What Business Are We In? The Emergence of Health as the Business of Health Care

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On January 19, 2012, after 131 years of operation, the Eastman Kodak Company filed for Chapter 11 protection in U.S. bankruptcy court. No doubt some people were surprised by this filing, because they grew up at a time when bright yellow boxes of film accompanied every family vacation and celebration. Those who were paying more attention offered many explanations for the bankruptcy. Central among them was that Kodak was late to recognize that it was not in the film and camera business: it was in the imaging business. With the advent of digital imaging, Kodak was outpaced by other companies that could better achieve consumer goals.

This lesson has been repeated many times over. In 1960, the editor of the *Harvard Business Review*, Theodore Levitt, wrote that the failure of railroads could be explained in part by the myopic view that they were in the railroad business and not the transportation business, which left them vulnerable to competition from cars, trucks, and planes.[1] Levitt argued that it's always better to define a business by what consumers want than by what a company can produce. Kodak had built a successful enterprise producing cameras, film, and photographic paper and chemicals, but what people wanted was images, and so when a better way to get those images was found, its customers followed.

The analogous situation in health care is that whereas doctors and hospitals focus on producing health care, what people really want is health. Health care is just a means to that end — and an increasingly expensive one. If we could get better health some other way, just as we can now produce images without film and transport people and freight without railroads, then maybe we wouldn't have to rely so much on health care.

To some of us, the point may seem both obvious and irrelevant. We might concede that even if people don't intrinsically desire doctors' visits, medications, surgery, and imaging, those services are still the way to get people the health they want. Although that may be true, the leaders of Kodak or the railroads may have had similar thoughts in their own day. Yet they seem to have missed some signals. What signals might we be missing?

One signal is that while much of recent U.S. medical practice proceeds as if health and disease were entirely biologic, our understanding of health's social determinants has become deeper and more convincing. An enormous body of literature supports the view that differences in health are determined as much by the social circumstances that underlie them as by the biologic processes that mediate them. Examples include the Whitehall study of British civil servants that revealed that civil-service grade is more strongly associated with mortality than any broad biomedical measure[2]; research conducted in the Veterans Affairs health care system and elsewhere demonstrating the persistence of health disparities even within fixed health insurance and delivery systems; and models of fundamental causes that provide a conceptual explanation of how such disparities can persist over time, following different pathways in changing circumstances.[3]

None of this evidence suggests that health care is not an important determinant of health or that it's not among the most easily modifiable determinants. After all, we have established systems to support the writing of prescriptions and the performance of surgery or imaging but have found no easy way to cure poverty or relieve racial residential segregation. But the evidence does suggest that health care as conventionally delivered explains only a small amount — perhaps 10% — of premature deaths as compared with other factors, including social context, environmental influences, and personal behavior.[4] If health care is only a small part of what determines health, perhaps organizations in the business of delivering health need to expand their offerings.

A second signal is that whereas in the past there was some implicit presumption that doctors and hospitals provide health care of consistently high quality, that presumption is now being challenged, and we're getting much better at identifying, measuring, reporting, and targeting health outcomes. For decades, health plans, states, and the federal government have been publishing quality data at the levels of con-

ditions, populations, physicians, and hospitals. Some of these data reflect processes — for example, which hospitals are better at giving aspirin to patients with acute myocardial infarction — but more and more data reflect outcomes, not just for patients within hospitals but for the populations surrounding them. The Mobilizing Action toward Community Health project has been publishing ratings of county-level population health. Employers increasingly focus on employee wellness, on one side, and disease management, on the other. Research funding increasingly supports efforts to improve these measures and effectively communicate outcomes. Each of these approaches has advanced incrementally over decades. This trend reveals an interest in what ultimately happens to individuals and populations.

A third signal is that health care financing is testing these pathways too. Payment systems that will not reimburse preventable readmissions or that bundle payments for goals or episodes of care rather than visits reflect a population approach to health focused on outcomes rather than processes. Today's standard approach of reimbursing for office visits and hospitalizations is likely to be displaced once better measures of outcomes can provide a substitute that's more relevant to our key goals. If we can measure success, why pay for process? If we can get the images we want in a better way, why use photographic film, paper, and chemicals?

In the future, successful doctors, hospitals, and health systems will shift their activities from delivering health services within their walls toward a broader range of approaches that deliver health. Although we're seeing the earliest steps in this shift toward accountability for health, we currently lack both good tools for moving forward in any substantial way and more established pathways for redirecting financing toward those outcomes.[5] What do we need to move from a product-oriented industry to a customer-oriented one?

Surely, Kodak's employees and shareholders lost something as their company lost business to other firms. But the world is at least narrowly better thanks to the ways photographs are now produced. Doctors and hospitals who pay attention to the business they are actually in — defined by the outcomes their "customers" seek — will leave the doctors and hospitals who don't behind, captured in a Kodak moment.

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