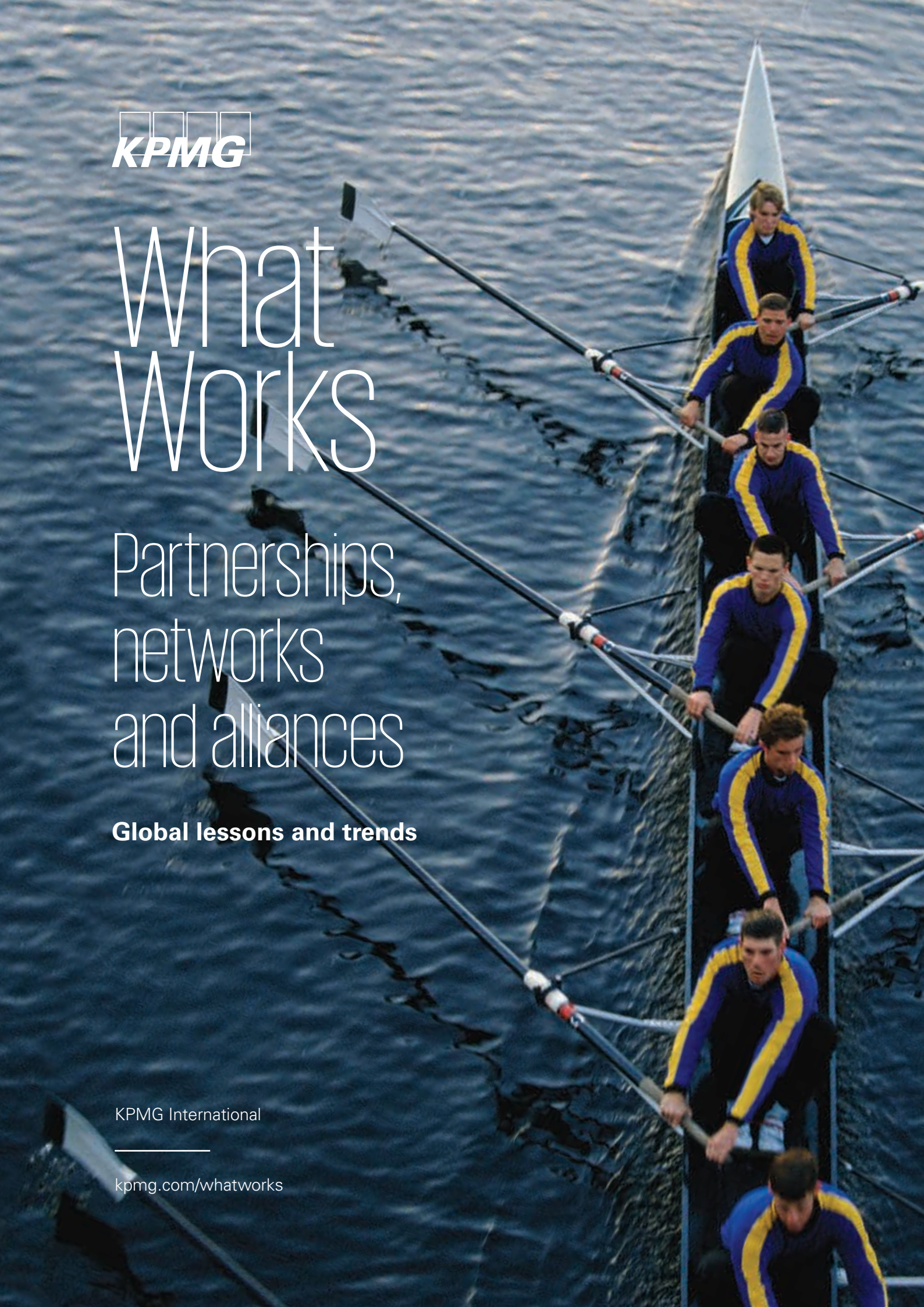

What Works

Partnerships, networks and alliances

Global lessons and trends

KPMG International

kpmg.com/whatworks

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Malcolm is currently an Advisory Partner in Australia and is part of KPMG's Global Healthcare Center of Excellence. One of his areas of expertise is the development and implementation of new care delivery models to achieve cross-organizational change. A prominent national and international figure, he has chaired the UK CEO's Research Forum and was a member of the NHS Future Forum, advising the UK Government on health legislation.

Malcolm has been at the forefront of the NHS's modernization efforts, having helped several UK healthcare authorities deliver change and improve performance, successfully working with multiple stakeholder groups. Most recently Malcolm was CEO of University Hospitals Leicester (NHS) Trust, England's third-largest university hospital trust with US$1 billion turnover and 11,500 employees, where he turned around a failing asset renewal program.

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Executive digest

Malcolm Lowe-Lauri

Healthcare with a purpose — that is where improved service quality and cost effectiveness begins. Hospitals, community healthcare providers and payers must go beyond their borders to create partnerships, networks and alliances (PNAs) in order to achieve an integrated, cost-effective and high-quality service environment. The specific model of collaboration is less important than ensuring the ability of institutions and their professionals to come together seamlessly. Such integration is not simple; it requires healthcare organizations to make purposeful, yet flexible, long-term decisions.

Factors driving coordination of care

The provision of healthcare is becoming more complex and specialized, making it difficult for institutions to match traditional structures to fit shifting patterns of demand. As a result, organizations around the world are looking to develop PNAs to coordinate care across different kinds of providers.

Complementary to this is the drive for information. Information alliances allow participating organizations to obtain wider access to data so they can achieve new levels of insight into what they are doing, their patients and the populations they work with. These insights can be critical for formulating activities that enhance the entire system of care.

There are also strong legislative (e.g. Affordable Care Act in the US) and financial drivers making the case for PNAs. Many payers are spending more on non-hospital and even non-health services to deal with growing volumes of patients, while providers are swamped trying to deal with increased volumes with less money.

Everyone needs a better solution. That is why these factors are driving convergence between acute care hospitals and primary and community providers — so that each can better manage their business processes, clinical pathways and their people more effectively. It is also why payer-provider alliances are becoming increasingly common.

Successful PNA players have often extended into international efforts in research and education and sophisticated commercial partnerships with the life sciences sector.

Avoiding PNA pitfalls

When it comes to creating effective PNAs, the biggest dangers come from not thinking long-term. The best PNAs have evolved over time and with a shared vision. Hospitals that move too quickly often find there is little-to-no positive impact on their organizations because they did not conduct the right due diligence or they did not pay enough attention to governance or defining strategic outcomes. The message is, pick the right partners, create or join the right networks, or form the right alliances.

Transition can also be a challenge if not planned for in advance. Organizations must understand the need to fully commit to an environment of shared sovereignty, to put their stake in the PNAs objectives. Without this buy-in, PNAs can devolve into focusing on issues within the network instead of on achieving strategic objectives.

Achieving benefits

When it comes to PNAs, there are a number of factors that can influence success. As a starting point, think strategically about what you are doing and how you are doing it. Be purposeful in your actions — flexible, but focused on the long-term. Successful PNAs often form out of organizations having an evolving but continuous strategy. A 'chop and change' approach rarely works.

Leadership is also essential. Ask yourself how active your leadership is with external partners and whether you are looking outside your organization as well as inside. The best leaders understand their position in the system and how their actions affect the broader group both positively and negatively.

Even if you are hesitant about PNAs, do not let your uncertainty stop you from considering options. Even in cases where the operating environment has looked unfavorable to collaboration, we find examples of success. With planning and effort, success is possible.

Most of all, do not be constrained by your organizational borders, and do not be distracted by the tyranny of the present.

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Six factors for successful partnerships, networks and alliances

Partnerships, networks and alliances (PNAs) have been a feature of health service organizations in many countries for decades. Around the world they are increasing in number, size and scope and this activity is being accelerated by regulatory changes in marketplaces, such as the Affordable Care Act in the US, care quality scandals like Mid Staffordshire in the UK and the growing international ambitions of some providers.

The rise of networks, both clinical and organizational, has been a trend driven by evidence that better quality health services could be secured through co-operation and collaboration between providers.

Across the 45 countries in which the KPMG Global Health Practices operate, we have rarely found examples of the successful, stand-alone health system. When renowned international examples are examined closely it is clear they are embedded in wider systems or have created systems of their own.

Simply put, the successful health organization is connected. Excellence cannot be achieved in isolation.

Global research

For two years, KPMG has conducted research into PNA activity in healthcare, involving interviews with dozens of clients, a review of many KPMG PNA projects — both forming and reforming PNAs — as well as a the culmination of our Global Center of Excellence for Healthcare knowledge, and a literature search of existing research. The result, this report, that identifies six factors which make successful partnerships, networks and alliances.

1. PNAs are successful when they are the product of long-term strategy — demanding vision.
2. PNAs are driven by the need to innovate, coordinate service delivery or open up new markets.
3. Focusing on quality is better than focusing on size or money.
4. The best PNAs expand upon opportunities beyond their original mission.
5. Avoiding failure requires strong payer-provider alliances.
6. Tension, flexibility and self-criticism are more important than the model.

In the following report, we expand on each of these factors. At the end of each, we set out the most important issues for healthcare organizations to consider.

The report concludes with a maturity matrix (see page 26) outlining the levels of sophistication KPMG commonly finds among clients thinking about PNA. This is a useful tool for organizations wishing to improve their use of PNA by understanding which factors they are already strong on and which require most improvement.

Across the 45 countries in which the KPMG Global Health Practices operate, we have rarely found examples of the successful, stand-alone health system.

The successful hospital is the connected hospital

The Coxa Hospital in Finland is a specialist joint replacement facility. It is successful due to its well organized referral system to and from partners, treatment and rehabilitation network and its well defined role for a specific treatment within the wider health system.

The Aravind Clinic in India is known for extremely high volume cataract surgery. It is highly successful as it trains staff, manufactures implants and undertakes researches in its field. It is in effect more of a specialist system than a hospital.

The Children's Hospital of Philadelphia is a high performing US children's hospital partly because of its integrated networks of neighboring providers and physicians, its improvements in care quality and sustainability are regional, well beyond the hospital itself.

Successful PNAs require a long-term strategy

PNA activity has undoubtedly increased since the global financial crisis of 2009, as organizations respond to stagnating revenues and increasing quality requirements.

Across the KPMG global network, we see a pattern of success where organizations work from a clear strategy and agreed opportunities, and failure where hasty attempts at merger and acquisitions are driven by the pursuit of cost savings without a coherent narrative or deeper vision.

The US offers some particularly interesting stories of success and failure.

According to Marianne Udow-Phillips, Director of the Centre for Healthcare Research, a partnership of the University of Michigan and Blue Cross Blue Shield Michigan, organizations are responding to price competition and, "the need to diversify and expand their offerings" through merger and acquisition, alliances and partnerships with community hospitals. The number of M&A transactions in the US has risen from 56 in 2002 to 105 in 2012. Many of these involved academic medical centers (AMCs).[1]

Murray and Burch, identify three main strategies US AMCs are taking: "anchoring multi-hospital integrated networks; pursuing partnerships with large non-academic systems; or staying independent while entering into affiliations to achieve aspects of their mission."[2]

Some of these approaches have struggled to work. A number of institutions have incurred a downgrade in their performance ratings (e.g. University of Michigan Health System, University of Massachusetts Memorial Healthcare, and Temple University Health System in Philadelphia). Others have been more effective.

One highly successful example that stands out is Yale New Haven Health System (YNHHS). YNHHS has a long history of successfully acquiring and integrating organizations. From a stand-alone academic medical center in the 1970s, it has steadily acquired physician groups and hospitals.

Most recently, it took control of the 500-bed Catholic Hospital of San Raphael — a century old community hospital with a strong history and culture. Consistent with its thinking about successful integrations, YNHHS focused on cultural alignment of the two entities.

As the President and CEO, Marna P. Borgstrom, explains:

"We did not want the acquired organization to experience the vacuum that can come from pulling it into the primary academic medical center, nor did we want to lose the legacy, values and heritage of this wonderful Catholic organization. We undertook a concerted effort to align both hospitals' values as an integrated organization. As we thought about it, we realized that this ought to include the others in our system: our physicians, the medical foundation, and our other hospitals."[3]

The outcomes have been impressive. Since the acquisition in 2012, a strong regionally integrated hospital network has developed alongside a similarly strong integrated physician network.

The organization's revenue growth rate has remained high (10.3 percent CAGR over 13 years to 2013), it has absorbed US$549 million of 'free care', Medicare and Medicaid shortfalls and bad debts in 2013 alone, and has averaged over 150 liquidity days between 2008 and 2013.

Children's hospital networks are another strikingly successful example of PNAs in the US. The Children's Hospital of Philadelphia (CHOP) and Boston Children's Hospital have built up an effective mixture of physician networks, extending well beyond the walls of their hub hospitals into primary and community care, satellite services and partner hospitals.

The Children's Hospital Association of America notes that regionalization strategies such as these have been developing across many states in the last decade.[4] Initiators of these strategies like CHOP have used regional networks to sustain and improve their position, remain highly profitable and relevant to local communities in Pennsylvania and New Jersey.

This success contrasts with leading children's hospitals in Canada or the UK.

Given the single payer nature of these systems, we would expect strong service integration. Yet Sick Kids Hospital in Toronto is looking to reinvigorate children's service networks that have existed for more than a decade and are not thought to be sufficiently active.

In England, attempts to reorganize tertiary children's services such as cardiac surgery have been derailed by strong opposition from potential 'losers'. Attempts by large tertiary centers to extend into secondary care have also not been successful, such as Great Ormond Street Hospital's attempt to support emergency services in north London.

1. Udow-Phillips, Marianne, quoted in Herman, Bob. Wave of consolidation rumbles toward Academic Medical Centres. ProQuest. 11 Jan 2015.
2. Murray, Jan and Burch, Kathleen. Recent trends in Academic Medical Center mergers, acquisitions and affiliations. ProQuest. 11 Jan 2015.
3. Marna P. Borgstrom. Interview by Stephen J. O'Connor. Journal of Healthcare Management. Vol 59, No 2 March/April 2014.
4. Developing local to international hospital markets. Children's Hospital Association 2008. Accessed on 14th November 2014.

Many leaders succumb to the temptation to overhaul structures and systems overnight. Such strategies are fraught with risk.

Those that have bucked this trend show that it is consistent, clear and committed strategy over many years which makes the difference between success and failure.

Many leaders succumb to the temptation to overhaul structures and systems overnight. Such strategies are fraught with risk.

The 30 year expansion story of the University Health Network (UHN) in Toronto, is far less dramatic than many other systems and has allowed PNAs to develop based on a firm foundation of trust and shared vision.

Dr Robert Bell, former CEO of UHN, sees the development of the UHN mission as subtly evolving through this history, and although this journey is still not wholly complete, both the KPMG ratings methodology, and the Academic Ranking of World Universities puts it in the top ten academic health science centers globally.[5]

The UHN story is quiet and prosaic when set alongside more seismic stories in other health systems. But that is the point. It is progress without fuss.

Slow and steady wins the race: The journey of the University Health Network, Toronto

In 1986, the Toronto Western Hospital merged with the Toronto General Hospital, becoming the Toronto Hospital.

On 1 January 1998, the Toronto Hospital was amalgamated with the Ontario Cancer Institute/Princess Margaret Hospital,

In April 1999, the name was officially changed to the University Health Network (UHN).

On July 1, 2011, UHN integrated with the Toronto Rehab Institute, a move which has physically expanded to eight locations around the city and allows it to better serve patients by bringing together acute hospital care with the rehabilitation care that so frequently follows a hospital stay.

The journey continues: A variety of other partnerships have formed. Most recently, with the Kuwait Cancer Centre for the education and training of Kuwaiti doctors.

http://www.uhn.ca/corporate/AboutUHN/OurHistory/Pages/our_history.aspx

Consider:

— What is your strategy for your PNA vision?

— When a PNA opportunity arises, how do you evaluate it against your strategy?

— How do you evaluate the success of each PNA transaction before the next one?

5. Lange Joep, Schellekens Onno, de Beer Ingrid, Lindner Marianne E, van der Gaag Jacques. Public-private partnerships and new models of healthcare access. In Current Opinion in HIV and AIDs. 3(4), 2008.

PNAs are driven by innovation, coordination or new markets

Across the key markets where PNA has been occurring, it is clear that different countries are pursuing partnerships for a variety of reasons, notably to spread innovation, coordinate service delivery or open up new markets. These motivations have a major impact on the types of PNA activity chosen and the ease with which these take place. However, it is clear that local market conditions are not a significant factor in the success or failure of PNAs.

Many countries are pursuing PNAs to stimulate care coordination

Innovation in patient care integration is one of the key issues in healthcare. The Netherlands has made significant progress in health system integration, yet as Dr Anna van Poucke, Head of Health, KPMG in the Netherlands, explains, the path to integration is not easy:

"Although coordinated care is one of the features of our health system, the reality is that integration is one of the hardest levels to achieve. It asks for an incredible stretch of all involved — letting go of old interests and converging these to collective goals and approaches. Finances, payment schemes and organizational boundaries must all be redesigned so that caregivers, patients, payers and providers are aligned."

Alberto De Negri, Head of Health, KPMG in Italy, is working with a number of regions to strengthen horizontal and vertical integration. A strongly regional government-led approach to market management is being taken — made necessary by the impact of the global financial crisis on Italy's public health system.

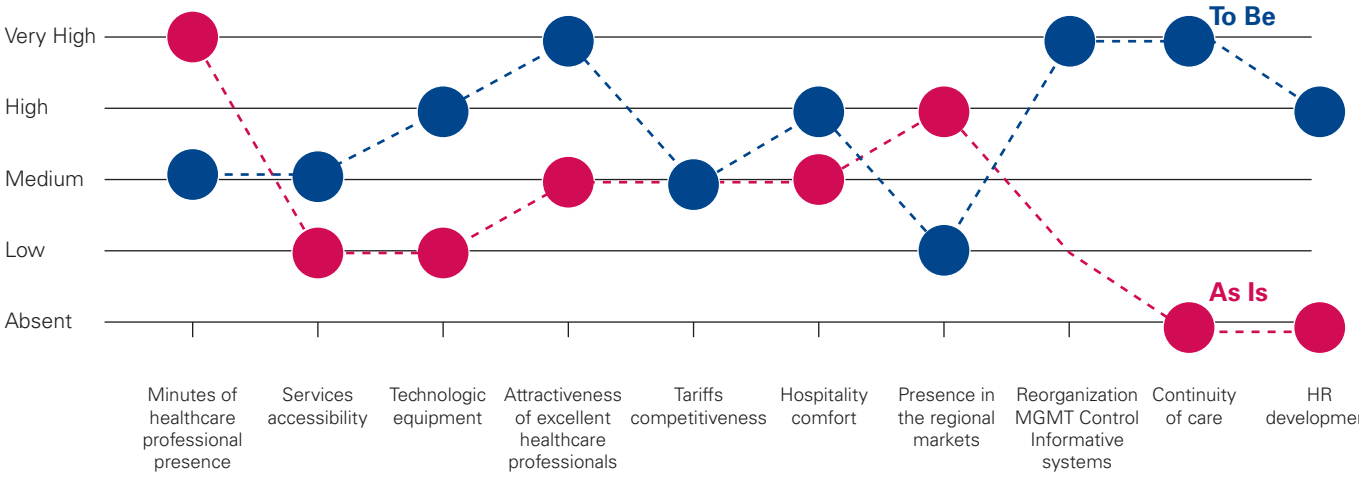
Alberto notes three key components to the Italian integration approach: creating a Care Delivery Value Chains Officer, reshaping provision through an Organizational Management Unit and centralizing non-core services.

He exemplifies the Fondazione Don Gnocchi, a provider of hospital, children's, disability and aged care services, as making particularly strong progress on integration and care coordination.

"The strong points of Fondazione Don Gnocchi lay in the diversification of the healthcare services offered and in its territorial fragmentation: together they constitute an essential asset that has the potential to let Fondazione Don Gnocchi become the first Italian provider to provide true continuity of care."

Figure 1 shows what the Fondazione strategy looks like in practice.

Figure 1: Fondazione Don Gnocchi strategy



Source: KPMG in Italy, 2015

However, New Zealand's strategy is quite different. Here, District Health Boards operate as all-in-one commissioners, providers and market managers, fostering integration through the abandonment of all forms of marketization in favor of a 'one system' approach.

One Board in Canterbury, NZ, can point to improvements in finance and access without serious impact on quality as a result of organizational integration. Contracting has become more 'relational' rather than transactional, and they have been able to achieve greater control over services for long-term conditions and greater engagement of primary care.

Countries are using PNAs to open up new markets

In Germany, PNAs have led to considerable market movement through mergers, takeovers (e.g. of local authority hospitals) and revenue. High quality hospital and health service chains have evolved through this process — often funded by private equity. The largest of these is the Fresenius-funded Helios group.

The Sana group, the third-largest private-sector hospitals operator in Germany, has sold two hospitals in regions where they felt they could not be strong. This reflects clever positioning and recognition of limitations.

As Wolfram Wildermuth, Partner, KPMG in Germany and previously Sana's Chief Financial Officer, says,

"We are committed to developing our profile in parts of Germany where we can concentrate our expertise, where we understand all the components of the health environment and can thus partner with public health services properly. This is so we can deliver on our commitment to quality, effective operations and strong finances. Where we are less certain about these factors we prefer not to invest."

The Asia-Pacific market is quite different. With emerging economies, such as Indonesia and Malaysia and established economic hubs such as Singapore, consolidations and expansions into new markets are an equally striking feature.

Singapore operates a public hospital system and it is also home to IHH/ Parkway, one of the world's largest private hospital chains. It targets a customer base among the emerging affluent within and beyond Singapore's borders, including Indonesia whose citizens generate 1.5 million overseas consultations a year and treatments valuing US$10 billion.

CEO Dr Tan See Leng describes how the company adapts in each new country to different market conditions, working under different payer arrangements, sometimes competing with existing providers, sometimes collaborating.

"As a healthcare company, clinical quality and patient safety are our core values and are deeply engrained in our culture. Quality indicators are measured in all our hospitals and reported to the highest level. We rely on the trust and recognition of our brand standards for our success and ability to attract talent."

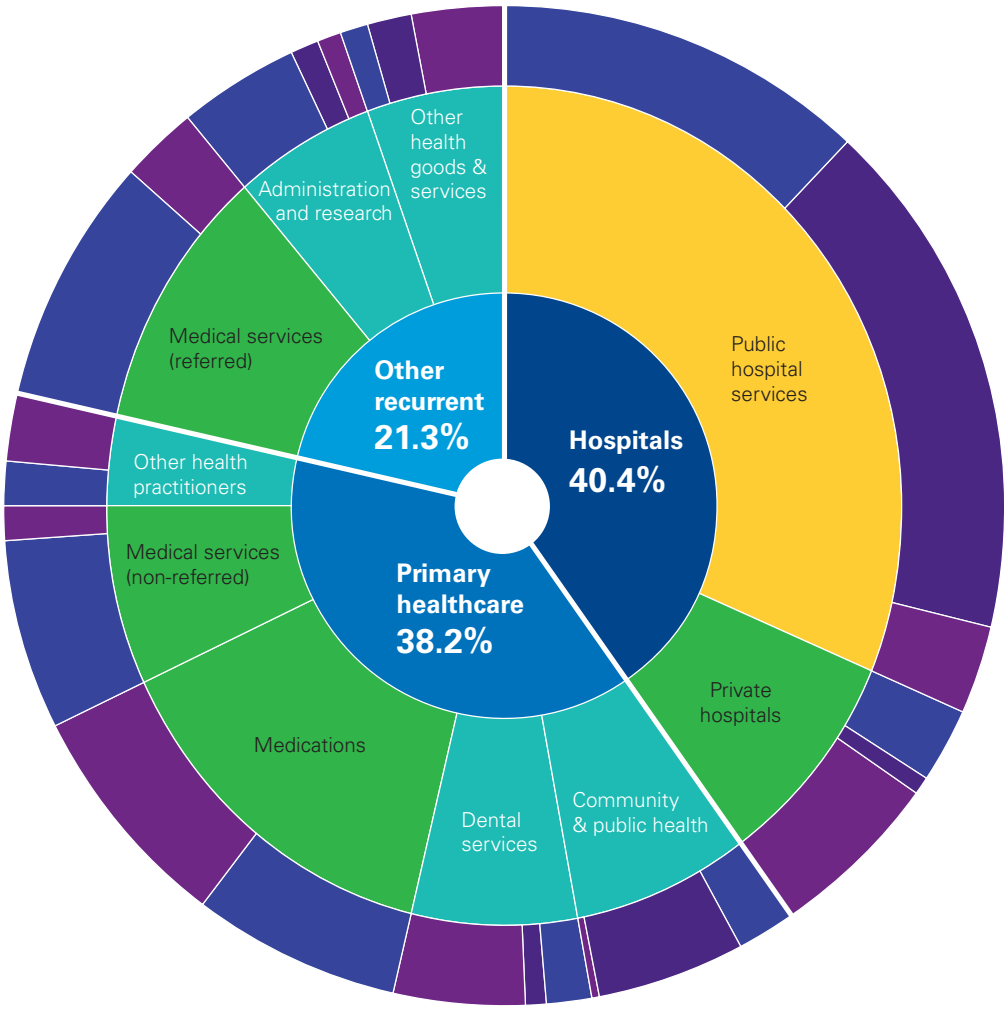
PNAs are helping government and the private sector work together

Australia is often perceived as a public payer — public provider environment, but a closer look reveals a complex and intricate picture of partnerships and co-existence.

In recent years, the balance has shifted through the developing policy of contestability in New South Wales, Queensland and Western Australia (already operating in Victoria). Here a growing range of publicly funded services, including some clinical services are subject to market testing and outsourcing (see figure 2).

Figure 2: Australia's healthcare sector

The structure of Australian's healthcare sector should not be considered as binary — mixture of public, private and NGO providers is established and should continue



Share of expenditure
- Hospitals
- Primary healthcare
- Other recurrent

Responsibility for services
- Combined private sector and public sector – all levels of government
- State and territory governments
- Private providers

Funding
- Australian government funding share
- State/territory government funding share
- Private funding share

Source: Australia's Health 2014, Australian Institute of Health and Welfare

PNAs spread improvement and innovation

In the National Health Service (NHS) of England, both providers and payers have linked together into 15 Academic Health Science Networks. The intention is to ensure adoption of proven innovations across health systems. In other words, 'leveling up' standards.

These innovations are either locally produced or identified more generally. The key will be how far innovations from 'islands of excellence' can be implemented across other providers in a regional system.

It is early in the journey of these networks and they are a bold attempt to challenge the concept of organizational sovereignty which has been the hallmark of provider development in the NHS.

Another policy being pursued by the NHS is the horizontal partnering of 'successful' providers with 'unsuccessful' ones. Challenged organizations that fall into the 'special measures' category have been able to select 'buddy' organizations to help them work their way out of trouble.

For instance, University Hospitals Birmingham NHS Foundation Trust has buddied with Medway NHS Foundation Trust after the quality regulator, the Care Quality Commission, labelled Medway as inadequate in July 2014.

The early signs are not promising. While this opens up useful contacts and understanding within the challenged organizations, at the time of this report, none had moved out of the special measures category.

Consider:

- Do you understand your market conditions and market signals prior to a PNA activity?
- Does your PNA work reflect those conditions?
- How can you lead as well as follow the market?

Focus on quality, not size or money

While there are often strong financial motivations behind organizations wishing to work closely together, these should not be the overriding motivation for PNA. Reactive, finance-driven activity often fails to take hold once the initial compulsion fades.

Partnerships, networks and alliances can be divided into two broad categories – proactive and reactive.

For example, in the US, a new wave of PNA activity is being driven by the Affordable Care Act (ACA). Larger systems are extending their reach into the growing insured population, and smaller hospitals perceive the benefit of partnering or ownership by the larger system in order to leverage resources towards sustainability.

This could be described as activity rather than success. It is a response to current policy initiatives or the quest for financial sustainability. It follows rather than leads (reactive).

The Yale New Haven strategy, on the other hand, has a much broader foundation, seeking to achieve better value in terms of quality, cost and population health; embedding financial aims as a part of its wider mission — an important but not dominant consideration of the strategy.

In the Netherlands, success is planned rather than emergent, and no less dependent on thinking beyond simply size and money.

An insurer, Menzis, has a goal for a high-performing triangle of access, quality and affordability. Working with the care system redesign methodology from KPMG, it has created a collaborative process between providers in the north east of the country to shift services and create more out-of-hospital alternatives.

This process is grouped into three themes:

— a regional vision for integrated care

— an analysis of optimal portfolios for each hospital and paths for co-operation between them

— an analysis of optimal hospital capacity.

Good from bad: PNAs as a response to failures in care

Children's Healthcare Networks in New South Wales, Australia provided a study of new networks driven overwhelmingly by the intention to improve health and health services, as opposed to 'empire building'. In response to high-profile hospital service failures and a state-wide inquiry, two levels of network for children were established in 2011.

The last decade has witnessed serious quality failures in a number of health systems — Mid Staffs Hospitals NHS Foundation Trust in the UK and hospitals in New South Wales, Australia, for instance.

The formal reviews of these have prompted major changes in partnerships and networks. In NSW the Garling Report of 2008, recommended the integration of children's services into networks.

In addition the Healthcare Reform Act of 2011 required the creation of statewide children's services to ensure access, linkage and continuity so that no group or geography is disadvantaged.

This culminated in two levels of network for children: one between the major children's hospitals (Sydney Children's Hospital Network), and another to coordinate primary and community services across the state (NSW Kids and Families). The hospital network has a broad-based strategy focused on collaboration and integration across four domains — clinical care, research, education and advocacy. These clearly add up to a focus on sustainable quality.

So, while clearly regrettable, major service failure can generate the new partnerships, networks and alliances needed to drive quality. One downside of this can be a lower chance of success if PNAs are engineered by government rather than naturally occurring.

Nevertheless, in the case of NSW Kids and Families, the quality focus means they are not perceived as evidence of creeping bureaucracy or political interventions. This is largely because of their transparency and capacity for self-reflection. NSW Kids and Families, for instance, goes regularly to the market for evaluation of its current programs and advice on the creation of new themes.

Consider:

— What are the drivers or motivations for PNA targets?

— How will you test these drivers?

"Health networks are more successful when the Boards, physician leaders and executive teams demonstrate low self-interest and a relentless focus on improving care for patients. Unfortunately, there are too many cases of leaders defending turf and bricks and mortar rather than integrating to improve quality, access and value."

— Georgina Black, Head of Health, KPMG in Canada

The best PNAs expand opportunities beyond their original mission

Not all PNA effort is about benefiting the originating institution and many of the most successful global partnerships develop a series of wider missions geared towards educational, social or economic goals. Three particular types stand out: international partnerships, commercial partnerships and models without government.

International partnerships

KPMG analyzed 53 educational collaborations between health service providers from different jurisdictions to look for trends and key features of success.

For the most part, these are institutions from high-income countries, most notably the US, assisting underdeveloped or emerging health systems. Some of these partnerships date back as far as the 1970s and 1980s.

Many of these partnerships are done on a charitable basis, while others are revenue neutral or even revenue generating for the originating institution.

Governments are often a key player, as with the partnership between National University of Singapore (NUS) and Duke University in North Carolina. Work commissioned by NUS identified that it needed to develop a postgraduate medical course, particularly if it wanted to develop the physician-scientist role.

Thus equipped, it could strengthen its contribution to the Singaporean economy and to the quality of clinical services at the National University Hospital. It identified Duke's MD/PhD program as highly relevant. An agreement was reached in 2005, for Duke to support the postgraduate program with US$100 million over 10 years.

Similarly, the Ministry of Health in Kuwait in 2010, went out to the North American market looking for a partner to secure sustainability for the Comprehensive Cancer Centre in Kuwait City. Without such a partner, its workforce would lack experience (and probably interest) to deliver services locally and thus the tendency for Kuwaiti citizens to travel for treatment would continue.

The Ministry selected and contracted with the UHN in Toronto (see page 10 in this report). Contributory to the decision was a view that the UHN would be more likely than institutions with pre-conceived educational packages to adapt to the cultural requirements of Kuwait (for instance, email is not a preferred form of communication compared to text messaging or formal communications).

These partnerships can be highly effective at developing the soft infrastructure of a strong health system and often create two-way learning (or reverse innovation) for the originating organization. Not all partnerships are simple one-to-one arrangements.

KPMG is currently engaged in identifying multiple international academic partners to assist an Indian client with ambitions to grow from an acute hospital into a major academic health sciences provider.

Nilaya Varma, Head of Health, KPMG in India, notes, "Our client is clear, for the development of a major health sciences mission, a number of partners are required. That gives us the challenge of sourcing the partners and also creating a commercial and governance structure which works for all the partners and the client's overall mission."

Commercial partnerships

The role of health organizations as economic generators is increasingly well understood. Governments in Australia, Canada, the UK and US are seeking to develop strategies to maximize the economic return of their major healthcare institutions.

One popular form of economic partnership is between health services and the life sciences industry. Our research indicates two developing trends: first, for life sciences to forge stronger alliances with universities; and secondly, for these alliances to be concentrated in fewer institutions.

The most prominent of these is the decision by Astrazeneca to invest close to US$600 million in and transfer approximately 1,000 staff to the Cambridge University Hospital. Smaller and equally significant partnerships include, Sanofi with the University of California, San Francisco; Johnson and Johnson with the University of Queensland; Novo Nordisk with Oxford University.

Relevant to the success of these partnerships is academic pre-eminence. What is also striking are the number of developments aiming to consolidate a range of partners in a single location. Examples include, the longstanding plans at Charite in Berlin, Parkville Precinct in Melbourne and Liverpool in the UK.

For Aidan Kehoe, CEO of the Royal Liverpool and Broadgreen NHS Trust, this raises interesting challenges of working with and evaluating the capability of academic and commercial partners.

He places high value on the personal relationships between the key leaders and notes how particularly important this has been for his work with Liverpool University. The relationship permits candor which in turn enables realism about the partnership. It also helps the management of potentially conflicting or ambiguous objectives.

Other partnerships operate as part of health science-related economic zones. The University of Maastricht, embedded in the most economically productive region of the Netherlands, with its associated university hospital, was launched in 1976.

It is closely linked to the Brainport Eindhoven technology initiative and neighbor to a range of health technology companies such as Medtronic and Phillips. Its services and science are closely aligned to these industries with a focus on cardiovascular disease and neurosciences.

Non-government models

When it comes to wider social contribution models, those countries with either Bismarck or Beveridge based health systems, or the US aiming to increase the insured population, would say they are underwriting or increasing the social relevance of health services.

But what is interesting within some countries is where the healthcare model works successfully *without* articulation by the state.

In India, Apollo Hospitals has for some time worked on extending reach from primary through to tertiary care in many cities. In recent years it has become a payer as well as a provider. The intention is to increase access to services through low-cost health plans. By doing this, it effectively creates a health system independent of the state.

Successful models for low-cost healthcare, independent of the state, are even more striking in Africa. Here, organizations such as PharmAccess, have created models of usage for grants and private equity funds to secure health insurance cover for 110,000 people across three sub-Saharan African countries. Investments in specific donor programs, e.g. for HIV, malaria, tuberculosis, are structured through risk equalization mechanisms to pool risk more effectively.

This in turn encourages investment into the health supply chain and the introduction of technology and services based on the size of the insured populations to create scale and thus a return.

Dr Onno Schellekens, Managing Director of PharmAccess, states that private equity is demonstrably superior to the state in the development of access to, and delivery of health services in Africa.

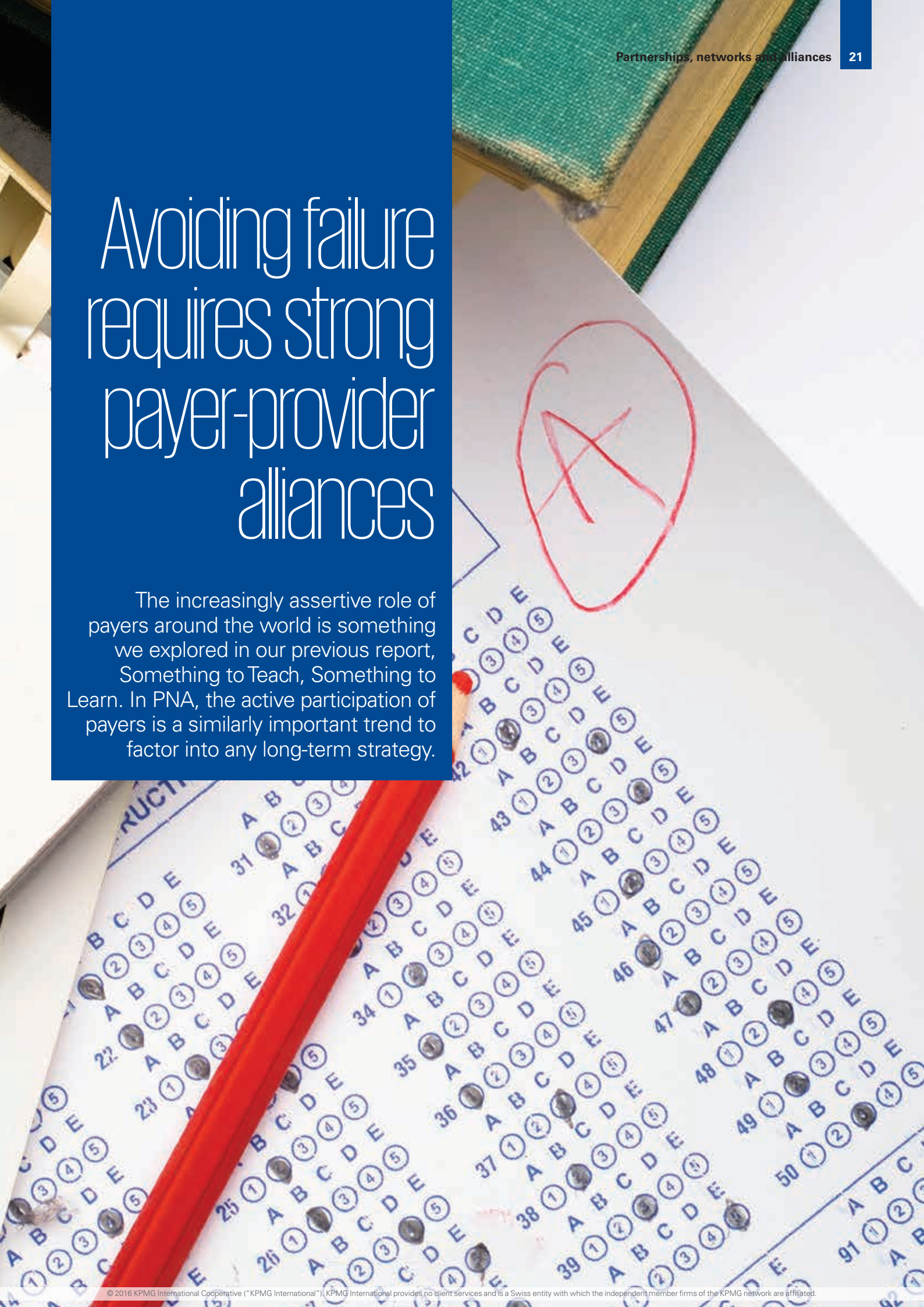
"These schemes initially offered solidarity based on disease risk while enabling the development of an efficient private supply chain through insurer-provider contracts, which allowed the willingness to pay for healthcare to increase. As a result, a shift took place from systems with a large share of expenditure financed out of pocket towards systems with a high risk pooling and prepayment element."

Consider:

— What are the benefits beyond your own organization you want from your PNA activity?
— How will you measure those benefits?
— How will this create value for your organization?

Avoiding failure requires strong payer-provider alliances

The increasingly assertive role of payers around the world is something we explored in our previous report, Something to Teach, Something to Learn. In PNA, the active participation of payers is a similarly important trend to factor into any long-term strategy.



The importance of 'activist payers' is a vital consideration for future PNA activity as these frequently play a vital role as brokers of various kinds of collaboration:

— convening players to review and reshape their markets

— care system redesign

— to create data, governance, safety and quality clusters.

Convening players to review and reshape their markets

A number of successful payer-provider collaborations involve the convening of local and regional players to make shared decisions at a system level.

These 'information alliances' are a key stage in the progress towards the free flow of data and the opportunity to convert this into useful information to be shared across a health system.

While this has previously been thought of as a feature of largely public systems — Australia, Canada, New Zealand and the UK — other countries are now finding ways to make this happen, such as the creation of ACO-type arrangements in the US.

These PNAs help bring academic and clinical expertise to key health problems and provide a means of balancing rather than denying commercial or financial imperatives.

One leading example of such payer-provider collaboration is the Optum Labs experiment — part of the United Healthcare group in the US.

The Labs provide a safe environment for groups of payers, providers, life sciences companies and academics to come together, pool identified data and contribute ideas for research and innovation.

Certain rules ensure the management of commercial incentives – pharma companies are not permitted to research their own drugs for instance. Clusters of organizations with common ideas and interests can group together as semi-autonomous units to pursue specific themes, such as congestive heart failure.

Optum Labs make joint agreements on intellectual property. They are beginning to contribute sponsorship to these initiatives. So the conditions are available to form a mini-health system process for research, development and innovation.

Some of the conditions of their success are explained by Paul Bleicher, Optum Labs' CEO:

"Academic institutions are bringing academic talent, research, etc. The non-academic providers bring the willingness to take some of the things we've found in the clinics and bring them into clinical transformation — the management of diabetes, chronic heart failure …You can build a program to see if it improves … but all of this requires providers to put part of their organization into a test environment."

This is not without challenge for the providers concerned. But in an environment without alternative means to experiment at scale on what works, for providers, a remarkable opportunity is available through the Optum Labs collaborations.

Care system redesign

Some payer-provider collaborations go further — focusing on large-scale redesign of care systems and services, in partnership with providers. In this report we mention Dutch insurer Menzis (see page 17), and the rebalancing of the roles of hospitals, primary and community care.

There is also the work of DFZ in Friesland, Netherlands, to create a distribution of clinical services that is relevant to populations but also clinically safe. It has been the payer which has lead the provider change process and managed public and political opinion.

Some of this — such as the reduction in scope of cancer services and the transfer of some obstetric and maternity services in several hospitals — has been highly contentious. But the relationship with provider effectiveness is clear and compelling.

Create data, governance, safety and quality clusters

In the Academic Health Science Networks (AHSNs) in England there is a strong push to level up service quality to that of the best hospital in the network.

For example, with University College London (UCL) Partners there is a mandate to raise standards in outer London and Essex hospitals to that of the leading partner UCL Hospital. This complements the direct payer-to-provider relationship for those hospitals by exposing clinical collaborations in a way which addresses professional ambitions.

If this is to work, UCL Partners and the other AHSNs will need to demonstrate governance which reconciles their strong excellence imperatives with the sovereignty of the individual member organizations. If they succeed, we have an exciting new organizational form.

Contestability driving market diversity

Elsewhere in publicly funded health systems — such as Australia — we see a strong push to contestability, where historically publicly-provided services are market tested to give an opportunity for new entrants.

State payers in Queensland, New South Wales and Western Australia are increasingly required to offer up a range of services to for-profit and not-for-profit providers. This creates two levels of opportunity: first, the potential to reduce cost through competitive tendering, and second, to stimulate all providers in the system to raise their game and become more efficient.

This process of market pluralization is visible at the new Lady Cilento Children's Hospital in Brisbane, the Sunshine Coast Public University Hospital in South East Queensland, and Sydney's Western Health District, among others. But it comes with challenges. State providers have to learn to be part commissioners of services and effective contract managers — a new skill. It is too early to declare victory, but the concept of local hospital boards as mixed market managers is exciting.

Consider:

— Does your strategy map to payer strategy?

— Can you create a safe environment with payers to consider PNA initiatives?

Tension, flexibility and self-criticism are more important than the model

Organizations exploring PNAs often become fixated on the model they should use — often ignoring the more important considerations.

The model is important. However, most important is whether the model fits the context. For instance:

— Does the model create sufficient tension for desirable change, such as quality improvement and appropriate service redistribution?

— Is the model sufficiently flexible to avoid imprisonment through its funding sources, e.g. state payment systems based on hospital activity?

— Is the model sufficiently self-critical in its governance (especially clinical governance) to understand and deliver on change requirements?

What this means for CEOs and Boards is that for PNAs to work, they need to think in 'systems terms'.

The unit of analysis cannot simply be the institution. It has to take into consideration the wider ambitions and constraints of all players.

This is often at odds with low-risk approaches to corporate governance driven by narrow performance parameters, such as short-term fiscal measures and operating process targets.

So healthcare CEOs often face a tension between how their organizations are rewarded and the behaviors on which their sustained development depend.

For Aidan Kehoe, CEO of the Royal Liverpool and Broadgreen Hospitals in England, a number of conflicts threatened to block the development of a 'health precinct' around the largest of the organization's existing hospitals.

Their plans aimed at securing long-term health and wealth creation for the city and beyond. It now comprises:

— an 'accelerator' facility to house start-up life sciences companies

— the relocation of a tertiary cancer hospital onto the campus

— the assimilation of research and other activities into a 'Knowledge Quarter'

— furthering their relationship with the Northern Health Alliance — a regional collaboration of eight universities and eight university hospitals.

The complexity and tensions presented by these ambitious plans were significant, but for Kehoe the most important thing was to focus on the long-term goal of improving the health of the people of Liverpool.

The model, business case and multiple compliance requirements of regulators and other authorities could then all be developed around that strategic vision.

He lays strong emphasis on the skills needed of himself and his colleagues. "Most good teams can manage the day-to-day, but different skills are needed to stay with the big picture and to build the relationships necessary for all the collaborations and partnerships concerned."

This system lens through which organizations and their leaders must look for success was identified by Katz and Khan in the 1970s, Senge in the 1990s, and many commentators since.[6, 7, 8]

The challenge for leaders in the coming decades is to choose and stick to a sustainable path and protect it from the tyranny of the present.

Consider:

— Have you addressed the questions on context listed in this section?
— Have you understood how your organization will be changed by PNA activity?
— Have you clarified your internal capability to deliver PNA activity?

6. Katz D and Khan Robert L. The Social Psychology of Organizations. New York. Wiley. 1966.

7. Senge Peter M. The Fifth Discipline: the Art and Practice of the Learning Organization. New York. Doubleday. 1990.

8. Hofstede Gerd. Cultures and Organizations : Software of the Mind. Administrative Science Quarterly 38. 1993.

KPMG Partnerships, networks and alliances maturity matrix

PNA is becoming an ever more vital part of the long-term ambitions of healthcare organizations. The following matrix is a tool organizations can use to assess their level of sophistication and identify those success factors where they are most strong and those where they most need improvement.

(5=high; 0=low)

Maturity level	**5**	**4**	**3**	**2**	**1**	**0**
Successful PNAs require a long-term strategy	All past, present and future PNA activity is reviewed in the context of the overall aims of the organization	Placing PNA activity at the heart of the organization's overall long-term strategy.	Development of a strategic approach to PNA by the Board, linked directly to wider purpose and objectives	Recognition of the range of different forms that could exist with different kinds of partners	Board discussion about developing a relationship with another health care organization	Your organization believes that it can succeed on its own
PNAs are driven by innovation, coordination or new markets	Being a go-to partner for other organizations who want to develop PNA activity. Saying 'yes' and 'no' to these according to the overall strategy.	Successfully engaging in new PNA relationships to secure better positioning and start shaping the market.	Having identified common goals with partners, assess what factors are really likely to determine success or failure	Rigorous analysis of which barriers and restrictions to PNA are truly insurmountable, and which can be innovated round	Board scans existing market to see which forms of PNA are operating successfully	Your organization believes that current system conditions dictate its ability to innovate by forming PNAs
Focus on quality, not size or money	Your organizational strategy for improving quality rests upon a constant search for new and deeper PNA relationships	In reviewing its PNAs the Board recognizes that some improve quality more than others, and cuts or reforms those than are less successful	Board develops strong clinical governance across different forms of PNA with different organizations	Small scale, ad hoc and informal quality improvement PNAs are allowed to develop — often at the level of individual clinical teams	The Board recognizes that quality improvement will need a set of relationships that go beyond your organization.	Your organization does not believe it needs other organization to improve quality

Maturity level	5	4	3	2	1	0
The best PNAs expand opportunities beyond their original mission	Your organization reviews and develops its strategy for different PNA relationships with economic educational and social organizations as a part of your overall mission	From its PNA work with non-healthcare organizations your Board develops a new, broader purpose including economic, educational and social elements	Board develops new forms of PNA governance with a range of very different non-health care organizations	You start to approach organizations with very different missions in order to create PNA relationships that achieve shared goals	The Board recognizes how other health care organizations are succeeding through developing wider missions and explores this issue	Your organization has a narrow conception of 'healthcare', and avoids straying beyond this.
Avoiding failure requires strong payer-provider alliances	Your payers look to you for alliances which will lead innovation in health are outcomes	Your innovations in health care help set the strategic innovations for your regional market place	Your strategy and your payers strategy are developed together	Your joint Board-to-Board meetings with the Boards of your payers to look for joint strategic confluence.	The Board takes into account all your payers' strategies in developing its own strategy	Your organization is at best at arm's length from its payers and at worse in conflict
Tension, flexibility and self-criticism are more important than the model	Staff from the top to the bottom of your organization understand the system-wide purpose of their work and feel they can question deviations from this	The governance models of PNAs allow space for organizations to challenge short-sighted behavior or misalignments on the part of other partners	PNAs feature, are assessed on and even rewarded, based on broad system-wide metrics	The organization signs up to a meaningful 'big picture' vision shared by many partners across the system	The Board assesses your organization's goals against those of the wider system and society	Your organization accepts the limits of its own organizational structure as the limit of its organizational experience

How KPMG can help

The six success factors outlined in this report distill some key lessons from the work completed by KPMG member firms with healthcare clients around the world to create PNAs with purpose. KPMG member firms are helping organizations identify long-term goals and design the strategies to get them there. A global perspective makes it easier to see pitfalls coming and identify when key contributors to success are missing.

1 Developing a PNA strategy

— Creating a strategy from scratch
— Refreshing an existing strategy
— Shaping for your Board, payer and regulatory environments
— Building a PNA culture at key organizational levels
— Partner assessment
— Support for difficult market conditions
— Comparative environment assessment

2 Due diligence tools for M&A activity

— Target performance assessment
— Target quality assessment
— Target capability assessment
— PNA maturity and readiness assessment
— Market assessment

3 Development of PNA governance

— Commercial structures for different PNA categories
— Creating effective networks
— Creating effective alliances
— Organizational systems, processes, data and performance management needs
— Skills and characteristics for PNA
— Ambiguity management

4 Working on PNA with payers

— Engaging with payers for PNA convergence
— De-risking PNA for providers
— Workshops and scenario planning
— Data sharing for mutually assured construction

5 Support for wider PNA missions

— Economic planning with academic health science systems
— International missions in service, education and/or research
— Health and related industry cluster development
— Health precinct development

6 Information alliance development

— Using partnerships for data volume
— Recognizing and leveraging your IP
— Identifying information benefits
— Opening new safety & quality and research possibilities
— Risk sharing with information partners
— New world information governance

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Georgina works closely with boards, executive teams and diverse stakeholder groups to develop strategies to improve performance. Throughout her career, she has led several transformational projects (mergers and acquisitions, restructuring, governance and program reviews, shared services and organizational design) in the public sector to improve effectiveness and efficiencies within complex stakeholder environments. Through her work with provincial, local governments, not-for-profits and healthcare organizations, she brings a systems perspective to identifying and addressing cross function, organization and sector opportunities. Georgina is an Advisory Partner in Canada, national Sector lead for Health and member of KPMG's Global Healthcare Steering Committee. She has 20 years of experience advising organizations in the areas of executive governance and leadership, strategic planning, performance improvement and complex organizational change.

Alberto De Negri, Partner, KPMG in Italy

Alberto has more than 20 years of experience working within healthcare. He led many projects redesigning the network of services and seeking opportunities through cost reductions. His advisory work with regional and local health authorities has led to improved efficiency and effectiveness in hospital and community care. Alberto has been advising the Italian Ministry of Health for 15 years. He was the project leader for the design of the Italian national health information system, balancing cost and quality in healthcare service, and for the national project "the bricks of the National Health Service", developing shared methodologies and classifications across the Italian NHS.

Dan Harradine, Director, KPMG in Australia

Since joining KPMG in 2013, Dan has worked on major transformational projects ranging from large-scale engagements which have re-invented service delivery models, governance processes and linkages that achieve major performance improvements at a whole-of-health system level, through to specific engagements that have achieved precise outcomes aligned with policy objectives. He has designed network and partnership arrangements for organizations to allow health systems to leverage the benefits of scale, while concurrently allowing organizations within the systems to maintain their individual flexibility. As an economist with formal qualifications in business management, and with practical experience working at senior executive levels within healthcare organizations and government agencies, Dan has a unique ability to develop and translate strategy into real, practical solutions. He is a Director in KPMG Australia's Health, Ageing and Human Services sector, and leads our health advisory services in Queensland and the Northern Territory.

Dr. Anna van Poucke, Partner, KPMG in the Netherlands

With extensive experience in transforming healthcare systems, Anna has been at the forefront of care integration, hospital restructuring and mergers, enabling the turnaround of several underperforming hospitals in the Netherlands. Her work aims to help in the creation of high value healthcare: more efficient healthcare systems with a focus on the outcomes and accessibility of healthcare. Anna joined KPMG in 2010 and holds a PhD in Economics from Erasmus University, Rotterdam, an Mphil in Economic Sciences from the University of Wales, Cardiff, and an MsC in Labor and Organizational Psychology from University Tilburg. @AnnavanPoucke

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Nilaya has over 18 years of experience advising State and National Governments improve public service delivery and help build IT and Physical Infrastructure. Nilaya Has been involved in some of the largest Government Transformation Projects in India. He has also been involved in the design of very large Public Private Partnership (PPP) projects for eGovernment and Physical Infrastructure. Nilaya had worked across over 15 countries including India, South Asia, Vietnam, Middle East, Africa and CATRAC countries.

What Works: A series of thought leading reports from KPMG Global Healthcare

The need for change in healthcare is well understood. There is also an increasing consensus about what needs to be done to address these challenges:

— a focus on quality, safety, controlling costs and improving population health

— a move from the emphasis being on the volume of treatment toward ensuring high-value care

— activist payers working with patients and providers to reshape the system

— the development of new models of delivery including increasing convergence between healthcare payers, providers and the life sciences industry

— reaching out to patients and communities in new ways.

The question is how to make these changes happen. We argue that there are a number of changes of both mind-set and capability that are required across a number of areas. These include:

— creating systems to drive clinical and operational excellence

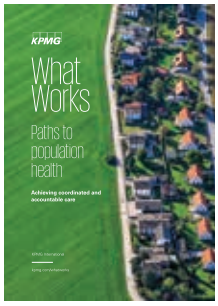
— developing new models for coordinated care and population health.

— growing the ability to contract for value

— creating new partnerships and networks

This report looks at the last of these and makes a strong case that organizations need to identify long-term goals and determine the strategies to get them there.

For more information, or to reserve your copy of future **What Works** reports, please contact your national partner, see back cover, or email: healthcare@kpmg.com or visit **kpmg.com/whatworks** for the latest report.



What Works: Paths to population health — Achieving coordinated and accountable care

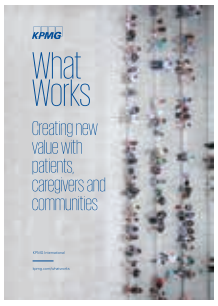
Health needs are changing fast, but systems are simply not keeping up. It is clear that organizations are struggling to convert theory into practice. This report describes the practical steps that organizations need to go through to reshape themselves and their services.

kpmg.com/pophealth

What Works: As strong as the weakest link — Creating value-based healthcare organizations

Organizing care to deliver value for patients requires change in five main areas. Start with a clear vision and understanding of what value means and focus energy on cohesive action across all the areas. This report focuses on the different lessons drawn from work done with clients and discussions with providers from all over the world.

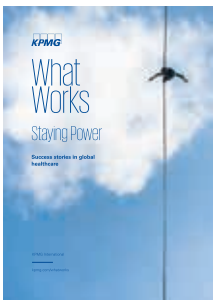
kpmg.com/valuebasedcare



What Works: Creating new value with patients, caregivers and communities

Globally some parts of healthcare are beginning to make the changes that will involve patients, carers and communities more fully in their own healthcare. Using our experience across the world, this report outlines the answers that you need to fully realize the value inherent in better patient involvement and communities to improve care.

kpmg.com/patientvalue



What Works: Staying Power — Success stories in global healthcare

KPMG gathered together 65 healthcare leaders from 30 countries across 6 continents to discuss effective strategies for successful transformation. These discussions were centered around 7 key themes ranging from population health and accountable care to clinical and operational excellence. This report summarizes the insights shared between organizations, cultures and countries.

kpmg.com/stayingpower

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