Longer, Better Lives in the Sharing Economy

By Ninie Wang , Pinetree Care Group

Technology can turn the burden of long-term care into a new growth engine.

Much has been made of the sharing economy's ability to automate traditional occupations like taxi drivers out of existence. But can similar principles be applied to the business of improving health and renewing lives? I would argue that they can, which is why we've pioneered a new model of healthcare delivery using technology that both lowers the cost and the burden of elder care by empowering both patients and care professionals.

The biggest financial and health risk associated with ageing is not age itself but functional loss. For the conventional healthcare sector, this means growing healthcare bills and a need for more professionals to work in the sector. These challenges are exacerbated by a shrinking number of working-age people to fill all the care roles. The working-age population in China for

example, has been shrinking for four consecutive years. China's demographic dividend is being replaced by a longevity paradox.

China today already needs to care for over 40 million dependent seniors out of the 222 million aged over 60. Some calculate that at least 12 million caregivers are needed. But we currently only have fewer than 300,000, 99 percent of whom have no relevant training.

That's why, in the spirit of disruptive innovation, we are thinking very differently about the future of elder care. Rather than joining the uphill battle of putting a shrinking number of professionals in hospitals and extending services to visiting patients, we're enabling patients to seek care at their convenience in their homes, from professionals who work at their convenience too.

Disruption for life

We follow two principles to achieve this. First of all we do not accept "functional decline and loss" as a final verdict. For at least 90 percent of frail, dependent or even bed-ridden seniors, much can still be done to help them regain and maintain functionality. In public health promotion, governments are looking at prevention of diseases, or delaying the onset of chronic diseases. On top of that, we believe that functional decline/loss can also be prevented or at least delayed, therefore our choice of "restorative care" focusing on identifying and providing interventions to the functions that can still be restored and maintained. For as long as possible, we work together with the patients and their family caregivers to address this issue rather than accepting "fate" and providing life support which might replace their own functionalities and result in unnecessarily earlier dependency.

Over 85 percent of mortality in China is caused by non-communicable or chronic diseases. Unlike acute illness, such diseases can rarely be "cured", and interventions outside of hospitals decide patients' quality of life just as much as diagnosis and treatments inside, if not more.

Secondly, since such restorative care is much more complex and demanding than basic life care (such as housekeeping, feeding, etc.), caregiving needs to be provide by much better educated and trained professionals. In many developed countries, a multidisciplinary team including geriatricians, nurses, rehabilitation therapists, nutritionists and social workers work together to provide comprehensive care to an elderly person. However, given the scale

of demand in China, we came up with the new talent model: hybrid. We train our physicians, nurses, therapists and social workers into generalists and we have developed a support system so that any trained and certified Pinetree caregiver can follow the “expert” in the system to complete a comprehensive care need assessment, understand the holistic care plan suggested by an algorithm based on the data accumulated from our millions of service sessions, and give real-time care reports and feedback for plan modifications if necessary via their smartphones.

A platform for care

The challenge in building a scalable and sustainable business model was to “lure” enough professionals to leave their hospitals and join Pinetree. Instead we decided to mobilise existing healthcare professionals to engage in a new model of care. In this model, services are not provided where institutions are built, but wherever patients are; long-term care does not mean hopeless, ever-degenerating functions replaced by a caregiver but continuous monitoring and a personalised plan to restore one’s autonomy for as long as possible. This restorative care model was inspired by the lessons learned in many developed countries and localised to fit the reality in China.

We also carefully introduced tele-care. After numerous trials between 2014 and 2015, we chose to run our services on a companion robot that helps connect the patients, their family members, medical experts (wherever they are) and our own health assistants. Instead of overloading doctors, especially specialists with basic questions that can be easily solved by our “gatekeepers”, we created the triage pyramid to ensure that only the most relevant and demanding cases are presented to the top experts. This way when they do engage in a patient conversation, it would be a well-prepared, valuable discussion for both sides.

A major difficulty in ramping up services was the unexpectedly low broadband penetration. Only less than 5 percent of Chinese elderly have a broadband subscription at home. Although more of them have a smartphone today, very few would use video services in fear of the high cost of data volume. After successful launch of our services via the companion robot which requires broadband connection, we started looking at other platforms that would give us access into more homes. Interactive set-top boxes made it possible. Working with operators of cable TV networks, we could expect to extend our services to millions of families at 1/10 of the cost of the robot.

As our tele-care patients came from every province and even outside of China, our offline home healthcare services couldn't keep up. In order to enable patients in smaller cities and remote areas where resources are scarce and we are unlikely to establish our own caregiver team any time soon, we desperately needed to work with local healthcare professionals. In 2015, we piloted the "contractor caregivers" in Beijing following the successful models in sharing economy such as Uber or Didi drivers. Instead of encouraging more talented professionals to leave their current positions and join Pinetree, we simply gave them an option to provide our type of services in their neighbourhood whenever they are available, and the whole process is facilitated by our online application, just as you would book a hotel room or hire a car using online platforms.

Sharing is caring

Today we are still comparatively small against the quickly increasing need for care, yet with the empowerment of potentially millions of healthcare professionals in the Pinetree model; it is becoming ever clearer that our society can enjoy longevity with good quality of life, instead of a huge economic burden. Long-term care can even be turned into a new engine for economic growth, if we deploy the sharing economy model of connecting consumers and providers conveniently and quickly with technology.

Two things I learned at INSEAD have held true over the past 12 years. First is that in entrepreneurship "anything that can go wrong, will go wrong" (repeated daily in classes by the late and beloved **Professor Patrick Turner**), therefore it is crucial to "hold on to your dragon". The other is to believe in sharing: at INSEAD we worked on almost every major problem with our peers rather than alone. For our venture, which is aimed at solving an enormous social issue, the better we can share the work, the more everybody gains.

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Healthcare Management

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