PERTH LEADERSHIP INSTITUTE

White Paper: Obamacare

HIPPOCRATES MEETS FRIEDMAN– FROM MEDICAL CONCIERGE TO HEALTH PORTFOLIO PRACTITIONER

Obamacare aims to extend health coverage and reduce overall healthcare cost increases. Regulatory fiat cannot achieve this unless there is widespread behavioral change by providers. New findings from behavioral finance open up new approaches to do this. This implies a transition from the traditional Medical Concierge delivery model to one of Health Portfolio Manager. This White Paper shows what is needed.

1/18/2013

EXECUTIVE SUMMARY

Behavioral Finance Shows New Ways to Improve Financial Outcomes

There's a new kid on the block. It's called **behavioral economics and finance** and it gives us a new way to **view our decisions**. All of your decisions are systematically biased due to your own particular **cognitive biases**. Only problem is you don't know it. You will be **surprised** at how human you really are…..

Cognitive Biases Lead Us to Have Distinct Financial Signatures™

There are nine Financial Signatures™ that result from these biases. These **predict** your financial outcomes, including **wealth for your family and financial performance for your organization**. The vast majority of people don't have financial signatures that create capital. What a surprise…**that probably means you**.

The Widening Gap between Patient Needs and Healthcare Providers

The gap between patients and their healthcare providers **is widening**. Partly this is because **medical acumen is declining**. That is occurring partly due to pressures within the healthcare system and partly **due to behavioral responses** by healthcare providers. If you think that's bad news be aware that if nothing changes, **things will get worse, including healthcare costs**.

Introducing the Health Portfolio Manager Approach

Things can be **changed**. We must move to a **new model of healthcare delivery**. From individual to social, medical to health, cure to prevention and other changes. But it's going to take **training and behavioral change** for all **roles and levels** within the healthcare system. **Can healthcare providers make this leap?**

Table of Contents

Table of Figures

"..The biggest question of all is whether the new approach will affect behaviors in a productive or unproductive manner regarding the overall costs of the system…"

Hippocrates Meets Friedman:

From Medical Concierge to Healthcare Portfolio Practitioner

Introduction – What about Healthcare Costs?

Obamacare is now being progressively phased in for the US population. By common consent it is revolutionary in extending care to so many people. It is also revolutionary in its likely impacts on the US economy, US welfare and in how it will impact the costs of the US healthcare system.

Obamacare will impact how people think about healthcare and therefore it will impact their responses. Above all Obamacare will have massive impacts on behavior. The big issue is what these impacts will be and how they will affect the costs of the system. The biggest question of all is whether the new approach will affect behaviors in a productive or unproductive manner regarding the overall costs of the system.

The driving force behind financial outcomes in the US healthcare system is the behaviors of both the providers and the consumers. These behaviors are impacted by a number of factors including the regulatory environment, pricing of services, incentives for providers to provide particular sorts of care, the legal system and the possibility of lawsuits,

In this White Paper we are going to reveal a new ways of analyzing the US healthcare system in terms of a formal approach to analyzing the financial response of both providers and patients. Our aim is to show how innate behaviors will tend to drive the system in terms of overall costs and suggest ways to improve both these behavioral responses and therefore the resulting costs of the new healthcare system.

Behavioral Finance Shows New Ways to Improve Financial Outcomes

We have to recognize that the innate behaviors of both providers and consumers play a powerful role in the outcome of the costs of

"…Much of what we regard as being rational decision-making in fact is decisions based on non- or partly rational considerations that are rationalized later by us to convince ourselves and others that in fact we made the decision on purely rational grounds, even though we didn't…"

the new system. In other words there are two components to the behaviors in the healthcare system that results in the present financial outcomes of high and rising costs. One is external factors such as those mentioned above in the Introduction. The other is internal behavioral factors. The resulting financial outcomes are the result of a complex interplay between these two sets of factors, both external and internal behavioral.

In this White Paper we are going to particularly focus on these internal behavioral factors. That is, we are going to focus on the innate and learned behaviors of providers and consumers independent of these external factors. This is not to say that the external factors do not play a powerful role; they clearly do. However it is to recognize that innate and learned behaviors also play a powerful role and that in seeking to improve financial outcomes in the healthcare system, we must consider these internal behavioral factors also if we want to have a chance of positively influencing financial outcomes in the overall healthcare system.

Our Biases Unconsciously Affect Decisions, Often Adversely

The healthcare system is comprised of millions of decisions taken by all of its participants. Each of these decisions is subject to unconscious cognitive biases of which modern decision science is only just becoming aware. The disciplines that deal with these biases are behavioral economics and behavioral finance.

Classical decision theory taught that humans make rational decisions. These new behavioral disciplines are telling us that, to the contrary, many, if not most of our decisions are actually not based on rational considerations or at best are only partly rational.

Much of what we regard as being rational decision-making in fact is decisions based on non- or partly rational considerations that are rationalized later by us to convince ourselves and others that in fact we made the decision on purely rational grounds, even though we didn't.

We Are Gradually Recognizing the Importance of These Biases

The significance of cognitive biases is that they systematically bias our decisions in unconscious ways such that these decisions have sub-optimal and adverse outcomes. The new behavioral disciplines

"…healthcare systems, and particularly the ones in the US are a good example of cognitive biases that result in decisions which on the surface look optimal but that are in fact sub-optimal with adverse consequences much of the time…"

are showing us that there are numerous cognitive biases that act in this way without most people being aware of them. Until we become aware of these cognitive biases, the implication is that our decisions will at best have sub-optimal or even adverse financial and social outcomes.

By now it will have become obvious that we can apply a similar sort of analysis to the healthcare system. Some of the issues that we might cite as being evidence of mixed rationality in decisions in the healthcare system include:

- Resources are frequently used very wastefully
- There is huge over-use of resources in the system
- Healthcare is often prolonged at huge cost even though there is almost no prospect of the care being effective
- Tests and procedures are used even though it is clear that they are not needed in many cases
- We over-spend on individual care often to the huge detriment of others who receive much less care and who are more deserving
- We tend to spend most of the resources on trying to cure the condition rather than spending less on preventing it

The behavioral disciplines have now formally recognized scores of cognitive biases. We have included some examples below in the box.

But There's a Lot of Them…..

- Framing effects: The way a problem or decision is presented to the decision maker will affect their action.
- Sunk cost fallacy: The tendency to continue to invest in something, even if it is a hopeless case
- Status quo bias: people prefer that things remain the same, or that things change as little as possible, if they absolutely must be altered.
- Illusion of control bias**:** is the tendency for people to overestimate their ability to control events, for instance to feel that they control outcomes that they demonstrably have no influence over.
- Endowment effect: people value a good or service more once their property right to it has been established.
- Loss aversion: people's tendency to strongly prefer avoiding losses to acquiring gains. Some studies suggest that losses are twice as powerful, psychologically, as gains

"…healthcare systems, and particularly the ones in the US are a good example of cognitive biases that result in decisions which on the surface look optimal but that are in fact sub-optimal with adverse consequences much of the time…"

- Anchoring effect: the tendency to rely too heavily, or "anchor," on a past reference or on one trait or piece of information when making decisions
- Overconfidence effect: excessive confidence in one's own answers to questions. For example, for certain types of question, answers that people rate as "99% certain" turn out to be wrong 40% of the time.
- Survivorship bias: concentrating on the people or things that "survived" some process and ignoring those that didn't, or arguing that a strategy is effective given the winners, while ignoring the large amount of losers.

These cognitive biases will impact all types of decisions in all types of organizations, including public and private, profit and nonprofit. So we can conclude that healthcare systems, and particularly the ones in the US are a good example of cognitive biases that result in decisions which on the surface look optimal but that are in fact sub-optimal with adverse consequences much of the time.

Don't assume that these are the only cognitive biases. Actually there are many of them. Here we just show some of the more important ones. Behavioral science is constantly discovering more of them. That is because we are still in the early stages of these new disciplines.

No doubt at some stage researchers are going to find new ways of classifying them so that they show some internal logic rather than just forming a long list. However for the purposes of this paper, we do have such a neat classification that enables us to use just two of these biases to develop a new theory of behavior that links financial styles to financial outcomes. We show this theory in the following section.

Cognitive Biases Lead Us to Have Distinct Financial Signatures™

How are our cognitive biases linked to our decisions and the financial outcomes of these decisions? How do these biases lead to our creating good versus bad financial outcomes both for ourselves personally and for the organizations we work for? These are critical issues in both the private and the public sectors, and indeed in healthcare itself.

"…It turns out that of all the many cognitive biases that have been identified by behavioral economists, there are two that are particularly important in identifying our financial styles and how this is linked to financial outcomes…"

Two Key Cognitive Biases Drive Our Financial Style

It turns out that of all the many cognitive biases that have been identified by behavioral economists, there are two that are particularly important in identifying our financial styles and how this is linked to financial outcomes, both for individuals and teams and for personal and organizational financial outcomes.

This work has been conducted by the Perth Leadership Institute. This research has resulted in the development of the **Perth Leadership Outcome Mode**l (PLOM). This model shows the links between cognitive biases and both business and financial outcomes. In this White Paper we will deal mainly with the financial outcomes since the business outcomes side of the model is broader in its scope[1] and at this stage we are focusing mainly on the narrower and more focused financial outcomes.

The two cognitive biases that we will particularly focus on are the status quo and the illusion of control cognitive biases. Perth's work many years ago led it to identify these biases independently of other work in the area of behavioral finance. We can explain the significance of these biases as follows.

Each of us has a preference regarding how much we personally like change versus the status quo. Behavioral economists call this the **status quo** (SQ) bias. If it is high, I don't like things to change, even if I have the intellectual agility to envision change. If the status quo bias is low, I like change. In this case I prefer to see if I can transform things like products and services.

When I am successful in my change efforts I add a lot of commercial value – we call this the value-added behavioral driver. In this case my gross margin will be high relative to my competitors. So actually this behavioral preference has a direct impact on how innovative I will be and how this will reflect in my financial decisions and outcomes, or my financial style.

Likewise each of us has a preference on how much we like to control events. Behavioral economists call this the **illusion of control** (IC) bias since usually we think we can control things even if we can't. This bias causes those who are more subject to it to use more resources than are needed, objectively speaking.

This results in higher costs than are otherwise needed. This is the basis of what we call the resource utilization driver. This bias exists independently of external factors. If I have a high IC bias I will tend

to be a big spender, if low then frugal. So this also reflects in my financial style, independent of my intelligence or external circumstances.

For a given level of VA, someone with a high IC bias will not make as much money and or will create less capital compared with someone with a low IC bias (because expenses are higher relative to gross margin). Conversely, for a given level of IC bias, those with a higher VA driver will make more money, or generate more capital, than someone with a lower level of VA drive. So the combination of these two cognitive biases results in a number of characteristic financial styles and financial outcomes.

This Results in Nine Financial Signatures™

The amalgam of these styles leads to the identification of what we call Financial Signatures™. There are nine Financial Signatures™. These are set out at

Figure 1 The Nine Financial Signatures™

"… this combination of innovation and resource utilization behaviors will determine whether I create or consume capital and make or lose money…"

A Financial Signature™ represents our behavioral propensity to create or to consume capital. It's our ability to generate positive financial outcomes. In the private sector it might be called "a nose for profit". In the public sector it's the ability to create positive budgetary outcomes.

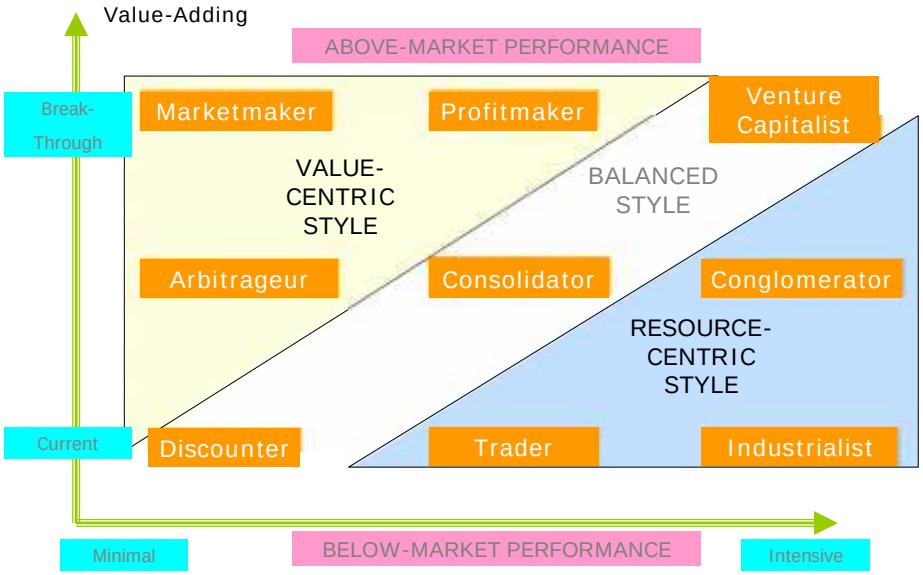
In this approach, financial style is simply an amalgam of my value-adding and resource utilization behaviors. If my VA behaviors are higher than my resource utilization behaviors, I will create capital. If VA behaviors aren't as strong as resource utilization behaviors I will consume capital. So this combination of innovation and resource utilization behaviors will determine whether I create or consume capital and make or lose money. This is depicted in the diagram depicting the nine Financial Signatures™ that result from combining these two biases.

Where the VA driver is stronger than the RU driver, I will create capital. We call this a **value-centric** behavior. Where the VA driver is weaker than the RU driver I will consume capital. We call this a **resource-centric** behavior.

This leads to the identification of three financial styles. These are value-centric, resource-centric and balanced, also set out at

Figure 1 The Nine Financial Signatures™

Figure 1 The Nine Financial Signatures™



Healthcare Providers Also Have Distinct Financial Signatures™

How do the Financial Signatures™ we presented above fit with those of providers in healthcare? While the signatures we showed clearly refer to roles in the private sector, some of the terms used may not feel as appropriate in the healthcare sector. It turns out that we can apply these Financial Signatures™ to people in the healthcare field too and show what are recognizable characteristics of healthcare providers that we would all recognize, just as we can do for private sector roles.

In Figure 2 The Nine Financial Signatures™ of Medical Providers, we have addressed this issue. For each position denoting value-adding and resource utilization we have shown the corresponding type of role for a healthcare provider in the Medical Concierge model. We can expand on these roles as follows:

Value-Centric Styles

Medical Entrepreneur: The Medical Entrepreneur is a highly innovative individual who comes up with new medical and health therapies, services or products. However he does this without the usual high cost associated with big science medical research and usually has a frugal approach.

The Medical Entrepreneur's new therapies usually open up totally new ways of looking at disease and at totally new ways of addressing medical problems. He usually bucks the conventional medical wisdom doing this. He is frequently at loggerheads with the medical establishment.

Often the Medical Entrepreneur is in individual practice where he has total control over his expenses and can keep them very low. Medical Entrepreneurs frequently do not stay in established institutions and build their own, often either individual practices or their own private medical practice or institute. Often they are not found in established medical institutes or hospitals since they become too frustrated and leave to do things on their own. They often work on their own as individual practitioners. However they can occasionally be found in larger organizations. Here they are usually misfits, viewed at best as gadflies and at worst as being dangerous to their patients.

Since Medical Entrepreneurs have high value-adding and are frugal, they tend to be financially successful or at least create capital which they might either keep themselves or give to others.

However they (Medical Entrepreneurs) can occasionally be found in larger organizations. Here they are usually misfits, viewed at best as gadflies and at worst as being dangerous to their patients.

One example of a Medical Entrepreneur is Dr. Barry Marshall, the Australian doctor who discovered that stomach ulcers are caused by a bacterium, rather than, as tradition had it, stress and rich foods. He was thus able to show that this condition could be cured quickly using certain regimes of antibiotics.

The Medical Entrepreneur is the rarest of all the nine medical signatures.

Medical Surplus-Maker: The Medical Surplus-Maker is an innovator who at the same time creates capital by ensuring that the financial resources are large enough to sustain the investments required to lead to research success while at the same time ensuring that they are not so large as to lead to the project consuming capital.

This individual is sometimes one with a financial as well as a medical qualification, and has often moved into a position of medical administration or management where his duties are much more managerial in nature than medical. Often they are located within a hospital as a hospital administrator with a medical background. They can also be the head of a medical institute that is focused on making sure that it makes money, at least within the financial framework set up for this kind of healthcare organization.

"…As the name implies, Medical Surplus-Makers create capital because of the combination of high value-adding and medium expenses. That doesn't mean that they necessarily personally keep the capital. Usually they are in a medium- or large organization where their leadership creates an operating financial surplus which allows the organization more financial flexibility in the future…"

This Financial Signature™ is focused on making sure that medical advances are also financially responsible and sustainable and result in benefits outweighing costs in a financial as well as a medical sense.

Note that the Medical Surplus-Maker need not be a medical practitioner or researcher; the innovations can also be in the area of health systems, medical performance approaches and so on. Their characteristics are the ability to innovate and reform with a focus on positive financial outcomes. Usually they are in larger organizations although this might also not need to be the case.

As the name implies, Medical Surplus-Makers create capital because of the combination of high value-adding and medium expenses. That doesn't mean that they necessarily personally keep the capital. Usually they are in a medium- or large organization where their leadership creates an operating financial surplus which allows the organization more financial flexibility in the future.

An example of this Financial Signature™ is George Halvorson, CEO of Kaiser Permanente. He has held management not medical positions but is a health system reformer rather than a medical researcher or innovator.

Medical Surplus-Makers are uncommon but not rare, about 7% of all healthcare leaders.

Health Optimizer: This Financial Signature™ is characterized by their relentless focus on costs and minimizing them, but that is also open to and actually implements some reforms, although not necessary sweeping or innovative ones since this is not essentially an innovative person.

This individual is often found in regional practices or in smaller healthcare organizations and hospitals where there is strong local control over costs. They are not comfortable with innovation and major change. They are more financially than medically focused.

Health Optimizers create capital because of their medium value-adding drive combined with very low costs. They won't necessarily invest in the future but for the moment you can be sure they will run a tight ship.

Examples of this type of person are to be found in organizations that have to be run conservatively and medical practices that are run on the basis of strong business principles.

"…While this Financial Signature™ (Health Incrementor) will result in medical improvement, it won't create capital, but that's something this Financial Signature™ doesn't really care about; her aim is more one of stability and moderation…"

However Health Optimizers are unusual, probably only around 5% of all healthcare leaders.

Balanced Styles

Medical Moon-Shooter: The Medical Moon-Shooter is an innovative individual. They have big ideas that usually take a huge amount of resources to pursue. This type of medical innovator is the most common sort of medical innovator, even though they are a small minority of all medical professionals.

Medical Moon-Shooters are usually after the medical equivalent of the moon-shot. They are usually charismatic since one of their key roles is to raise money and capital for their project.

However often – usually – these innovations are not successful, or, if they are, only at such a huge cost that they consume more capital than they create, even though from a medical viewpoint it might have been a successful endeavor.

Medical Moon-Shooters usually end up losing lots of money although occasionally one will end up hitting for the boundaries. It's not that they don't create value; it's just that they spend so much money doing it that usually it's impossible to recoup the investment.

An example of this type of Financial Signature™ is Dr. Craig Venter who was the founder of the effort to sequence the entire human genome for the first time.

Medical Moon-Shooters are not rare but are relatively uncommon at around *5 of the healthcare population.

Health Incrementor: The Health Incrementor Financial Signature™ is a middle-of-the-road signature. It is neither innovative nor pure status quo; in the event it takes a position in-between to take a responsible approach that is not too risky and not too conservative.

The overall aim of the Health Incrementor, as the name implies, is to improve medical status moderately without aggressive measures, at a cost that doesn't break the bank.

While this Financial Signature™ will result in medical improvement, it won't create capital, but that's something this Financial Signature™ doesn't really care about; her aim is more one

"…Health Discounters are very risk-averse and so they never invest in anything. Conversely they keep costs to an absolute minimum. So they don't make or lose money but they never achieve much either because they can't invest in anything. But they always have some cash on hand…"

of stability and moderation.

For a health organization that was previously resource centric, this Financial Signature™ represents a distinct improvement. This is probably the most common Financial Signature™ amongst medical and health providers.

Health Incrementors are relatively common, probably around 20% of the healthcare population.

Health Discounter: The Health Discounter is characterized by an extreme focus on reducing cost, even if this adversely impacts patient health. This Financial Signature™ is much more focused on financial rather than health outcomes. Even if it's a medical person involved this is still the case.

The majority of those with this Financial Signatures™ are probably non-medical personnel either being in the management or administration side, or in the insurance, HMO or pharmaceutical distribution area.

Health Discounters are very risk-averse and so they never invest in anything. Conversely they keep costs to an absolute minimum. So they don't make or lose money but they never achieve much either because they can't invest in anything. But they always have some cash on hand.

Health Discounters are unusual, less than 5% of the healthcare population.

However it is possible for people with a medical background to have this Financial Signature™ such as in the emerging medical concierge segment. The chances are that this is becoming a growth segment in the Obamacare environment.

Resource-Centric Styles

Medical Process-Impresario (MPI): The MPI is characterized by his reliance on high resource utilization to meet his goals. On the VA side he is not conservative, but neither is he an innovator.

The MPI comes in two flavors. One is focused on a high level of process to achieve his medical goals, thus requiring extensive reliance on rules, process and standards and thus resulting in high costs that exceed benefits. The other flavor is focused on a high level of promotion of the organization in order to attract patients

"…Medical Safety-Makers are relatively profligate and require high levels of financial support and subsidies. Their revenues will never cover their high levels of costs and they tend to go out of business, get moved so that someone more financially conservative can take over, or they hold on through force of personality and then the institution has major financial difficulties…"

and revenues and reliant on high levels of marketing, promotion, investments in relationships and the advertising, but therefore resulting in high costs which again exceed benefits.

There are two types of individuals with this Financial Signature™. One is introverted, service-focused with a very clinical, detached view of life that sees process as being a good in itself. The other is an extroverted, promoter-type who sees process as being a limiting factor on their initiative. This individual may flaunt the system by relying on charisma and force of personality.

Either of these types can be seen usually in large organizational settings which can sustain abnormally high levels of expenses and where the system can be used or gamed to protect this type of approach.

MPIs are quite creative but they spend so much money that their creativity cant compensate for their much great spending. So they either need high levels of financial support or subsidies to sustain them, or they go out of business.

MPIs are relatively common at around 20% of the healthcare population.

Medical Safety-Maker: This Financial Signature™ is characterized by their extreme focus on safety, both for their patients and themselves. This leads to a strong tendency for avoidance of new types of treatments and approaches until he is sure not only that they work but that they are in common use before he tries them. So this Financial Signature™ avoids all types of risk.

In addition, so as to avoid risk, this Financial Signature™ uses a very high level of resources in the belief that this also offers protection against risks. Normally this level of resource is linked with an extreme dependence on rules, procedures, compliance, standards and bureaucracy coupled with a high level of dependence on tests, opinions, committees and second and third opinions.

Medical Safety-Makers are relatively profligate and require high levels of financial support and subsidies. Their revenues will never cover their high levels of costs and they tend to go out of business, get moved so that someone more financially conservative can take over, or they hold on through force of personality and then the institution has major financial difficulties.

An example is in many hospitals in the Veterans' Affairs system

and other government hospitals and healthcare organizations.

Medical Safety-Makers are much less common, around 5-10% of the healthcare population.

Health Trader: The Health-Trader Financial Signature™ is characterized by its avoidance of any sort of medical or health risk by sticking to tried and true procedures and leaving new and more risky procedures and approaches to others.

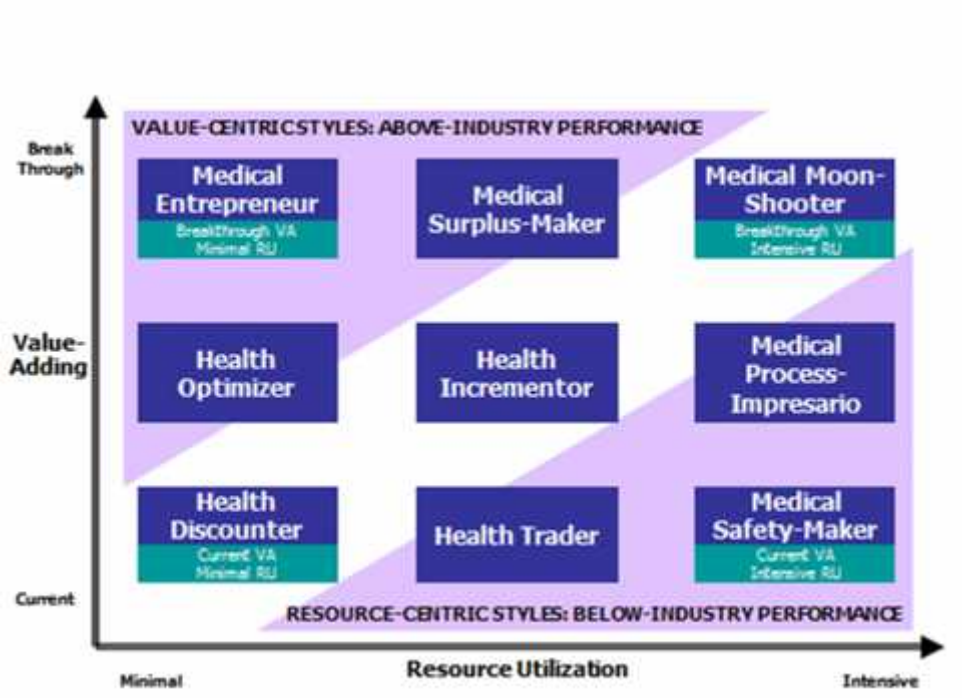
This individual also relies on a medium level of process and standards to reduce risk. However much of the resource utilization and expenses associated with this style is due to their use of a trading paradigm in order to address some of the negatives associated with risk avoidance in this financial style.

Health Traders usually consume capital, but not at high levels since they are no high spenders.

This Financial Signature™ tends to attempt to achieve their medical goals by trading favors and services for others rather than implementing these approaches himself. An example is medical clinics and centers that make extensive use of outsource practitioners, services and other approaches rather than possessing them themselves.

Traders are quite common at some 20% of the healthcare population.

Figure 2 The Nine Financial Signatures™ of Medical Providers



"…The big issue is: can we change our Financial Signature™? The answer is we cannot since these are innate (or as near as we can tell). However this does not mean we cannot change the way we behave in practice if we put our minds to it. What we change to in practice is called our **financial mission**…"

Which May Differ from Their Actual "Financial Mission"

There is one other important part of PLOM that needs to be discussed. Thus far we have identified the nine Financial Signatures™. These can be viewed as being the nine innate behavioral styles that impact financial outcomes.

The big issue is: can we change our Financial Signature™? The answer is we cannot since these are innate (or as near as we can tell). However this does not mean we cannot change the way we behave in practice if we put our minds to it. What we change to in practice is called our **financial mission**.

In practice we might not behave according to our innate drivers for a number of reasons. These could include the following:

- We are being motivated by a rich compensation package to act in ways which don't feel comfortable to us, but which we are prepared to accept in order to receive this compensation.
- We have a strong boss or team who induce us to act in ways we would not normally do. The organizational culture is strong enough to impel us to change the way we would normally behave.
- We have figured out for ourselves that our natural behavior is not doing us any good, and we change it, such as the habitual spendthrift who has finally realized he has got to change.
- We could have an influential spouse, partner, boss, or friend.

In other words, there could be a number of reasons for which our Financial Signature™ and our financial mission could be very different.

In practice we find that this is in fact the case. Many, if not most people have a financial mission that is different from their Financial Signature™. However we can never assume that the financial mission will be an improvement over our Financial Signature™.

Often our financial mission will be "worse" than our Financial Signature™. A common example is when a naturally frugal personal finds themselves in a large organization that tends to be, by comparison, very profligate with resources and who changes to become like the organization so that they are aligned with their organization, colleagues and its performance standards.

One of the things we needs to look for in the decisions and

behaviors of people in organizations is the extent to which their financial missions are different from their Financial Signatures™ and if so, whether the change in an improvement or otherwise. Then we can have the basis to judge whether organizational incentives are helping people to change their behaviors in a positive or a negative way.

As you can imagine this is particularly important in public sector and nonprofit organizations where accounting and financial systems are not usually configured to give us good feedback on these issues. The issue is of paramount importance in judging whether the new healthcare environment will have the right types of impacts on behaviors to create more positive financial outcomes in an area where these have been hard to find.

Financial Signatures™ Impact Public Sector Managers Too

What this model shows us is that we can explain decision-making in terms of its financial styles and associated financial outcomes. The outcome of decisions results from the particular combination of value-adding and resource utilization drivers that result from the SQ and IC cognitive biases.

Since we can predict the impact on gross margin and expenses we can also predict the operating margin that results from any combination of these particular behaviors. Although we don't have time to go into it here, we can use this model to show how the income statement, balance sheet and valuation of an organization results from these behaviors. To find out more see the book by E. Ted Prince.[2]

However we can never assume that the financial mission will be an improvement over our Financial Signature™.

Just because someone happens to be in a government, nonprofit or a healthcare organization doesn't mean that this model is not relevant. The nine Financial Signatures™ are a universal behavioral trait that results from fundamental human behaviors. Therefor they operate in all environments, personal and organizational.

Even if the organization is a governmental one, the status quo and illusion of control biases still operate in exactly the same way. However the only differences are that the outcomes might be recorded differently due to the differences between private and public sector financial recording systems. However the VA driver still results in more or less innovation and higher or lower demand for the governmental product or service involved. The illusion of control bias still results in more or less expenses and resources used.

Another way of viewing the nine Financial Signatures™ is that these signatures are actually recording the notional or presumed profit-and-loss (P&L) statement, albeit in behavioral terms, that results from a person's or a team's or an organization's behaviors,

"…we use the Financial Signature™ of an organization to show what its financial culture is and how this will impact its financial outcomes, in particular its ability to create or to consume capital…"

even if the actual financial figures are not being recorded. In other words a Financial Signature™ shows us the virtual P&L of an individual, team or organization based on its behaviors as shown in the Financial Signature™. These behaviors can be value-centric, resource-centric or balanced.

No matter if an organization records the actual financial outcomes, or records it in a different way to that in the private sector, the individual, team or organization will have financial outcomes which are recorded in the virtual P&L reflected in its actual behaviors.

So a public sector, nonprofit or healthcare organization will also have a financial outcome that is value-centric, resource-centric or balanced, resulting from its particular overall Financial Signature™. The result will be that the organization will be revealed to be capital-creating, capital-consuming or break-even. So we will be able to use Financial Signature™ results to show whether or not a particular healthcare organization, team or individual is one of these three types also.

These Tell Us Much More than Just About Individual Behaviors

The Financial Signatures™ of providers at first glance just tell us about individual behaviors. However they also tell us much more, as we see below.

Individual vs. team vs. organization: The nine Financial Signatures™ appear to refer to individuals, and so do they, in the first instance. They tell us for any given Financial Signature™ how the two cognitive biases impact their decisions-making, how this impacts gross margin and expenses, and how this impacts their level of capital creation. These Financial Signatures™ also tell us how these factors act on the individuals personally, in their family life, and corporately, that is their impact while they are in an organization.

But we can also use the same nine Financial Signatures™ to shown us how teams act and are impacted by these factors. A team whose membership comprises all of one signature will also have the same impacts as for an individual. And a team whose average Financial Signature™ is also in particular position will also act as predicted, especially if the individuals tend to be less dispersed compared to one with the same average value but more dispersion. So the Financial Signature™ can also show us the impact of a team on

financial decision-making and outcomes.

Finally we can use exactly the same principle to show how Financial Signature™ can apply to an organization. We can use it this way by calculating the average for the organization in exactly the same way as we would for a team. So the Financial Signature™ of an organization will predict the decision-making and financial style of an organization and its financial outcome. This is another way of saying that we use the Financial Signature™ of an organization to show what its financial culture is and how this will impact its financial outcomes, in particular its ability to create or to consume capital. Or we can use it to predict if it will be profitable or otherwise and the level of capital it will create or consume relative to its industry peers.

Type of role: The Financial Signatures™ will cover all the roles in healthcare. These include medical, paramedical, medical technicians, nurses, administrators, managers pharmaceutical and so on. We might expect to see differences in Financial Signature™ depending on type of role, educational background and focus and length of education.

Type of organization: Financial Signatures™ can reflect a lot about the organization as well as its financial outcome. We might expect to see differences in Financial Signature™ depending on the type of organization, for example, research institute, hospital, practice, testing laboratory.

The Financial Signatures™ will tell us not just about the likely outcome and profitability of an organization but also the extent to which it sees itself as maintaining, improving, or stabilizing health outcomes for their patients.

We might also expect to see a difference depending on the aim of the organization. Financial Signature™ will also reflect differences in aims such as for primary care, preventive care, emergency care, HMO, etc.

Size of organization: Financial Signature™ is also usually quite sensitive to the size of the organization. Larger organizations tend for example to have relatively higher resource utilization and less value-adding, other things being equal. So this can shed light on the likely level of demand for their services, its impact on pricing (even taking into account regulatory concerns) and the importance of cost factors in its financial performance relative to peers.

Type of financial culture: Different Financial Signatures™ for different organizations reflect different financial cultures. The Financial Signatures™ will tell us not just about the likely outcome and profitability of an organization but also the extent to which it sees itself as maintaining, improving, or stabilizing health outcomes for their patients.

Innovativeness: Financial Signature™ gives us a direct read on the relative level of innovativeness of the organization and how much value it is adding to its treatments and services.

Because there are three types of innovators in the Financial Signatures™, the data will also tell us about the character of this innovation; that is whether or not it is creating or consuming capital, whether it is likely to meet patient needs and the likelihood of patient success of the innovations that are emerging in the organization.

Resource utilization: Just as the Financial Signatures™ provide feedback on the characteristics of the innovative activity in the organization, so it does also with resource utilization. The Financial Signature™ data will tell us the extent to which the resource utilization is productive or whether it has gone beyond the productive stage and is now not providing commensurate benefits.

Financial Signature™ vs. financial mission: in this area the Financial Signature™ and mission can tell us a great deal. These include the following:

- Whether the organization is having a positive or a negative impact on the financial behaviors of its employees and managers.
- The degree of alignment or misalignment between the financial mission of the staff and that of the overall organization and its management.
- Whether there are differences in this level of alignment depending on the organizational location of the staff, there physical location, their organizational level, their specialty, level of education.
- If the level of alignment is improving or otherwise.

One of the key objectives of Obamacare is to improve the efficiency of the US healthcare system. **In order for this to happen, leaders, managers and employees in the system need to understand how their innate and learned behaviors contribute to financial outcomes.** The Financial Signature™ offers us a rich set of approaches to help achieve these objectives.

The Widening Gap between Patient Needs and Healthcare Providers

Medical Acumen is Declining

Patients, of course, have a multiplicity of needs. However these needs boil down in essence to two:

- To get the best care possible
- To get this care at the lowest possible expense.

"…It might seem strange that more availability of new treatments and more data are actually leading to behaviors that are less value-adding. However in behavioral finance this is now being recognized as a critically new important behavioral phenomenon. This is that more information can actually lead to a less effective response…"

We can recast the issue of the care that patients receive as being an issue of medical acumen. By "medical acumen" we mean the art as well as the science of medicine. Medical acumen comprises three main parts:

- **Treat**: the ability to identify and treat a medical condition
- **Prevent**: the ability to prevent a condition
- **Do nothing:** the ability to know when not to treat a condition – Hippocrates' famous "do no harm".

If a physician performed well on all three tests, then we could say that she possessed a high degree of medical acumen.

But More Treatment Doesn't Mean More Value

The key problem is that value-adding in the healthcare system has been declining. This might seems strange given the vast increase in the number of technologies, drugs and new treatments available. But the real issue to look at is not the availability of these treatments, but what the behavioral response has been. As we have indicated earlier, this has led to overtreatment and a lack of emphasis on evidence-based treatment.

It might seem strange that more availability of new treatments and more data are actually leading to behaviors that are less value-adding. However in behavioral finance this is now being recognized as a critically new important behavioral phenomenon. This is that more information can actually lead to a less effective response for two reasons:

- There is so much information available and there is no way to distinguish between what is good and bad

- When so much information is available, often decision-makers unconsciously filter out the information which they don't agree with and make a decision in a way which accords with their unconscious biases.

The upshot is that we cannot rely on having a high level of education or of information about the choices that are available since there are unconscious mechanism at play which subtly distort decisions in ways that most decision-makers are not aware of and do not understand.

What this means in effect is that it really doesn't matter how many

*"…In other words, **we cannot confuse medical skills with medical acumen**. It is quite possible for the rise in skills to be occurring as medical acumen declines because of these behavioral issues and because of trends in the healthcare system…"*

new technologies, drugs and treatments are developed. Value-adding for patients is ultimately a behavioral issue and unless providers are made aware of these behavioral issues, no matter what the number of new approaches, the amount of education and training in them, value-adding will tend to decline. In particular it will probably decline even more as new treatments become available since the factors of confusion and behavioral filtering will still operate even more strongly.

Note that we are not saying here that medical skills are declining. In fact in all likelihood medical skills are increasing. What we are saying is that financial missions of healthcare providers are declining because of the cognitive issues we have raised above. In other words, **we cannot confuse medical skills with medical acumen**. It is quite possible for the rise in skills to be occurring as medical acumen declines because of these behavioral issues and because of trends in the healthcare system.

In some medical acumen in the area of treatment is declining. So in this area patients' needs are being met less effectively than could be the case given the potential to help them.

Prevention is A Dirty Word in Healthcare

The second criterion we indicated for identifying and measuring medical acumen was the ability to provide effective preventive approaches. But here again the healthcare system is falling massively short of what is needed.

It is well-known that the healthcare system provides little incentive for preventive care. As a result the vast majority of treatments are aimed at curing rather than preventing. The most important reason for this in the healthcare system is perverse monetary incentives which provide the highest fees for services currently provided and almost no monetary incentive for preventive services and success.

This factor is one of the reasons behind obesity, diabetes and the many diseases connected with this condition. The healthcare system provides much more incentive for providers to give treatment than to prevent it. This too means that medical acumen is again reduced through the impact of these systems and factors.

"Do No Harm" Honored in the Breach

Declining to provide treatment when it is not warranted is a critical component of medical acumen. Powerful social, economic and

"…"Do no harm" is honored in the breach particularly in the case of end-of-life treatment. It is true that there have been some moves to curb some of the excesses in this area in recent years. However it is still a major cost-driver in the healthcare system…"

ethical factors exacerbate the incentive to offer treatment even when it shouldn't be given. Although some progress has been made – e.g. a reduction in the knee-jerk reaction to prescribe antibiotics for minor ailments – declining to provide any treatment is still a minor priority in medical care. This is largely because of the fee-for-service system which provides perverse incentives to provide treatment even when there is no benefit.

"Do no harm" is honored in the breach particularly in the case of end-of-life treatment. It is true that there have been some moves to curb some of the excesses in this area in recent years. However it is still a major cost-driver in the healthcare system.

However in the case of end-of-life care, the ready availability of numerous procedures and tests, such as MRI, diagnostic procedures and so on means that it is genuinely difficult for a provider to know when such diagnostics should be given or not. In almost all cases there are powerful financial and legal reasons for providing these, even if they are not medically warranted. So once again medical acumen is compromised.

System factors are a major driver in this problem but so are behavioral factors. As we have mentioned, most Financial Signatures™ are resource-centric so for most healthcare providers it is a comfortable response to provide more care, even if it is not warranted. This is because the illusion of control cognitive bias acts strongly to convince the healthcare provider that the treatment is giving them more control over the situation when in fact it isn't.

Severe Illness Impacts Providers' and Patients' Financial Missions

There is yet another important factor. This is the importance of severe illness and the prospect of death in leading to changes in financial mission. Simply put, even if there is little or no likelihood of any improvement in health status, those in severe distress and those treating them will often change their financial mission to one that is even more costly even if their Financial Signature™ is more value-centric.

The salience of life-ending scenarios makes healthcare very different from most other areas of business and government. Factors that might otherwise lead people to alter their financial mission to one that was more value-centric, or at least would lead them to moderate a movement towards being more resource-centric, will be reduced or even eliminated in these end-of-life health scenarios.

"…The implication of this factor is that as patients' health status worsens, then the financial mission of their providers will become more resource-centric thus exacerbating the cost issue. So an ageing population means a systemic move to a more resource-centric position. In turns this movement widens the gap between patient needs and health provider treatment approaches…)

In these cases a whole range of factors ranging from emotional, ethical and empathetic will lead to behaviors that will deviate from what is optimal is a wider sense. We have to take this into account in devising strategies for change in the healthcare system.

The implication of this factor is that as patients' health status worsens, then the financial mission of their providers will become more resource-centric thus exacerbating the cost issue. So an ageing population means a systemic move to a more resource-centric position. In turns this movement widens the gap between patient needs and health provider treatment approaches.

So it's also the case that medical acumen is declining in the area of "do no harm" because of both system and behavioral factors, with systemic incentives compounding the impact of these behavioral drivers.

Today healthcare is powerfully driven by quality, compliance and professional standards. These all combine to form a medical diagnostic and treatment edifice that actually tends to reduce medical acumen. The result tends to be overtreatment and over-use of resources where the outcomes are hardly assured. This is the case despite the immensely successful strides that medicine has made in treatment due to modern methods.

Even where healthcare providers understand personally that these things are happening, and their own personal behaviors make them feel uncomfortable about these approaches, current healthcare systems and factors will oblige them to bring their behaviors in line with the compliance, legal and professional standards that lead to these sub-optical financial outcomes. Thus is medical acumen systemically compromised in modern healthcare regimes.

But of course, different people have different innate financial styles too. Some of these styles will unconsciously welcome these trends because their innate behaviors are actually in line with them. Others will not. So we need to understand at a more granular level the Financial Signatures™ of healthcare providers in order to be able to develop ways to improve medical acumen and thus financial outcomes.

"…No matter what the innate behavior of the provider, they will tend to move more into resource-centric territory. The Medical Concierge model, in other words, systematically moves provider behaviors in ways that increasingly adversely impact financial outcomes. It might also move them into adverse medical outcomes by spurning a higher focus on prevention and by encouraging them to provide treatment when it should not be…"

The Traditional "Medical Concierge" Model is Based Primarily on Resource-Centric Behaviors

We can call the current model of medical practice, the **Medical Concierge** approach. This model comprises a focus on purely medical issues, at the level of the individual only, and focused on cure rather than prevention. This is the traditional model of medicine.

The Medical Concierge model is one that relies on the ability of a provider to have the quality of medical acumen. In this model, the level of medical acumen could be either high or low or anywhere in-between. This model doesn't just apply to a physician but to any healthcare role in the current healthcare system. This is because other roles, such as those for paramedical, financial, regulatory are still based on this traditional model of medicine and exist to support and sustain this model.

Unfortunately this sounds rather like the old-new model of medicine that has recently undergone a revival. In this model doctors charge a monthly fee for unlimited access to a medical practice. Usually they don't accept insurance. But the models are similar in the major respects that they focused on cure rather than prevention, on the individual rather than the social financial outcomes and focus on strictly medical rather than health issues.

In the Medical Concierge model of medicine, providers are searching for the cause of a condition, and services to address it for a particular individual. Heroic measures are normal since the broader cost impacts and the social opportunity costs incurred have no place in this model. The more services a provider gives, the higher the financial return, the lower the legal risk. The more conservative a service, the lower the legal risk and the lower is the insurance cost.

This looks familiar. Actually what it says is that the healthcare system is impelling financial missions towards the lower right of the Financial Signature™ diagram, towards less risky and more expensive procedures.

No matter what the innate behavior of the provider, they will tend to move more into resource-centric territory. The Medical Concierge model, in other words, systematically moves provider behaviors in ways that increasingly adversely impact financial outcomes. It might also move them into adverse medical outcomes by spurning a

higher focus on prevention and by encouraging them to provide treatment when it should not be.

Provider Financial Missions Have Been Deteriorating

All of those who work in healthcare will have one of the nine Financial Signatures™. However these will; not be evenly distributed if the distribution is the same as the private sector which is likely to be the case.

In the private sector we have found that 12% of all those tested have value-centric styles, 44% have balanced styles and another 44% have resource-centric styles. That is, it is probable that in the healthcare sector, 12% of individuals, teams and organizations create capital, 44% of them neither creates nor consumes capital and 44% consume capital.

We can divide those in healthcare between the providers and the patients. For the providers the model predicts that the vast majority will be low or medium value-adding and with medium to high resource-utilization. That is, the providers are likely to be Consolidators, Traders, Conglomerators and Industrialists.

What the above analysis tells us is that, if we consider just behavioral factors, there is a strong tendency for towards higher costs and lower value-adding.

But many of the providers will have a different financial mission. We have not done enough testing to be sure how these have changed but we can be reasonably sure that many will have increased their resource utilization due to the overwhelming pressure on a number of fronts. Moreover many will not try to provide higher value-added services that are on the cutting edge.

Reasons for this include:

- Many providers will use a greater number of procedures for ethical reasons, knowing that although there is little likelihood that they will work, but because they are available despite high cost, and they want to do everything in their power in the hope that it will work, even if it is a low probability.
- There are severe penalties for being on the cutting edge where it leads to a failure of care; these particularly include legal penalties; this tends to favor providers who are not high or even medium value-adding.
- There are equally severe penalties for those who are frugal, including lower incomes than average, low revenues (because higher costs lead to higher reimbursements), and higher legal and insurance costs where lower costs lead to problems in care.
- Regulatory, compliance and cultural factors are powerful incentives leading to higher resource use and expenses.

"…We might think that further action on the side of cost containment systems, compliance; regularly action and so on could have a greater impact. But the existence of pre-existing biases towards higher resource utilization makes it very likely that these strategies would never work. Simply put, they are battling innate behaviors which, in the absence of action to formally and explicitly change them, are very unlikely to change…"

- A higher number of procedures lead to higher incomes for many people in the healthcare field.

What the above analysis tells us is that, if we consider just behavioral factors, there is a strong tendency for towards higher costs and lower value-adding. External factors will strengthen this tendency by leading many people to change their financial mission to one that is even lower value-adding and higher resource utilization.

Although there would be others whose financial mission would be higher value-adding and lower resource utilization we can be reasonably sure that the ones who become more resource-centric will be more numerous than those who become more value-centric.

In other words, the behavioral tendency in healthcare as for other industries and organizations, in the absence of offsetting action, is for the system to become more resource-centric over time. That is it will tend to consume more capital over the longer-term.

Reducing Resource Utilization Doesn't Necessarily Cut Expenses

As we have found in our research into Financial Signatures™, there is a tendency for most people to be higher on this side. So the healthcare system in any case starts off with a decided behavioral bias towards higher resource utilization.

But we have to add to this the systemic tendency in the healthcare system, independent of behavior, also to favor higher resource utilization approaches and ways of doing things. So both systemic and behavioral factors lead to higher costs and expenses.

Over the past few years there has been a move to rein in healthcare costs through a variety of means ranging from insurance reimbursements, regulatory action, and compliance audits and so on. But these have demonstrably had little impact on the overall problem.

We might think that further action on the side of cost containment systems, compliance; regularly action and so on could have a greater impact. But the existence of pre-existing biases towards higher resource utilization makes it very likely that these strategies would never work. Simply put, they are battling innate behaviors which, in the absence of action to formally and explicitly change them, are very unlikely to change.

"…The only way of ensuring that the right decisions are made by individual healthcare providers is to train them into changing their behaviors by showing them the principles of these changes so that they make the right decisions in the unique circumstance in which they so often find themselves…)

The focus in the healthcare system is to cut costs. But this isn't always the right answer.

Where cutting costs leads to lower healthcare system value, such a decision is wrong. The correct answer is to ensure that for any decision, overall value increases.

Where the value-adding of the system doesn't change due to a particular approach, increasing overall value will indeed mean reducing costs. But there are going to be plenty of cases where in order to increase value, costs have to be increased. This should be done where the amount of value added is greater than the cost increase.

In the hurly-burly of modern medicine, confronted with reality, emergency cases and real people, it is not always easy to make the right decision. Certainly rules from headquarters, State regulators or Washington will not fix the problem.

The only way of ensuring that the right decisions are made by individual healthcare providers is to train them into changing their behaviors by showing them the principles of these changes so that they make the right decisions in the unique circumstance in which they so often find themselves.

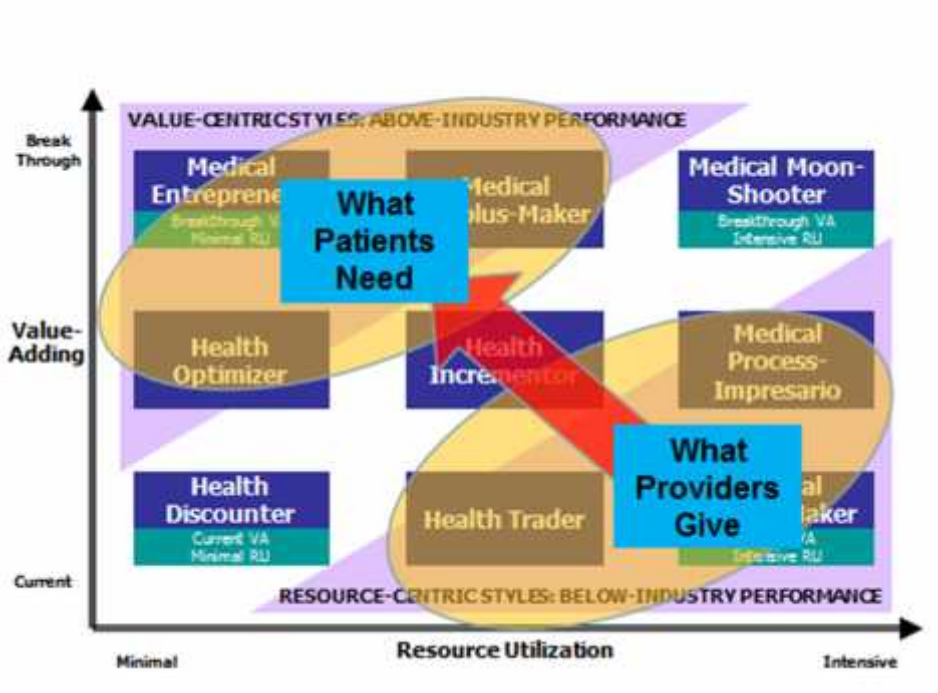
Provider Behaviors are Increasingly Falling Short of Patient Needs

All of the above can be summed up simply. Patients want better care and lower costs.

But medical acumen is declining because of system and behavioral factors in providers. So the value of treatment is increasingly falling short of its potential. And resource utilization is inexorably rising because of both perverse incentives, social and other factors and also due to powerful behavioral factors. The gap between what patients need and what provide give is widening, as we show at Figure 3.

"…But it's now clear that in order to address the issues of cost/benefit, mounting healthcare costs, and the issue of providing healthcare to everyone at a reasonable cost, healthcare providers must become more aware of the business goals of the healthcare system. To do this they must understand how their own behaviors impact social and business outcomes. We call this the Health Portfolio Manager (HPM) approach…"

Figure 3 Meeting Patient Needs



The issue is how to get healthcare providers to move their financial mission to ones that are closer to those in the upper left of the Financial Signature™ diagram.

Introducing the Health Portfolio Manager Approach

The traditional concept of the healthcare provider was what we have called the Medical Concierge. That required a certain level of medical acumen but as we have seen, medical acumen has been under pressure due to multiple factors.

But it's now clear that in order to address the issues of cost/benefit, mounting healthcare costs, and the issue of providing healthcare to everyone at a reasonable cost, healthcare providers must become more aware of the business goals of the healthcare system. To do this they must understand how their own behaviors impact social and business outcomes. We call this the Health Portfolio Manager (HPM) approach.

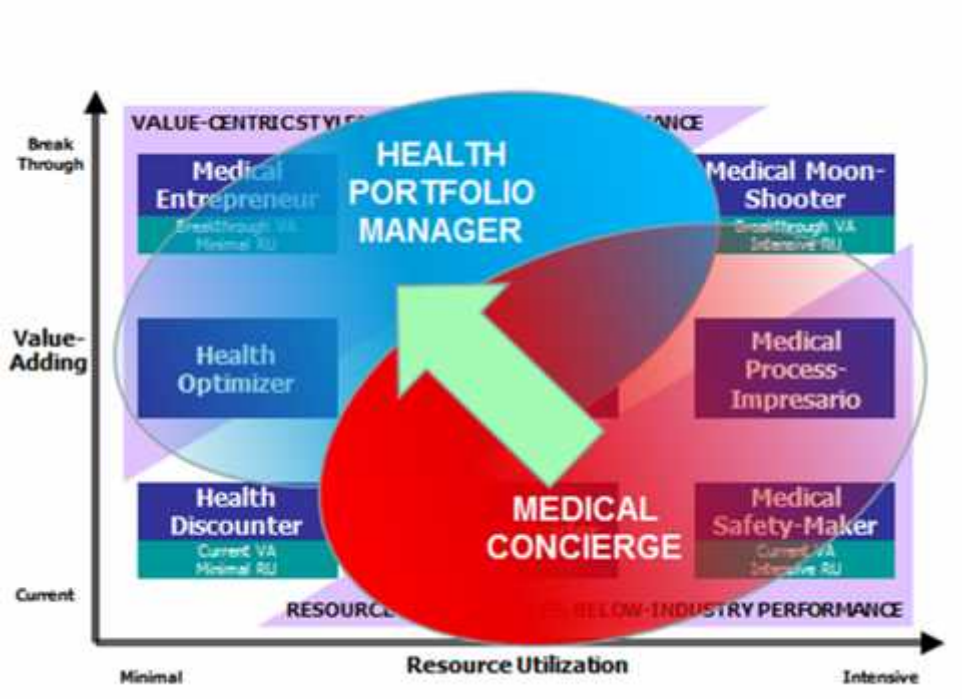
In the HPM approach, goals change. The Medical Concierge aims to get the best medical outcome for current conditions for an individual. In the HPM approach, the aim is to achieve maximum health value for optimum resource use for all the patients being looked after by the organization of which the provider is a part.

The HPM approach includes the following aims:

- Focus on prevention, not just cure
- Views health of a community not just separate individuals as goal
- Aim is to reduce social opportunity costs of individual care
- Aim is to increase overall value of the healthcare system
- Reduce overall system costs for a given level of care
- Not to give care where it isn't needed
- Method is to leverage behavioral change in providers to increase healthcare system value

In effect what we are saying is that the HPM approach entails a move to the upper left of the Financial Signature™ diagram. We show this at Figure 4 Migration to Health Portfolio Manager.

Figure 4 Migration to Health Portfolio Manager



Such a move doesn't necessarily mean that providers must become Medical Entrepreneurs, Medical Surplus-Makers or even go to the top line of innovator Financial Signatures™. Nor does it mean they have to move to become frugal Health Optimizers or Health Discounters, although there could always be cases where this might be an appropriate move.

But what the figure does mean that behaviors in the health system must move gradually towards the upper-left, even if they don't to move any of the edges or corners. The principle is that even small and incremental moves towards the upper left by many providers will produce major changes in financial outcomes at the level of the overall healthcare system.

The principle is that even small and incremental moves towards the upper left by many providers will produce major changes in financial outcomes at the level of the overall healthcare system.

Even movement that takes providers from, say an average of Safety-Makers (in the upper left of the Safety-Maker box) to an average of Health Incrementors (in the lower right of the Safety-Maker box) would have an enormous positive impact on financial outcomes in the healthcare system implying a change from the massive consumption of capital, to little or no consumption. At the national budget level this implies a huge positive change in outcomes and thus a huge positive impact in fiscal outcomes for the US.

For the new healthcare system to work as it is intended, providers must transition from a Medical Concierge to an HPM role. This will require changes in behavior. That in turn will require widespread training.

Behaviors Need to Change, Not Just Systems

Providers at all levels and in all roles need to understand the principles behind business acumen and behavioral change. They need to understand how to recognize their own cognitive biases and to develop the level of self-awareness that will enable them to recognize and compensate for them and to make the correct behavioral change which will results in the right decisions in their own unique situations.

Need for Outcome-Based Decisions

This behavioral training needs to show providers how to focus on long-term health and not just short-term medical outcomes. **It needs to show them the extent to which their own innate behaviors tend to favor one or the other and how to change their**

behaviors so that they more accurately show the right decisions to make in their own circumstances.

Training On Social As Well As Individual Benefits and Outcomes

The training in business acumen needs to show the differences in behavior needed to improve **social as well as individual outcomes**. That means understanding how decisions in the cases of individuals will increase social benefits such as price and cost rather than the inverse. It needs to show them how individual provider innate financial behaviors can lead to high social opportunity costs and what they need to do regarding their own behaviors so that they reduce social opportunity costs.

Training in Business as Well as Medical Acumen

Traditionally the practice of medicine has focused purely on individual medical outcomes, with little attention to both individual and especially social costs. The training needs to show how to **integrate both medical and business acumen**. It needs to show how quality of care concerns need to integrate business issues so as to improve overall social health cost-benefit and social health outcomes.

All Levels and Roles Need to be Involved

It would be a mistake to see this as being a matter just for financial or insurance roles in the healthcare system. Medical and para-medical professionals on the front-line play a critical role in making decisions that impact financial and business outcomes and arriving at the right balance of medical and social cost-benefits. All **medical and para-medical roles need this training** since it is their collective behaviors that will determine how successful the change in behavior is with respect to overall financial and medical outcomes.

In effect we are saying that these issues should be integrated into medical education at as an early stage as possible. Where it is not possible to integrate it at the pre-professional training stage it should be introduced as professional training for existing providers. **It is only if this training occurs that parallel change in systems, compliance and regulation can be truly successful**

Training Should be at the System Level

It isn't just training within hospitals that is needed. Individual and primary and specialty care practices are also critical players in the overall system and should also undergo training in business acumen training. This also includes mental health as well as physical health since this area is rapidly expanding in terms of its importance in overall health outcomes and overall health cost increases.

And we can't just limit training to the front-line healthcare providers. We also need to include insurance companies and roles, government and private regulators and government policy-makers themselves so that they also understand how to integrate these

approaches in business acumen into the broader healthcare system, its policies and regulations.

Appendix 1: Team Financial Performance Improvement Program (TFP)

Description

A TFP

- Improves a team's profitability and financial performance.
- Achieves this by aligning the financial traits of executives (Financial Signatures™) and managers with their organization's financial performance targets
- Provides an assessment of each executive's and the leadership team's financial and leadership profiles
- Assesses their likely impact on achieving the desired financial performance target
- Identifies specific strengths, vulnerabilities and individual development possibilities
- Enables companies to more directly link executive assessment, development and team deployment to measurable business outcomes

The Program

Conducted on teams with a minimum of 3 members and a maximum of 35.

Team Package Components

1. Pre-session objectives and launch meeting
2. Complete assessments
3. Training, Team Feedback and Planning Session
4. Individual coaching sessions
5. Summary reports with recommended development plan

1. Pre-session Objectives and Launch Meeting

One session of two hours with team leader to do the following:

- Set out objectives
- Review expectations
- Discuss how the assessments will be used and who they will be seen by
- Set out tasks to be completed by team participants
- Review team business environment

- Set schedule
- Assign responsibilities for program implementation actions

2. Complete Assessments

Conduct **Perth Assessments**:

- FOA
- EXOA
- CFOA – assesses the company's Financial Signature™

3. Training, Team Feedback and Planning Sessions

Sessions to complete the following:

- Team Training Session on PLOM™ (half-day session)
- Team Feedback session on team assessment results (half-day)
- Financial Mission Impact Planning Meeting (half day)

Team Training Session on PLOM™ (half-day session)

- Orientation to the PLOM™ model and research underlying the assessments so executives can have a platform to subsequently understand their personal and team assessment results

Team Feedback session on Team Assessment Results (half-day)

- Identifies the team's collective Financial Signature™™ and leadership outcome profile and the gaps in alignment with the business's financial performance and valuation target,
- Identifies realistic financial performance and valuation targets for the organization based on assessments and analyses.

Financial Mission Impact Planning Meeting (half day)

- Conduct a Financial Mission **Impact Action Plan** development session
- Develop a Financial Mission Impact Plan to improve the financial performance of the team and to align it more closely with financial performance targets.
- Provides recommended actions to improve team composition, deployment and financial performance outcomes.

4. Individual Coaching Sessions

- Conduct individual **coaching sessions** for all participants as part of a customized developmental program for each.
- Two post-assessment sessions 2 x 1.5 hour sessions

5. Summary Reports with Recommended Development Plans

- Prepare customized development plans for each participant and provide it to them subsequent to the final coaching session.

Outcomes

- Improves individual capability to deliver improved financial performance outcomes
- Assesses "Nose for Making Money" and links executive behaviors to financial performance opportunities
- Leadership teams have increased clarity on how to achieve financial performance improvement in the context of the organization's financial goals.
- Stronger and aligned management systems and processes

Results

- Reduces expenses materially by individuals and at the team level.
- Increases unit and healthcare system overall value through reduced expenses in the short- to medium-term and through increased margins in the medium- to longer-term providing the program is sustained.
- Improves business acumen and the ability to see and advise on financial opportunities and to maximize their commercial benefit.

[1] Prince, E. Ted, Business Personality and Leadership Success: Using The Leadership Cockpit To Improve Your Career And Company Outcome, Amazon Kindle 2011

[2] Prince, E. Ted, The Three Financial Styles of Very Successful Leaders: Strategic Approaches to Identifying the Growth Drivers of Every Company, McGraw Hill, 2005.