 300,000 total knee replacements take place every year in the US, but the costs vary across the country from \$16,000 to \$24,000 per surgery. The project focuses on identifying best practices in eight conditions that show a wide variance in the cost of treatment and the quality of outcomes across the country.

As physicians show a growing willingness to embrace new healthcare models, providers can collaborate with payers to restructure the

payment system. That will not be easy—provider revenue models will be altered, risk management capabilities developed and reinforcing compensation structures created. But this effort has the potential to realign incentives in a way that can truly enable effective and efficient delivery of care. Providers can then harness the trends we now see among physicians and empower them to rethink delivery of care. They can do this effectively by developing strong practice guidelines and protocols—grounded in compelling, evidence-based information and cost data—and provide the tools and incentives to ensure broad use.

### Preparing for change

Of course, it would be a mistake to imagine that all these changes in physician attitudes will resolve all of the industry's cost and quality challenges. In addition to cost-consciousness, the survey surfaced some disquieting trends, too. About 40 percent of physicians voice the concern that cost pressures force them to make decisions that are not always aligned with the best patient care. These physicians fret that in two years more than 50 percent of their patients might not get the best care due to cost-cutting (see Figure 9). The two areas physicians are most concerned about: restrictions on their ability to prescribe the best drugs or treatments and limits to their use of necessary tests and diagnostic methods.

Over the next two years, physicians predict that cost will play a great role in all care decisions across the board: prescription drugs, devices, diagnoses, procedures and referrals. That shift will require action from companies throughout the healthcare value chain. These changes spell opportunity, but they also imply responsibility. Increasingly, as physicians shift their focus on costs, the onus of finding the balance on ensuring quality care will also get reallocated across the industry.

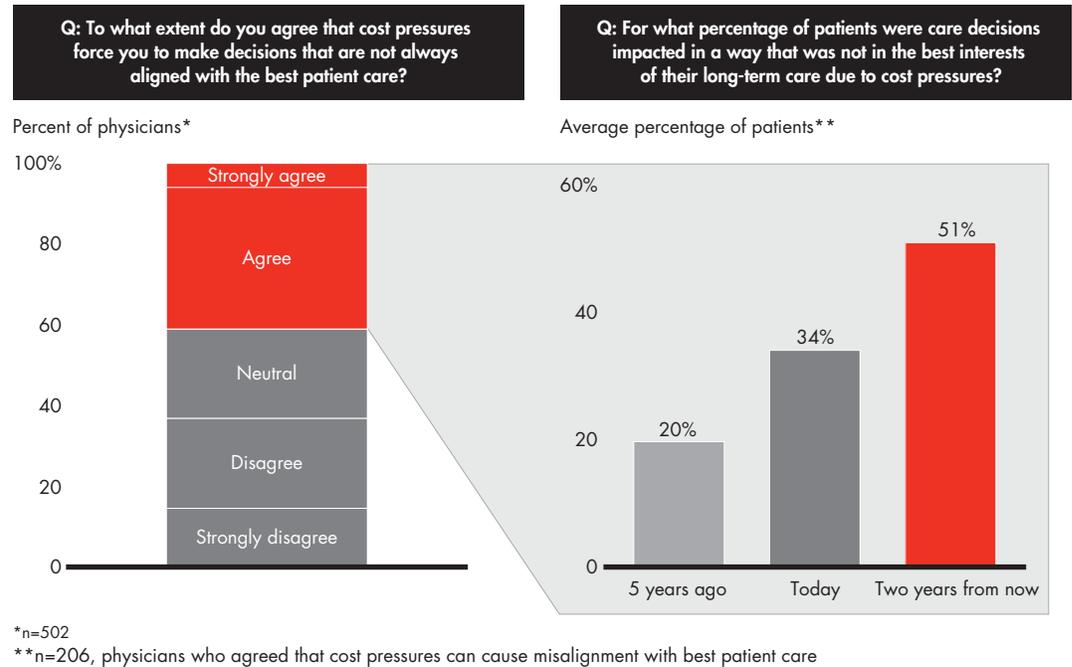
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The new cost-conscious doctor: Changing America's healthcare landscape

Figure 9: Physicians express growing concern over the quality of patient care in the face of cost pressures



It's our belief that the shift in physician attitudes will enable substantial change in the healthcare industry. Ignoring the shifts or betting on too slow a pace of transformation will steer companies into a dangerous place: they risk being swept away by disruptive forces. Instead, leading companies can take charge of the

future by embracing change. They can review their current model through the lens of evolving physician attitudes and identify practical approaches that will deliver results as trends gather even more momentum. By getting ahead of the swell, they can position themselves for success now as well as in the future. 🔄

<sup>1</sup> NEHI. "Improving Physician Adherence to Clinical Practice Guidelines." February 2008. See also O'Malley, Ann, Pham, Hoangmai H. and Reschovsky, James D. "Predictors of the Growing Influence of Clinical Practice Guidelines." Center for Studying Health System Change, March 2007.

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