



# CURBING THE COST CURVE IN HEALTH CARE: PLUGGING THE LEAKAGE

## Overview

In this perspective, we look at one of the most daunting challenges facing health care systems today across the globe: the steadily rising costs of health care. We look at health care systems from a proprietary framework of funding flows, identify the most common “leakages” in the system, and propose ways to address them using principles derived from our case work and experience.

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# 1. Executive Summary

The findings in this study are addressing the basis of organizing healthcare systems and hence, are fundamental in nature. Consequently, the findings on how to organize effective and efficient healthcare systems are even more valid in a post-Covid-world. Health care costs across the globe have been steadily rising and the high cost of health care is having major implications on services provided to citizens and on the economies of countries worldwide.

This report outlines a framework to identify and prioritize the various “leakage” points in health care systems and proposes a variety of ways to address them. Our framework looks at health care systems as *flows* of financial resources—from the sources that **fund** the system, to the **payment** mechanisms, to the way services are **provided** and, finally, to how services are **consumed**. Essentially, we explore both the supply of health care services and the demand for these services. Our framework applies to all health care systems, whether publicly funded or privately funded, fee for service or budget-based, public or private providers. Our framework points to integration and collaboration among stakeholders as key to improving value for patients and rooting out inefficiencies in the system. In the era of value-based health care (VBHC), a constant drive to improve outcomes and reduce/control costs is essential.

This paper provides a deep dive into some of the biggest and most common issues facing health care systems worldwide and offers practical solutions along four areas of the health value chain: funding, payment, provision, and consumption.

## 2. Introduction

Countries across the globe have built or are building sophisticated national health care systems in pursuit of what the world health organization (WHO) describes as the most important objective of all: universal health coverage. Half of the world’s population is without access to health care and those fortunate enough to have access are struggling with rising costs. More than 800 million people spend at least 10% of their household incomes on health care, while 100 million people are driven into poverty annually through out-of-pocket spending on health care. Rising costs, an unintended consequence of national systems, can be relentless, both limiting GDP growth and impacting a country’s overall economic sustainability.

Compared to other government spending—for example, on education, the environment, and the arts—health care systems have always received generous support from governments. In the past two decades, however, governments worldwide have been trying to control and even reduce their health care costs. This has led to further issues in global health systems, mainly:

1. **Less funding for education and infrastructure.** Governments are responsible for most of the financial costs of their citizens’ health care, and that spending often cuts funding for other social commitments such as education and infrastructure which advance societies.
2. **Less access.** Long wait times, especially for drugs and elective treatments, impact access and quality especially in publicly funded health care systems.
3. **Less investment in R&D.** Health care spending often leaves little money for research and development of innovative new medical technologies, the kind that can save lives. This ultimately leads to more lives lost than saved by expanded access to care.

Clearly, an aging population and the rising costs of medical services are throwing a wrench in national healthcare systems (see sidebar: [Health Care at Risk](#)). A large portion of health care costs are driven by a small portion of the population, such as people with chronic conditions and the elderly. The growth of these high-risk groups combined with rapid overall population growth in many countries are leading to a worldwide explosion in health care costs.

The pressure is on governments to redesign their health care systems—experimenting with new care models and delivery systems, developing new funding and payment models and, importantly, reshaping consumer behavior.

With current systems no longer sustainable, countries have begun a concerted effort to regain control of health care costs by “Curbing the Cost Curve” of health care. This report identifies common challenges across health care systems and proposes solutions for governments that want to optimize their health care spending and improve health care services for their citizens.

### 3. Structural Issues and Plugging the Leaks

Health care systems are generally built incrementally, with different stakeholders employing their own ideas on policy, technology, and interventions. They are often a compilation of unique offerings that can be viewed along four dimensions of financial flows: funding, payment, provision, and consumption (see [figure 1](#)). Based on our analysis of several national health care systems, we have identified structural “leakage” – which reduces the share of funding that reaches the population where it is valued most – that is common across countries’ health care systems and leakage that is specific to certain countries. The following provides a summary of our analysis along the four dimensions.

Figure 1: Health care system financial flows framework



Funding



Payment



Provision



Consumption

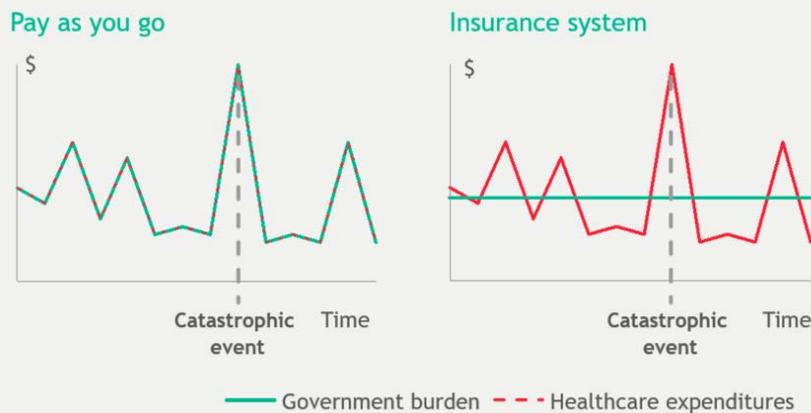
#### Funding

The main funding model for health care systems worldwide is direct government funds allocated to different players across the system. Direct models present certain advantages, for example, they are simpler and cheaper to manage. But, they also present disadvantages, such as lack of transparency, fragmentation, and disproportionate access to services. A direct funding model impacts the health of the population and drives up costs. After all, when funding is not adjusted to changes in demand the result is surpluses in some services and gaps in others.

Exposure to risk is also an issue – see exhibit 2. Unless governments purchase “risk protection” through insurance or reinsurance, they carry the full risk for catastrophic events—such as the SARS outbreak in KSA or today’s global Covid19 epidemic. These sorts of events can lead to higher costs and rationing of services.

Therefore, it is important to diversify funding sources to make these systems more resilient and ensure their sustainability (e.g., personal or employer contributions, select direct taxes).

## Exhibit 2: Illustrative representation of a “pay as you go” model vs. the insurance system



Source: BCG analysis

Another drawback is consolidating diverse funding sources into different “funds” as it impairs a government’s ability to allocate funds properly. Instead, governments that administer funding at a national level are able to optimize and prioritize resources to areas in most need rather than deal with trade-offs in a crisis. For instance, it is not unusual to shut down services in one region to provide urgent services in another. And combining funds where reasonable reduces duplication of funding and consolidates risks.

Also critical is measuring the impact of funding. This requires transparency into the utilization of funds to determine the efficiency of providers and the quality of services provided. The goal should be to allocate funds toward improved quality and appropriate services, which will contribute to the sustainability of the health care system and reduce the government burden. To do so, regulators must differentiate providers by the quality of their services, which requires tracking and reporting a minimally sufficient set of health outcome metrics against the funding provided. A good example of this is Sweden’s “Open Comparisons” system, which monitors health care outcomes and public health indicators by neighborhood and municipality.

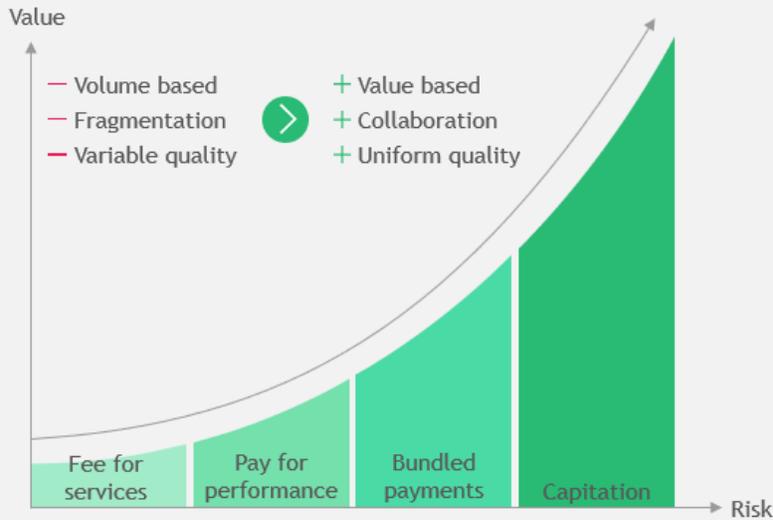
A database waste control system can help improve transparency and reduce costs across a health care system. An analysis and visualization of available data (such as claims and medical outcomes) is a powerful tool to reveal differences in providers’ overall performance, cost-effectiveness, treatment strategies, and medical outcomes. For example, a waste control system can detect overutilization of select treatments that lead to unnecessary costs and might even be harmful to patients; such systems can also compare treatment pathways to identify the most effective ones. By improving patients’ health and controlling leakage, the overall value of health care goes up.

# Payment

The way in which we pay for health services can be a source of leakage that shapes providers' behaviors and encourages a focus on volume rather than value.

A key milestone in the transition to a transparent and efficient system is minimizing use of a traditional fee-for-service (FFS) payment model. FFS models incentivize providers to focus on volume rather than value (see exhibit 3). However, moving away from an FFS model presents challenges as most stakeholders in the system (e.g., payers, providers, and caregivers) have business models that maximize personal value. Regulators should expect resistance from those accustomed to systems that reward volume as they may not be ready for systems that reward value.

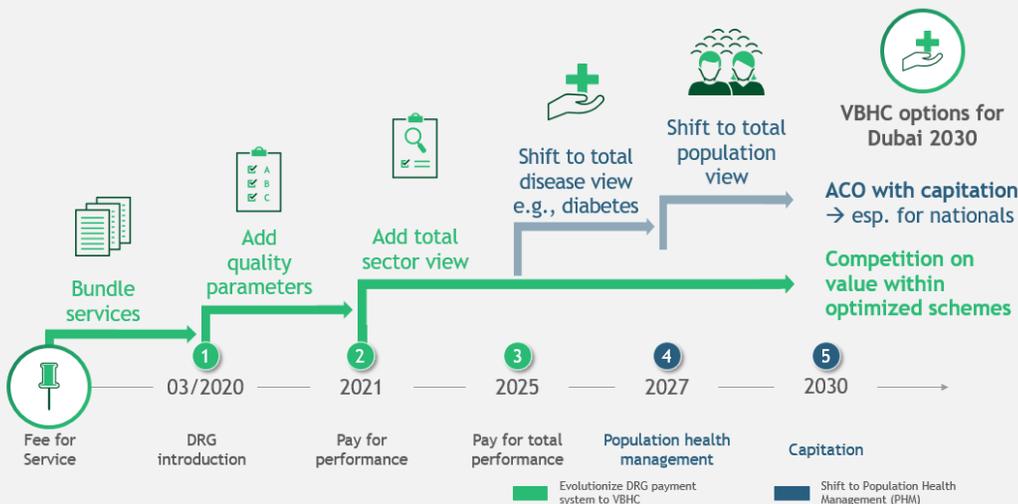
**Exhibit 3: Representation of risk and value across various payment models**



Source: BCG analysis

One possible path to value-based health care is shown in exhibit 4. However, not even in a future value-based health system, will a single payment model be appropriate for all situations or all patient groups. The challenge is choosing the right payment model for specific activities or patient groups and then bringing the different models into a comprehensive value-based payment system that incentivizes different players to display the appropriate behaviors.

**Exhibit 4: The path to value-based health care**



Source: BCG analysis

The transition to a value-based system begins with diagnosis-related group (DRG) systems and pay-for-performance (PfP) models. Both are stepping stones to accountable care organizations (ACOs) and an even larger shift to full capitation models.

DRG is a patient classification system that standardizes payments to hospitals. DRGs encourage a fixed payment from the insurance provider to the health care service provider based on a patient's diagnosis. They can be designed as a pure upside incentive to base compensation in order to limit provider risk, or they can put some portion of base compensation at risk if providers miss their performance targets. An early step in the transition could be to bundle some common and straightforward services, such as orthopedics' and maternity, and run pilots to become familiar with the new payment models.

Based on our case experience, five factors are key to operating a successful DRG system: 1) exclude high-cost drugs, medical devices, and procedures with highly variable costs (e.g., psychiatry); 2) introduce outlier financing mechanisms (e.g., upper threshold for length of stay); 3) introduce cost calculations in hospitals at the case level (to identify P/L numbers per case); 4) link DRGs to quality metrics with a financial impact; and 5) install mechanisms against upcoding, for example, an analytics-based visualization system to identify suspicious behaviors of providers compared to their peer group.

One common implementation challenge is the need for sophisticated analytics, such as financial and quality performance for each patient population. During the pilots, it is difficult to generate clinical and cost data and then link the data via an appropriate IT system. It can be a virtual Catch-22 as data upon diagnosis is a prerequisite for DRG-based payments, but the systems that generate the data are usually not set up until a DRG-based system is in place. In Estonia, for example, providers were not motivated to apply the coding scheme until the DRG payment systems were in place. Some countries find that when DRGs are accompanied by performance-based staff bonuses there is less resistance.

## Provision

Integrating health care services across providers is vital to establishing the highest quality health care systems. Information sharing across health care facilities ensures oversight and coordination among single hospitals as well as throughout the public and private sectors. All too often, medical and outcomes data is maintained in a single, standalone hospital (if at all) and is not shared. In some countries, Dubai for example, even detailed claims data is only available to some private-sector hospitals.

### Data access and operational efficiency

Access to *all* data is a prerequisite for transparency and control throughout the patient journey and is essential in avoiding unnecessary or duplicate treatments. Data access is beneficial for patients as treatments can be optimized independent of the chosen provider. Data access also helps bring down costs as overutilization and mis-treatments can be detected sooner and avoided. Essentially, access to all data helps moderate the government burden.

An even more basic but powerful topic is the sometimes poor operational effectiveness of hospitals. Many providers fail to reach sufficient levels of operational efficiency, which is typical when comparing public versus private providers. Governments can help resolve such issues by taking a central role in managing providers. For example, governments can fund efficiency programs and offer financial incentives to

Encourage providers to report outcomes, or mandate reporting outcomes as part of a national policy.

In the end, it's all about transparency. The mere act of making outcomes transparent can drive significant improvements in healthcare value.

## Advanced analytics

Investment in advanced analytics platforms will help meet the growing need for more comprehensive tracking of outcomes, costs, and overall performance. Such platforms integrate data from several sources and continually feed information to stakeholders on progress made in creating health care value. Stakeholders then have an opportunity to react. For example, a patient might choose a provider based on quality of services or one based on costs.

Yet, providers in some countries have neither the data nor the analytics capabilities to develop such platforms on their own. In these cases, payors have visibility across the system and can develop the needed data and analytics platform, which is then delivered as a shared service to providers. BCG's work with ICHOM,<sup>1</sup> for example, leveraged data through standard sets to help the Consortium develop a new paradigm focused on health outcomes.<sup>2</sup> This helped lay the foundation for other programs, such as Sweden's SVEUS, that provide comprehensive and nearly real-time data.

## Low cost, high quality care

Providers' survival in such performance-oriented systems hinges on the ability to provide high quality, low cost care. Two measures can easily contribute to this: group purchasing organizations (GPOs) and capacity-productivity systems.

GPOs optimize the procurement of medical supplies, which can comprise 20% or more of operational costs. GPOs are often used by groups of providers to negotiate contracts with vendors, unify procurement, and cut costs through aggregate purchasing. The advantage for providers is reduced costs, improved capital management, and standardized purchasing; the advantage for vendors is reduced sales and marketing costs while safeguarding access and volume commitments.

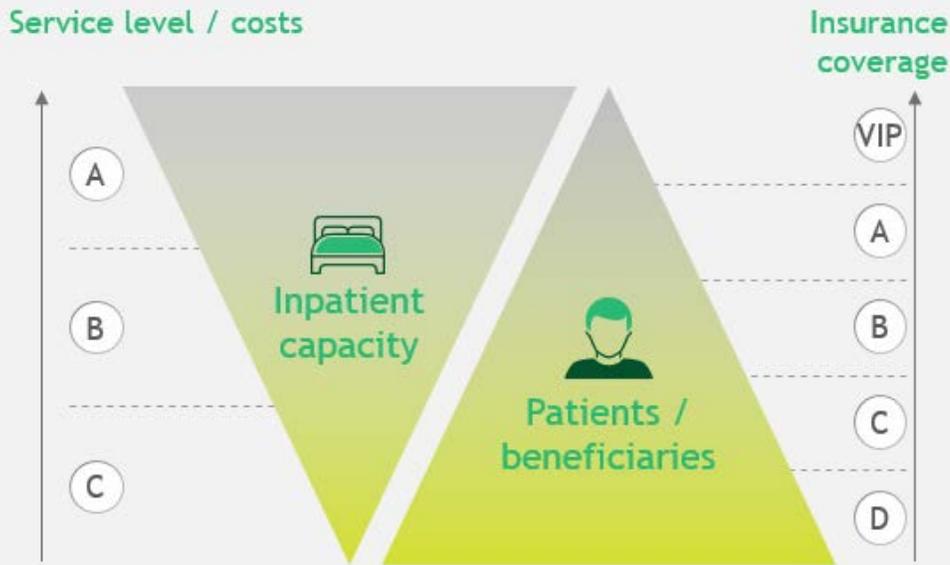
Capacity-productivity systems help providers assess efficiencies in resource allocation by evaluating core tasks, quality improvements, and supply/demand imbalances. A common issue in the GCC is a mismatch of supply and demand especially in lower tiers of insurance beneficiaries. The high margins in VIP categories indicates that most providers focus on these categories at the expense of others. [See exhibits 5 and 6](#)

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<sup>1</sup> [ICHOM](#) is the International Consortium for Health Outcomes Measurement

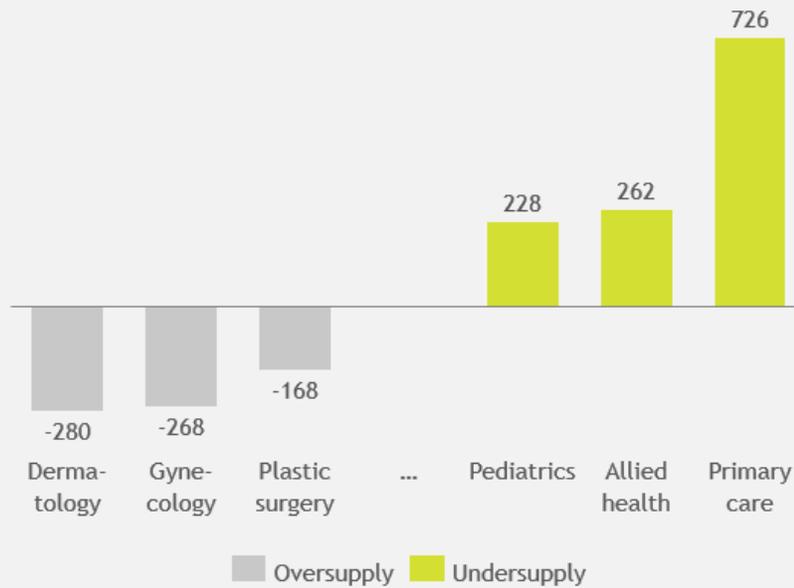
<sup>2</sup> [Paying for Value in Health Care](#), Horner, Larsson et al., Sept 2019

Exhibit 5: Representation of the imbalance of provider networks



Source: Belief audits

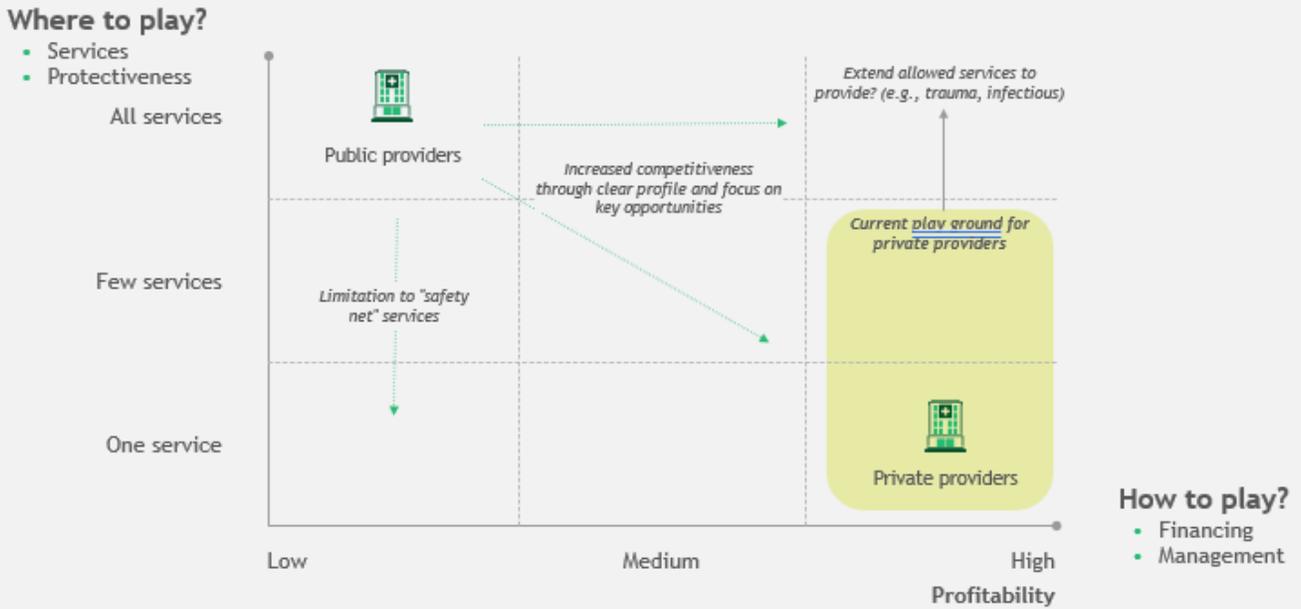
Exhibit 6: Provision gaps and surpluses by specialty: outpatient rooms by 2030



Sources: BCG analysis; Dubai Health Investment Guide, 2019

Capacity planning across a system or region is best when performed centrally. This ensures collaboration between the public and private sectors and minimizes duplication and redundancies and clarifies the role of the public and private sector providers (see exhibit 7).

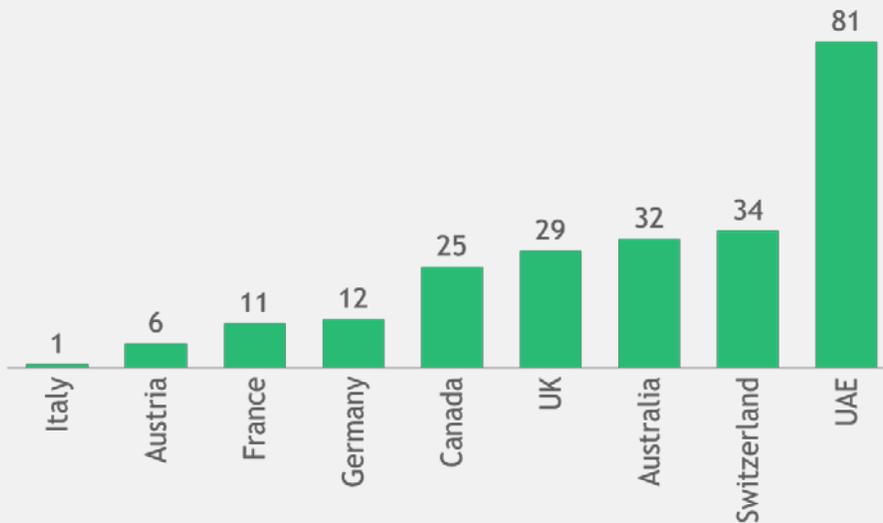
## Exhibit 7: Matrix of services to provide and depth of provision



Source: BCG analysis

Also important is investing in continuous education of health care staff to ensure everyone meets all international performance standards, especially in GCC countries which have high reliance on a foreign workforce in the health system (See exhibit 8)

## Exhibit 8: Percentage of foreign-trained doctors compared to total number of doctors



Sources: BCG analysis; OECD data 2017 for all countries except UAE; UAE figures from Health Workforce in the UAE: analytic point of view, Hannawi, et al., 2014

Shopping for health care services is a common practice worldwide. And while more tests and procedures are thought to be beneficial, the truth is, they often drive up health care services and costs without a positive return on investment. In some cases, more services can even lead to harmful outcomes for patients.

### Changing patient behavior

An awareness of health care consumption and costs is still limited in many countries, and even more so is an understanding of what true quality and value in health care means. To mitigate this, more governments are launching programs to share knowledge of health drivers in order to change patient behavior. At the most basic level, education campaigns using on- and off-line channels and leveraging media personalities can help change patient behavior. Rewards programs and digital patient advocates also encourage positive behaviors. For example, South Africa's leading health insurer, Discovery, launched a program to reward members for adopting healthier habits and lifestyles. Called *Vitality*, the program was so successful that it led to joint ventures with insurers across the globe, including Humana (USA), PruUK (UK), and Tawuniya (KSA).

Steering patients through full-care management programs, pre-authorization processes, differential co-payments, and gatekeeping are all ways to manage consumption and change patient behavior.

BCG's experience suggests that patients are becoming more health aware. Expectations and demands are involved in every step of health care. With high Internet penetration and a tech-savvy population, governments have an opportunity to promote digitized offerings, including suites of patient-focused tools. Teleconsultations, digital appointment management, and access to lab results via smartphone are just a few of the tools available to citizens. Armed with more knowledge, patients are actively engaging in their own health, well-being, and health care choices, which is leading to improved care.

### Gatekeepers vs. open-access health care

In many mature health systems, primary health care professionals, or "gatekeepers," often have the first encounter with patients' entry into the health care system (see sidebar: [Help patients control their own health care access](#)). Gatekeepers ensure that patients receive appropriate care and often help control costs by suggesting ways to avoid unnecessary secondary or tertiary care. Studies show that countries with gatekeeping systems spend less on health care as a percentage of their GDP than those with open-access health care models.<sup>3</sup> The gatekeeping function might also be handled by someone other than a doctor, such as a social worker or even an app.

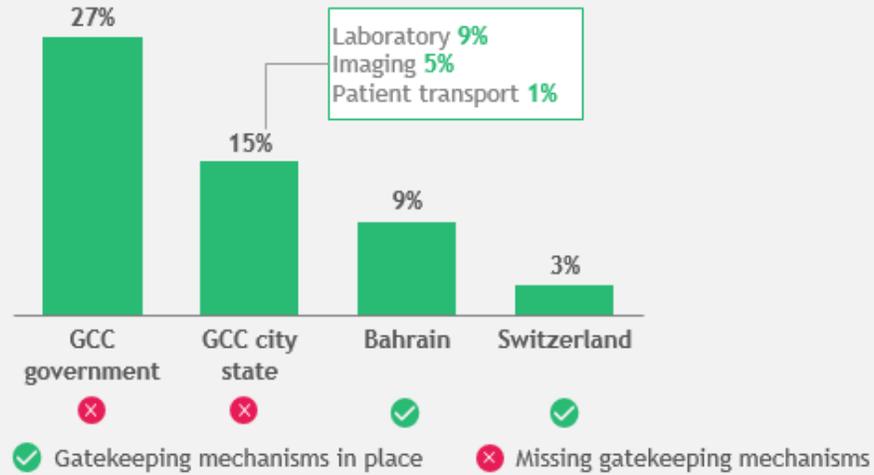
An open-access health care model has no gatekeepers. Patients go directly to a specialist even for minor conditions. Countries with no gatekeeping mechanisms will demonstrate significant amounts of ancillary spending in their overall health expenditures (see exhibit 9).

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<sup>3</sup> [Health Spending and Outcomes](#): Trends in OECD Countries, 1960-1998, Health Affairs, 2000

## Exhibit 9: Relationship between ancillary expenditures and gatekeeping mechanisms

% of ancillary/outpatient procedures expenditures from current health expenditures on schemes



Sources: GCC government data: paid claims performance in all categories, all programs; local actuarial consulting firm, 2018; Bahrain MoH financial resources, 2016; GCC city state, Switzerland data: comparison of ancillary services share from current health expenditures between Dubai (2014) and select countries (2013)

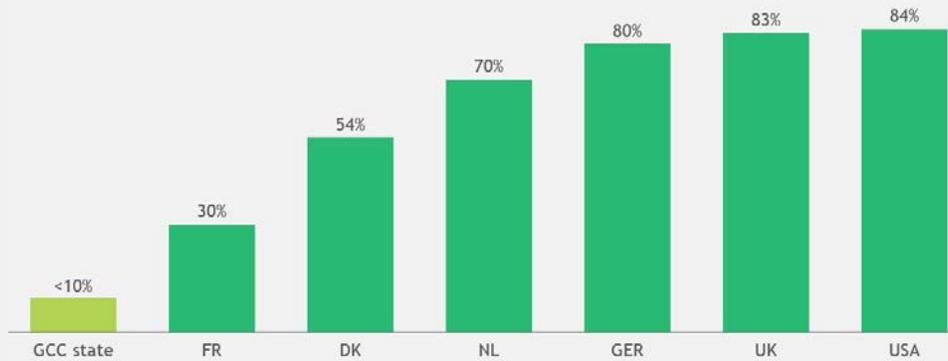
Indeed, what turns out to be a visit for the common flu can quickly contribute to the spiraling costs of health care as specialists order multiple tests and repeat consultations. This usually indicates over consumption of laboratory, radiology, pharmacy, and physical therapy services.

Countries are launching initiatives to tackle inconsistent quality of care, but more effort is needed to motivate people to take health matters into their own hands.

Changes in health policies present an opportunity to reduce costs and complexity. Two simple yet economical solutions are changes in sick leave policies and use of generic medications. Many countries require employees to submit a physician's note on the first day of sickness even for a common cold. This drives up costs, overutilizes the system, and pushes out those in medical need. Such sick leave policies could be amended to require a sick note only after 2 or more days. Based on our analysis of one country, requiring a sick note in 2 days rather than 1 day can save US\$16 million per year.

In some countries, generics constitute less than 10% of all drug prescriptions compared to more than 80% in countries such as the US, Germany, and the UK (see exhibit 10). The GCC has some of the lowest utilization rates of generic medications globally. One way to steer patients away from branded products to less expensive generics is to lower co-pays on generics. Our experience globally finds that this works well in conjunction with patient campaigns to raise awareness of the similarities between generic and branded medications.

## Exhibit 10: Percentage of generics compared to all prescriptions



Sources: BCG analysis; Comparing Generic Drug Markets in Europe and the United States: Prices, Volumes, and Spending, The Milbank Quarterly, 2017.

## 4. Case Examples

### UAE: Abu Dhabi

Abu Dhabi's health care system is regulated by the Department of Health, financed primarily by Daman (National Health Insurance Company) and includes a mix of public and private providers (of which SEHA is the state-owned provider)

#### Funding

Abu Dhabi has mandatory health insurance structured along three tiers: Nationals are funded by the government, low-income expatriates are funded partly by their employer and partly subsidized by the government, and high-income expatriates are funded by their employer

The system is primarily funded by the government. As health care expenditures continue to rise, Abu Dhabi will need to further leverage other sources of funding such as employers, individuals, and taxes.

#### Payment

In 2010, Abu Dhabi started implementation of payments through the DRG system. The aim was to stabilize rampant costs and increase transparency of hospitals. Data collection on a wide range of metrics allowed health stakeholders to measure impact and take appropriate actions to link payments to quality, thereby providing access to quality health care. The next challenge is to include quality measures in payment systems and initiate a more outcome-based approach for some diseases.

#### Provision

Health care offerings in the Emirate have increased in the past decade, largely due to rising demand and the arrival of leading private providers, such as Cleveland Clinic and Johns Hopkins Tawam Hospital. Capacity demands are expected to increase, with estimates of 29% growth in inpatient care and 27% growth in consultations over the coming years. However, there are limitations on the coverage of some service lines, notably medical oncology, home health, and long-term care. The challenge for Abu Dhabi is to control rising demand while increasing coverage levels for underserved specialties and addressing the access imbalances between rural and urban areas.

#### Consumption

Today, Abu Dhabi is a world leader in the number of internationally accredited hospitals with 178. Despite these improvements, Abu Dhabi still shows alarming levels of lifestyle related diseases (obesity and diabetes). To address this, the Department of Health has started using information from electronic insurance claims to develop disease progression models. A future challenge is to improve capacity planning by implementing real-time data monitoring to identify emerging problems and capacity shortfalls.

## Kingdom of Saudi Arabia (KSA)

Saudi Arabia has a mainly publicly financed HC system (~70% of expenditures in 2018 were public) with a strong public provision of care. In 2018, KSA spent around 7% of its total public budget on the Ministry of Health.<sup>4</sup>

Compulsory private health insurance is the law for all those working in the private sector. In 2016, in a population of 32.3 million, 12.1 million people were insured with 2.69 million of these were nationals; while the rest of the population received free public health care.

A critical point to mitigate in KSA is double dipping from dual coverage. The overlap of public and private systems means that some people have both types of coverage and utilize services from both systems.

### Funding

Despite substantial government resources allocated to the health care system, the system is increasingly under strain—struggling with rising expenditures and demand while resources remain finite. The challenges range from demographic changes, an ageing population, and more sedentary lifestyles to rising costs, higher user expectations, and changing disease patterns. The present situation appears unsustainable particularly in the face of uncertainties regarding oil prices.

With compulsory private insurance, the essential benefits package (EBP) includes a broad range of prevention services and curative outpatient and inpatient care. However, because this EBP is generous, it has a wide price spectrum and leaves a number of the population uninsured due to prohibitive costs. Changes in regulations should seek to render the EBP more competitive by reevaluating benefits and opening up a new supplementary insurance segment. Also important is balancing the trade-off of EBP coverage and its macroeconomic impact; for example, a reasonably priced EBP typically does not drive SMEs to conduct fraudulent acts.

### Payment

Payments to private providers through the health insurance system are based on a fee-for-service model that encourages over consumption of health care resources and inefficiencies. On the public sector side, the government pays public providers through annual budgets.

Saudi hospitals do not follow a unique coding system and do not consistently monitor data sets. The medium-term challenge for Saudi health authorities is to put in place a uniform process for coding that is used by all providers. In the long term, KSA should include quality-based payment models that reward the best patient outcomes. This will ultimately translate into value-based pricing for providers rather than pricing driven by provider reputations and perceptions.

### Provision

The health care sector in KSA consists of three systems: Ministry of Health (MoH), quasi-government facilities,

<sup>4</sup> Source: [Ministry of Health Statistical Yearbook, 2018](#)

and private sector entities. In 2017, the MoH supplied 57% of all hospitals and 58% of the total bed supply. The primary aim of these facilities is to provide free care for Saudi nationals.<sup>5</sup> However, under certain conditions, expats can access MoH facilities. These certain conditions include: areas in which private hospitals are not available, specific emergency circumstances, and specialized treatments that are not performed at local private hospitals.

Quasi-government facilities are hospitals and health centers that cater primarily to employees of government organizations. These include the National Guard, Ministry of Defence, Ministry of Interior, Royal Commission, and Saudi Aramco. Finally, private sector entities are available to expatriates with no access to public facilities and, at times, to Saudi nationals who want to avoid long waits at public facilities. In 2018, according to the MoH statistical yearbook, the private sector operated approximately 32.2% of hospitals and 24.6% of the total bed supply. In terms of geographic distribution, hospitals are highly concentrated in urban areas, with roughly 50% in Riyadh and Jeddah.

These three KSA health care systems are further fragmented as individual facilities operate within siloes. While there are opportunities for more integrated care, the challenge is integrating care across all providers, limiting overlaps in service offerings and duplication of capacity. Consolidating volume and sharing resources will lead to higher value.

On the technology front, electronic medical records (EMRs) are neither fully implemented across the provider network nor harmonized among users. The main barriers to full implementation include lack of skills, technical limitations, and a workforce that doesn't fully understand EMR's usefulness. These issues need to be addressed in order to create a national EMR system that ensures transparency for patients and eliminates silos for providers. Also important is improving beneficiaries' knowledge regarding their rights, expectations, and use of health insurance services.

### Consumption

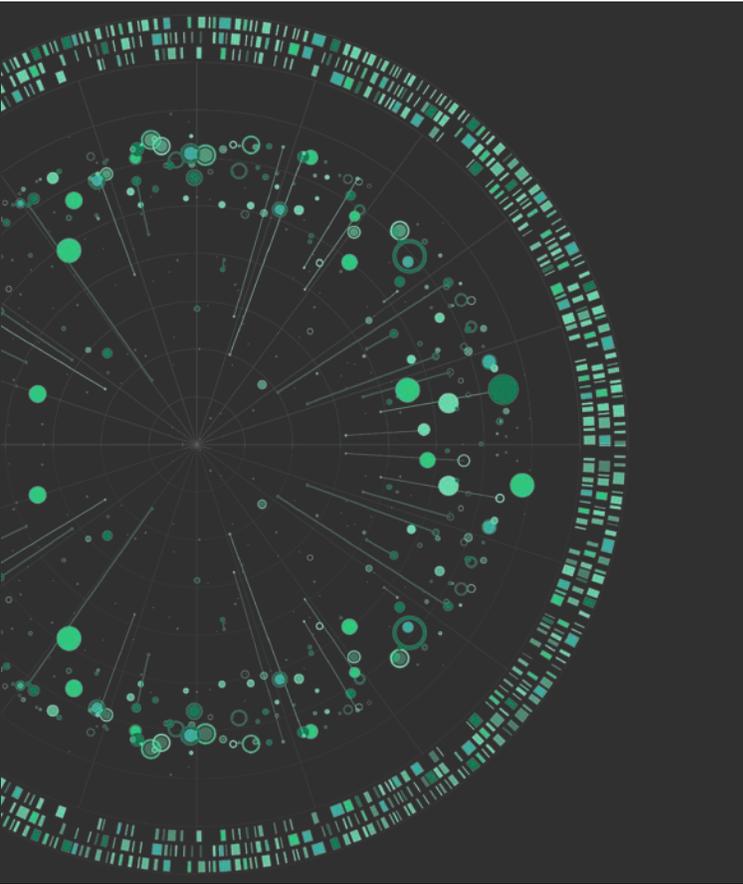
While the focus has been largely on Primary Health Centers (PHCs), hospitals still present very high occupancy rates. The latest target set by the MoH is to double the number of primary care consultations per patient, going from two consultations to four. The challenge is to change the patients' mindset so they visit a GP first not a specialist.

A major health sector transformation is currently underway in KSA to harmonize quality of care, ensure the population has access to all areas, and control HC costs. The transformation includes establishing a national health care regulator to unify governance throughout the sector, a national health insurance program to function as the public health care payer, and a public holding company to create and manage regional provider clusters with a new model of care. In its initial phase, the national health insurance program will be accessible to nationals covered by the MoH. In the second phase, each cluster will develop AOCs enabled by technology and a competent HC labor force.

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<sup>5</sup> Source: [KSA MoH Statistical Yearbook, 2018](#).

## 5. Looking to the future



There are considerable lessons learned in the GCC's evolution from a public block-funded health system to an insurance-based system. This paper proposes practical solutions to the challenges typically encountered across the funding, payment, provision, and consumption of health services. While the various systems throughout the GCC—including Dubai, Abu Dhabi, and Saudi Arabia—have different specificities, the key principles presented in this paper apply throughout.

To ensure sustainability of GCC health systems, it is essential to plug the leakage in funding, payment, provision, and consumption of health services to maximize the share that reaches the population. The BCG framework illustrated in this paper can be used to identify the leaks, prioritize the most relevant ones, and develop solutions.

In developing solutions, a value based health care (VBHC) approach directs spending toward areas that add the most value to consumers. Whatever the solution, they must be holistic and consider the entire health system rather than its individual parts. All too often, reforms take place in siloes leading to unintended consequences in other parts of the health system. Only with a holistic approach can patients derive true health value from their health care providers.

# Sidebar 1

## Health Care at Risk

Two factors are raising alarms about health care costs: ageing populations and rising costs of medical services.

### Ageing population.

The population base in the GCC is relatively young with a median age of around 30 years. However, these young GCC populations have high chronic disease prevalence rates for conditions such as diabetes, heart disease, and others – see exhibit 1.

Exhibit 1: Prevalence ratio (%) of diabetes in populations aged 20 to 79



Source: BCG analysis.

For example, several GCC countries, including UAE, KSA, Bahrain, and Qatar are among the top 20 countries in terms of age-adjusted comparative prevalence for diabetes. Health care needs are directly related to age and increase exponentially as a population ages. This leads to escalating demand for health care services and more so given chronic disease prevalence rates.

### Rising costs of services.

Health care is a labor intensive industry in which labor costs can exceed 60% of operational costs — in hospital, for example—driven primarily by the clinical staff. As a highly skilled industry, the inflation of labor costs in health care is higher than general inflation. This is further compounded by a shortage of health care talent that leads to intense competition for the same pool of resources and drives up salaries. Additionally, given the rapid advances in science and technology, new methods of diagnosis and new treatments are coming available albeit at a high price. For example, specialty drugs make up roughly 30% of all spending on drugs, but only account for 2% of prescriptions; almost half of these drugs cost more than \$100,000 per patient, per year.<sup>6</sup> Overall, medical inflation in the GCC has outpaced general inflation by nearly three times and is growing at an annual rate of 13%-14%.<sup>7</sup>

<sup>6</sup> America's Health Insurance Plans (AHIP) report, 2019

<sup>7</sup> Mercer Marsh Benefits Key Medical Trends Report, 2019 and 2020

## Sidebar 2

### Help patients control their own health care access

Gatekeeper systems have been standard practice in Western Europe for decades. Even countries with medical insurance systems offer incentives for patients to visit their primary care providers first. On the other hand, while gatekeeper systems ease spending on specialists, it is not at the expense of increased primary care spending. What must be managed is patient expectations and satisfaction especially in the short-term. A change from the freedom to access specialists directly to one with potentially longer wait times needs to highlight the benefits of a continuum of care that the new system offers.

BCG's experience in managing such transitions highlights three potential solutions:

#### Make the most of technology.

Although the typical gatekeeper is a primary care physician, in-person physician consultations are still expensive and time consuming. This role can be performed by allied health professionals such as social workers or even technologies such as telemedicine and health apps.

#### Incentivize and regulate.

Using technology to reduce premiums is an obvious mechanism to control costs. But even in systems where telemedicine is not fully developed, patients can be encouraged to see a primary care or family doctor instead of a specialist. One way is to reduce co-payments.

Also, gatekeepers need to be incentivized to not send patients to specialized care unless absolutely necessary. One method that works well in the US is withholding a portion of payments when a defined percentage of patients has been referred or when specialists believe a referral is unwarranted. Regulations to prevent overuse can be a protective measure.

#### Education.

The effectiveness of these mechanisms requires all stakeholders to understand the rationale and benefits of revamping systems. Health organizations can use a range of channels to target patients, physicians, payors, and providers—each one tailored to encourage behaviors that improve health outcomes.