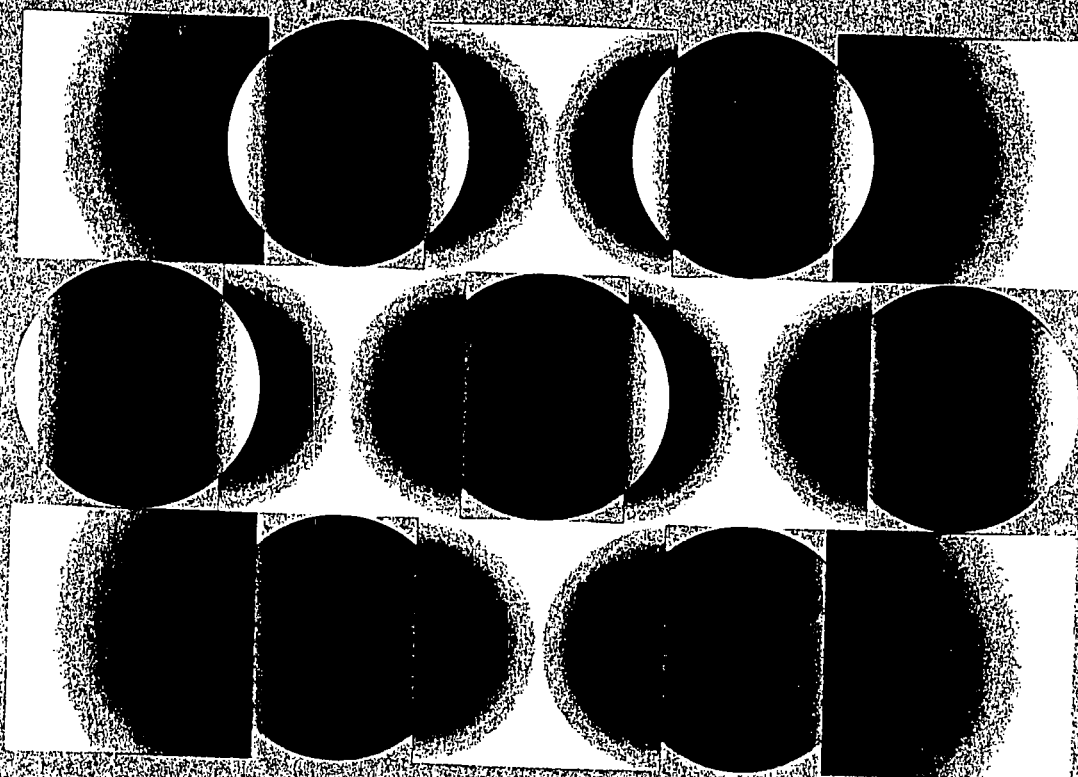


1997 Environmental Assessment Redesigning Health Care for the Millennium



AN ASSESSMENT OF
THE HEALTH CARE
ENVIRONMENT IN
THE UNITED STATES

VHA Inc.

VHA is a performance improvement company serving more than 1,300 health care organizations, including 20 percent of the nation's community hospitals and 26 percent of the nation's inpatients. Several VHA organizations have majority ownership in local health maintenance organizations, covering more than 3.5 million lives.

VHA provides information, products and services to help these organizations improve community health, clinical effectiveness and operational efficiency.

VHA, with headquarters in Irving, Texas, serves the VHA network in collaboration with Regional Health Care Systems across the country. Together, VHA's national and regional offices employ more than 1,100 staff members.

VHA's efforts are focused on helping selected health care providers respond to the challenges that matter most to their patients, their communities and the purchasers of their care.

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Deloitte & Touche LLP serves more than 4,000 health care clients nationally. Our combined client base represents all facets of the health care industry, including providers of service, academic institutions, government agencies, insuring organizations, long-term-care facilities and suppliers. We bring knowledgeable resources to assist our clients on a broad range of strategic, management, systems and financial issues. Health care is one of four industry-service priorities set by our firm's senior management. Our national health care practice is coordinated by a National Healthcare Industry Group, a formal cross-functional organization of more than 1,000 professionals who devote the majority or all of their time to health care clients and industry issues. Located across the country, our health care specialists offer multiple perspectives and insights from their hands-on involvement with many of the leading organizations in the industry.

Dear Colleagues

The current environment is the context for the decisions and directions that will guide American health care into the next millennium. The pages in this book examine the trends of this changing environment, detail the context and raise the difficult issues that must be faced by health care leaders in the near future.

This assessment of the health care environment gives substance and shape to the enormous changes moving through the delivery and financing systems: the aging of Americans, the inexorable penetration of managed care and the increasing influence of government. These factors plus many more must be balanced by hospitals and physicians, integrated health systems, health insurers and employers to be stable in current markets and poised for the future.

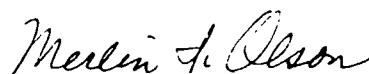
Other major trends in health care today are: increasing clinical efforts to reduce costs, continued consolidation and patient-capacity reduction, growing consumer demands for access and service, constantly changing roles and opportunities for physicians, strengthening insistence on outcomes and quality measurements, and the rapid deployment of information technology in the field.

These trends and many more are outlined in this book, "Redesigning Health Care for the Millennium." It includes reference points to guide you and your organization as you deal with the context of constant change, and provides a comprehensive analysis of health care as we step boldly into the next thousand years.

We sincerely welcome your comments.



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The View from 30,000 Feet

2 Rising Expectations:
Managing Consumer Demand

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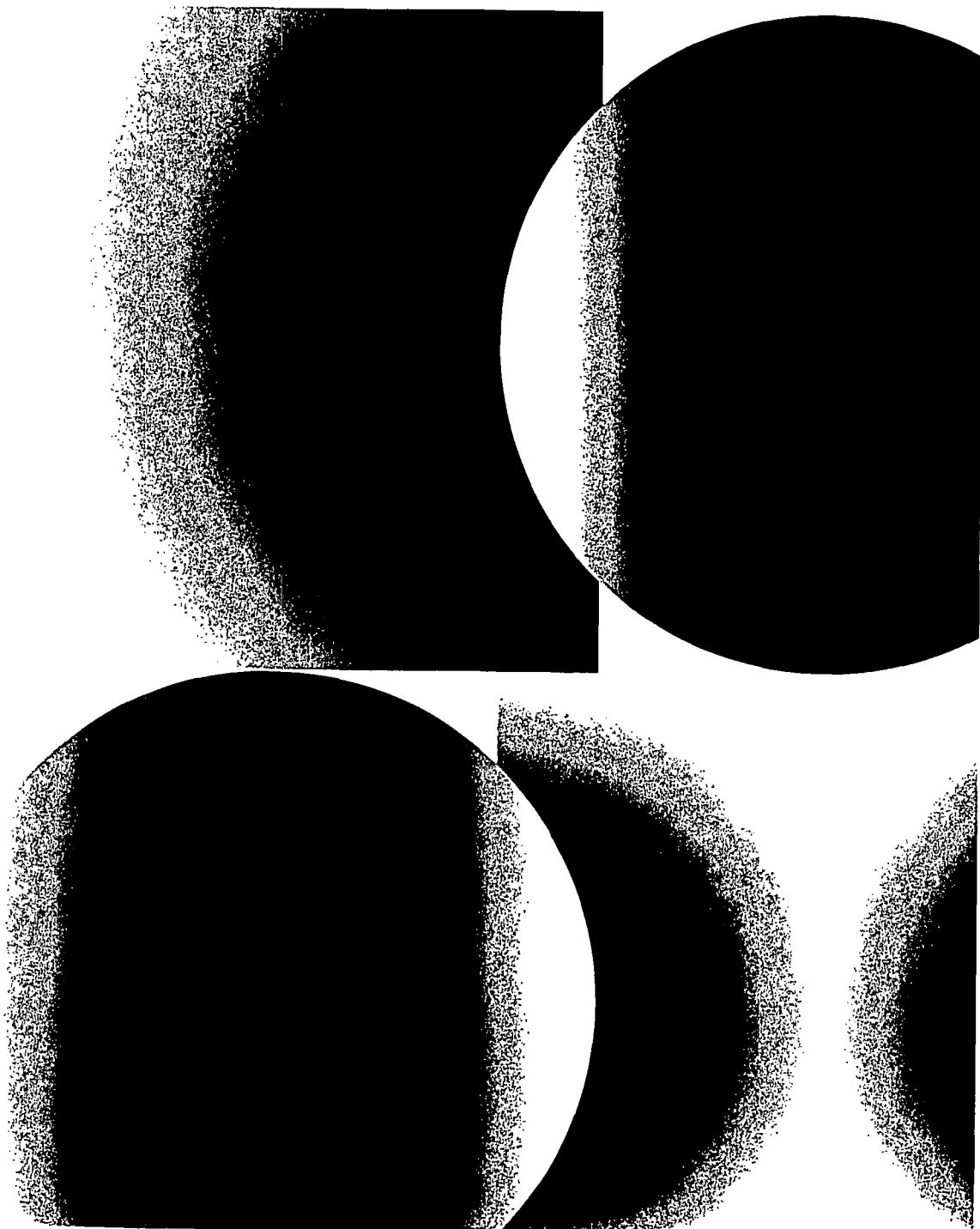
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INTRODUCTION



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INTRODUCTION

Redesigning Health Care for the Millennium

It's the most exciting of times; it's the most challenging of times. As the millennium approaches, health care providers and organizations are wrestling with issues that will have repercussions beyond the turn of the century. The nation is rapidly growing older, new strains of viruses and increased incidences of some diseases challenge our research communities, and new medical technology is being developed more quickly than the ethical dilemmas it often raises can be resolved. It is in this environment of ceaseless change and discovery that health care organizations will greet the new century.

Chapters one through five of this 1997 environmental assessment give an overview of the major changes and challenges facing health care today. The final chapter is a road map of where the health care industry has been and offers strategic initiatives to help health care organizations prepare for the millennium.

Chapter One focuses on cost pressures that are bearing down on health care organizations. Medicare enrollment and costs are skyrocketing, but how

long can that growth be sustained? Managed care continues its rapid penetration of American health care coverage. Which plans are growing and why? How has this growth affected other health care providers? How are physicians reacting to these market forces?

In Chapter Two, we look at how employers, consumers and other groups are changing the way health care is viewed and purchased. How does the public perceive health care, and how does this affect their use of health care services? What measures are being used to determine health care quality and value? How are health care providers responding to — and influencing — the needs of communities? And how successfully are Americans taking control of their own health?

Chapter Three explores the many ways health care organizations are responding to continued cost and competitive pressures. What are the most common organizational responses, and which of these are most effective? Why are some groups undertaking redesign and re-engineering initiatives? How successful have they been? How can organizations overcome resistance to change?

In Chapter Four, we focus on information technology in health care. How will the Internet be used by providers and patients? What are the top IT challenges health care organizations face in the next few years? What is the computerized patient record and how will clinical data repositories be used? What are physicians' IT needs today, and how will they change in the future? How are managed care organizations using information technology to remain competitive?

Chapter Five explores the changing physician market, from the growth of independent physician associations to the rapid disappearance of solo practices. Who is acquiring physician practices, and how do physicians benefit? Which specialties are seeing increases in compensation? Which specialties are attracting newly graduated medical students and why?

Finally, Chapter Six looks at the health care landscape today with an eye on how key trends are likely to affect health care into the next century. From the growth in managed care, to rapid consolidation in the industry, to active consumer involvement, health care organizations can best prepare for the future by understanding the larger issues at work today.

"Redesigning Health Care for the Millennium" offers an in-depth look at the present while it seeks to outline the future challenges of the health care industry. We hope it is both an informative and useful tool in your strategic planning discussions, and assists your efforts to develop the most effective health care delivery system for the millennium.

CHAPTER ONE

*Health Care Under Control:
The View From 30,000 Feet*

The View From 30,000 Feet

Managing Consumer Demand

Organizations Are Still Evolving

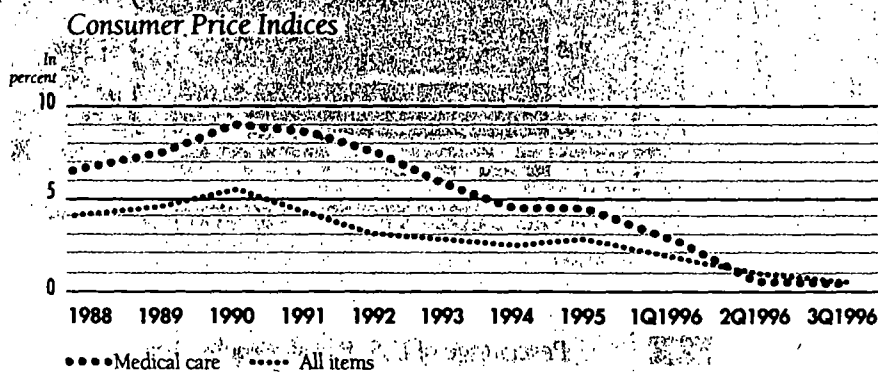
Health Care Under Control: The View From 30,000 Feet

Costs flattening out

A decade of health care competition has put the brakes on rising costs. In the second quarter of 1996, for the first time in nearly two decades, the medical care price index dropped below the U.S. Consumer Price Index (Fig. 1.1).

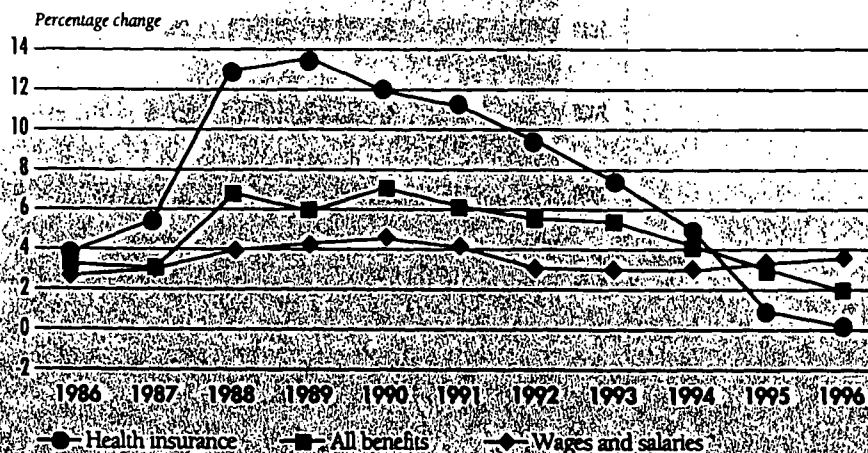
Health insurance costs have also dropped. After years of growing much faster than other employee benefits and wages and salaries, the increase in employers' cost of employee health insurance fell to near zero in 1996 (Fig. 1.2). Also in 1995, the premium rates for health maintenance organizations and preferred provider organizations decreased for the first time in years, mainly because of pressure from payers and competitors (Fig. 1.3).

1.1



1.2

Employment Cost Index



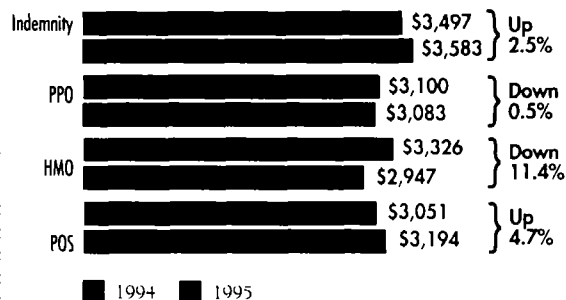
Aging baby boomers strain the system

The nation's population is getting older. There are 15 million people age 75 and older in the United States today, and that number is projected to climb to more than 25 million by 2025 (Fig. 1.4 and Fig. 1.5).

Health care is naturally more costly for older people, with the result that without Medicare reform, total health care expenditures are expected to reach 18 percent of the nation's gross domestic product by 2005. That's up from about 14 percent today (Fig. 1.6), the bulk of it on hospital and physician services (Fig. 1.7).

1.3

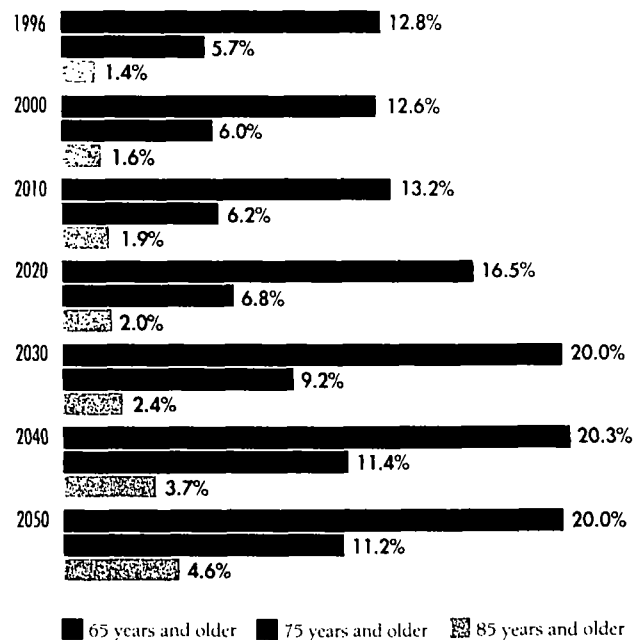
Average Cost of Coverage Per Employee in a Midsized Firm



Sources: *American Medical News*, Sept. 23, 1996, from Johnson & Higgins, July 1996

1.4

Percentage of U.S. Population by Age

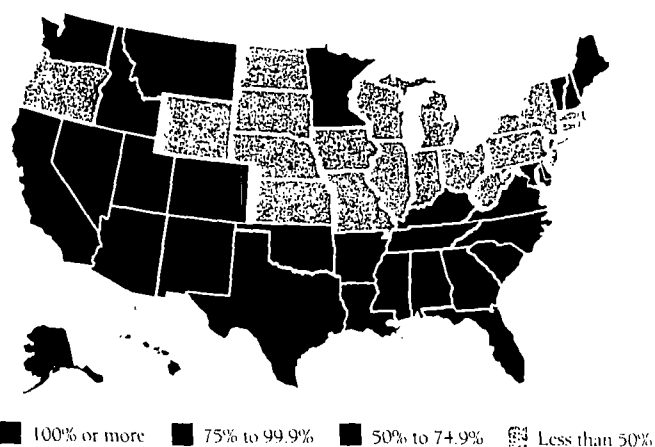


Source: U.S. Census Bureau, 1996

1.5

Elderly Population Growth Is Dramatic in Some States

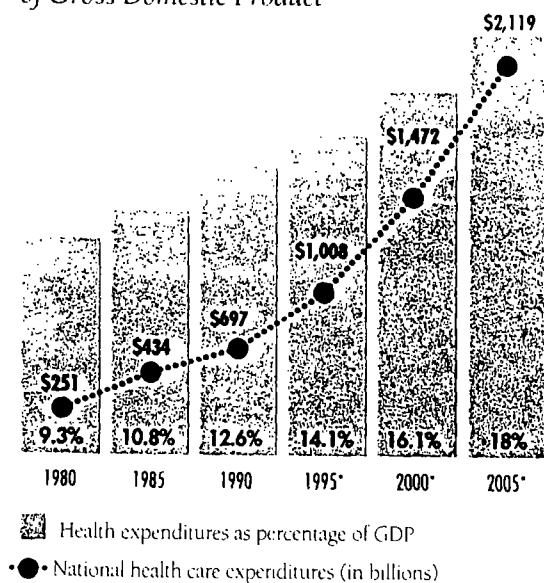
The increase, by state, in the number of people age 65 and older from 1993 to 2020



Source: U.S. Census Bureau, 1996

1.6

Growth in National Health Care Expenditures in Dollars and as a Percentage of Gross Domestic Product



Source: Congressional Budget Office, 1996

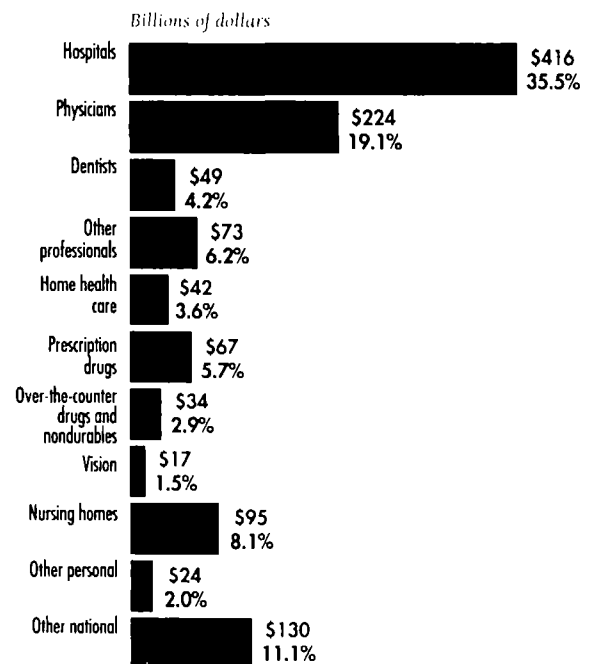
Medicare just keeps growing and growing ...

Mostly through Medicare and Medicaid, state and federal governments pay for 45 percent of the nation's health care expenditures, up from less than 25 percent in 1965. Over the same period,

private sources dropped from 75 percent of total health care expenditures to about 55 percent (Fig. 1.8). In 1996, Medicare spending was more than \$196 billion, and if current laws stay in effect, that number is projected to almost double by 2004 (Fig. 1.9).

1.7

Projection of 1997 Health Care Expenditures



Note: Percentages do not add to 100 due to rounding

Source: Congressional Budget Office, 1996

1.8

National Health Expenditures by Source of Funds

As a percentage of total expenditures

Year	Private	Government		Total
		Federal	State and local	
1965	75.3%	11.6%	13.2%	100%
1980	58.1	28.7	13.3	100
1985	59.7	28.4	11.9	100
1990	58.9	28.1	13.0	100
1993	56.1	31.7	12.1	100
1995*	54.8	33.2	12.0	100
2000*	52.3	35.8	11.8	100
2005*	49.6	38.8	11.6	100

*Projected

Source: Prospective Payment Assessment Commission, 1996 Annual Report to Congress, from Congressional Budget Office data

Contrary to popular opinion, most Medicare beneficiaries cost the program very little. A small number of enrollees—slightly more than 3 percent—are very expensive to the program, costing \$25,000 or more per year and accounting for about 39 percent of all Medicare spending. More than half of all enrollees have annual health care payments of less than \$500 (Fig. 1.10).

... Until it bursts

The trustees of the Medicare Hospital Insurance Trust Fund estimate it will be depleted by 2001, if not sooner. While they've warned of this for years, the fund's negative cash flow in 1996 is raising fears that the fund is going broke at an alarmingly faster rate than expected.

1.9

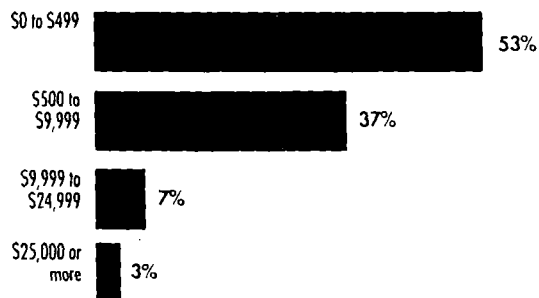
Selected Congressional Budget Office Medicare Spending Projections

Category	1996	1998	2000	2002	2004	2006
Total mandatory (in billions)	\$196.1	\$236.4	\$279.5	\$328.5	\$388.9	\$463.0
Part A enrollment (in millions)	37.5	38.6	39.5	40.6	41.7	43.0
Part A benefits (in billions)	\$126.0	\$150.5	\$175.6	\$203.0	\$235.0	\$273.4
Hospitals	84.1	93.7	104.7	115.3	126.6	138.6
Home health	17.5	22.5	26.7	31.3	36.5	42.4
Skilled nursing facilities	11.0	13.6	16.0	18.6	21.4	24.6
Part B enrollment (in millions)	36.0	36.9	37.7	38.6	39.5	40.6
Part B benefits (in billions)	\$70.1	\$85.9	\$103.9	\$125.6	\$153.9	\$189.6
Physicians	35.1	39.3	43.1	46.3	50.7	56.2
Hospital outpatients	17.3	21.9	27.7	35.0	43.4	52.7

Source: Congressional Budget Office, based on April 1996 budget baseline

1.10

Payments Made on Behalf of Medicare Beneficiaries by Percent, 1993



Source: Prospective Payment Assessment Commission, 1996 Annual Report to Congress

Yet health system profits are up

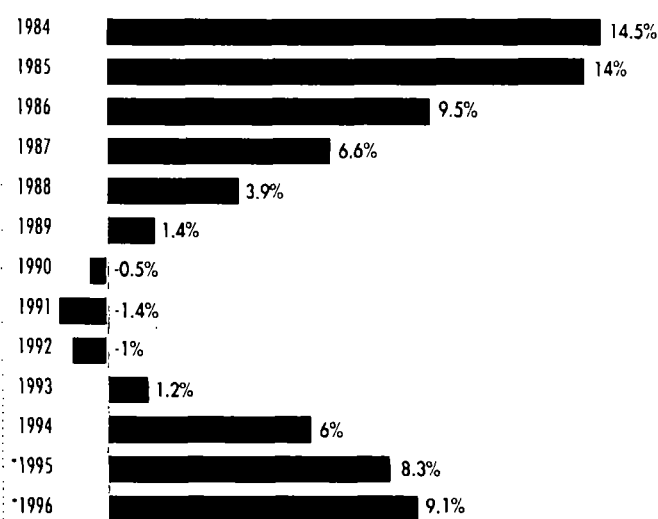
While Medicare is going broke, preferred provider system profits are increasing dramatically. After having double-digit figures in the mid-1980s, operating margins were negative in the early 90s. But now they're on the rise again, climbing almost as steeply as they did in the mid-80s (Fig. 1.11). Substantial profit margins are a clear sign that health systems are successfully controlling their costs, which could influence Medicare to slow its growth of provider payments in the coming years, which in turn could reduce health systems' operating margins.

Medicare managed care plans—still a political darling

Both the Congress and White House still like the idea of expanding Medicare enrollment into managed care plans to hold costs in check. Many managed care firms already have a significant Medicare enrollment (Fig. 1.12), and that has grown substantially, mostly in California and Florida (Fig. 1.13). Medicare beneficiaries elsewhere have been hesitant to join managed care plans, and less than 10 percent of eligible beneficiaries are enrolled nationwide, although that's expected to grow to about 23 percent by 2006 (Fig. 1.14).

1.11

Prospective Payment System Aggregate Preferred Provider System Operating Margins



*Margins for 1995 and 1996 are estimates based on current cost and payment trends

Source: Prospective Payment Assessment Commission, 1996 Annual Report to Congress

1.12 Top 25 Health Maintenance Organizations by Medicare Enrollment

HMO name	Medicare enrollment	Net change six months ending 1995	Percentage of total enrollment from Medicare
1. PacifiCare of California	364,818	32,668	28.3%
2. Kaiser Foundation Health, Northern Calif.	265,373	10,131	10.5
3. FHP Inc. (Calif.)	215,339	8,467	22.8
4. Kaiser Foundation Health, Southern Calif.	186,469	8,415	8.2
5. Humana Medical Plan Inc., South Fla.	100,700	4,100	35.5
6. Health Net (Calif.)	87,930	11,402	6.4
7. FHP Inc. (Ariz.)	84,125	679	49.1
8. Health Insurance Plan of Greater New York	77,450	336	9.2
9. MEDICA (Minn.)	75,238	672	12.8
10. AvMed (Fla.)	63,168	13,079	22.5
11. Humana Medical Plan Inc. (Tampa)	63,100	900	37.9
12. Oxford Health Plans of New York	62,144	18,657	32.0
13. PacifiCare of Texas	54,682	10,084	36.0
14. Aetna Health Plans of California	54,459	1,404	26.1
15. Group Health Cooperative of Puget Sound	54,376	4,756	8.6
16. HMO Pennsylvania/U.S. Healthcare	52,914	14,387	7.4
17. HMO Oregon/Health Maintenance Plan	51,801	1,984	10.7
18. CAC-United HealthCare Plan (Fla.)	47,523	3,319	18.2
19. Kaiser Foundation Health of the Northwest	46,965	49	11.9
20. SHARE Health Plan of Illinois Inc.	44,993	10,363	36.5
21. Health Options Inc. (Fla.)	44,719	6,843	8.9
22. PCA Health Plans of Florida	40,569	9,715	36.5
23. Humana Health Plans Inc. (Chicago)	38,400	3,600	11.1
24. PacifiCare of Oregon	38,193	3,904	21.9
25. HealthPartners (Minn.)	37,767	894	6.7

Source: The InterStudy Competitive Edge: HMO Industry Report, 1996

1.13 Enrollment in Medicare Risk-Contract and Cost-Contract Health Maintenance Organizations for States With at Least 1 Percent of Enrollment, 1995

State	HMO enrollees as share of national HMO enrollment	HMO enrollees as proportion of all beneficiaries in state
California	35.5%	33.3%
Florida	12.5	16.4
New York	5.9	7.6
Arizona	5.0	28.7
Oregon	4.2	30.4
Texas	4.1	6.7
Pennsylvania	3.7	6.2
Minnesota	3.4	18.7
Washington	3.0	15.1
Illinois	2.9	6.0
Massachusetts	2.5	9.1
Colorado	2.4	19.8
Ohio	1.4	2.8
Hawaii	1.3	30.3
Nevada	1.2	22.3
New Jersey	1.2	3.6
Missouri	1.0	4.1

Source: Prospective Payment Assessment Commission, 1996 Annual Report to Congress

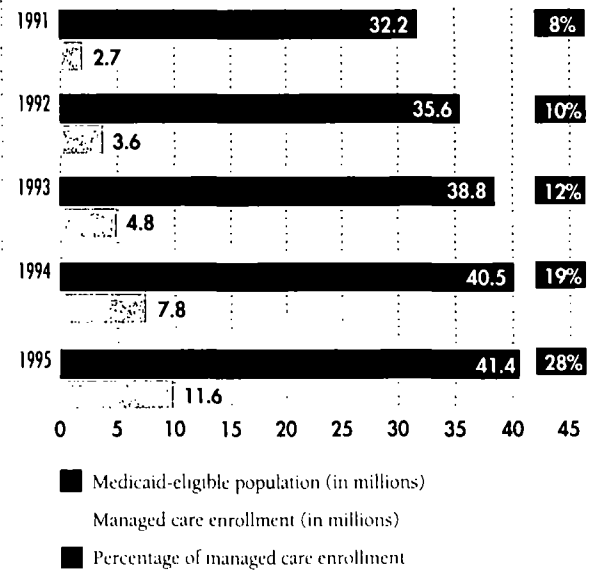
1.14 Projected Medicare Managed Care Enrollment in Risk Plans

Year	Medicare managed care risk enrollment (in millions)	Percentage of total Medicare enrollment
1996	3.4	9.0%
1997	4.1	10.7
1998	4.7	12.1
1999	5.1	13.2
2000	5.7	14.3
2001	6.2	15.5
2002	6.8	16.9
2003	7.5	16.3
2004	8.3	19.9
2005	9.1	21.6
2006	10.0	23.3

Source: Congressional Budget Office, 1996

1.15

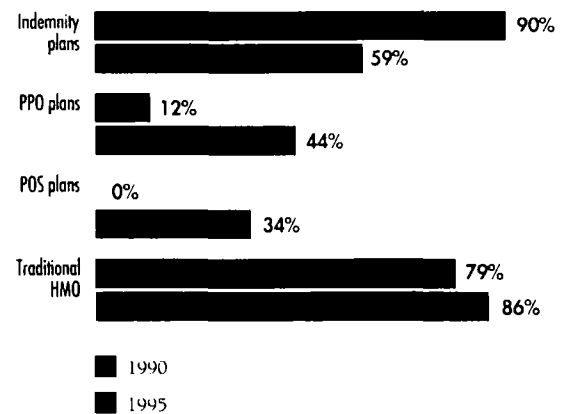
Medicaid Enrollment in Managed Care



Source: Health Care Financing Administration, Office of Managed Care, 1996

1.16

Types of Health Plans Offered by Major U.S. Employers



Sources: *Managed Care Outlook*, Volume 9, Number 6, March 22, 1996, from *Salaried Employer Benefits Provided by Major U.S. Employers in 1990 and 1995: A Comparison Study*, Hewitt Associates

Medicaid is becoming more managed

Federal and state governments are working together to offer managed care plans to Medicaid beneficiaries across the country, both to control costs and improve access. In fact, Medicaid managed care plans have grown from less than 10 percent of total beneficiaries at the turn of the decade to about one-third today (Fig. 1.15). And that number will continue to grow since 14 states and the District of Columbia have federal waivers to offer managed care options.

At the same time, access to Medicaid is becoming more limited. The Work Opportunity Reconciliation Act of 1996 (known as the "welfare reform" bill) will decrease welfare and supplemental security income eligibility, in turn terminating millions of people from Medicaid. The Congressional Budget Office estimates the bill will reduce federal

outlays by \$54.1 billion and increase federal revenues by \$394 million from 1997 to 2002. All future legal immigrants will be ineligible for Medicaid coverage for 10 years, and by CBO estimates, 22 percent of children now receiving Supplemental Security Income will lose their eligibility and their Medicaid coverage with it. This reduction in eligibility could lead to a marked increase in the amount health care organizations spend on charity and uncompensated care.

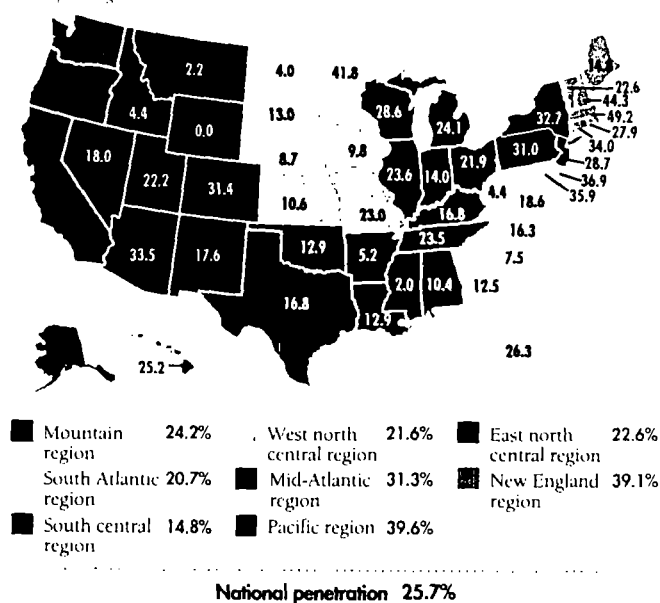
Managed care: still the watchword of the decade

Managed care continues its penetration of American health care coverage, with traditional indemnity plans on a curve toward extinction (Fig. 1.16). In 1995, national market share of health maintenance organizations was almost 26 percent, up from 21 percent in 1994 (Fig. 1.17).

1 Health Care Under Control: The View From 30,000 Feet

1.17 Health Maintenance Organization Penetration, by State and Region

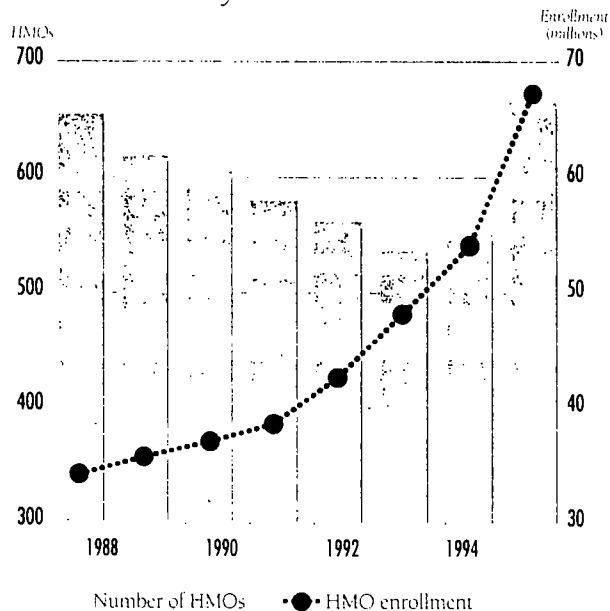
By percentage



Source: SMG Marketing Group Inc., 1996

1.18

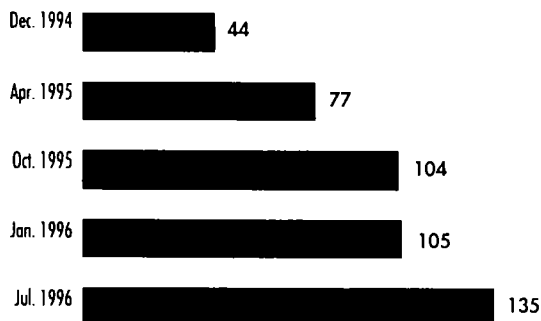
Health Maintenance Organization Historical Analysis



Source: SMG Marketing Group Inc., *Market Letter*, August 1996

1.19

The Number of Health Maintenance Organizations Belonging to Integrated Health Networks



Source: SMG Marketing Group Inc., *Market Letter*, August 1996

Enrollment continues to climb as the total number of HMOs is increasing (Fig. 1.18), reflecting that HMOs have become the preferred form of managed care by integrated health networks and employers. The number of HMOs belonging to integrated health networks, in fact, grew by 207 percent from December 1994 to July 1996 (Fig. 1.19). The largest HMO network, Blue Cross and Blue Shield, has nearly 11 million enrollees (Fig. 1.20).

What is more, the number of individual hospitals with 10 or more managed care contracts has increased significantly in the last two years (Fig. 1.21).

1.20 Multiple-Plan Health Maintenance Organization Corporations Ranked by Enrollment as of Dec. 31, 1995

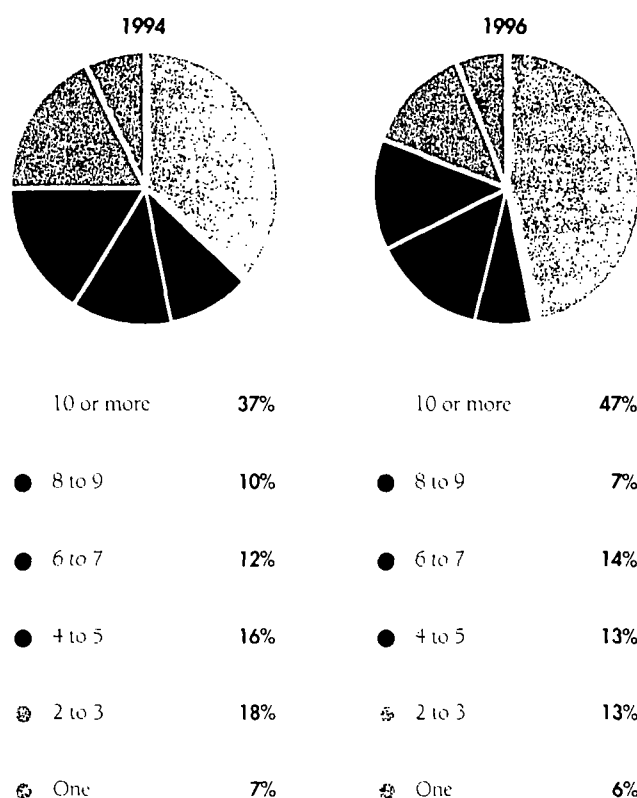
Name of HMO	Number of plans operational	Total enrollment
Blue Cross/Blue Shield	72	10,672,609
Kaiser Foundation Health Plan	14	6,655,309
United HealthCare Corp.*	52	5,525,756
The HMO Group**	20	4,418,732
CIGNA Health Plans	46	3,957,680
Prudential Insurance	35	3,898,790
U.S. Healthcare***	13	2,322,574
FHP International	11	1,903,919
Humana Health Care Plans	22	1,867,400
Health Systems International	9	1,834,187

* United HealthCare Corp. acquired MetraHealth and Healthwise of America

** The HMO Group is a professional association that affiliates with HMOs, but does not own or manage them.

*** U.S. Healthcare was acquired by Aetna Health Plans in 1996.

Source: SMG Marketing Group Inc., *Market Letter*, August 1996

1.21
Number of Managed Care Contracts Per Hospital


Source: *U.S. Hospitals and the Future of Health Care*,
Deloitte & Touche Biennial Survey, 1996

1.22
Managed Care Enrollment

In thousands

Plan type	1993	1994	1995	1997*
HMO: traditional	34,880	38,140	43,913	57,100
HMO: Open-ended	2,252	2,904	3,508	5,050
HMO: Point-of-service	4,931	6,221	9,948	15,300
HMO: Medicare total	2,659	3,080	3,588	6,200
Medicare risk	N/A	N/A	2,725	N/A
Medicare cost	N/A	N/A	863	N/A
HMO: Medicaid	2,091	2,665	4,743	9,400
FEHBP	2,165	1,996	1,829	1,600
Total HMO enrollment	48,978	55,006	67,529	94,650
Medicaid: Non-HMO managed care	2,921	5,058	4,979	6,800
Total Medicaid managed care	5,012	7,723	9,722	14,200
Preferred provider organizations+	76,561	79,042	79,596	73,000
Total managed care enrollment	128,460	139,106	152,104	174,450

Data as of Dec. 31, 1995

* Projected

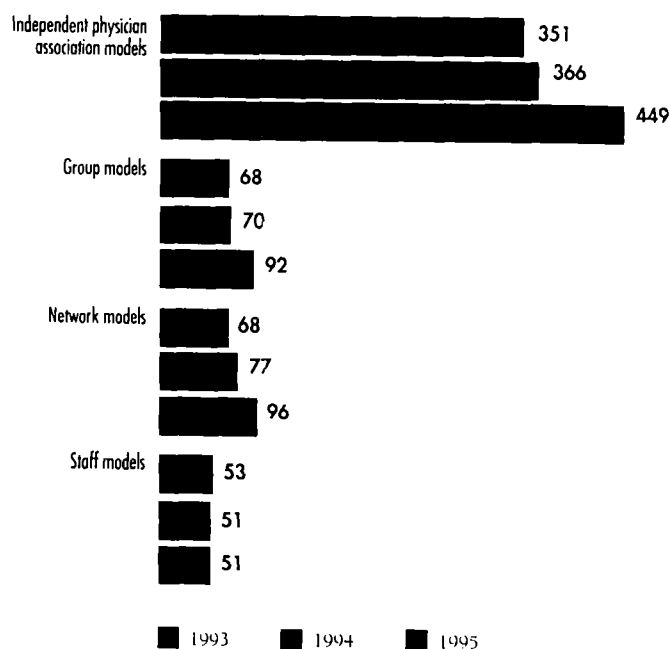
+ Excludes double-counting of PPO-eligible employees across
rented networks

Source: SMG Marketing Group Inc., *Market Letter*, August 1996

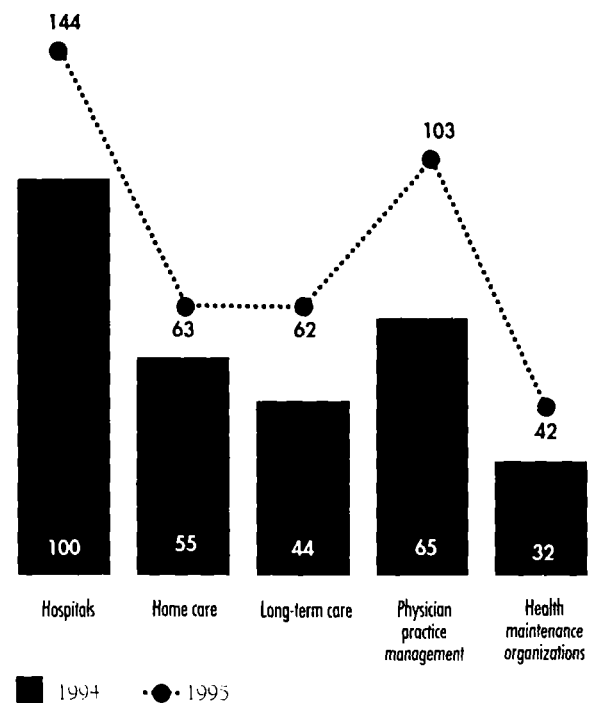
Of the various HMO types, consumers continue to prefer point-of-service and open-ended plans because of their flexibility, and those plan types are growing most rapidly (Fig. 1.22).

In 1995, independent physician associations accounted for more than 65 percent of all HMO model types nationally; an almost 23 percent increase over the year before, while staff models remained flat (Fig. 1.23).

Number of Health Maintenance Organizations by Model Type



Source: SMG Marketing Group Inc., *Market Letter*, August 1996

1.24
Health Care Merger and Acquisition Transactions


Source: Lewin Associates Inc., 1996

1.25
Steady Growth of Integrated Health Network Affiliations Continues

	Number of IHNs	Percentage of U.S. hospitals belonging to IHNs*	Percentage of U.S. hospitals claimed by IHNs	Percentage of U.S. hospital beds claimed by IHNs	Percentage of U.S. community hospital beds claimed by IHNs*	Percentage of U.S. surgeries performed by IHNs	Percentage of HMOs affiliated with IHNs	Percentage of nursing homes affiliated with IHNs	Percentage of home health agencies affiliated with IHNs	Percentage of alternate care sites affiliated with IHNs	Percentage of physician centers affiliated with IHNs
Dec. 1994	255	16.4	22.9	22.2	40.8	30.7	6.8	0.7	1.3	3.3	3.2
May 1995	435	24.7	31.2	32.6	51.2	43.6	12.8	1.1	2.3	5.0	6.8
Feb. 1996	504	32.2	38.7	43.1	61.7	50.5	13.0	1.5	3.0	6.5	10.9

*Numbers based on short-term, nonfederal, acute care hospitals

Source: SMG Marketing Group Inc., *Market Letter*, April 1996

1.26
Health Network Expansion

Projected growth in regional health networks, to 2000

Population of Standard Metropolitan Statistical Areas	Number of metropolitan areas	Average networks per metropolitan areas	Total networks
Fewer than 450,000	221	2	442
450,000 to 1.5 million	72	3.5	252
More than 1.5 million	28	5	140
Total	321	2.6	834

Source: Bedford Health Associates, 1994

Coming together: more mergers and acquisitions

Mergers and acquisitions of hospitals and clinics are continuing at a fast clip (Fig. 1.24). Columbia/HCA alone completed 30 such acquisitions or joint-venture relationships in 1995.

Most consolidation activity for hospitals will be through acquisitions, mergers and the creation of integrated health networks, which function through long-term contracts and affiliations (Fig. 1.25). Ninety percent of all U.S. hospitals are projected to align with one or more regional networks by 2000 (Fig. 1.26).

Looming over all this consolidation activity is the problem of significant inpatient overcapacity (Fig. 1.27 and Fig. 1.28). To remain competitive, hospitals are closing facilities, eliminating jobs and watching costs closely.

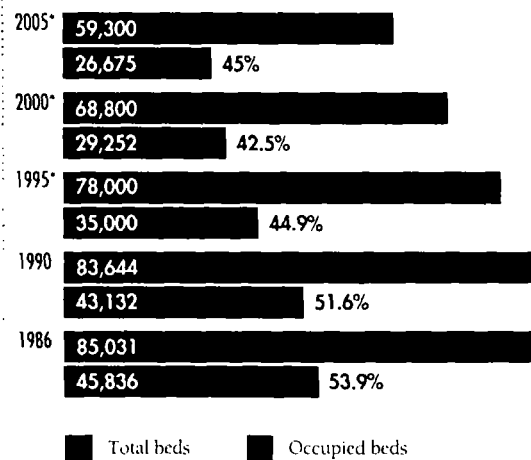
1.27 Hospital Bed Supply and Demand, 1995

Market	Days per 1,000 population, 1995	Days per 1,000 population in a 100% managed care market
Atlanta	667	345
Boston	1,014	366
Chicago	692	354
Cleveland-Lorain-Elyria	778	374
Dallas	636	335
Detroit	714	350
Houston	640	327
Indianapolis	681	366
Los Angeles-Long Beach	474	337
Miami	734	389
Minneapolis-St. Paul	548	348
New York	1,036	360
Philadelphia	1,011	365
Phoenix-Mesa	505	399
Pittsburgh	1,203	403
San Diego	460	352
San Francisco	506	378
Seattle-Bellevue-Everett	469	363
St. Louis	752	365
Tampa-St. Petersburg-Clearwater	841	470

Source: The Sachs Group, 1996

1.28

Total vs. Occupied Hospital Beds in California



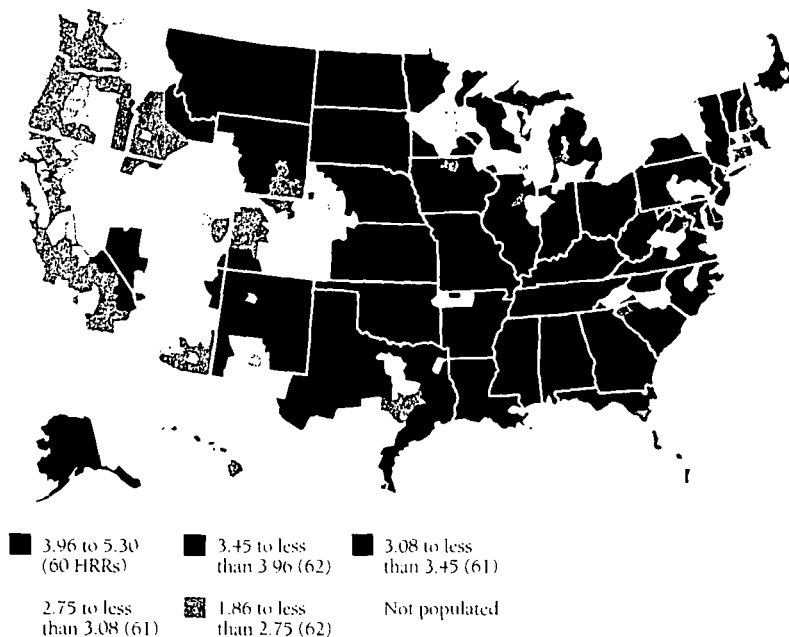
*Estimates and projections

Source: AHA News, from California Healthcare Association, 1996

1.29

Acute Care Hospital Beds Per 1,000 Residents

By hospital referral region (1993)



Source: Derived from *The Dartmouth Atlas of Health Care*, 1996, from U.S. Census Bureau data

1.30

State-by-State Hospital Revenues and Profits Ranked by Profit Margin, 1994

Dollars in thousands

State (number of hospitals)	Revenues	Profits	Margin
South Carolina (67)	\$3,847,147	\$482,963	12.6%
Idaho (41)	817,898	97,646	11.9
Nevada (21)	1,280,902	132,737	10.4
Montana (53)	812,747	63,627	7.8
New Hampshire (28)	1,135,421	87,697	7.7
Arizona (60)	3,517,583	266,731	7.6
South Dakota (50)	717,633	54,138	7.5
Georgia (157)	7,467,584	546,913	7.3
Texas (422)	18,713,540	1,348,405	7.2
Nebraska (91)	1,774,462	127,052	7.2
Kansas (134)	2,464,074	174,853	7.1
Louisiana (132)	5,389,518	369,596	6.9
Colorado (69)	3,315,873	225,060	6.8
Missouri (129)	7,171,412	475,357	6.6
Virginia (96)	5,796,154	385,097	6.6
Alabama (114)	4,579,322	292,981	6.4
Kentucky (105)	3,991,607	248,171	6.2
Utah (42)	1,552,044	96,068	6.2
Hawaii (19)	1,150,181	71,195	6.2
Indiana (114)	6,535,785	397,024	6.1
Iowa (116)	3,026,184	183,428	6.1
North Carolina (119)	6,943,378	417,260	6.0
Minnesota (143)	4,557,207	274,973	6.0
Mississippi (98)	2,433,985	146,733	6.0
Illinois (207)	14,258,883	845,707	5.9
Arkansas (86)	2,385,611	140,690	5.9
New Mexico (37)	1,387,698	80,466	5.8
Florida (218)	15,481,281	872,801	5.6
Wisconsin (127)	5,103,093	287,422	5.6
Washington (88)	4,757,712	264,393	5.6
Vermont (15)	506,414	28,374	5.6
North Dakota (46)	839,882	45,598	5.4
Ohio (187)	13,499,430	626,201	4.6
Oregon (63)	2,618,657	119,106	4.5
Delaware (8)	868,390	39,156	4.5
Michigan (169)	11,220,557	481,580	4.3
Pennsylvania (230)	16,703,262	665,089	4.0
New Jersey (94)	9,884,223	391,890	4.0
Maryland (49)	4,606,232	179,190	3.9
Maine (39)	1,227,589	46,635	3.8
Wyoming (25)	360,786	13,645	3.8
Tennessee (126)	6,191,859	222,843	3.6
West Virginia (58)	2,106,353	73,988	3.5
Oklahoma (110)	2,890,018	96,575	3.3
California (427)	30,765,647	915,729	3.0
Alaska (16)	473,424	13,711	2.9
Massachusetts (95)	8,883,598	190,807	2.3
Connecticut (37)	3,902,445	30,498	0.8
New York (229)	26,825,080	180,305	0.7
Rhode Island (11)	1,064,893	-3,789	-0.3
District of Columbia (12)	1,763,395	-24,990	-1.4

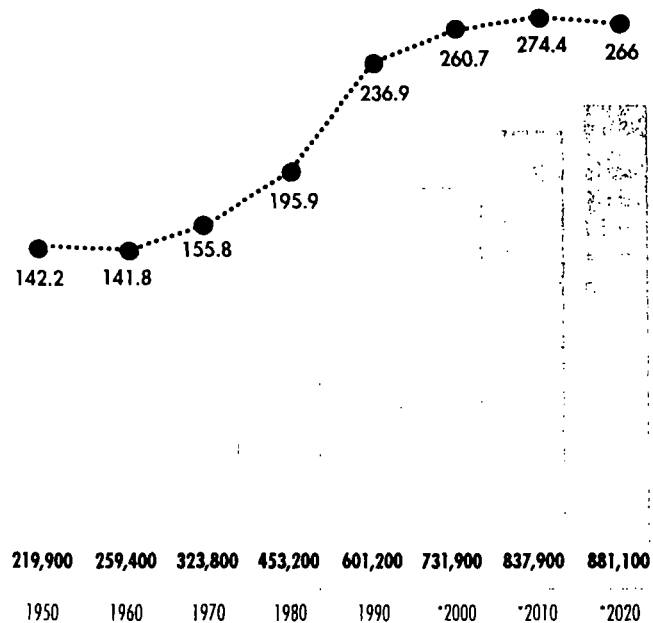
Source: *Modern Healthcare*, April 29, 1996, from American Hospital Association data

Even by 1993, much overcapacity had been eliminated in and around metropolitan areas, with rural areas having the most oversupply of acute care hospital beds (Fig. 1.29). Continuing declines in hospital inpatient utilization could mean that up to 30 percent of the nation's hospital beds may no longer be needed.

Decreased utilization and increased managed care pressures won't go away, which means health care organizations will continue to watch their costs closely. Many hospitals are doing this so well they're chalking up impressive profit margins (Fig. 1.30).

1.31

The Doctor Boom



Total number of physicians in the United States

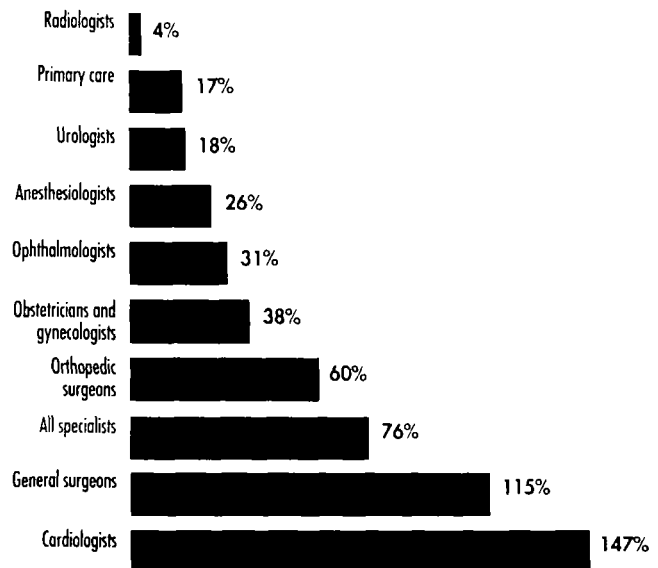
●●● Number of nonfederal physicians per 100,000 population

*Projected

Source: *AMA News*, from the Institute of Medicine's Committee on U.S. Physician Supply, 1996

1.32

Percentage Oversupply of U.S. Physicians Per 100,000 Relative to Numbers Used by a Large Health Maintenance Organization



Source: *The Dartmouth Atlas of Health Care*, 1996

A flood of physicians

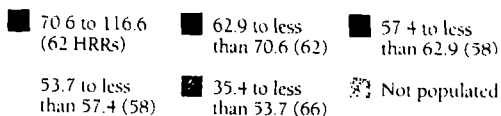
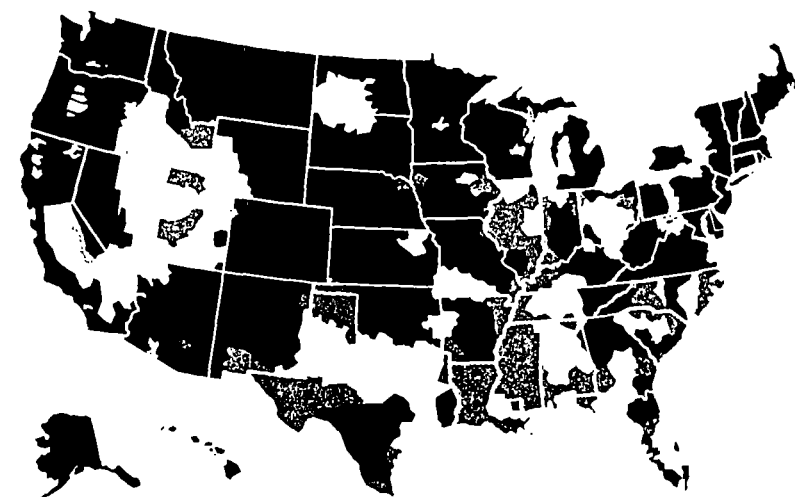
The number of physicians in the United States has soared since the 1960s (Fig. 1.31), to the point that most studies conclude there is and will continue to be an oversupply of physicians in the United States.

Managed care organizations consider primary care physicians the most effective at managing patients and their associated health care costs.

This belief makes primary care physicians more attractive to managed care organizations than specialists, which in turn creates a significant oversupply of specialists (Fig. 1.32). Interestingly, most primary care physicians are concentrated in the Rocky Mountains, along the West Coast, in Minnesota and in a few metropolitan areas along the East Coast — all areas with advanced and maturing managed care-based delivery systems (Fig. 1.33).

1.33 Primary Care Physicians Per 1,000 Residents

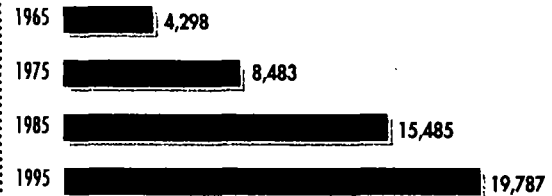
By hospital referral region (1993)



Source: Derived from *The Dartmouth Atlas of Health Care*, 1996, from U.S. Census Bureau data

1.34

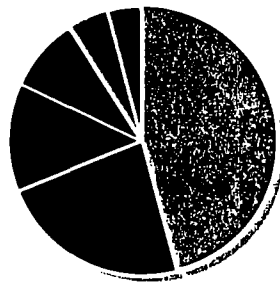
The Growing Number of Medical Group Practices



Source: AMA Group Practice Survey, 1996

1.35

Distribution of Medical Group Practices by Group Size, 1995

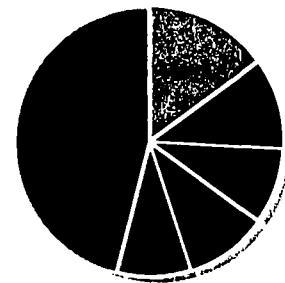


● 3 to 4	46%
● 5 to 6	23%
● 7 to 9	13%
● 10 to 15	9%
● 16 to 25	5%
● 26+	4%

Source: AMA Group Practice Survey, 1996

1.36

Distribution of Physicians in Medical Group Practices by Group Size, 1995



● 3 to 4	15%
● 5 to 6	11%
● 7 to 9	9%
● 10 to 15	10%
● 16 to 25	9%
● 26+	46%

Source: AMA Group Practice Survey, 1996

Fight for physicians

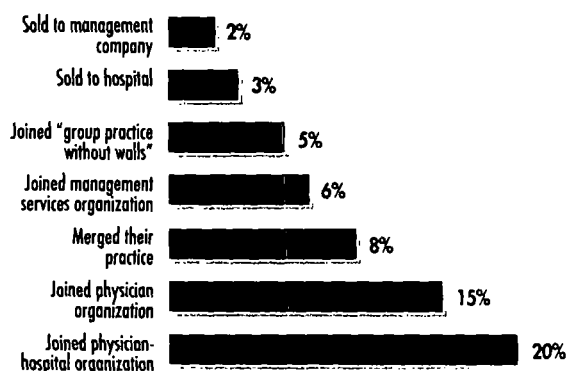
These volatile trends are pushing physicians into larger practices (Fig. 1.34). Most of these groups are small, with about 69 percent having no more than six physicians (Fig. 1.35). Even so, nearly half of all physicians in group practices are in larger ones, with 26 physicians or more (Fig. 1.36).

Physicians are joining group practices or selling their practices to professional management companies or hospitals as never before (Fig. 1.37) and (Fig. 1.38). At the same time, physicians, not surprisingly, still play the largest role in hospital-selection decisions (Fig. 1.39).

Many community-owned health care organizations are trying to cement their relationships with physicians, even though most that have acquired physician practices are losing money, according to a 1996 VHA member survey.

1.37

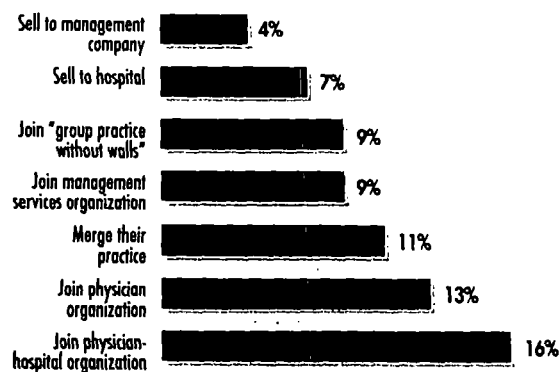
Percentage of Physicians Who Made These Moves in the Past Year



Source: Medical Economics & Healthcare, March 1996

1.38

Percentage of Physicians Who Plan These Moves in the Next Year

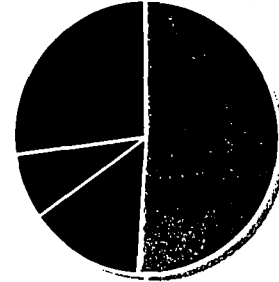


Source: Medical Economics & Healthcare, March 1996

1.39

Most Important Decision-makers

Physicians and consumers still (largely) control hospital selection

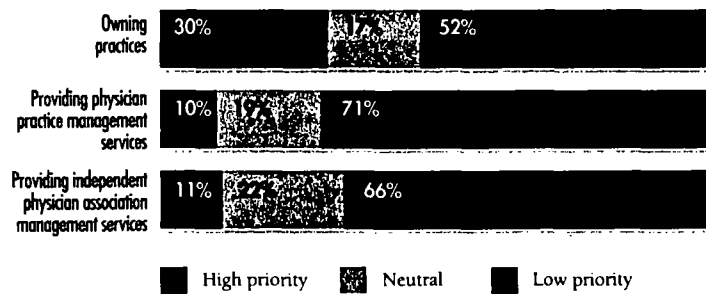


- Physician 51.2%
- Joint decision (physician and patient) 14.2%
- Health plan 7.8%
- Patient and family 26.8%

Source: Advisory Board,
Channeling Incentives, 1995,
from the National Research
Corporation, Lincoln, Neb.

1.40

Percentage of Health Care Organizations That Cite Each of These as Priority Strategies



Source: VHA Survey, 1996

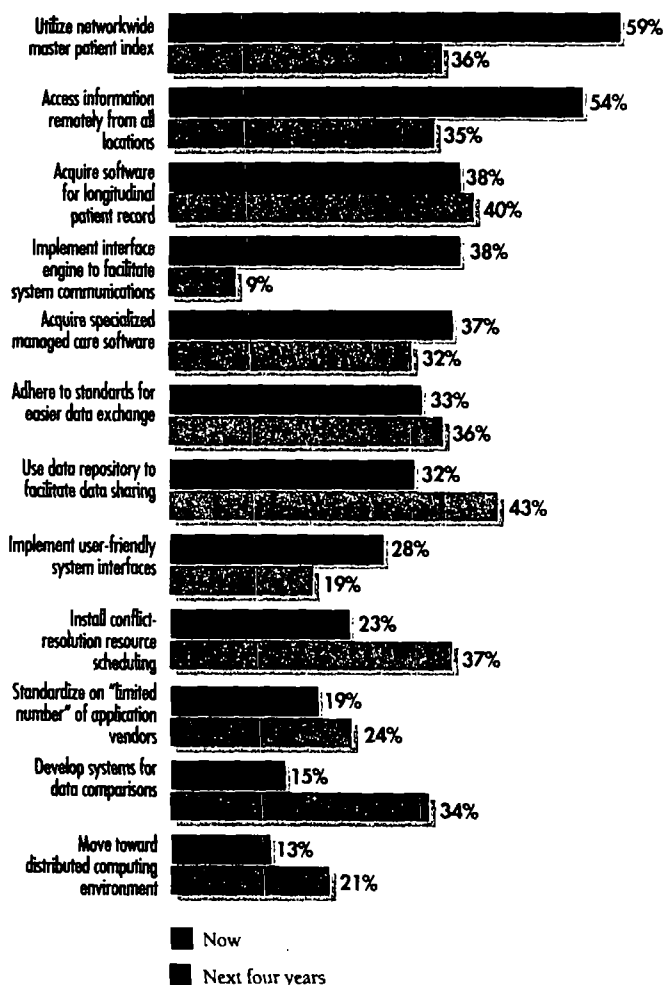
Even though owning practices is still a high priority, many survey respondents are beginning to focus less on acquiring physician practices and more on offering management services to physician practices and independent physician associations (Fig. 1.40).

Information technologies: the force of the future

Advanced information technologies are viewed as essential in managing health care organizations, especially in sharing and comparing data, creating networkwide patient records and accessing information from remote locations (Fig. 1.41).

1.41

Most Pressing Information Technology Needs in Managed Care and Integrated Health Care Delivery Systems

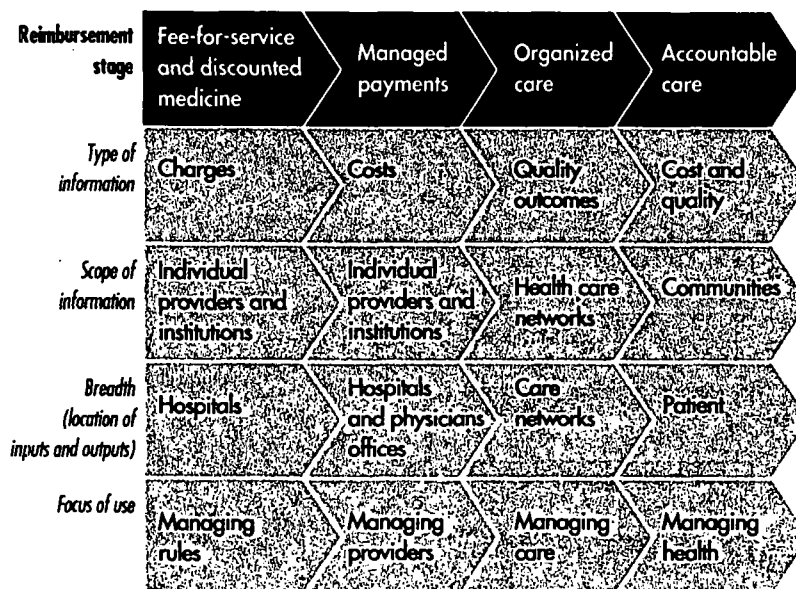


Note: Respondents could select a maximum of four needs for each time period.

Sources: *Modern Healthcare*, March 4, 1996
from Coopers & Lybrand

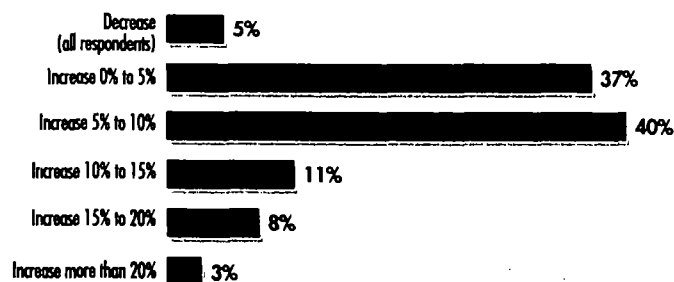
There is an enormous need for health care organizations to implement state-of-the-art information technologies to improve communications among physicians, other providers within their systems, insurers, managed care plans and patients (Fig. 1.42).

1.42 Redefining the Patient Care Information System



Source: *Patient Care Information Systems* by Drazen, Metzger, Ritter and Schneider, 1995

1.43 Average Annual Change in Direct Operating Expense for Information Systems Projected for Next Three Years



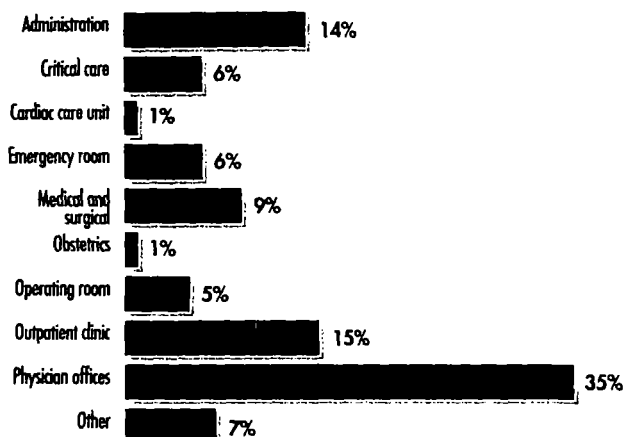
Due to rounding, total may exceed 100%

Source: *Modern Healthcare*, March 4, 1996

As the health care industry makes plans to expand its technological abilities substantially (Fig. 1.43 and Fig. 1.44), it is spending more for information systems than other industries (Fig. 1.45).

1.44

Which Area Will Have the Top Priority to Implement Computer Technology This Year?

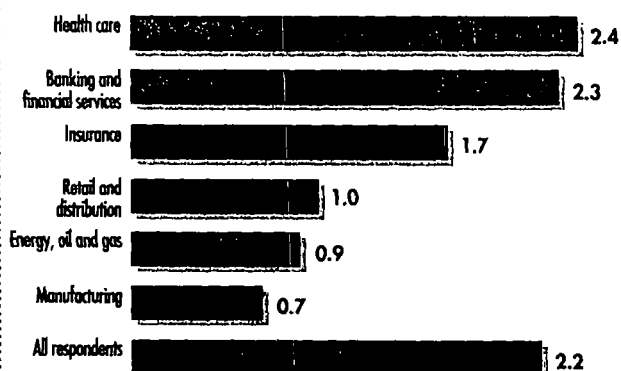


Due to rounding, total may exceed 100%

Source: 1996 Healthcare Information and Management Systems Society (HIMSS)/Hewlett-Packard Leadership Survey

1.45

Percentage of 1995 Company Net Revenue Devoted to Information Services



Source: Deloitte & Touche, 1996

Coverage is still a problem

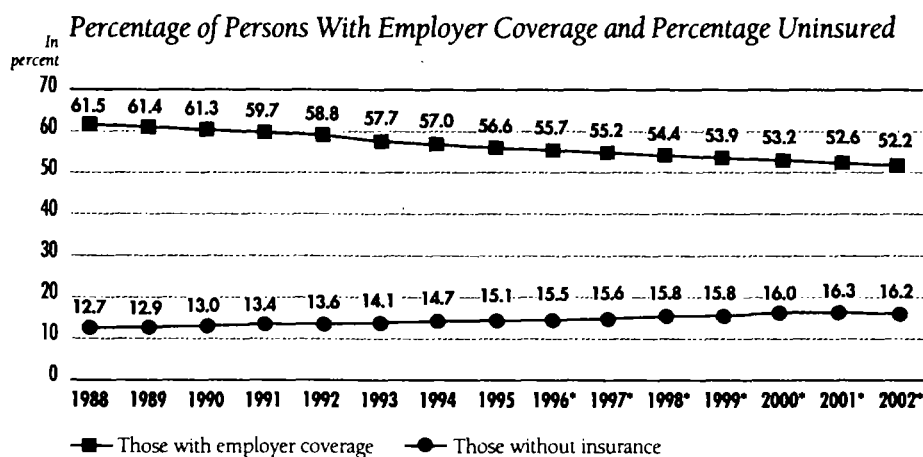
The United States has more physicians and hospitals than any other industrial country in the world, yet more than 15 percent of the population does not have health care insurance.

One reason is that fewer employers are offering their workers health coverage. By 2000, only about half the population will get health coverage from their

employers. Over the same time period, the percentage of the population without health insurance is expected to slowly rise (Fig. 1.46).

As the number of uninsured people rises, access to health care becomes more difficult, especially for those with poor health (Fig. 1.47). And, of course, paying medical bills is a problem for those without insurance (Fig. 1.48). Uninsured people are

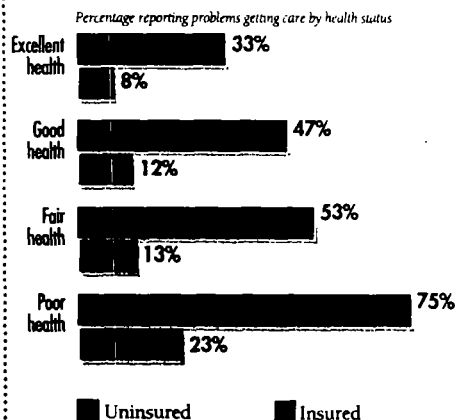
1.46



Source: Lewin Group, 1996

1.47

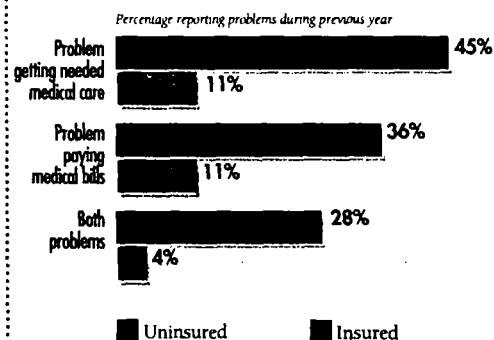
Uninsured Adults in Fair and Poor Health Are Most Likely to Have Problems Getting Needed Medical Care



Source: "Getting Behind the Numbers on Access to Care," Harvard School of Public Health, Kaiser Family Foundation, National Opinion Research Center, October 22, 1996

1.48

Uninsured Adults Are More Likely to Have Problems Getting and Paying for Medical Care



Source: "Getting Behind the Numbers on Access to Care," Harvard School of Public Health, Kaiser Family Foundation, National Opinion Research Center

four times more likely not to get needed medical care and three times more likely to have problems paying for medical attention. While these problems were a major campaign issue in 1992, in 1996 they were barely on the political map.

Improving the nation's health

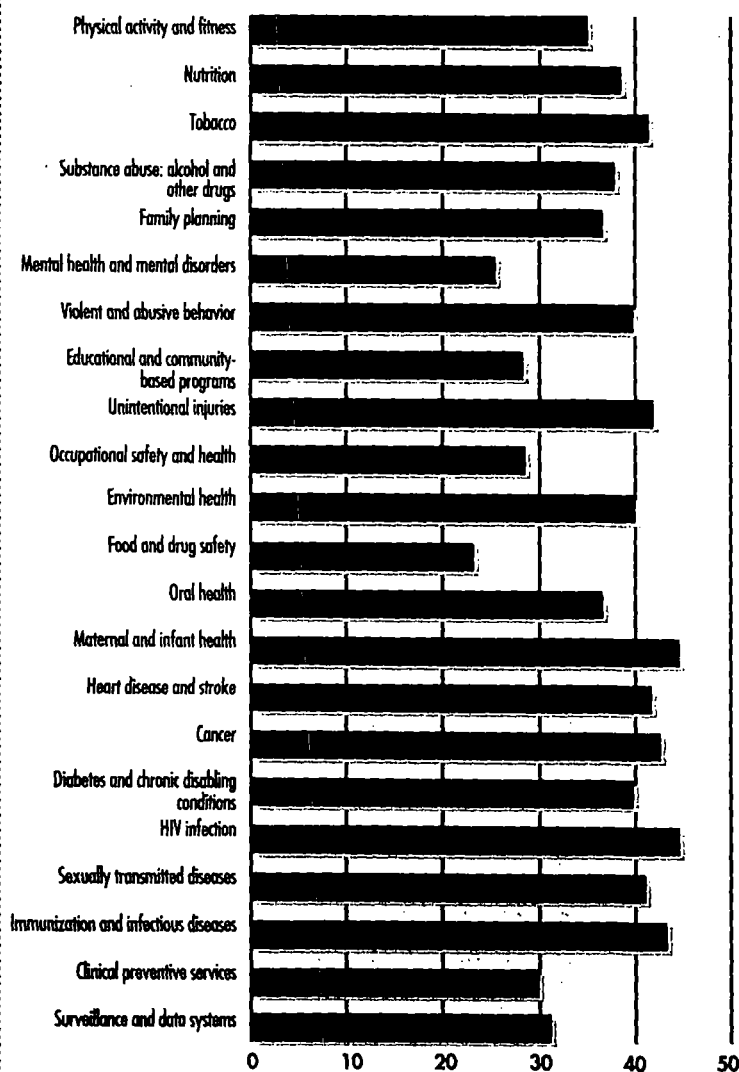
The federal government's national health initiative, "Healthy People 2000," has gained recognition and

acceptance throughout the country. Nearly every state and two territories have implemented health objectives as of 1995 (Fig. 1.49). The program seeks to increase life spans, reduce health disparities and improve access for all Americans.

About 8 percent of the health objectives identified by "Healthy People 2000" have surpassed the targets for 2000, and progress has been made on another 41 percent of the objectives (Fig. 1.50).

1.49

Number of States With "Healthy People 2000 Objectives" by Priority Area



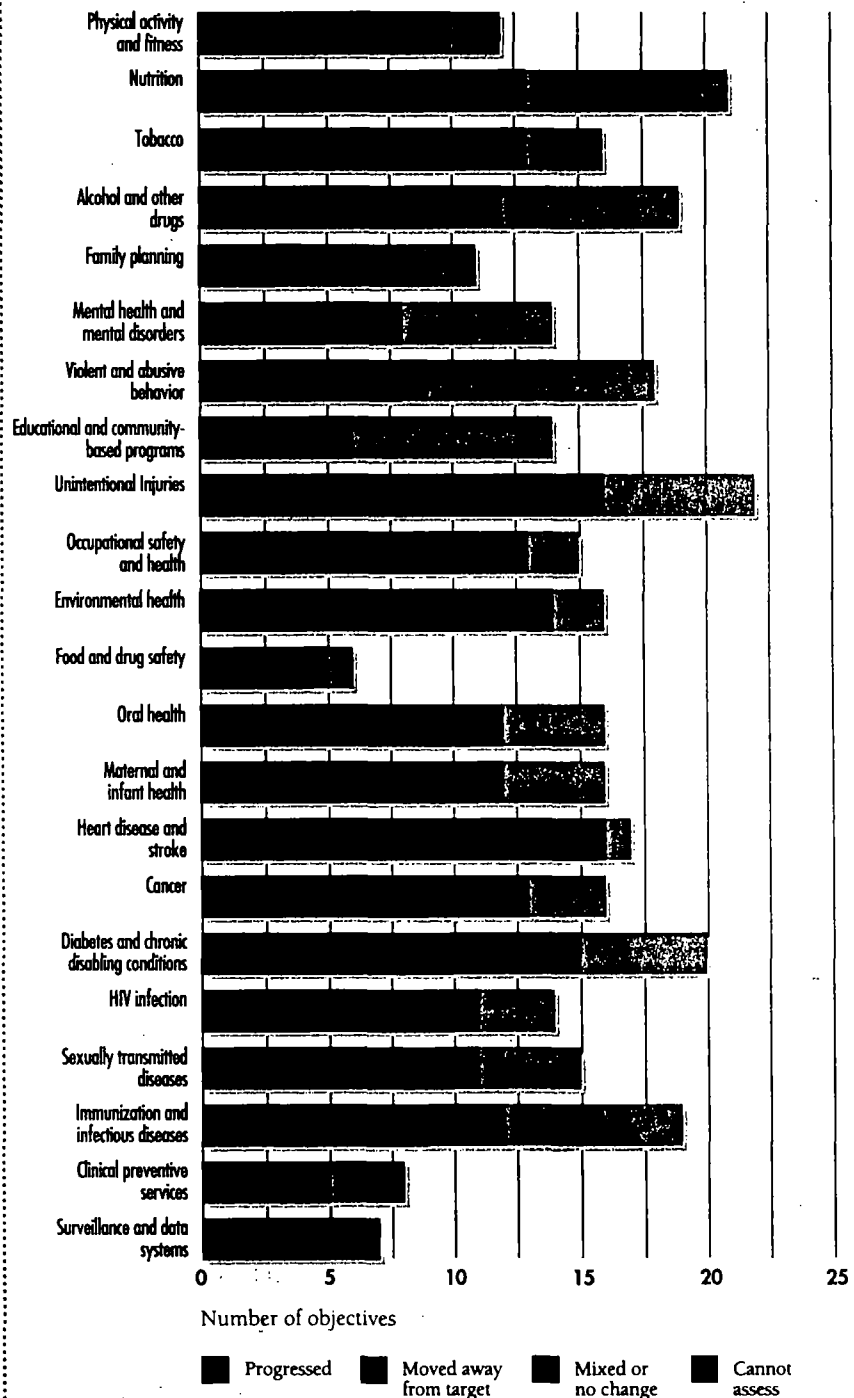
Source: *Healthy People 2000 Midcourse Review and 1995 Revisions*. U.S. Department of Health and Human Services and U.S. Public Health Service

But almost one-quarter of the health objectives have either moved away from the targets, showed no change or had mixed results. Full achievement of the federal program's goals isn't

likely until the health care system reaches all Americans and integrates personal health care efforts together with population-based health goals.

1.50

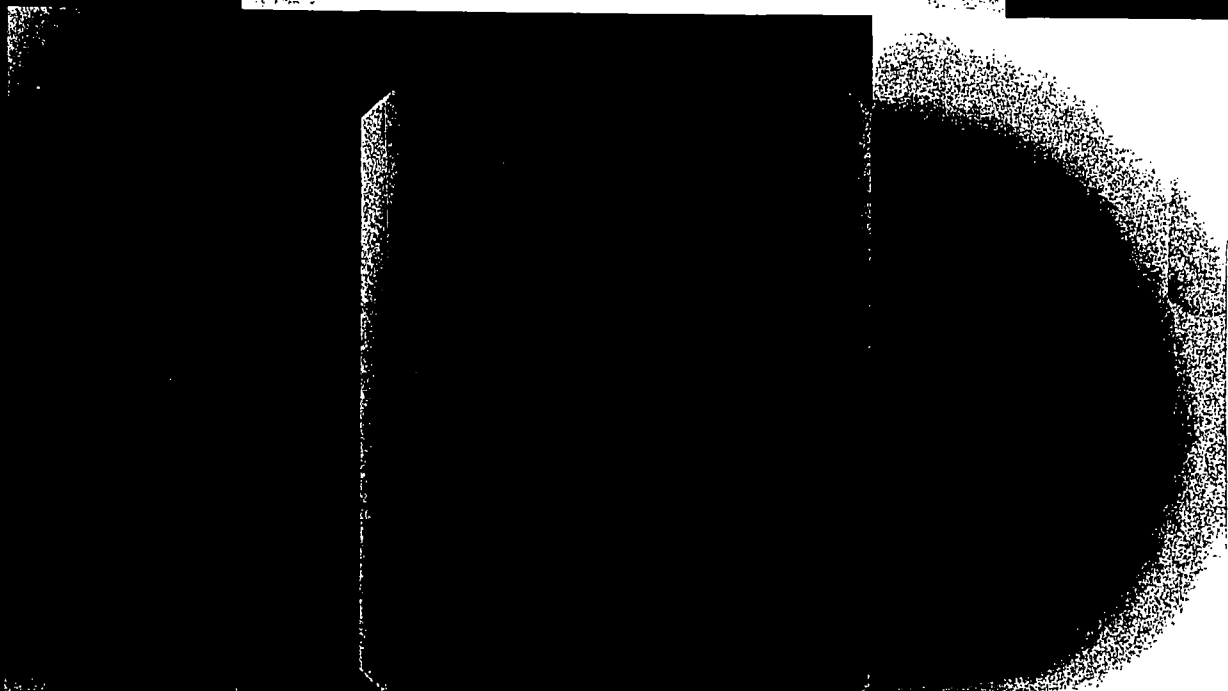
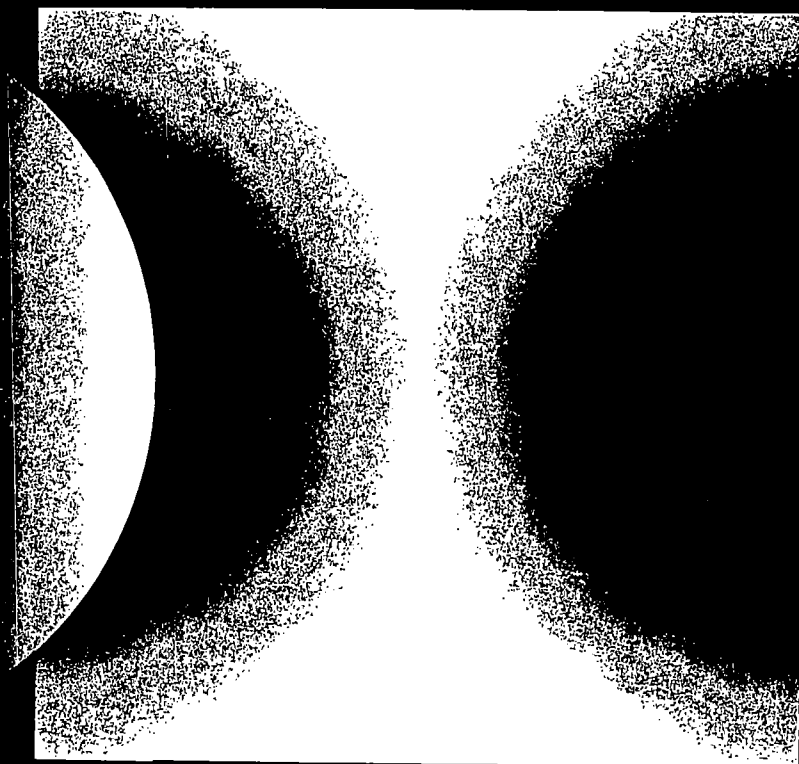
"Healthy People 2000" Objectives: Summary of Progress by Priority Area



Source: *Healthy People 2000 Review*, 1994, U.S. Department of Health and Human Services and U.S. Public Health Service

CHAPTER TWO

Rising Expectations: Managing Consumer Demand



Rising Expectations: Managing Consumer Demand

What consumers want

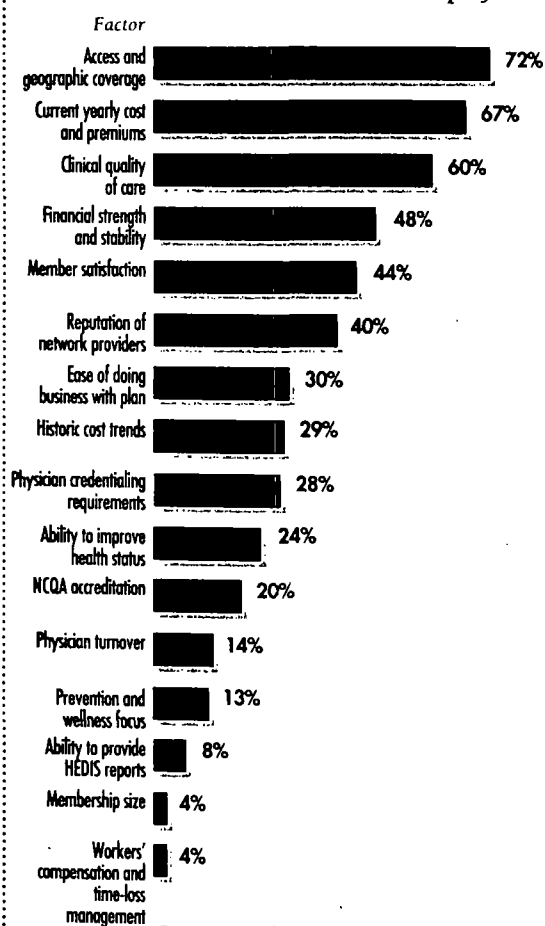
The wishes, preferences and demands of those who buy health care are becoming more clear. Employers, which are buying health care for their employees, are primarily concerned with geographical coverage, cost and clinical quality (Fig. 2.1).

As employers continue driving providers to reduce cost, it's likely that geographical coverage and measures of clinical quality will strongly influence employers' choices of health plans in the future.

Patients' definitions of health care value are also becoming more clear. Speedy, convenient access to their usual physicians is most important to patients, outweighing concerns about cost or clinical credentials (Fig. 2.2).

2.1

What Matters Most to Employers?

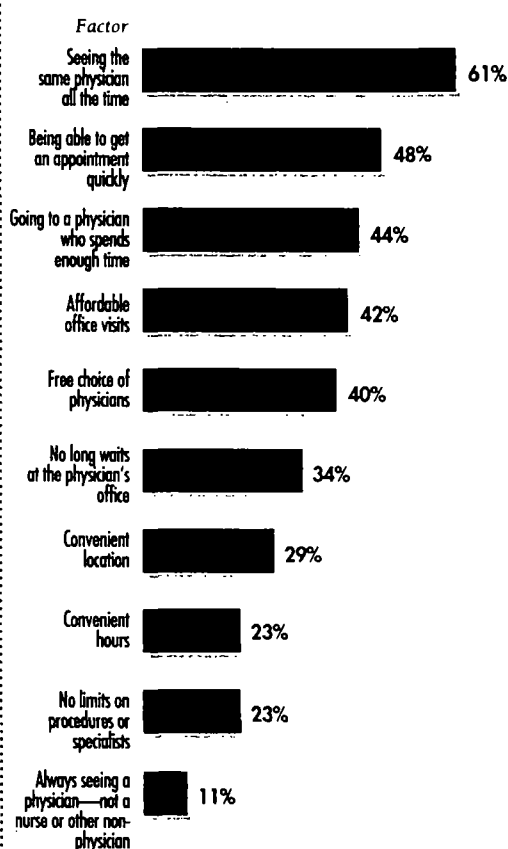


Percentage of companies surveyed that cite given factors as "extremely important"

Source: *Benefits and Compensation Solutions*, November 1995, from William M. Mercer Inc.

2.2

What Matters Most to Patients?



Percentage of patients who consider a factor important

Source: *The Quest for Accountability/DATA WATCH*, 1995, from *Medical Economics Magazine's Patient Attitude Survey*

Public perceptions about health care

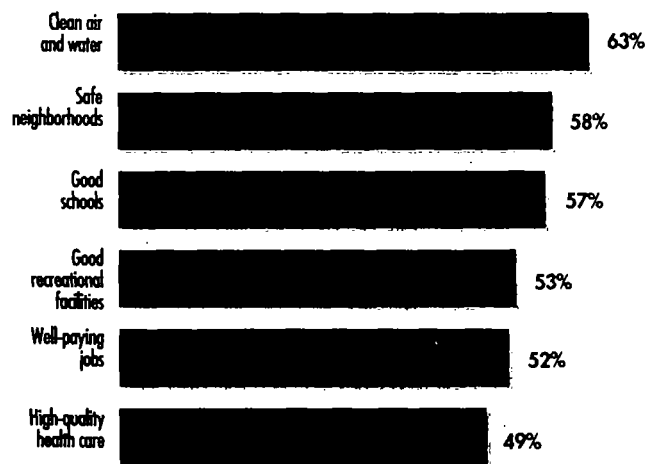
Health care providers have traditionally focused on the physical and clinical aspects of health. The public sees things differently. They believe a range of social and environmental factors contribute heavily to a healthful life, such as a clean environment and safe neighborhoods (Fig. 2.3). There is also substantial disparity between what some community leaders and residents feel are the top quality-of-life needs of their communities (Fig. 2.4).

While the public has become more aware of health care issues since President Clinton's health care reform initiative and the media attention that followed, they're also losing trust in each other and in institutions (Fig. 2.5). An example of both is the groundswell of activity that resulted in recent federal legislation requiring minimum lengths of stay for maternity patients in managed care plans.

2.3

What Contributes to Health Status?

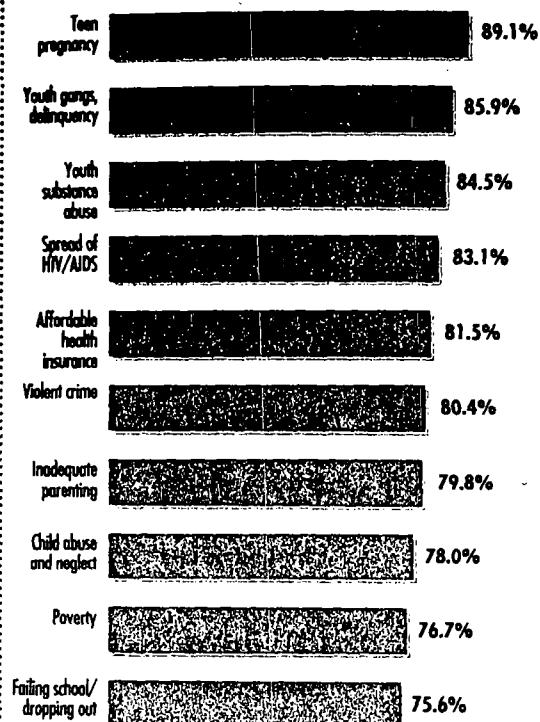
Factors that Californians think contribute "a good deal" to health status



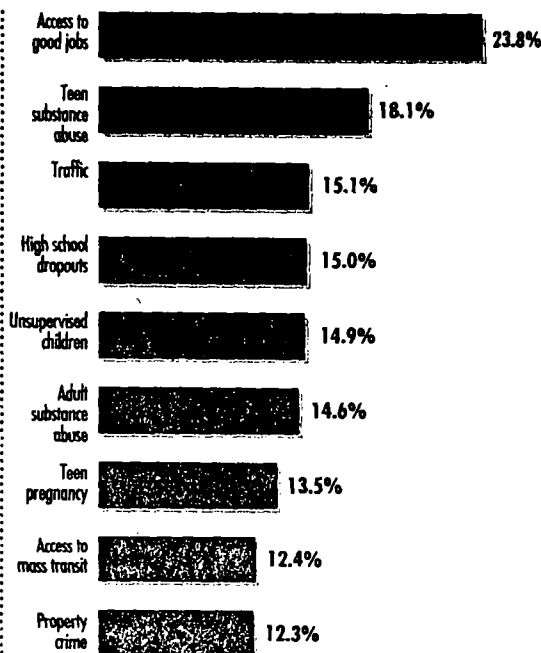
Source: Getting Involved Survey, Louis Harris & Associates, December 1995 – January 1996

Assessment of Dallas County Needs

Community leaders:



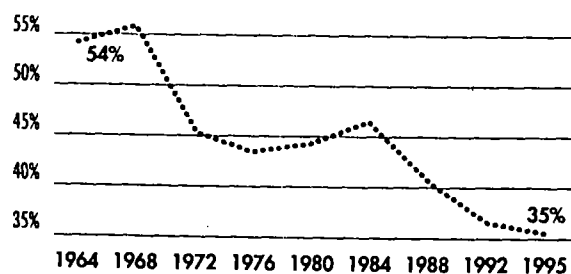
Residents:



Source: United Way of Metropolitan Dallas survey of 4,000 households and 527 community leaders, 1995

2.5

Americans Who Think "Most People Can Be Trusted"



Source: California Center for Health Improvement General Social Survey, *The Washington Post*, Jan. 28, 1996

2.6

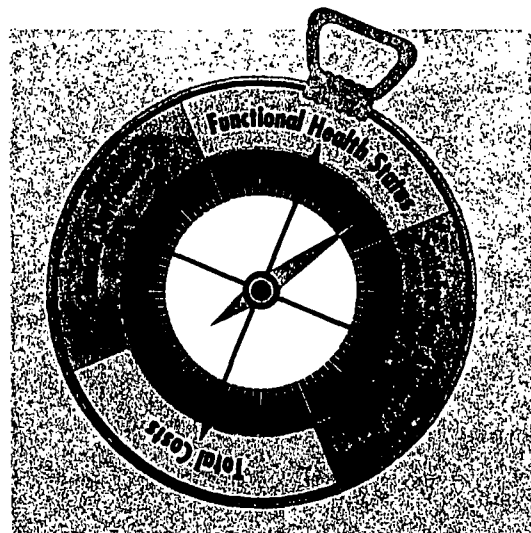
Existing and Emerging Methods for Measuring Quality

Tools	Audience	Use
Value compass	Purchasers, employers, providers	Measure quality, satisfaction
Health Plan Employer Data and Information Set, or HEDIS	Purchasers, employers, providers, consumers	Measure quality, access and satisfaction
Report cards	Purchasers, employers, consumers	Comparison measures of quality, access and satisfaction
Balanced score cards	Providers, purchasers	Measure links between long-term strategy and short-term actions
Community-based report cards	Coalitions, consumers, employers, providers, purchasers	Measure health status and quality of life in a single community
Civic index	Coalitions, consumers, employers, providers	Measure and evaluate civic infrastructure and its impact on health status and quality of life
"Healthy People 2000"	Government, coalitions, employers, purchasers	National health objectives for the United States

Source: VHA Inc., 1996

2.7

Value Compass



Clinical Value Compass © 1995, Lahey Hitchcock Clinic

Measuring value

Among consumers, especially employers, demand is growing for greater clinical value for their dollar, and there is more interest and activity in developing methods to measure the quality of health care. To show the quality of managed care organizations, these measures must account not only for the quality of care given individual patients, but also health improvements at the community level. Some existing and emerging tools for measuring quality (Fig. 2.6) are:

The Value Compass: This is a measure of health care value along four dimensions:

- cost
- outcomes
- health status
- satisfaction

The compass (Fig. 2.7) acts as a touchstone for health professionals as they design and improve specific care processes, and it also helps patients, employers, payers and other groups measure the care provided (Fig. 2.8). In a broader sense, the compass could be used to structure the work of a clinical quality improvement team, or help clinicians develop methods for improving their daily practices.

2.8

The Four Dimensions of the Value Compass

Measure	Provider level	Community level
Total cost	The costs of all forms and sites of assistance for the provider's patients	The costs of all forms of care for the community at large
Clinical outcomes	Desired and undesired clinical results — death, infection, survival rates	Overall morbidity, mortality and risk-factor prevalence
Functional health status	Patient or member judgments of their physical, mental and/or life-role functioning	Population-based surveys of individuals' perceptions of their functioning
Satisfaction against needs	Judgments of satisfaction with the degree to which needs were met by the provider	Judgments of satisfaction with the degree to which basic health and quality-of-life needs are being met in the community

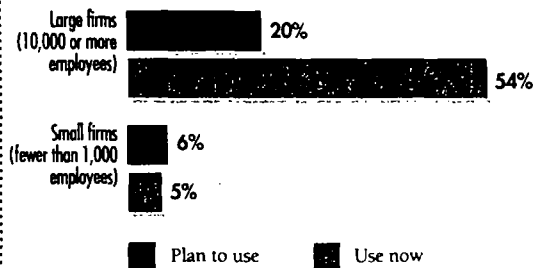
Source: VHA Inc., 1996

Health Plan Employer Data and Information Set: A measurement tool developed by the National Committee for Quality Assurance that helps consumers, corporations and governmental purchasers evaluate the quality of managed care plans, HEDIS has 60 measurements that assess health plans' equipment, personnel and overall effort in providing quality care. The latest version, HEDIS 3.0, has 75 measurements, including new ones to track such things as how well health

plans help sick people get better, how effectively plans are addressing the nation's most pressing health needs and a survey of how consumers rate the care they've received. HEDIS has been well-received by large employers in choosing health plans, with as many as three-quarters using it now or planning to use it (Fig. 2.9). Smaller employers, on the other hand, barely use it at all.

2.9

Large and Small Firms' Use of HEDIS

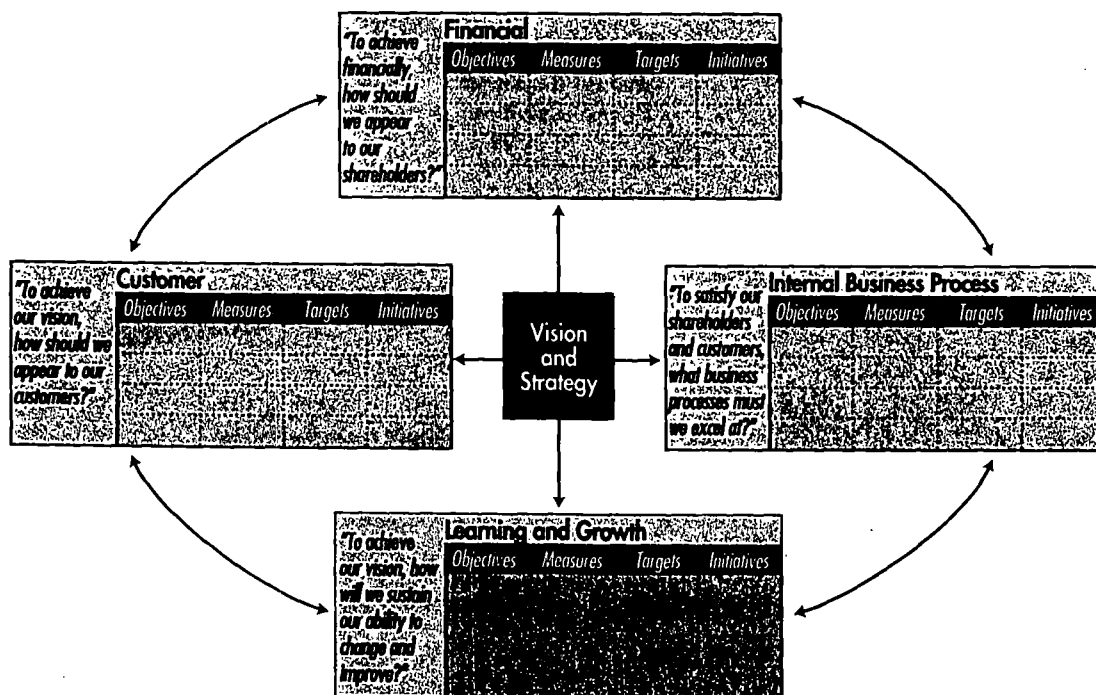


Source: *Business & Health*, May 1996, from "Is Cost everything? Getting Value for Your Health Care Dollar," 1996, Washington Business Group on Health and Watson Wyatt Worldwide

Balanced Score Cards: These business planning tools help companies align their management processes and focus the organization on implementing long-term strategies. Traditional financial measures are supplemented with performance indicators gathered from customers, internal business processes and how the company is learning and growing (Fig. 2.10).

Report Cards: Health care organizations are beginning to issue report cards to consumers and employers that include benchmark measures of quality. Crozer-Keystone Health System in Pennsylvania, for instance, distributes report cards to members of the community on how it is achieving its health status goals.

2.10 Balanced Score Card: Four Perspectives of Vision and Strategy



Sources: "Balanced Scorecard," *Harvard Business Review*, January-February 1996

Managing and measuring demand

Most attempts to measure health care quality have focused on the “supply side”—how well physicians, hospitals and other health care professionals provide health care services. Today, the emphasis is more on the “demand side”—how consumers make health care decisions (Fig. 2.11).

Organizations are increasingly recognizing that individual behavior and perceptions play a critical role in how and why people seek health care services.

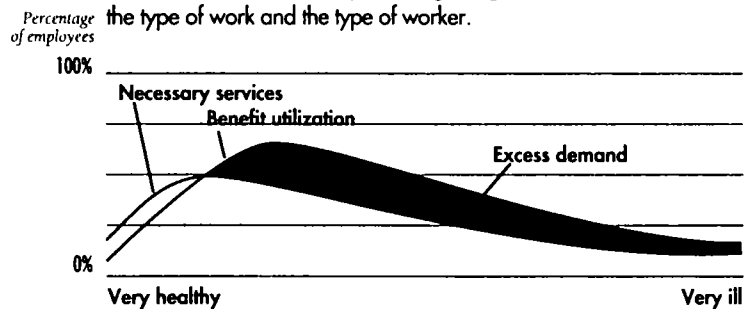
Capital Blue Cross and Pennsylvania Blue Shield of Harrisburg, Pa., recently analyzed claims data for 371 employees of a manufacturing company before and after the workers were given a self-care guide. Over the course of a year, health care costs were reduced by almost one-quarter, and total use of services declined by almost one-fifth (Fig. 2.12).

Such “demand management” is still in its infancy, but it is already being touted as the most effective means of managing patient entry into the health care delivery system. Designed to reside at the patient’s first point of access into the health care delivery system,

2.11

Health Care Need vs. Demand

The gap between health care need and benefit utilization is excess demand. It is a function of plan design, organizational climate, the type of work and the type of worker.



Source: *Benefits and Compensation Solutions*, January 1996

2.12

Self-care Savings Summary — 12 Months

Normalized per 1,000 employees

	Self-care group	Prior to self-care group	Total savings	Per employee Savings	Percent saved
Total payments	\$121,519	\$160,583	\$39,064	\$39.06	24.3%
Number of services	4,544	5,576	1,032	1.03	18.5%

Source: *Healthcare Demand Management*, January 1996, from a study by Capital Blue Cross and Pennsylvania Blue Shield of Harrisburg, Pa.

demand management provides good health and disease management, patient triage and other important functions (Fig. 2.13).

One of the most popular types of demand management is a 24-hour nurse-advice telephone service that answers consumers' health care questions, provides benefits information and identifies appropriate services and providers. These interactive services can help build an ongoing communication link between the consumer and the health care community.

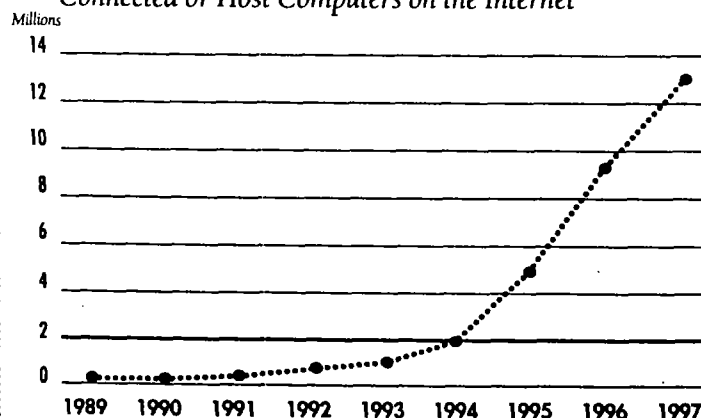
Computers, too, are influencing consumer knowledge of health care. Several software programs are available that address personal health care. The Internet already provides a wealth of health care information. It will continue to grow (Fig. 2.14) and be used by more consumers who want information on treatment, prevention, wellness and home care education.

2.13 The Components of Demand Management

Component	Potential payoff
Health management Engineering healthier behaviors Prevention and early detection	Long-term modest payoff
Disease management Chronic condition management Acute condition compliance	Short-term and long-term significant payoff
Decision management Acute-need triage and self-care Treatment option selection End-of-life planning Health plan and provider selection	Short-term intermediate payoff
Disability management Worker safety and accident prevention Provider and treatment selection Rehabilitation and return to work	Short-term and long-term intermediate payoff

Source: *Health Care Strategic Management*, April 1996

2.14 Connected or Host Computers on the Internet



Source: A.M. Ruthowski, General Magic Inc., 1996, from M. Lottor, *Network Wizards*

Last fall, when the American Medical Association launched its Internet Physician Select service, a listing of physicians' accreditation and other consumer information, the number of "hits" to its Internet home page doubled.

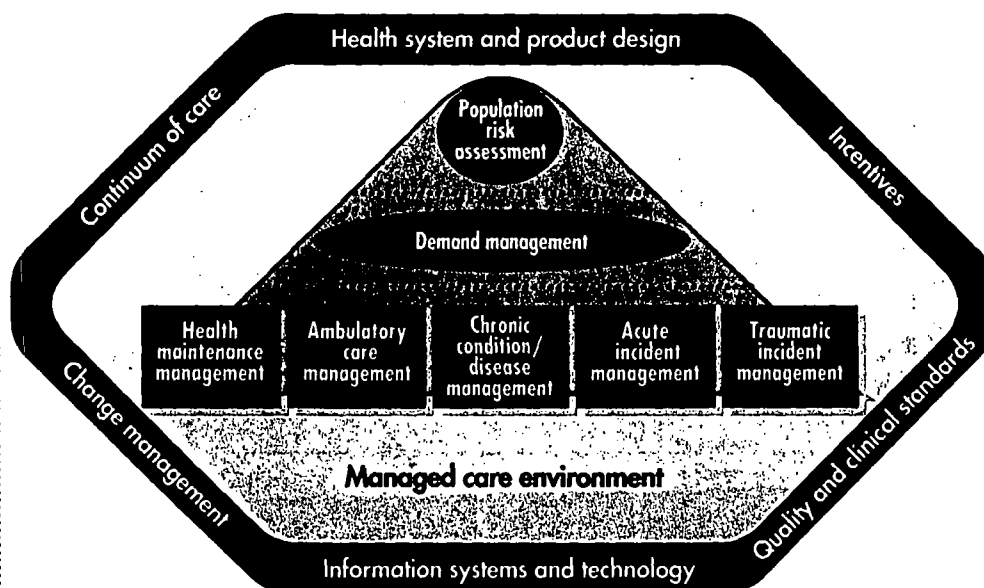
By influencing and educating health care consumers about when it is necessary and appropriate to seek care, demand management techniques will alter how consumers access the health care delivery system, which has potentially enormous long-term implications for the health care industry.

Total health management

Though well-intended, most managed care efforts have focused on managing payments. But managed care is beginning to imply managing the total health care needs and related costs of an entire patient population. Efforts to assemble the components of health care into an integrated delivery system capable of achieving this goal are still relatively new, but as cost and proof-of-quality pressures continue to build, such systems will mature.

A few groups have begun providing specific health management services, such as population risk assessment and demand management. Others are looking at how to develop processes to provide complete health care services and track populations for decades (Fig. 2.15).

2.15 Total Health Management Concept: General Schematic



Source: © 1996 Deloitte & Touche Consulting Group

Some third-generation managed care models exist, and more markets are moving in that direction, driven by the expanded use of capitation, continued cost pressures and an increasing focus on efficient use of health care services (Fig. 2.16).

These models, as more health care delivery systems will do in the future, place a strong emphasis on improving the long-term health status and managing the health risks of the populations they serve.

Sharpening clinical practice patterns

Clinical practice patterns are changing, largely because of efforts by managed care firms and health maintenance organizations to reduce costs.

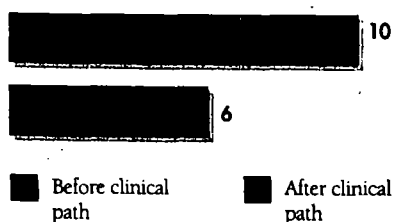
At one medical center, the application of a clinical pathway reduced the average length-of-stay per case from 10 days to six (Fig. 2.17), and the average charge per case from more than \$20,000 to less than \$12,000 (Fig. 2.18).

2.16 Managed Care: Stages of Evolution

	Stage I: Event-Driven Cost Avoidance	Stage II: Value Improvement	Stage III: Health Improvement
Objective Function	Price	Value/customer satisfaction	Health status improvement
Cost Targets	Inpatient days	Resource intensity	Health risks
Locus of Control	External	Peer-driven	"Contract" with family
Focal Point	Inpatient hospital	Physician network	Home and neighborhood

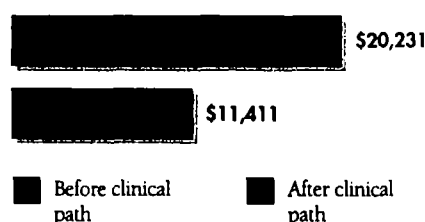
Source: *Healthcare Forum Journal*, September/October 1995

2.17 The Impact of a Clinical Pathway on Length-of-Stay



Source: Hoechst Marion Roussel Inc., *Managed Care Digest Series/HMO-PPO Digest*, 1995

2.18 The Impact of a Clinical Pathway on Cost



Source: Hoechst Marion Roussel Inc., *Managed Care Digest Series/HMO-PPO Digest*, 1995

Cost reduction is not the only motivation to reduce clinical practice variation. The most convincing reason to physicians, in fact, is that clinical pathways increase the quality of patient care when they're taken from evidence-based best practices. While many physicians consider clinical guidelines as little more than "cookbook medicine," when their concerns of losing flexibility and autonomy are addressed along with quality of care, physicians usually begin to support the plan (Fig. 2.19).

Clinical decision-making tools are beginning to be used on patient care outside of hospitals, including rehabilitation, skilled-nursing facilities and home health services, causing these types of outpatient care to grow dramatically. The Health Care Financing Administration reports that the number of skilled-nursing facilities increased by 10 percent from 1994 to 1995, to a total of 12,584, and home health agencies increased 11.8 percent to 7,827.

2.19 Barriers to Physician Acceptance of Clinical Guidelines and Pathways

Barrier	Possible intervention approaches
Fear of "cookbook medicine"	• Involve physicians in guideline and pathway development • Base them on evidence-based best practices • Continually measure and improve
Loss of flexibility and autonomy	• Build in mechanisms for physicians to try innovative procedures • Implement guidelines and pathways in a decentralized manner
Added documentation and work	• Tie them to the medical record • Consider computerization
Argument that patients don't fit pathway and guideline	• Consider levels of acuity and complexity within a patient population • Individualize for each patient
Resistance to change	• Convince by example • Engage physician leaders at hands-on level
Standards of care will be used against clinicians in malpractice suits	• Carefully choose the language used
Distrust in guidelines	• Adopt an evidence-based approach • Provide data reports that show their effect on outcomes and costs • Always document the reasons for a significant deviation from pathways and/or guidelines

Source: *The Quality Letter*, October 1995

With nonhospital sectors of the market growing so dramatically, it's not surprising that patients are spending less time in acute care inpatient units. The HCFA reports that the number of inpatient hospital facilities has declined from 6,707 in 1975 to 6,414 in 1995.

Employer coalitions demand better data

Employers are banding together to leverage their strength and encourage health plans to provide better clinical and quality data. The National Business Coalition on Health, a Washington, D.C., trade and lobbying group with more than 100 members, estimates there are 25 to 35 other such coalitions. Its members represent more than 8,000 employers—with some 30 million workers and dependents nationwide. But only about one-third of the member coalitions purchase health care as a group.

One of the largest of these coalitions is also one of the newest. In December 1995, the Dallas-Fort Worth Business Group launched its Health Care Value Initiative, a collaborative project of purchasers and providers developed to measure and improve health care in the area. The coalition's members represent 25,000 employees, 300,000 dependents, and spend an estimated \$800 million annually on employee health.

The rise of community focus

Health care organizations also respond to the demands of consumers by working to unify health and quality-of-life services around the needs of community populations (Fig. 2.20).

2.20

Characteristics of a Community-Focused Health Care Organization

- Adopt a population-based health focus and develop community-based services
- Embrace a systematic definition and understanding of health
- Manage care through early intervention, health promotion and disease prevention
- Develop community partnerships to share resources and responsibility
- Accept stewardship for community health

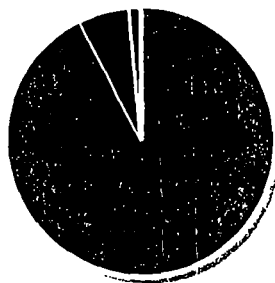
Source: "Improving Community Health: Building the Team," VHA Inc., 1996

Growing numbers of health care organizations and providers are working with patients, public health groups and the broader community. VHA's 1996 community health survey found that about 92 percent of health care organizations surveyed were active in community health improvement (Fig. 2.21).

Ninety-three percent of respondents cited their mission and responsibility as a community-based provider as the primary reasons for involvement in community health. Payer demands and decreasing the cost of uncompensated care are secondary drivers (Fig. 2.22). More health care organizations are likely to explore ways to address public health issues in a community-focused way as managed care grows and as baby boomers, who are well-educated and demanding about their health needs, age.

2.21

Percentage of Health Care Organizations Surveyed That Engage in Community Health



- Engaged 92.3%
- Considering 6.0%
- Not engaged 1.2%

Source: VHA Inc. unpublished research, 1996

2.22

Reason for Involvement in Community Health

Primary driver:

Mission and responsibility as a community-based provider 92.7%

Secondary drivers:

Respond to payer demands 26.5%

Decrease cost of uncompensated care 23.9%

Maintain tax exempt status 16.5%

Comply with legislative and regulatory mandates 11.7%

Other 21.4%

Source: VHA Inc. unpublished research, 1996

Quality of life vs. longer life

People are living longer than ever before. The average life expectancy at birth for Americans is 76 years—six years longer than in 1960 and 27 years longer than at the turn of the century. One reason is that many root causes of illness have been identified

2.23

Causes of Death

Leading

1. Heart disease
2. Cancer
3. Stroke
4. Accidents
5. COPD
6. Pneumonia and influenza
7. Diabetes
8. Suicide
9. Liver diseases
10. AIDS

Actual

Tobacco
Diet and activity
Alcohol
Microbial agents
Toxic agents
Firearms
Sexual behavior
Motor vehicles
Illicit drug use
Other: access to care and poverty

Root

Stress
Depression
Fear
Economics
Anger
Hopelessness
Empiness
Environmental factors

Sources: adapted from McGinnis & Foege, "Actual Causes of Death in the United States," *Journal of the American Medical Association*, 11/10/93-vol. 270, no. 18 and Ashley Files, Office of Disease Prevention and Health Prevention, presentation to National Civic League/Healthy Communities Conference, 1994

(Fig. 2.23), which has led to better means of prevention and intervention. This trend will undoubtedly continue and manifest itself in more community-focused care.

But there is a sobering side to these statistics. The leading causes of death have not changed in the United States for years, and the issue of providing a high quality of life as people live longer is difficult. Studies show that even as people's lives are extended, many face significant declines in the health-related quality of their lives. *Healthy People 2000 Midcourse Review and 1995 Revisions* estimates that 85 percent of life years are healthy, with the remaining 15 percent having limitations on major life activities such as self-care, recreation, school and work. And there are still huge discrepancies in life expectancies among various ethnic groups (Fig. 2.24).

2.24

Years of Healthy Life and Life Expectancy, by Race and Hispanic Origin, 1990

	All races	White	Black	Hispanic
Healthy years	64.0	65.0	56.0	64.8*
Life expectancy	75.4	76.1	69.1	N/A

*Estimated from preliminary data

Sources: Centers for Disease Control and Prevention/
National Center for Health Statistics

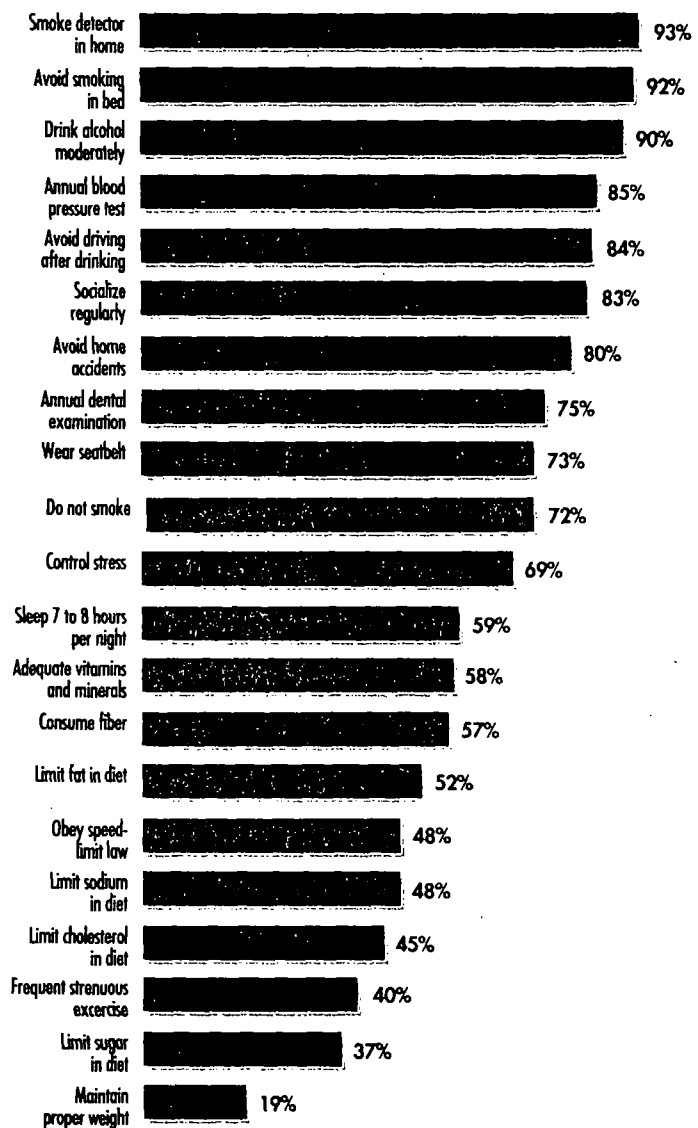
Healthy habits—barely on Americans' radar

Prevention magazine's 1996 Prevention Index shows that many Americans are not taking the necessary steps to control their own health, such as eating right, exercising regularly and getting enough

sleep (Fig. 2.25). While more adults are taking steps to avoid accidents in their home, fewer are socializing regularly with family and friends—a major factor in reducing stress. And 1996 was the third consecutive year that two of three adults older than age 25 were classified as overweight.

2.25

Health-Promoting Behavior

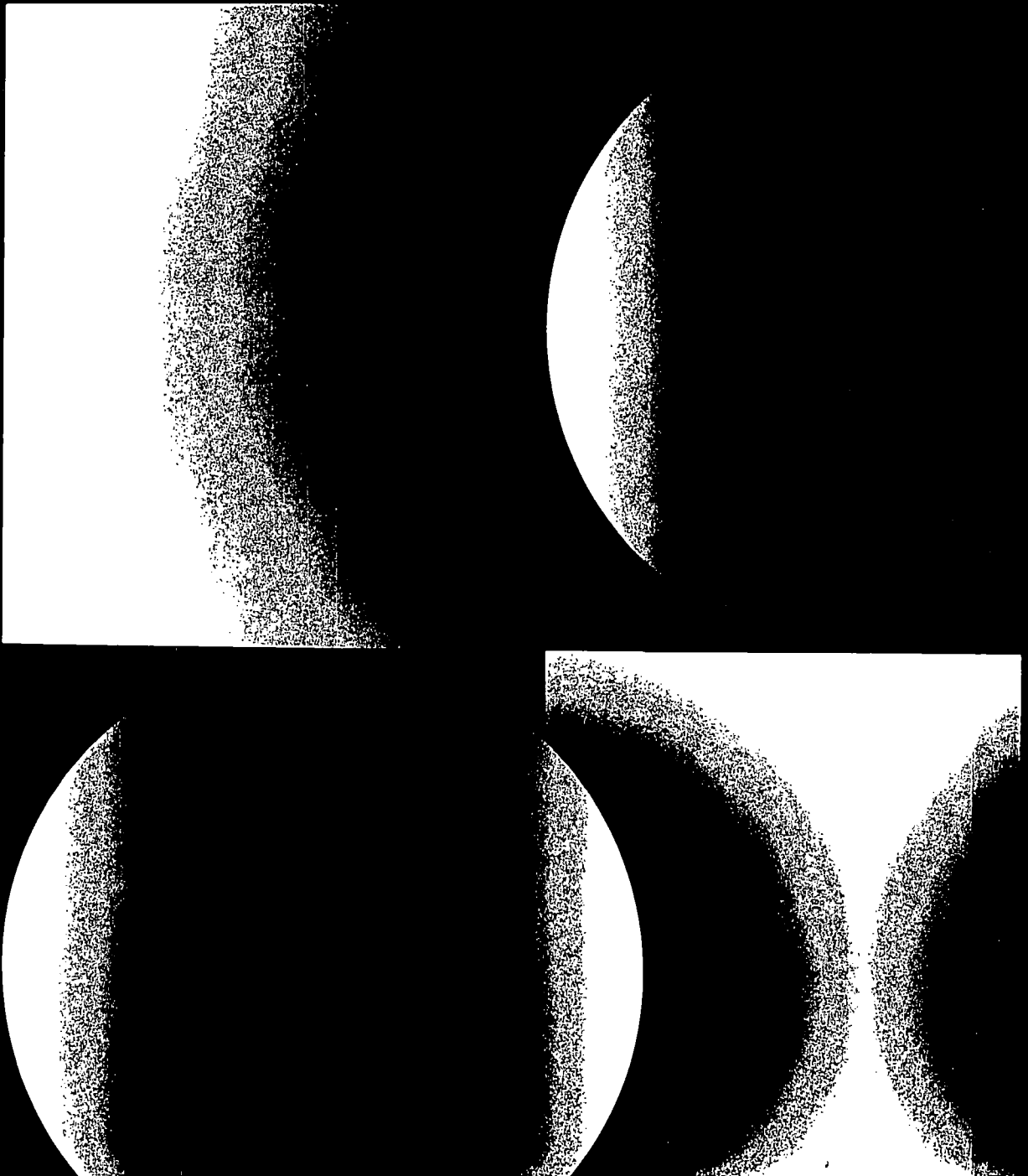


Percentage of practicing adults

Source: *Prevention* magazine's 1996 Prevention Index

CHAPTER THREE

Organizations Are Still Evolving



Organizations Are Still Evolving

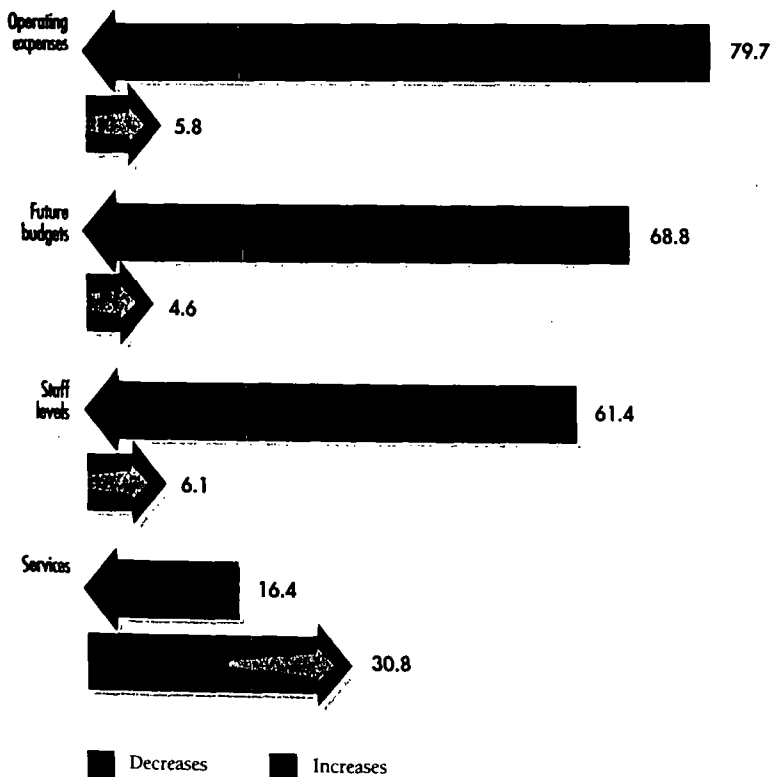
Cost pressures and market share

Even though hospital expenditures are dropping more slowly than in recent years, cost pressures are stronger than ever. Of 443 acute care hospitals that responded to a 1995 survey, 61 percent had reduced staffing levels (Fig. 3.1), up from 56 percent in 1994. Nearly 69 percent foresaw future budget cuts, compared with 47 percent in 1994.

3.1

Hospital Cost-Cutting in 1995

Percentage of survey respondents reporting decreases, increases



Source: Linc Anthem Capital Survey, 1995

Average net operating margins have increased, despite a slight increase in the all-payer case-mix index. This is due in part to reduced numbers of full-time employees (Fig. 3.2).

Both teaching and nonteaching facilities continue to re-allocate nursing resources from traditional inpatient settings toward nursing-based therapeutic services, such as operating room, emergency department, labor and delivery and clinics (Fig. 3.3).

3.2

Year in Review—December 1994 and December 1995

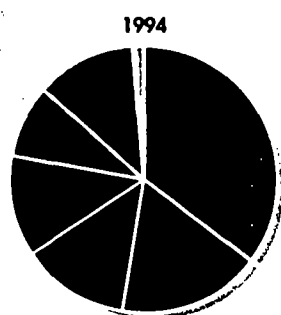
Location and academic status	Average net operating revenue* per adjusted** discharge		Average net operating margin per adjusted discharge		Average all-payer case-mix index		Average paid full-time employee per adjusted occupied bed		Average paid labor hours per adjusted discharge	
	1994	1995	1994	1995	1994	1995	1994	1995	1994	1995
East-teaching	\$10,788	\$9,711	\$266	\$318	1.45	1.34	5.99	5.48	263	217
East-nonteaching	6,978	6,040	373	477	1.16	1.13	4.59	4.21	170	157
Central-teaching	10,646	9,634	356	494	1.41	1.38	6.83	5.94	280	231
Central-nonteaching	5,947	5,535	250	192	1.12	1.14	4.98	4.65	168	151
West-teaching	10,646	10,571	158	142	1.37	1.41	7.43	6.20	250	226
West-nonteaching	5,994	6,273	388	352	1.09	1.10	5.39	5.43	145	142
Licensed beds										
Less than 125	\$5,047	\$4,276	\$461	\$136	1.01	1.00	5.13	4.49	124	124
125-299	6,195	6,138	371	342	1.10	1.13	4.80	4.61	160	152
300-499	7,182	7,574	174	313	1.21	1.30	5.39	5.22	194	184
500-699	8,977	9,553	169	325	1.34	1.36	5.78	5.53	223	213
More than 700	9,781	9,822	302	420	1.31	1.33	6.00	6.26	245	241
Academic status										
Teaching	\$10,690	9,910	\$200	\$389	1.42	1.37	¶ 6.56	¶ 5.82	¶ 268	¶ 225
Nonteaching	† 6,194	† 5,755	307	263	1.12	1.13	¶ 4.97	¶ 4.70	164	149
Overall	7,301	7,216	281	307	1.20	1.22	¶ 5.35	¶ 5.09	¶ 189	¶ 176

*"Net operating revenue" excludes interest income; **"Adjusted" factor = total operating revenue/inpatient revenue; ¶ Statistically significant at 95%; † Statistically significant at 90%

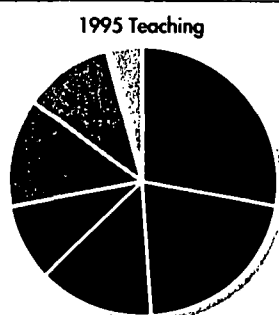
Source: MECON-PEERx ©1995

3.3

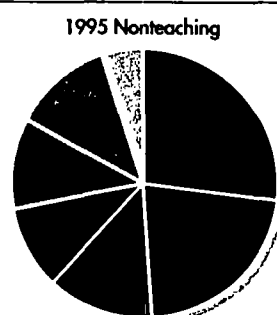
Percentage of Labor Costs* for Each Hospital Function Area



● Nursing services	35%
● Nursing-based therapeutic services	17%
● Ancillary diagnostic services	13%
● Ancillary therapeutic services	12%
● Hotel services	9%
● Fiscal and administrative services	13%
● Patient information services	1%



● Nursing services	28%
● Nursing-based therapeutic services	21%
● Ancillary diagnostic services	14%
● Ancillary therapeutic services	9%
● Hotel services	13%
● Fiscal services	11%
● Patient information services	4%



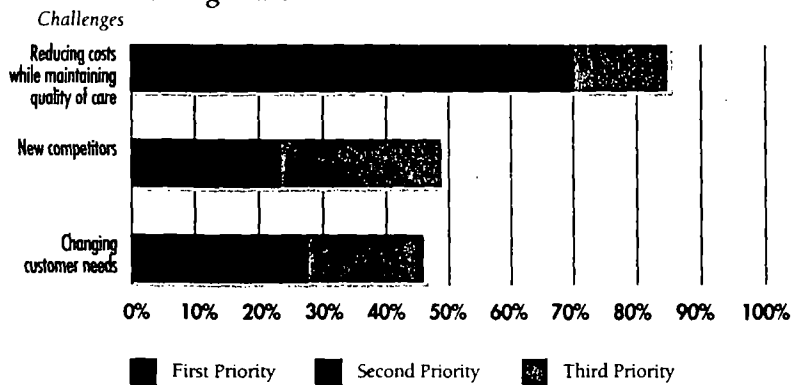
● Nursing services	27%
● Nursing-based therapeutic services	22%
● Ancillary diagnostic services	13%
● Ancillary therapeutic services	10%
● Hotel services	11%
● Fiscal services	12%
● Patient information services	5%

*Wage-adjusted labor costs per discharge

Source: MECON-PEERx ©1995

3.4

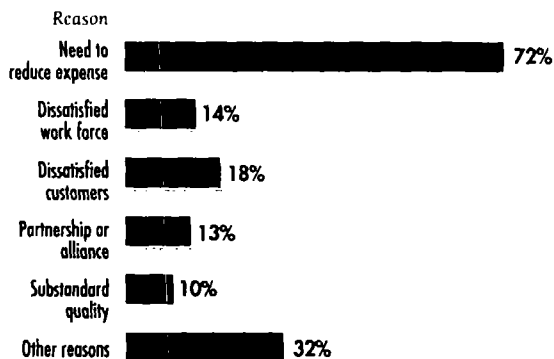
What Are the Top Three Challenges to Your Organization's Continued Success in the Coming Years?



Source: Survey of 300 health care executives attending Hammer Conference, Deloitte & Touche Consulting Group, Sept. 1995

3.5

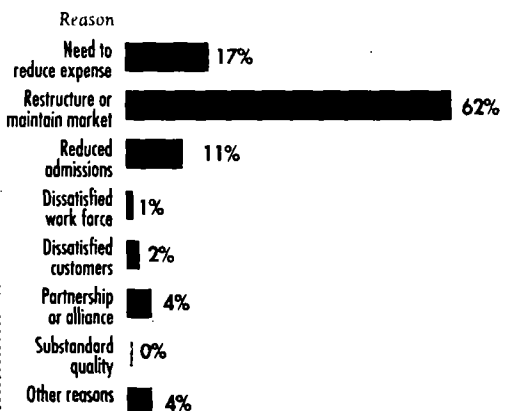
Primary Reason for Initiating a Redesign Project in 1993



Source: a VHA Inc. survey of nurse executives, fall 1993

3.6

Primary Reason for Initiating a Redesign Project in 1995



Source: a VHA Inc. survey of nurse executives, fall 1995

Continuing cost pressures are still causing the greatest stress on health care organizations (Fig. 3.4). But even as cost pressures remain strong, the motivations for re-engineering may be changing. In 1993, 72 percent of nurse executives who responded to a VHA survey cited cost reduction as the primary motive for change (Fig. 3.5). By 1995, that response rate had dropped to 17 percent, replaced by the need to maintain market share as the most common reason (Fig. 3.6).

The organizational response

The most common responses to intense cost pressures are:

Management restructuring: In some organizations, the number of management layers have been halved. Vice president and assistant vice president positions are also being consolidated, with the resulting positions assuming increasing spans of control.

Clinical integration: Historically, business and administrative functions have been consolidated first, but now organizations that are reconfiguring their clinical programs are reaping significant financial and quality benefits (Fig. 3.7). Some organizations have saved between 15 percent and 25 percent within specific clinical areas when they've integrated their clinical and case management programs.

3.7

Here's How

Successful delivery systems integrate clinical programs by:

1. Developing a common vision and joint planning
2. Emphasizing preventive services
3. Implementing uniform clinical pathways, case management and quality measures
4. Consolidating services to achieve economies of scale and optimize resource usage (staffing and operations, equipment and facilities)
5. Closing marginal (high-cost and low-quality) programs
6. Establishing consistent medical direction and program leadership
7. Coordinating acquisition and development of new technology for quality, cost-effective and competitive service
8. Aligning incentives (physician, management and technical staff)
9. Developing information systems to support redesigned operations and resource management

Source: *Hospitals & Health Networks*, Feb. 5, 1995

3.8***Re-engineering the Hospital: Care Management and Case Management*****Avoiding acute admissions****1. Enrollee health assessment program**

All new enrollees are given a health risk assessment; based on the results, an enrollee may receive further treatment or be assigned to a chronic care center or case manager if appropriate.

2. Chronic disease centers

Nurse case manager proactively monitors conditions of patients with chronic care needs; the goal is to ensure that high-risk patients receive treatment before their condition deteriorates, thereby reducing the number of emergency department visits and inpatient admissions.

Results: One hospital, using telephone case management for chronic heart failure, reduced average patient charges by 28 percent.

3. Placement center

The physician calls the center for advice about the most appropriate location for the proposed treatment; the goal is to triage patients to the most cost-effective site and avoid expensive inpatient admissions when possible.

- Provides physicians with up-to-date information on alternative treatment locations
- Provides resource directory for physicians who need information after hours

4. Preadmission education program

Hospital staff discusses the course of treatment and recovery with the patient and family; the goal is to minimize length-of-stay by reducing the risk that the patient or family may resist care decisions, due to lack of understanding of the normal course of treatment.

Reducing length-of-stay**5. Inpatient physicians and case managers****Inpatient physician**

The physician (usually an internal medicine specialist) performs inpatient rounding for all patients; the goal is to ensure that intensive care unit transfers, lab test turnaround, rehabilitation and discharge preparation occur in a timely manner.

Source: 1995 Advisory Board

Case management and case management: These programs tackle **length-of-stay costs** through clinical guidelines and other established systems to prevent unnecessary admissions, reduce length-of-stay and lower unit costs (Fig. 3.3). Case management is increasingly becoming a corporate- or system-level responsibility to ensure effective implementation of corporate objectives.

Customer service: One New York hospital is working with an area hotel to teach hospital staff members how to treat patients like hotel guests. The program includes mentoring, employee screening, training programs and employee relations strategies. The result has been documented improvements in patient satisfaction.

Re-engineering the Hospital: Care Management and Case Management, cont'd.

Reducing length-of-stay

5. Inpatient physicians and case managers, cont'd.

Case manager

A nurse is assigned to oversee patient stay, ensure high-quality care and allow the earliest possible discharge.

- Coordinates with discharge planning staff and social workers to begin earliest possible discharge planning activity
- Coordinates with physician on appropriate timing of patient transfer, discharge

Results:

- After implementing case management, one health center achieved a 12.5 percent decrease in length-of-stay, a 10 percent increase in office productivity and a 20 percent decrease in physician consultations.
- One medical group found that inpatient physicians saved more than \$1 million at the hospital that cared for the group's 22,000 covered lives.
- Another medical group, using an inpatient physician, found that length-of-stay skyrocketed when the inpatient physician went on vacation.

6. Placement center—outbound discharge planning and length-of-stay reduction

Hospital personnel assist physicians and case managers with discharge planning.

- Coordinate discharge planning upon patient admission
- Coordinate support services and transportation
- Conduct home and family assessment

Results: One hospital experienced a 35 percent increase in home health visits and a significant decrease in length-of-stay.

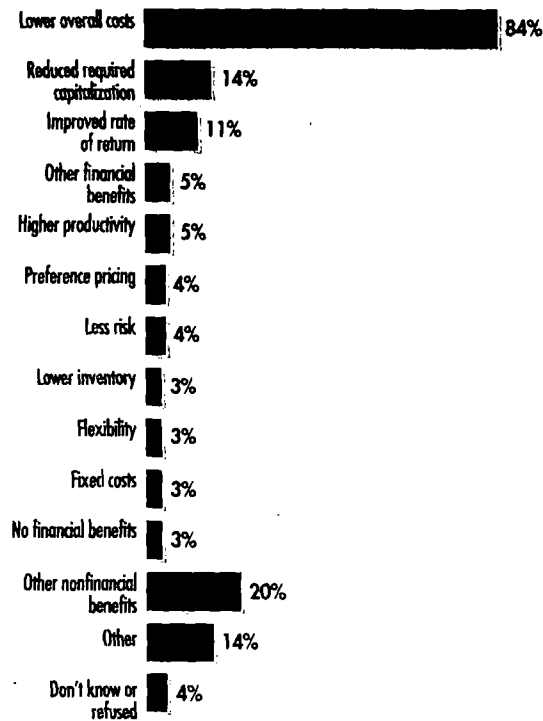
7. Postdischarge case management

A case manager is assigned to monitor high-risk patients after discharge.

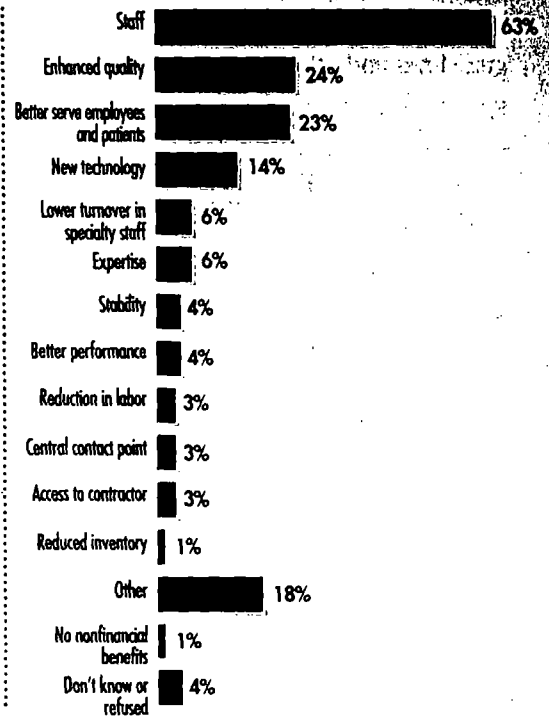
- Periodic telephone calls to monitor status
- Monitor drug compliance with dosage adjustment made as necessary
- Home health or therapy coordination
- Schedule follow-up visits
- Patient and family counseling

Source: 1995 Advisory Board

Financial Benefits of Outsourcing



Nonfinancial Benefits of Outsourcing



Source: ©Copyright 1996 by The Business World Inc., *Health Care Strategic Management*, January 1996

3.10

Foundations of Design for a New System of Care

- **Reduce waste in all of its forms** — We have barely scratched the surface to reduce waste in health care.
- **Strive for continuous flow** — The price of interrupted flow is inventory or waits.
- **Reduce demand** — We must demonstrate commitment to crafting better ways to make partners of our patients.
- **Plot measurements related to aims over time** — When important dimensions are continuously monitored, it becomes easier to study the effects of innovation.
- **Match capacity to demand** — Measure demand, measure supply, make a prediction using data and allocate to meet the need 70 percent to 80 percent of the time.

Source: From speech "Run to Space," given by Donald Berwick, M.D., president and CEO of the Institute for Healthcare Improvement, on Dec. 6, 1995

cing

1%

Facilities management
Facilities management:
 While **facilities management** in health care is attractive, it can rapidly reduce costs, improve productivity and enhance quality and service (Fig. 3.9).

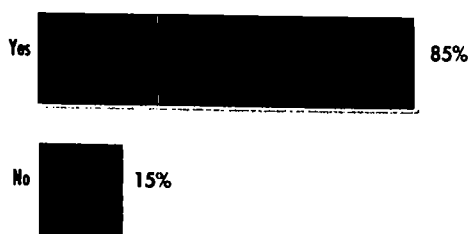
Many health care suppliers are working with providers to manage facilities' wastes, lighting systems and building improvements. Closely monitoring the use of materials is also paying off with programs such as electronic requisitioning, capital equipment planning and acquisition, and electronic data interchange standards, which improve turnaround times and reduce errors in shipping and ordering.

Continuous quality improvement:
 While many health care organizations have implemented continuous quality improvement programs, the results have often been disappointing. Nevertheless, health care organizations that concentrate closely on proven CQI programs (Fig. 3.10) often demonstrate good results.

The reality of redesign

Re-engineering has touched the lives of the great majority of health care personnel. Eighty-five percent of the nurse executives who responded to a 1995 VHA survey reported that their organization had participated in some sort of redesign project (Fig. 3.11).

3.11 Involvement in a System Redesign Project



Source: a VHA Inc. survey of nurse executives, fall 1995

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Why Re-engineering Failed

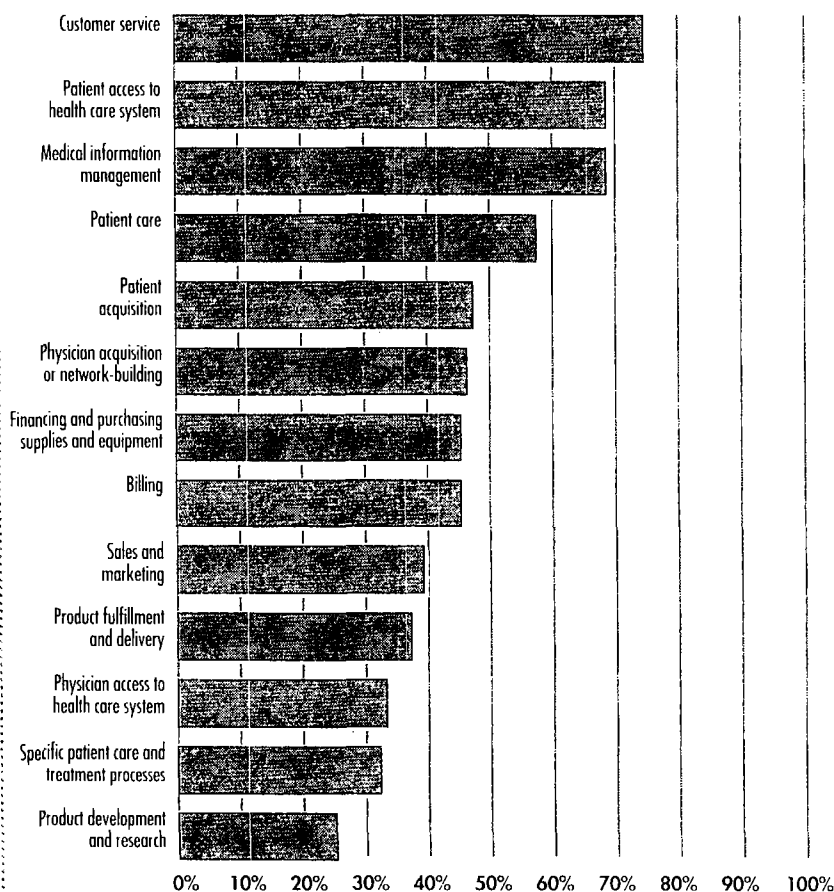
Aspects of re-engineering that should never have been missed in the first place:

- Re-engineering is strategic planning for how work gets done. As with all planning projects, implementation is always harder than design.
- The "clean sheet of paper" envisioned in the design phase gets dirty during implementation. Throwing away existing systems and structures is enormously expensive.
- The "top down" aspect of re-engineering falters when those who actually do the work have to change their behavior.
- Even the best project can run out of time. Radical, technology-enabled change takes a minimum of five to seven years.
- Companies still need to change; there's no such thing as a stable industry. Nor is there a single change method to use or a one-size-fits-all package.

Source: *Fast Company* magazine, "Why Reengineering Failed — and What Comes Next," by Thomas H. Davenport, Nov. 1995

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Processes That Most Need to be Improved Through Re-engineering



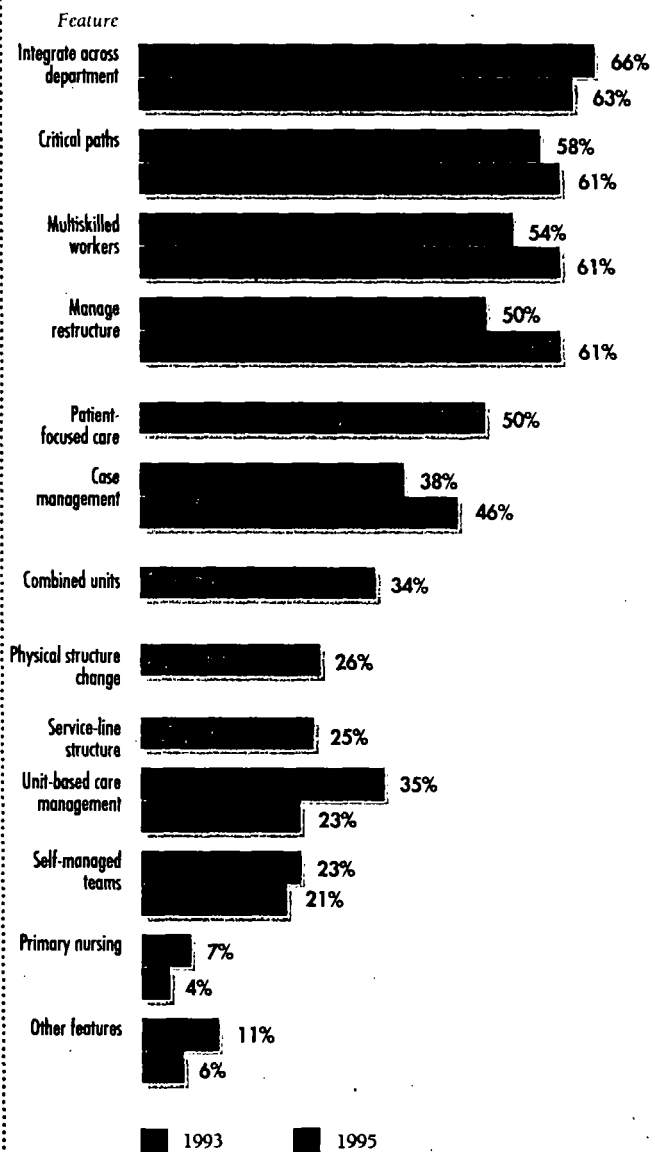
Source: a VHA Inc. survey of nurse executives, July 1995

Most involved the integration of duties across departmental boundaries, establishment of clinical critical pathways, efficient use of employees with multiple skills and restructuring of management (Fig. 3.12).

As re-engineering plans have proliferated, more lessons are learned from the implementation. Yet the most important things to keep in mind are still the basics (Fig. 3.13).

3.12

Core Features of a Systems Redesign Project



Total equals more than 100 percent, as respondents could select more than one response

Source: a VHA Inc. survey of nurse executives, fall 1995

Customer-focused and high priority

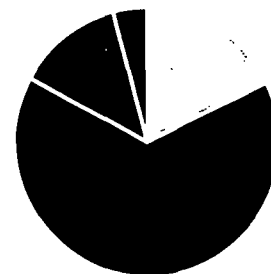
Nurse executives were highly mindful that improved customer service, patient access to care and the installation of medical information management systems are the most important goals of re-engineering (Fig. 3.14). Emphasizing the perceived importance of such changes, re-engineering efforts were rated as one of the top three priorities of 83 percent of the nurse executives' organizations (Fig. 3.15).

The roles of nearly 90 percent of nurse executives changed as a result of redesign efforts, with three-quarters having their responsibilities expanded (Fig. 3.16).

Compensating for obstacles

Organizational resistance is by far the most significant obstacle to effective systemic change (Fig. 3.17), and the most powerful way to overcome that is through a strong, unwavering organizational commitment to risk and change (Fig. 3.18). While re-engineering is often blamed for employee morale issues, disloyalty and distrust, these problems can be overcome by a management team that is clear in what it wants to accomplish and addresses how employees respond to and deal with change.

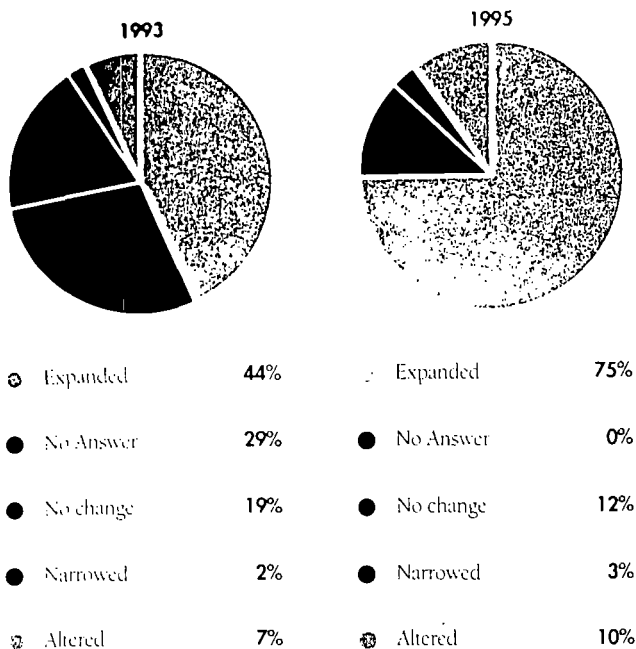
3.15 How Does Your Re-engineering Effort Rank in Terms of Your Organization's Priorities?



First priority	18%
Among top three	65%
Among top five	13%
Among top 10	4%

Source: a VHA Inc. survey of nurse executives, fall 1995

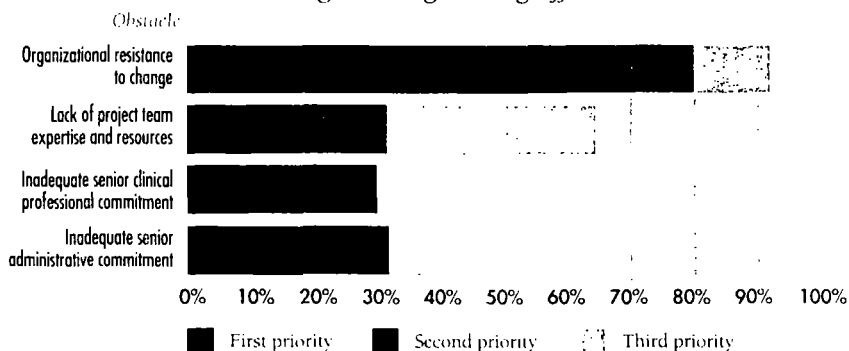
Nurse Executive Position Changes



Source: a VHA Inc. survey of nurse executives, fall 1995

3.17

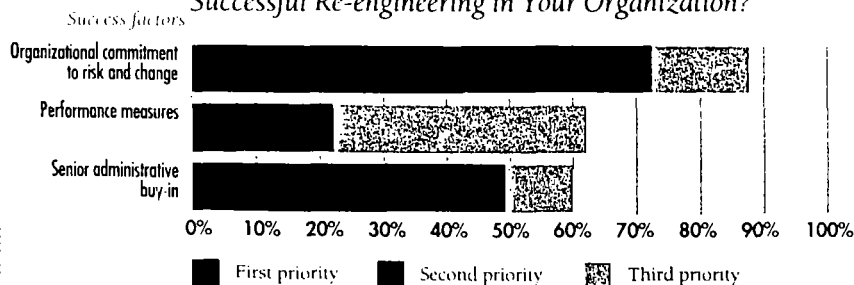
What Are the Top Three Obstacles You Face in Undertaking a Re-engineering Effort?



Source: Survey of 300 health care executives attending Hammer Conference, Deloitte & Touche Consulting Group, Sept. 1995

3.18

What Are the Top Three Factors Necessary for Successful Re-engineering in Your Organization?

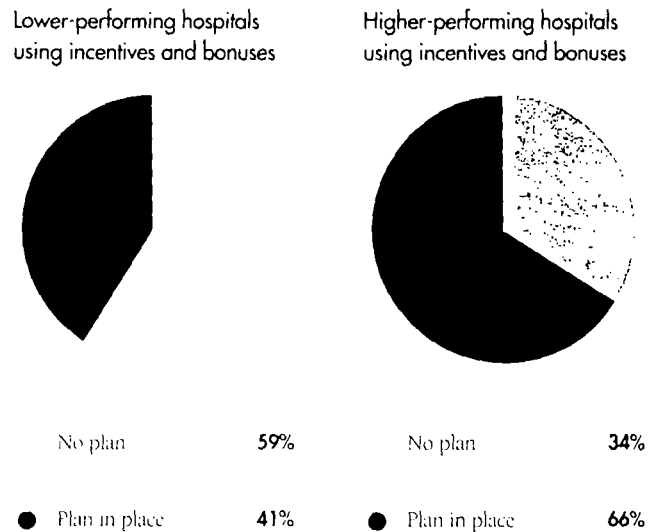


Source: Survey of 300 health care executives attending Hammer Conference, Deloitte & Touche Consulting Group, Sept. 1995

One way to encourage employee acceptance of change is through compensation programs that support new business strategies. Health care organizations are steadily moving from traditional compensation programs to strategies that vary compensation based on performance and teamwork.

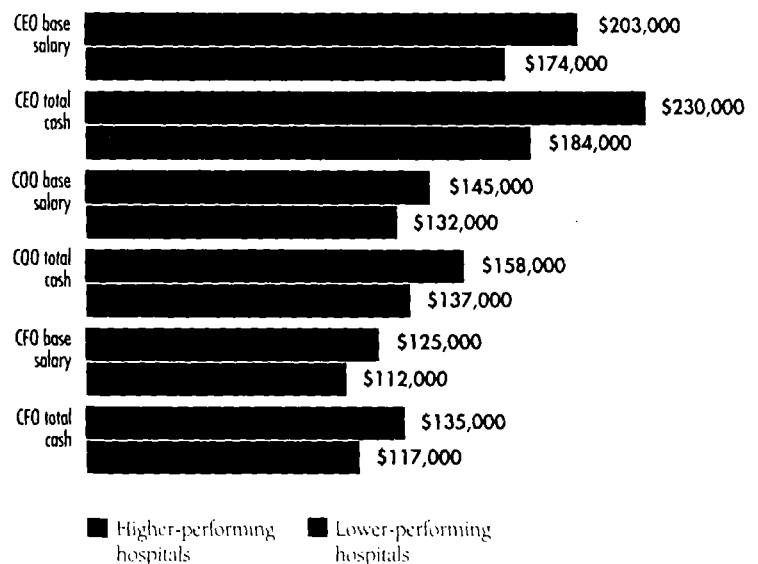
Higher-performing hospitals make greater use of incentive and bonus-compensation plans (Fig. 3.19), and the executives of higher-performing health care organizations earn more, both in terms of base salary and total compensation (Fig. 3.20).

3.19 Use of Annual Incentives and Bonuses



Source: Hay Group, 1995

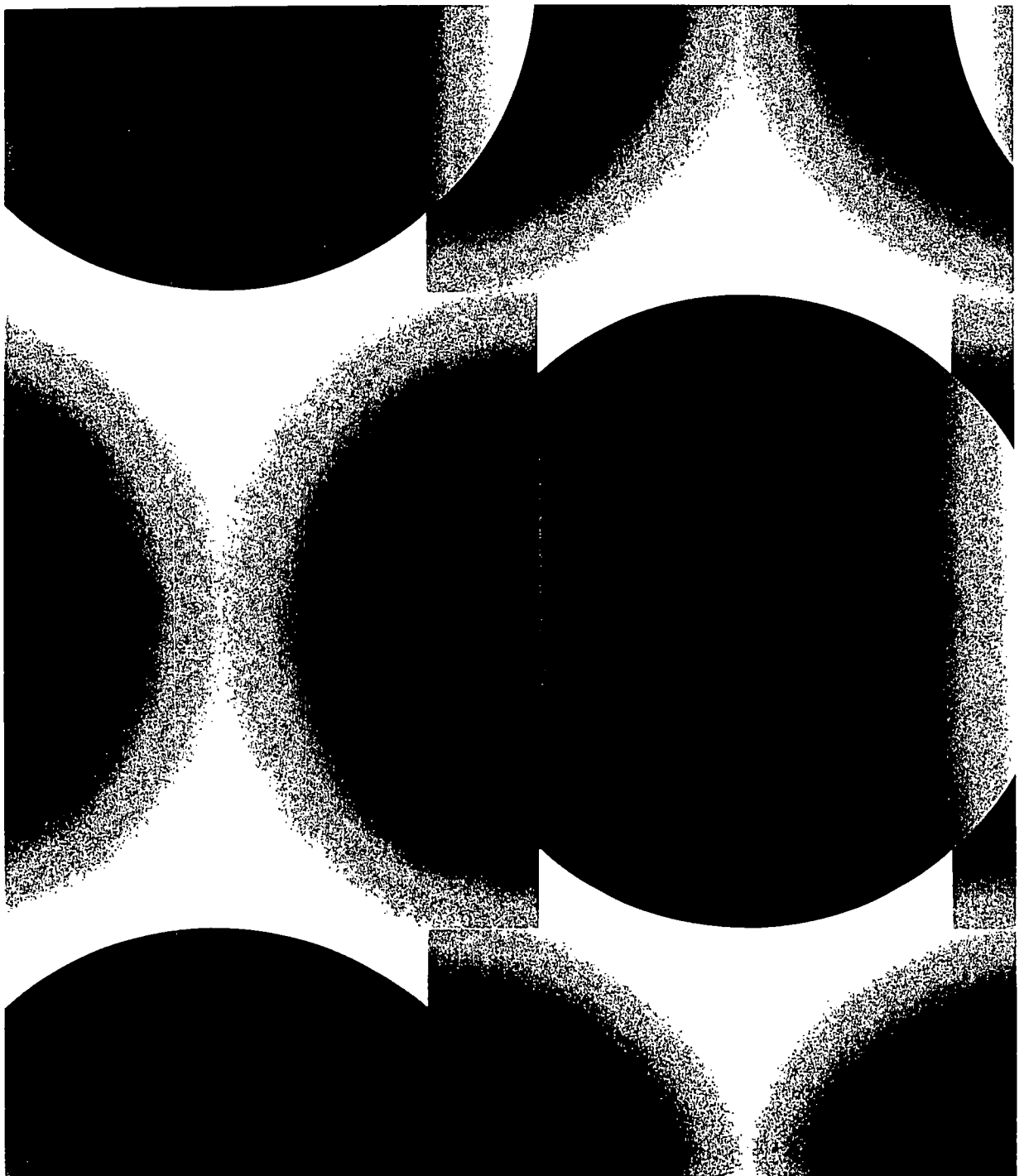
3.20 Executive Compensation by Hospital Performance



Source: Hay Group, 1995

CHAPTER FOUR

*Information Technology—
A Competitive Necessity*



Information Technology— A Competitive Necessity

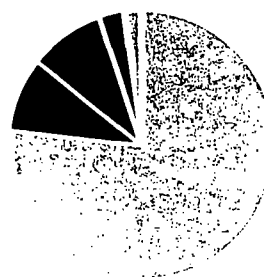
Computers in the clinic

Health care executives say information technology investment is their top priority for capital expenditures (Fig. 241). Improving managed care capabilities, getting accurate information and decision-support tools to clinicians, and improving ambulatory and outpatient capabilities are the most important goals (Fig. 242).

To manage the care of entire patient populations better, health care organizations are focusing their information technology systems on tracking individual patients and measuring clinical outcomes.

FIGURE 241

The Highest Priority for
Capital Expenditures by
Health Care Organizations

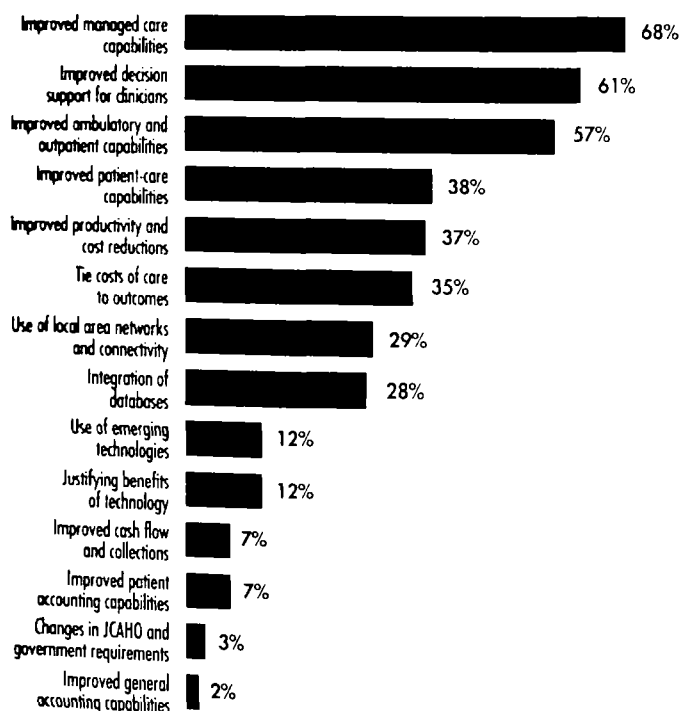


Information technology	77%
Human resource development	9%
Reporting	9%
Building and facilities	3%
Medical technologies	2%

Source: *Managed Health Care Magazine*, May 1995, from an Andersen Consulting LLP survey.

FIGURE 242

Information System Priorities During the Next Two Years



Note: Respondents could select a maximum of four priorities.

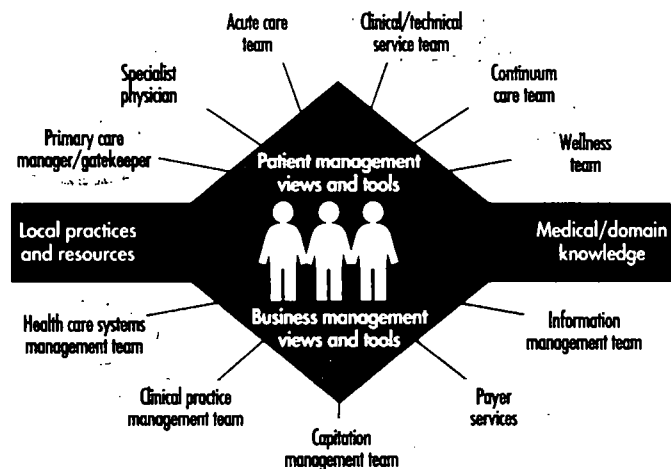
Source: 1996 Healthcare Information and Management Systems Society (HIMSS)/Hewlett-Packard Leadership Survey.

Outpatient settings such as freestanding surgical centers, ambulatory care centers and physicians' offices, where the bulk of care is provided today, are being connected at an unprecedented rate. Some organizations are developing seamless information networks in which information isn't tied to one department or business unit but is available throughout the continuum of care (Fig. 4.3).

The Internet

There are growing signs that the Internet will one day be used extensively by patients and providers alike. Some providers, for example, are beginning to use the Internet for registering patients, directing patients to alternative care sites and transmitting medical results. The Internet is now used mostly to support clinical research and facilitate communication between physicians, as well as offer health care information about providers to consumers (Fig. 4.4).

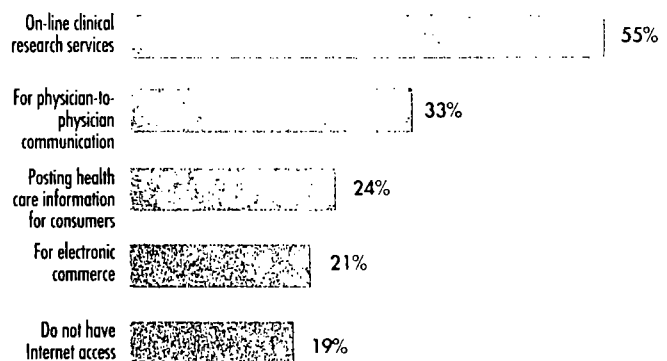
4.3 The Ultimate Patient Care Information System Supports the Whole Health Care Environment



Source: *Patient Care Information Systems* by Dragen, Metzger, Ritter and Schneider, 1995

4.4

How Is Your Organization Using the Internet?



Source: 1996 HIMSS/Hewlett-Packard Leadership Survey

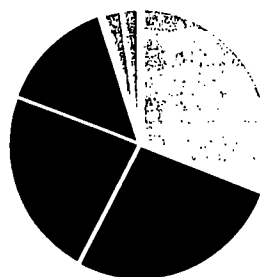
In the future, information technologies will be used to keep patient records on "smart cards," diagnose patients from home, transfer patient information over the Internet and automate pharmacies (Fig. 4.5). Internet technologies dramatically reduce the cost of communication and access to information, which is expected to have a major positive impact on health care delivery.

Upgrading and integrating

Many health care organizations, especially large, integrated delivery systems, are grappling with ways to integrate or interface their existing information technology systems. In fact, most planning in the information systems arena extends beyond a single entity and focuses on the entire health care enterprise (Fig. 4.6).

4.5

What Are the Top "Futuristic" Health Care Technologies You Expect to Become Common in the Next Five Years



Complete patient record kept on "smart cards" 31%

● Remote diagnostics for patients at home (telemedicine from the home) 27%

● Access to medical records over the Internet 23%

● Automated pharmacies and drug disbursement 14%

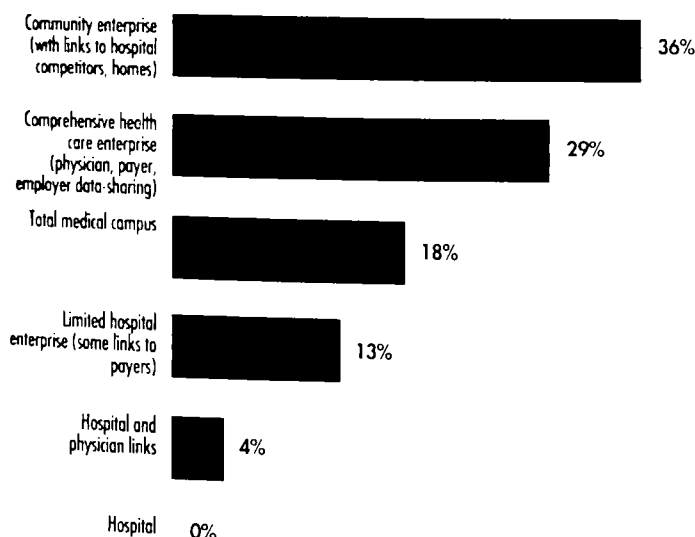
⊛ Other 3%

⊞ Computerized surgery, in which a patient is operated on by a surgeon in another location 2%

Source: 1996 HIMSS/Hewlett-Packard Leadership Survey

4.6

Scope of Plan and Vision for Information Systems

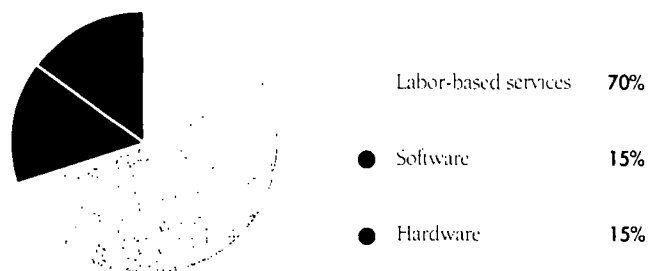


Source: 1996 HIMSS/Hewlett-Packard Leadership Survey

4.7 *Typical Three-to-Five-Year Capital Budget for Delivery System With \$1 Billion to \$2 Billion in Revenue*

Initiative type	Description	Capital Budget
Infrastructure	Planning, staffing and other foundation infrastructure	\$5 million to \$15 million
Communications network	LANs, EANs, EDI, E-mail, videoconferencing, telemarketing and others	\$10 million to \$30 million
Master patient index, central registration, enterprise appointment and resource scheduling		\$10 million to \$20 million
Data repositories and decision-support systems		\$10 million to \$30 million
Replacement and consolidated legacy systems	HIS capitation, claims, lab, pharmacy, radiology	\$10 million to \$50 million
Physician office support systems	Billing, EDI, risk reimbursement, appointment scheduling	\$10 million to \$30 million
Clinical information systems	Longitudinal patient records, order management, clinical guidelines	\$20 million to \$100 million
Total		\$75 million to \$275 million

Majority of funding growth from 1995 to 2000 will be applied to services



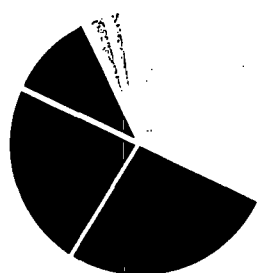
Source: C.J. Singer, August 1995

Indeed, one of the most pressing issues today is how to upgrade and integrate information systems successfully across separate facilities that have become part of an integrated delivery system. Attention and spending in information technology is moving from hardware and software applications toward connectivity, networking, data architecture and resulting labor-based integration services (Fig. 4.7).

The highest information system priority for many organizations is to upgrade their infrastructure and integrate their systems in a multivendor environment (Fig. 4.8). These systems typically involve hardware and software services, personal computers, networks, databases, installation expertise and systems integration capabilities.

Most new technologies being used or considered today reflect the health care industry's need to integrate and communicate with a variety of entities (Fig. 4.9).

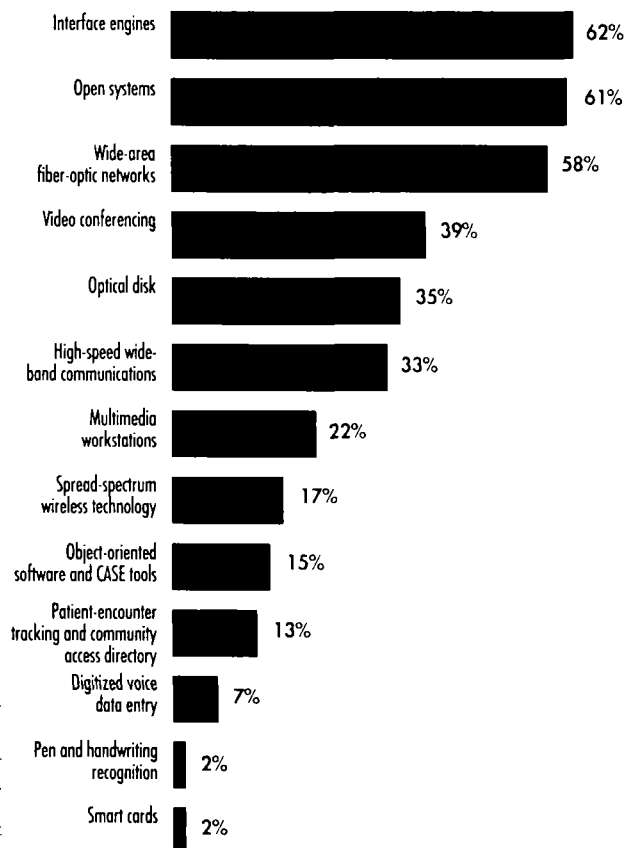
4.8 Most Important Information Services Priorities **4.9**



Upgrade information technology infrastructure	32%
Integrate systems in a multivendor environment	27%
Re-engineer to a patient-centered computing environment	23%
Migrate to client-server systems	11%
Mobile access for caregivers	3%
Outsource information technology services	2%
Other	2%

Source: 1996 HIMSS/Hewlett-Packard Leadership Survey

Current Information Technology Usage



Source: Modern Healthcare, March 1996, from Coopers & Lybrand

As health care organizations' relationships with consumers and physicians continue to change, decision-support functions and communications networks will become even more important (Fig. 4.10).

Computerized patient records

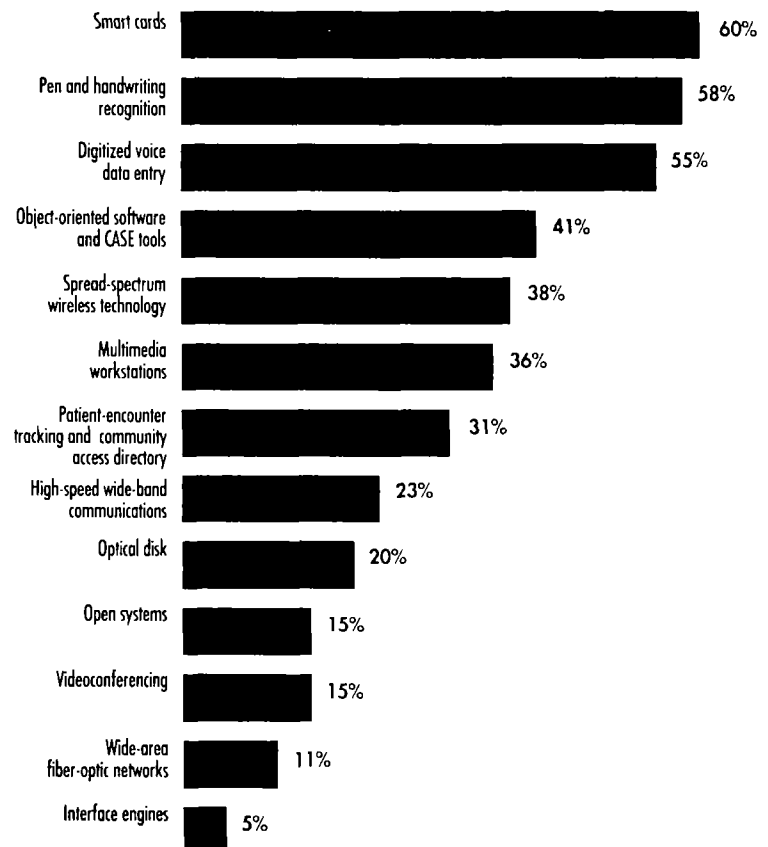
More than a single information system or one computerized package, computerized patient records are derived from a series of software packages, databases and information technologies. The records should include specific patient

care information, administrative components and medical domain information, such as clinical care guidelines and protocols (Fig. 4.11).

Developing the systems to create these records requires large investments, and some organizations are trying to measure the costs and benefits before jumping in (Fig. 4.12). However, many health care organizations have already moved beyond the planning stages and into development (Fig. 4.13).

4.10

Current Interest in and/or Planning for Information Technologies

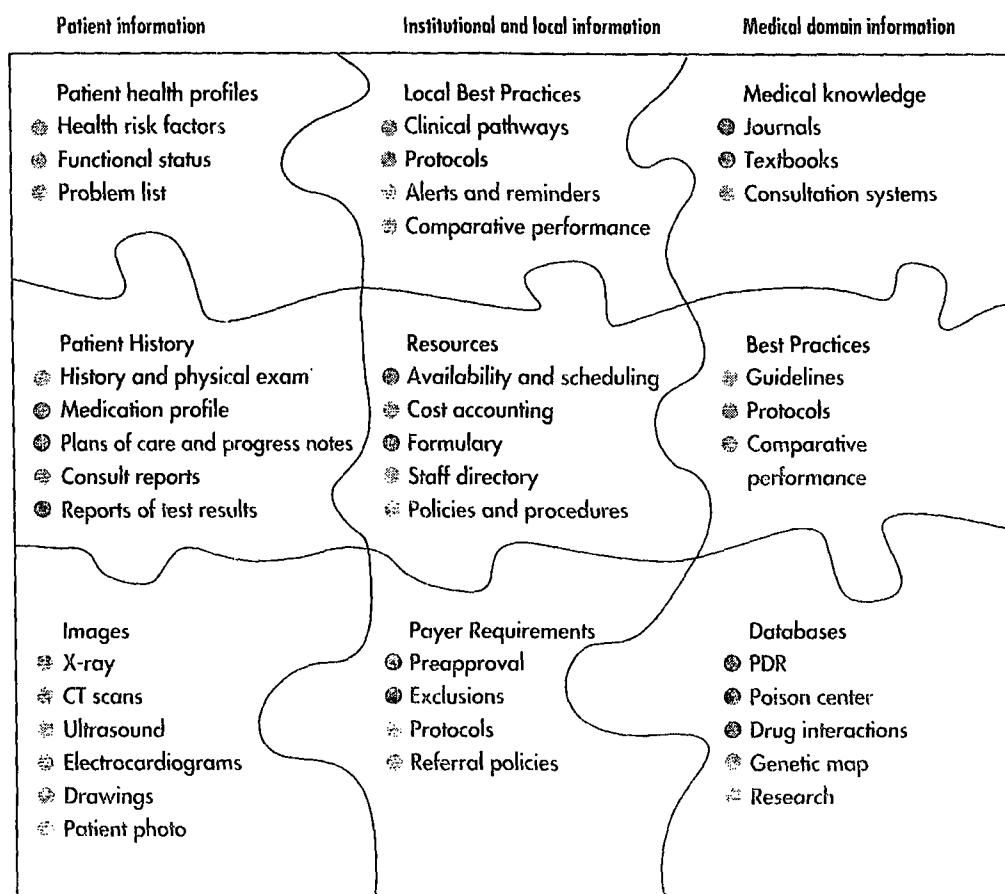


Note: Respondents could select a maximum of four priorities.

Source: *Modern Healthcare*, March 1990, from Coopers & Lybrand

4.11

Elements of a Comprehensive Patient Care Information System

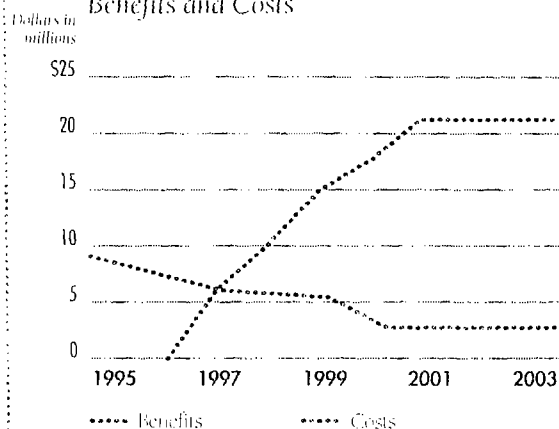


Key: ● Part of base product ● In limited use ● Emerging

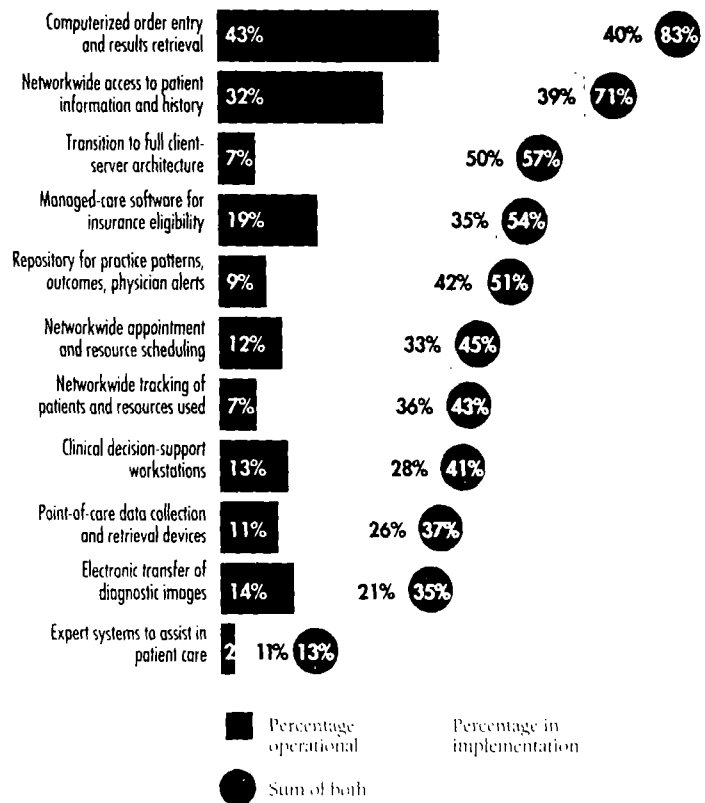
Source: *Patient Care Information Systems* by Druzen, 1995

4.12

Projected Computer-Based Patient Record Benefits and Costs



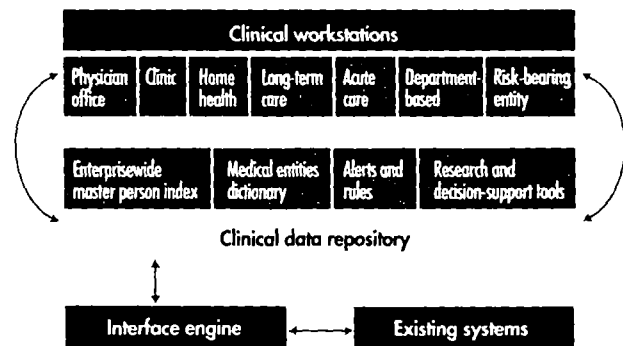
Source: *Journal of the Healthcare Financial Management Association*, July 1995



Source: *Modern Healthcare*, March 1996, from Coopers & Lybrand

4.14

Definition and Scope of Clinical Data Repository



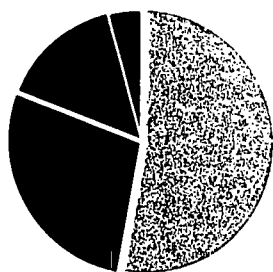
Source: VHA collaborative clinical data repository initiative, April 1996

4.14 Clinical data repositories

Clinical data repositories provide access to patient data, regardless of where in the health care system the clinical encounter occurred. They include medical entities, dictionaries, global person (patient or member) indices, clinical guidelines and research and decision-support tools (Fig. 4.14). Many organizations have plans to develop such systems (Fig. 4.15). These repositories can be centralized or decentralized, focus on inpatient or ambulatory data, provide detailed or summary information and offer combined or separate clinical and financial data.

4.15

Implementation of Clinical Data Repositories

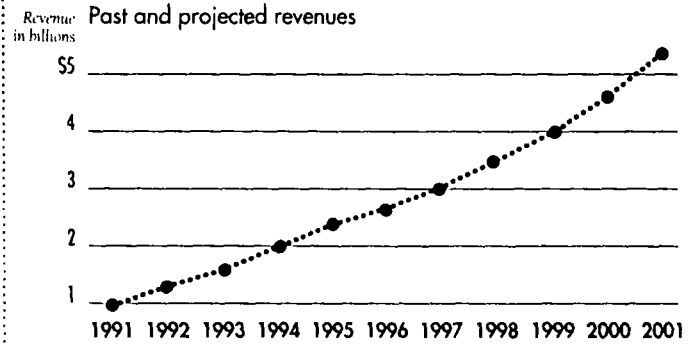


- ☉ Plan to have 53%
- Long-term strategic plans 28%
- Have 15%
- No response 4%

Source: VHA Clinical Data Repository Survey, November 1995

4.16

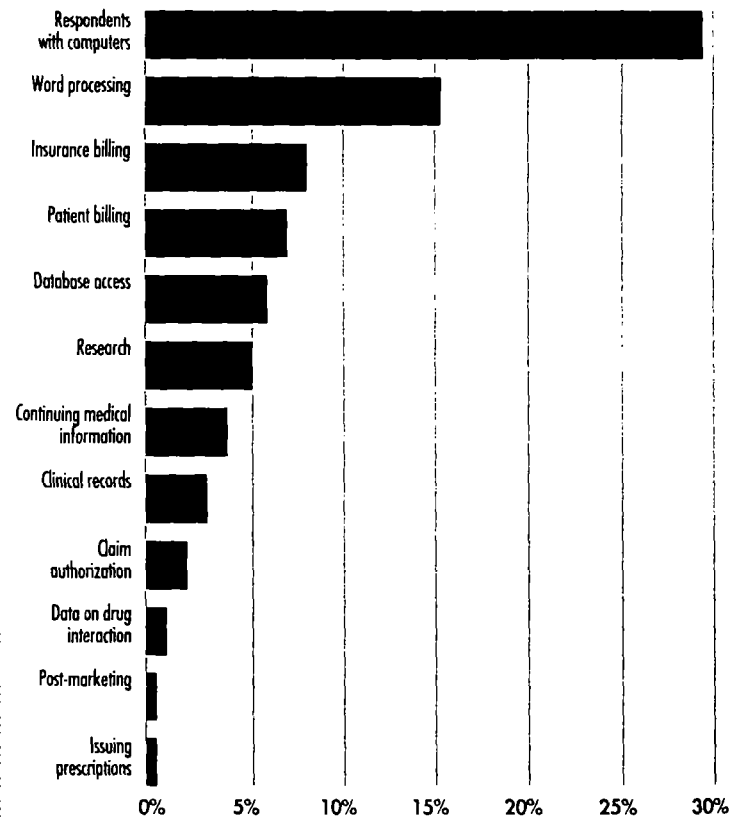
Physician Information Systems



Source: Frost and Sullivan, 1996

4.17

Physician Use of Computers



Total respondents = 548,900

Source: BMI Research survey, 1995, cited in Council on Competitiveness study

Connect the docs

Health care organizations, managed care firms, third-party payers and other groups are requiring expanded access to physician information for reimbursement, clinical care and outcome measurement, utilization review and case management. To meet these demands, health care organizations are making major investments. Total physician information system revenues are expected to increase from

\$2 billion in 1994 to an estimated \$5 billion by 2001 (Fig. 4.16), with most growth expected in the ambulatory electronic medical record segment of the market.

It's unclear whether this investment will be successful. While most physicians use computers only to help with general office and billing activities (Fig. 4.17), there is growing evidence that clinical automation will increase in popularity and usage (Fig. 4.18).

4.18

Case Study

Gaining acceptance of clinical automation

The Issue: Cox Health Systems, an integrated delivery system in Springfield, Mo., wanted to put clinical information from its newly remodeled clinic, Steeplechase Family Physicians, into an electronic medical records system. The goal was to support physicians with a state-of-the-art tool for capturing, retrieving and analyzing clinical information. The availability of this system at other clinics and practices within the system would enhance its ability to manage the health of its patient population.

The Challenge: Cox asked physician leader Tom Landholt, M.D., to lead the effort. Landholt decided to gain acceptance of the system by showing other physician practices how such a system would benefit them.

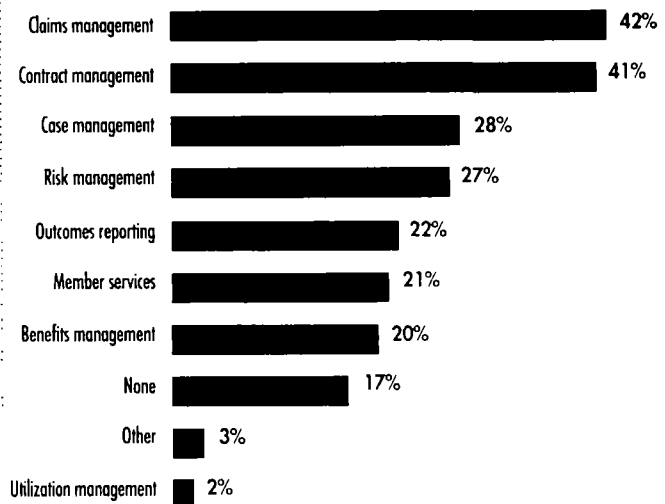
The Solution: Landholt worked to implement an electronic medical record into the Steeplechase Family Physicians clinic in about three weeks. When Landholt referred patients to specialists and physicians within Cox Health Systems, he informed their offices that the patient's chart was on his electronic system and could be sent automatically by fax. This capability increased interest and demand in the system; at least 12 other clinics within Cox requested implementation of this system.

The Benefits: Steeplechase Family Physicians became more efficient since becoming automated. It was able to accept overflow patients from other area clinics and still maintain its own busy volume. It now serves as an on-line site for other health systems and physicians to view the benefits of an electronic medical records system.

Source: Case Study, "Gaining Acceptance of Clinical Automation," adapted from interviews with Tom Landholt, M.D., at Steeplechase Family Physicians, Springfield, Mo., 1996.

4.19

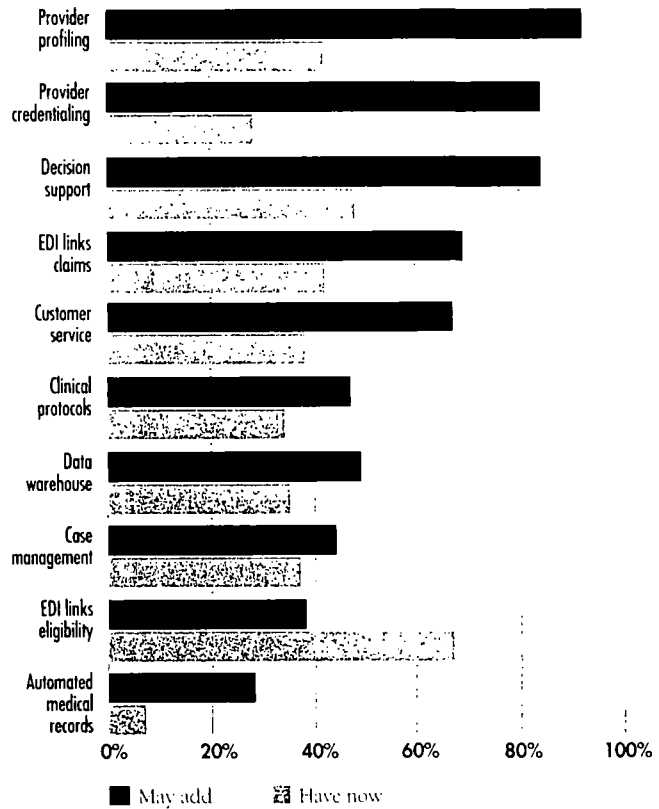
Current Applications of Managed Care Information Technology



Source: 1996 HIMSS/Hewlett-Packard Leadership Survey

4.20

Health Maintenance Organizations That Now Have or Are Planning to Add a Particular Application



Source: C.J. Singer, October 2, 1996

Managed care

Managed care organizations have three main areas of information technology needs: front-end enrollment and eligibility data for member-based services; operational and case management data, including scheduling, automated medical records and claims processing; and contract management and decision support tools (Fig. 4.19). Managed care organizations are making investments in these areas of need (Fig. 4.20).

Consolidating business operations

Consolidated business operations within health care organizations require data access across a multitude of billing entities and systems, including hospitals, ambulatory care centers, physicians' offices and freestanding surgery centers. Infrastructures that will support this effort include electronic data interchange networks, workstations with access to multiple systems and databases, interface capabilities, and voice, imaging and workflow systems.

To computerize their databases, health care providers will rely on document imaging systems that scan physical documents and transform them into electronic images. This technology has been used mostly by health insurers to store and transmit claims data and other information (Fig. 4.21).

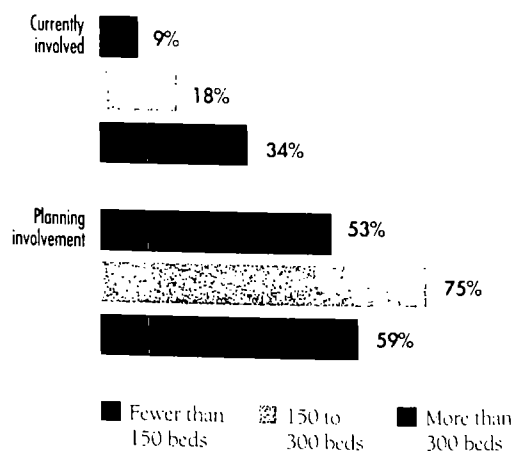
Emerging customer-focused technologies

A growing number of health care organizations are focusing on ways to provide information technology directly to patients or members. In addition to the Internet, patient "smart cards" allow health care organizations to store and retrieve patient medical information on small disks or cards.

Growing applications for information technology include pre-registration and systemwide patient scheduling, on-line information through kiosks, computer-based patient training, 24-hour nurse access systems and on-line access to patient clinical and financial information through voice applications.

4.21

Involvement With Document Imaging



Source: VHA Inc. 1995 survey

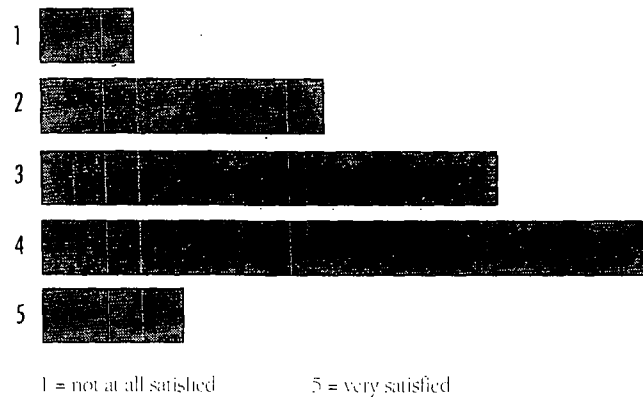
Health care automation

Health care organizations are hopeful about the ability of vendors to deliver products that will meet their information technology needs in the near future (Fig. 4:22). The increasing complexities and scope of health care

automation means that it is virtually impossible for any single vendor to meet all needs. The vast number of vendors and products makes it difficult to find, evaluate and select the best solutions, which adds to the obstacles of setting up a practical information technology system (Fig. 4:23).

4:22

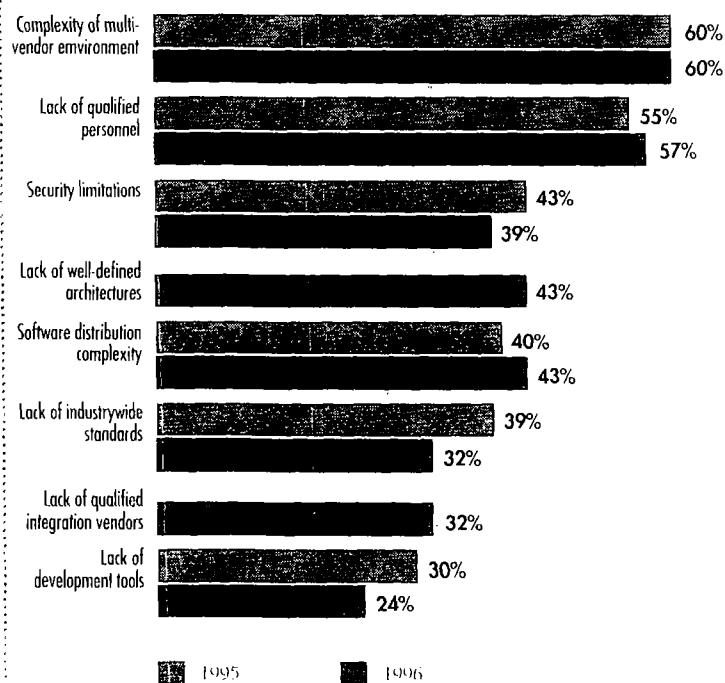
How Satisfied Are You That Information Services Products Will Meet Your Needs Over the Next Two to Five Years?



Source: *Hospitals and Health Networks*, February 1995

4:23

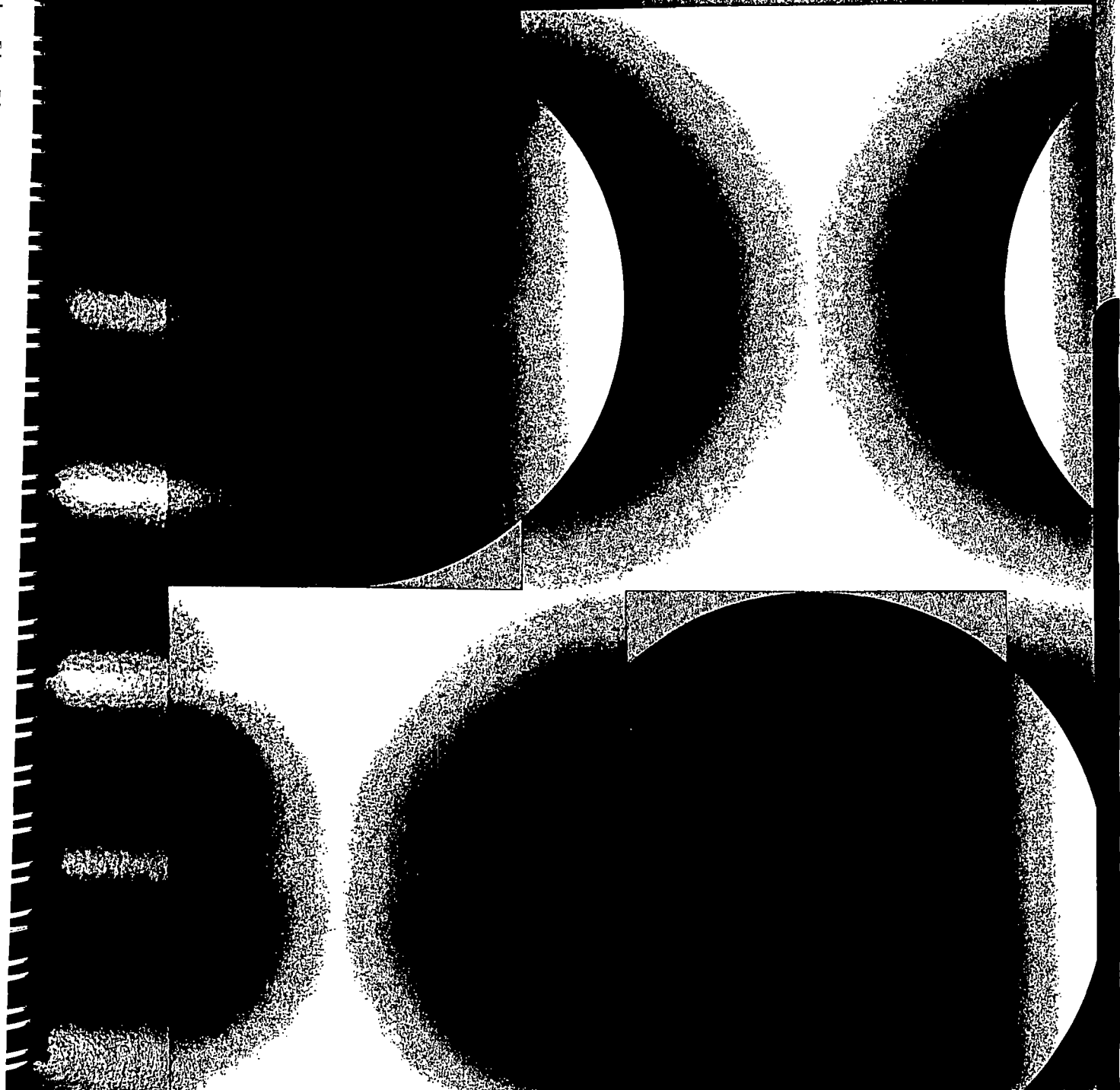
Obstacles to Implementing Client-Server Systems



Source: Deloitte & Touche Consulting Group annual CIO Survey.

CHAPTER FIVE

New Options, New Risks for Physicians



New Options, New Risks for Physicians

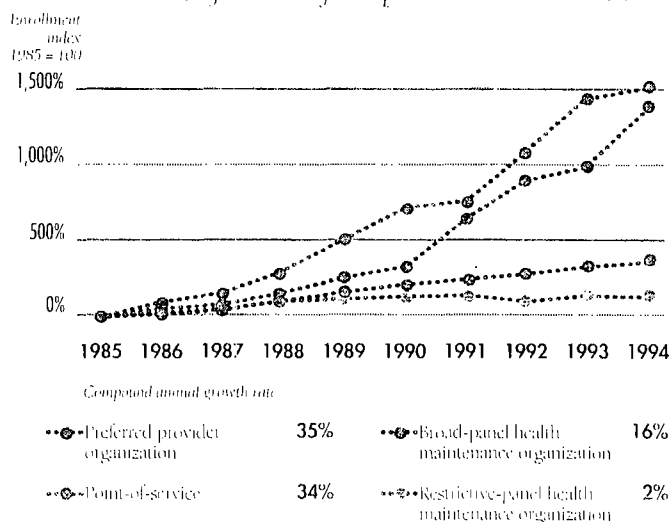
Wild growth: independent physician associations

For years it was assumed that integrated health plans, such as staff- and group-model health maintenance organizations, had superior communication and management oversight that allowed them to deliver the highest levels of customer satisfaction. Independent physician associations were believed incapable of competing with these more integrated models.

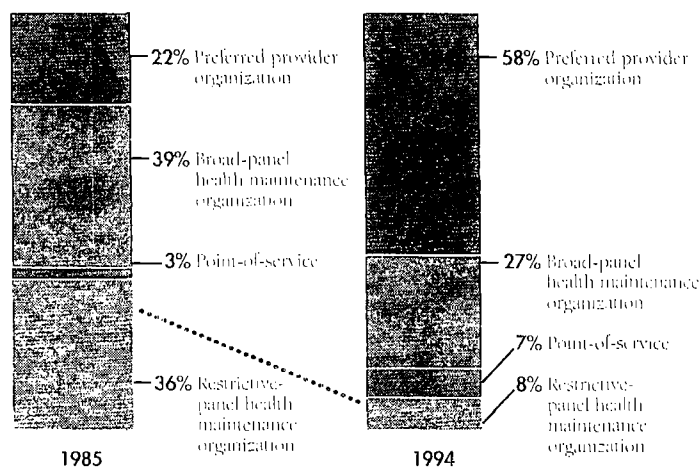
That perception is dying. While staff- and group-model health plans are barely surviving, IPAs are growing rapidly (Fig. 5.1). They are now recognized as offering both lower prices and higher patient satisfaction because of the freedom of choice they give customers. Health care organizations that limited themselves to staff- and group-model health plans in the past are now expanding their networks to include contract physicians (Fig. 5.2).

5.1

A Decade of Growth for Open Plans Nationwide



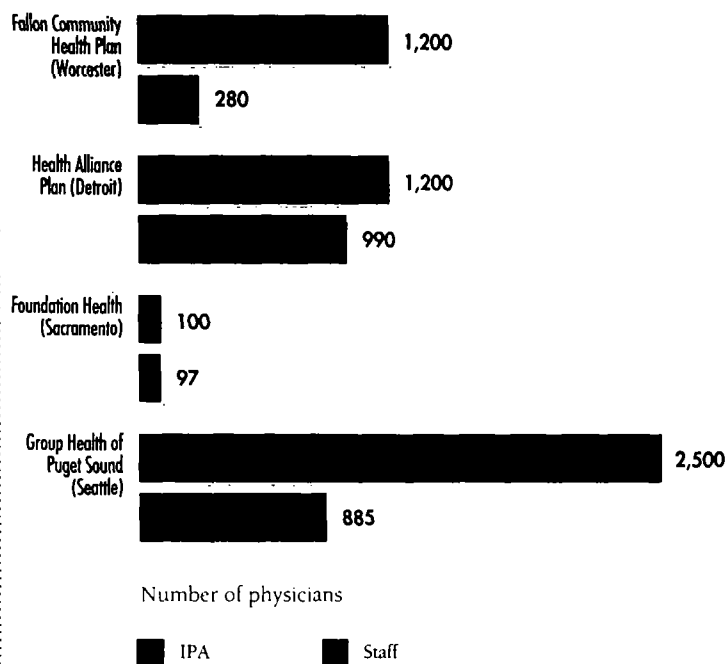
Share of managed care lives



Source: The Advisory Board, 1996

5.2

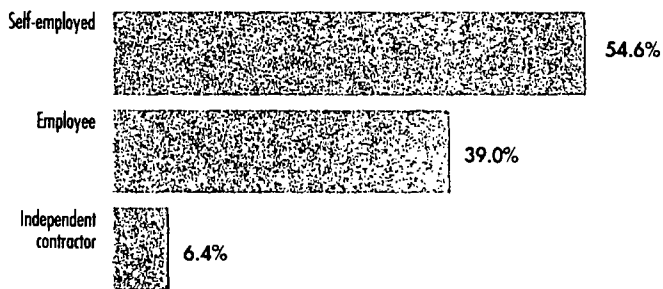
More Contract Than Employed Physicians



Source: Advisory Board interviews, Advisory Board, 1996

5.3

Distribution of Nonfederal Physicians, by Employment Status, 1995



Source: AMA Physician Marketplace Statistics, 1995

One reason is that IPAs can be capitalized at a fraction of the cost of staff-model clinics. Health plans are also able to shift most of their fixed costs to physicians in the IPAs, so loss of enrollment has little impact on the plan's profitability.

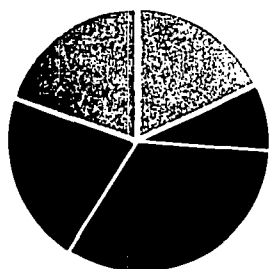
Finally, physicians in private practice are increasingly willing to price their services at marginal rates to gain access to HMO patients. In some markets, IPAs subsidize their HMO pricing by shifting costs to their remaining indemnity patients.

Physicians consolidate

Solo-practice, self-employed physicians are rapidly disappearing from the health care scene. Only slightly more than half of all nonfederal physicians were self-employed in 1995 (Fig. 5.3). The 40 percent of nonfederal physicians who are employed practice primarily in group practices (Fig. 5.4).

5.4

Distribution of Employed Nonfederal Physicians by Type of Practice, 1995



- Private hospital 18%
- Health maintenance organization 8%
- Group practice 33%
- Medical school 21%
- State and local government 20%

Source: *AMA Physician Marketplace Statistics*, 1995

There are about 20,000 group practices of three or more physicians today—an increase of almost 30 percent over a decade ago. Most are physician-owned (Fig. 5.5). The average size of group practices has grown from 6.6 physicians in 1965 to 10.5 in 1995, and almost three-quarters are single-specialty groups (Fig. 5.6).

In heavily managed care areas, a very small number of physicians remain in solo practices. In Minnesota, for example, only 6 percent of physicians are in solo practices and 33 percent are in large groups of more than 100 physicians (Fig. 5.7). In California, where managed care is king, there are predictions of even greater physician restructuring.

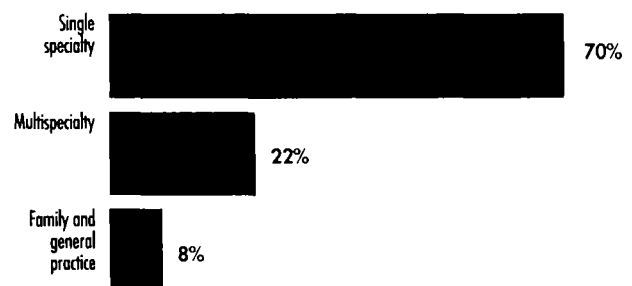
5.5 Medical Group Practice Ownership, 1995

	Percent	Number
Government	0.5%	99
Hospital	3.0	594
Industry	0.5	99
Integrated delivery system	1.0	198
For-profit investor	2.0	396
Physician-owned	82.0	16,225
Medical school	2.0	396
Unknown	9.0	1,780
Total	100.0%	19,787

Source: AMA Group Practice Survey, 1996, MGM member database and VHA estimates

5.6

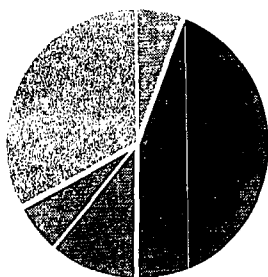
Medical Group Practices by Type, 1994



Source: AMA Group Practice Survey, 1996

5.7

94 Percent of Minnesota Physicians Are in Group Practices



● Solo	6%
● 2-25 MDs	45%
● 26-50 MDs	11%
● 51-100 MDs	6%
● 100+ MDs	33%

Source: Minnesota Medical Association, 1995

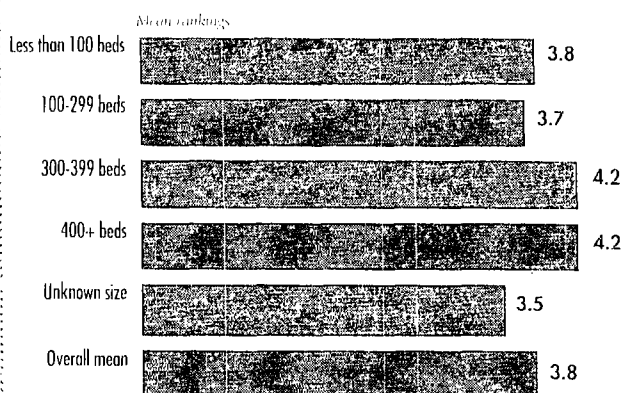
Practice acquisition

In a 1995 survey of hospital financial officers by Physician Services of America, only 17 percent said their facilities experienced positive financial benefits from the purchase of physician practices, and only 32 percent said these transactions met their revenue and expense projections.

Even so, most health care organizations are pleased with their physician practice acquisitions. In the same survey, respondents said their acquisitions had been effective (Fig. 5.8).

5.8

Overall Effectiveness of Acquisitions in Enhancing Strategic Position



Not at all effective = 1
Extremely effective = 5

Source: *Healthcare Financial Management* magazine, from Physician Services of America, 1995

Capital access

Banks have been the traditional source of capital for most physicians, but they've been supplanted by physician management companies. These companies purchase the physical assets of the practice from the physicians, then sign long-term contracts (up to 40 years for PhyCor) for management services in return for a percentage of total revenues. These firms aren't just lenders. They also provide management services and help physician practices capture market share and increase revenues.

For-profit practice management firms still account for only a tiny fraction of physician practices today, but they are growing rapidly. Wall Street has responded well to practice management firms that are investor-owned, and they have raised large amounts of capital.

Despite the growth in this sector, the financial performance of many of these companies is still marginal (Fig. 5.9). Most of these companies are highly entrepreneurial, face significant takeover risks and have a record of dramatic changes in operating strategy. For physicians considering relationships with these firms, the long-term prospects are highly speculative.

5.9 Physician Practice Management Sector

Income statement information, March 1995 to February 1996

Company	Net revenue last 12 months (thousands)	Net margin last 12 months (percent)	Revenue growth last two years (percent)
American Oncology Resources Inc.	99,174	11.7%	271.7%
AHI Healthcare Systems Inc.	114,284	N/A	59.5
Apogee Inc.	62,502	8.5	350.3
Coastal Physician Group Inc.	830,944	0.3	20.4
EmCare Holdings Inc.	156,826	5.5	28.0
FPA Medical Management Inc.	52,692	1.9	94.1
InPhyNet Medical Management Inc.	325,308	3.4	19.7
MedCath Inc.	41,401	11.2	50.8
MedPartners Inc.	725,713	N/A	N/A
Orthodontic Centers of America	41,556	21.7	48.6
OccuSystems Inc.	96,581	5.9	100.3
Pediatric Medical Group	43,860	15.3	36.4
PHP Healthcare Corporation	207,360	1.4	27.3
PhyCor Inc.	441,596	5.0	62.4
Physician Reliance Network	105,196	8.3	45.6
Sheridan Healthcare	60,186	N/A	18.3
Sterling Healthcare Group Inc.	99,812	3.4	26.2

Source: VHA study, 1996, from Smith Barney

Compensation

Physician compensation and salary expectations have leveled off or decreased in recent years. Median starting-salary expectations have decreased in selected specialties, such

as anesthesiology and radiology, but among high-earning specialists, such as cardiovascular surgeons, neurosurgeons and hematologists/oncologists, expectations have stabilized or increased only slightly (Fig. 5:10).

5:10

Salary Expectations

Specialty	Minimum	Median	Maximum
Primary care			
Family practice	\$95,000	\$125,000	\$150,000
General practice	85,000	100,000	130,000
Internal medicine	100,000	120,000	150,000
Internal medicine/pediatrics	95,000	120,000	145,000
Pediatrics	90,000	100,000	150,000
Obstetric/gynecology	120,000	170,000	250,000
Medical specialties			
Cardiology	\$125,000	\$150,000	\$200,000
Dermatology	70,000	120,000	180,000
Endocrinology	100,000	130,000	150,000
Gastroenterology	110,000	125,000	150,000
Hematology/oncology	120,000	135,000	150,000
Infectious disease	90,000	110,000	150,000
Nephrology	100,000	120,000	150,000
Neurology	95,000	130,000	200,000
Pediatric neurology	95,000	120,000	150,000
Pulmonology	115,000	140,000	150,000
Rheumatology	110,000	125,000	145,000
Surgical specialties			
General surgery	\$125,000	\$165,000	\$230,000
Cardiovascular surgery	175,000	210,000	250,000
Neurosurgery	150,000	250,000	300,000
Ophthalmology	70,000	130,000	200,000
Orthopedic surgery	150,000	180,000	300,000
Otolaryngology	125,000	180,000	250,000
Urology	100,000	140,000	200,000
Other specialties			
Maternal/fetal medicine	\$150,000	\$200,000	\$250,000
Occupational medicine	90,000	130,000	200,000
Physical medicine/rehabilitation	100,000	140,000	200,000
Psychiatry	90,000	130,000	250,000
Hospital-based specialties			
Anesthesiology	\$90,000	\$150,000	\$250,000
Emergency medicine	150,000	185,000	260,000
Pathology	80,000	130,000	200,000
Radiology	100,000	150,000	300,000

Source: Physician Services of America, 1995-1996 salary survey

In 1995, for the fifth-straight year, primary care physicians employed by hospitals saw their pay increase at a greater rate than their colleagues in private practice. Specifically, the pay of employed primary care physicians increased more than employed specialists (Fig. 5.11). Despite the increases, primary care physicians continue to earn less than specialists (Fig. 5.12).

Meanwhile, physicians in medical director positions are paid comparably to chief executive officers of health care organizations (Fig. 5.13).

Educational options for physician leaders are varied

Health care delivery systems are expecting a high degree of involvement from their physicians and this, in turn, has required a cadre of well-trained physician leaders. The skills required of these physician leaders go well beyond anything they learned in medical school or residency programs.

At the very least, physicians today need business and management expertise and managed care acumen if they wish to contribute to their health care organizations and represent their physician constituency. Several programs focus on helping physicians develop these important leadership skills (Fig. 5.14).

5.11 Average Salary Changes for Employed Physicians

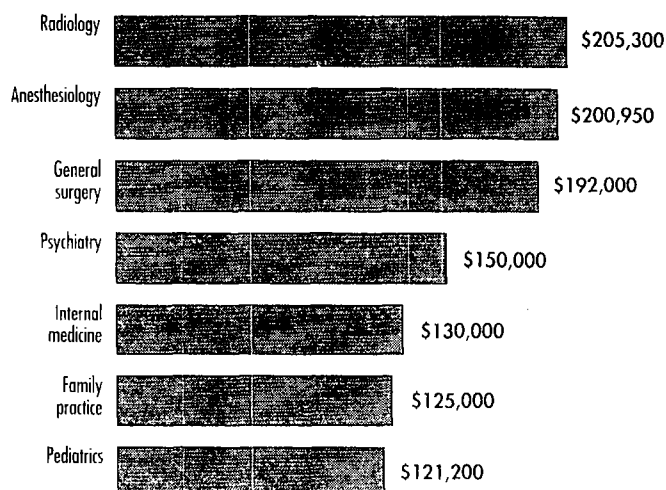
Discipline	1995*	1996*	Percentage change
Anesthesiology	\$203,326	\$193,242	Down 5.0%
Cardiology	207,690	211,283	Up 1.7
Emergency medicine	152,000	162,940	Up 7.2
Family practice	122,625	128,096	Up 4.5
General surgery	190,273	199,342	Up 4.8
Internal medicine	127,366	135,755	Up 6.6
Neurology	149,309	145,940	Down 2.3
Obstetrics/gynecology	214,081	200,901	Down 6.2
Oncology	173,655	164,621	Down 5.2
Pathology	175,048	168,903	Down 3.5
Pediatrics	121,776	123,247	Up 1.2
Psychiatry	130,267	134,725	Up 3.4
Radiology	194,925	210,050	Up 7.8
Urology	189,723	197,964	Up 4.3

* Based on year-prior compensation data compiled separately by several organizations, then averaged

Source: Derived from *Modern Healthcare*, July 10, 1995, and July 15, 1996

5.12

1995 Mean Total Cash Compensation for Selected Physician Specialties



Source: *Hospitals & Health Networks*, April 20, 1996

5.13

How Much Are You Worth?

Following is a gauge of how hospitals and health systems value their employees, comparing each position's salary with that of the chief executive officer

Chief executive officer	\$145,000	100%
Medical director	139,000	96
Chief financial officer	95,800	66
Group practice administrator	87,000	60
Top marketing officer	69,700	48
Top human resource officer	63,800	44
Top ambulatory care administrator	62,900	43
Physician's assistant	47,800	33
Security director	43,300	30
Admissions director	40,400	28
Volunteer services director	36,800	25
Nurse technician	18,600	13

Source: *Total Compensation in the Healthcare Industry*, Human Resource Advisory Group, Coopers & Lybrand, 1995

VHA's program for physician leaders, developed with the business school at the College of William & Mary, is held at member health care organizations on weekends to minimize the impact on physicians and their families.

A handful of medical schools and residency programs offer courses that focus on business skills, managed care negotiations, change management and leadership development, but is not a widespread practice.

The most-advanced training programs for practicing physicians are those provided by large health care systems, including the Henry Ford System, the Sharp System in San Diego and large clinics such as Fallon, Geisinger and Mulliken.

5.14 *Representative Physician Leadership Programs*

Sponsor	History	Duration	Cost	Delivered
American College of Physician Executives	20 years	3, 4 1/2-day seminars	\$1,200 per seminar	Centrally
Advisory Board	2 years	2 days	\$32,000-\$65,000 per hospital	Locally
Massachusetts Medical Society	4 years	Two modules of 70 hours	\$495 per module	Locally
VHA and College of William & Mary	2 years	4, 1 1/2-day modules	\$75,000 per hospital	Locally
Wharton School	3 years	4 days	\$3,100 (includes room and board)	Centrally
Dartmouth	2 years	3 to 4 academic quarters	\$20,000	Locally

Source: VHA, 1996

An oversupply of physicians

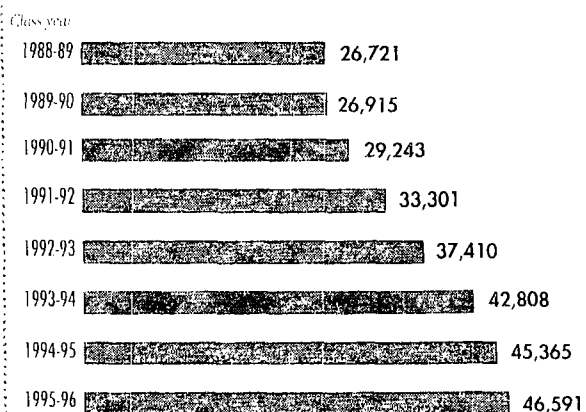
Physicians may be working harder, making less money and assuming more responsibility than ever before, but the dream of becoming a doctor continues to resonate among thousands of men and women across the country. The number of applicants reached a 25-year low in 1988-89, but increased by a staggering 74 percent in less than a decade to the highest number of applicants ever in 1995-96 (Fig. 5.15).

The number of applicants accepted to U.S. medical schools has remained slightly above 17,000 annually for the past 16 years. Medical schools and hospitals that sponsor residency positions have also consistently retained about 23,000 first-year residency positions.

Overall residency positions have increased from 99,000 in 1993, to 104,000 in 1995. The growth primarily has come from an increase in international medical graduates entering U.S. residency positions.

5.15

Medical School Applicants



Source: Association of American Medical Colleges, 1996

The Pew Health Professions Commission recommended that dramatic steps be taken to reduce the number of physicians in the United States. It suggests, for example, that the number of medical schools be reduced and entering class size be cut by 25 percent by 2005 (Fig. 5.16).

The Association of American Medical Colleges recommends limiting the number of international medical graduates allowed to enter the United States. The Institute of Medicine doesn't want to see any U.S. medical schools closed, preferring to focus attention on reducing the number of international medical graduates.

Primary care residencies grow

One sign of the profound changes in medical practice is the selection of specialties among newly graduated medical students. Since 1991, the number of graduates entering primary-care residency training programs has increased significantly (Fig. 5.17). In 1996, more than half of all U.S. medical school seniors entered a primary care residency program (Fig. 5.18).

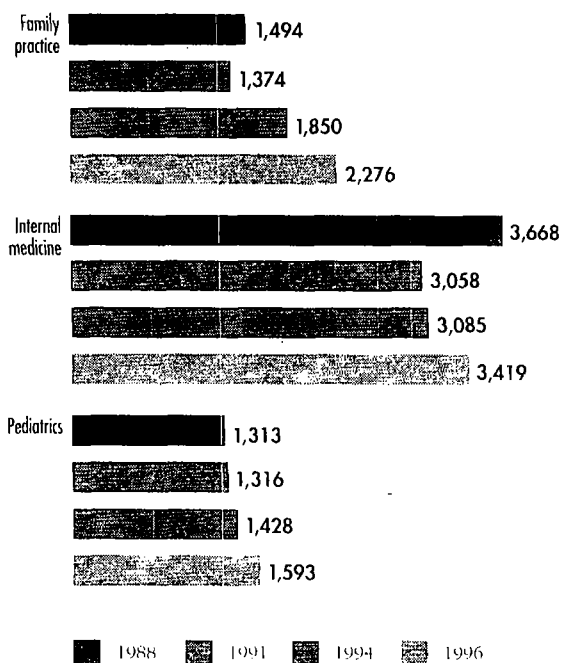
5.16 Recommendations for Medicine

- A. Reduce the number of graduate medical training positions to the number of U.S. medical school graduates plus 10 percent.
- B. By 2005 reduce the size of the entering medical school class in the U.S. by 20 to 25 percent.
- C. Change immigration law to tighten visa process for international medical graduates, ensuring that they return to their native countries for service upon completion of training.
- D. Redirect graduate medical training programs so that a minimum of 50 percent are in the primary care areas of family medicine, general internal medicine and general pediatrics by 2000.
- E. Move training of physicians at the undergraduate and graduate levels into community, ambulatory and managed care settings for a minimum of 25 percent of clinical experience.
- F. Create a public-private payment pool for funding health professions education that is tied to all insurance premiums and is designed to achieve policy goals serving the public's health.
- G. Create an enlarged National Health Service Corps to attract graduate physicians into service roles currently being met by the excessive number of residency positions.

Source: Pew Health Professions Commission, 1995

5.17

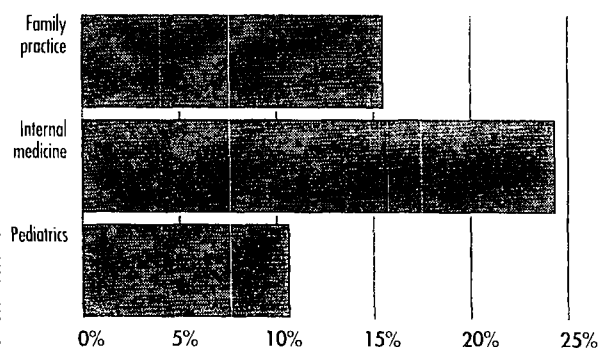
U.S. Medical School Students Entering Generalist Residencies



Source: Association of American Medical Colleges, 1996

5.18

U.S. Medical School Seniors Entering Primary Care Residencies in 1996

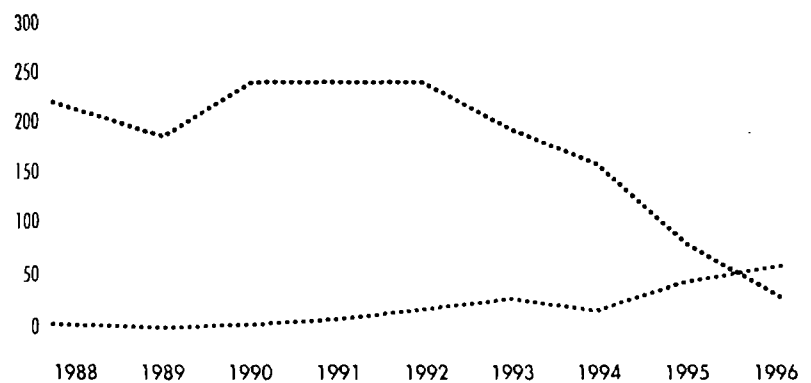


Source: Association of American Medical Colleges, 1996

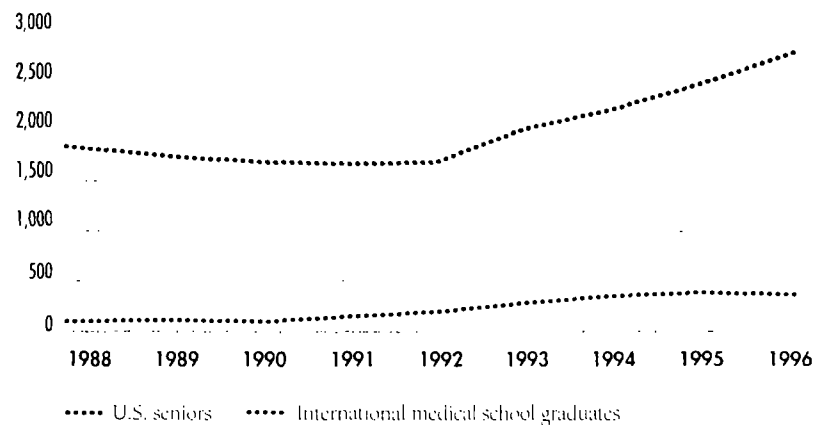
At the same time, fewer medical graduates are entering specialty programs, particularly hospital-based specialties. U.S. seniors entering first-year anesthesiology residencies declined more than 50 percent between 1995 and 1996 (Fig. 5.19). Radiology residencies experienced a 27 percent decline in their numbers, and pathology saw a 15 percent drop during the same period.

5.19

U.S. Seniors and International Medical School Graduates Entering First-year U.S. Anesthesiology Residencies

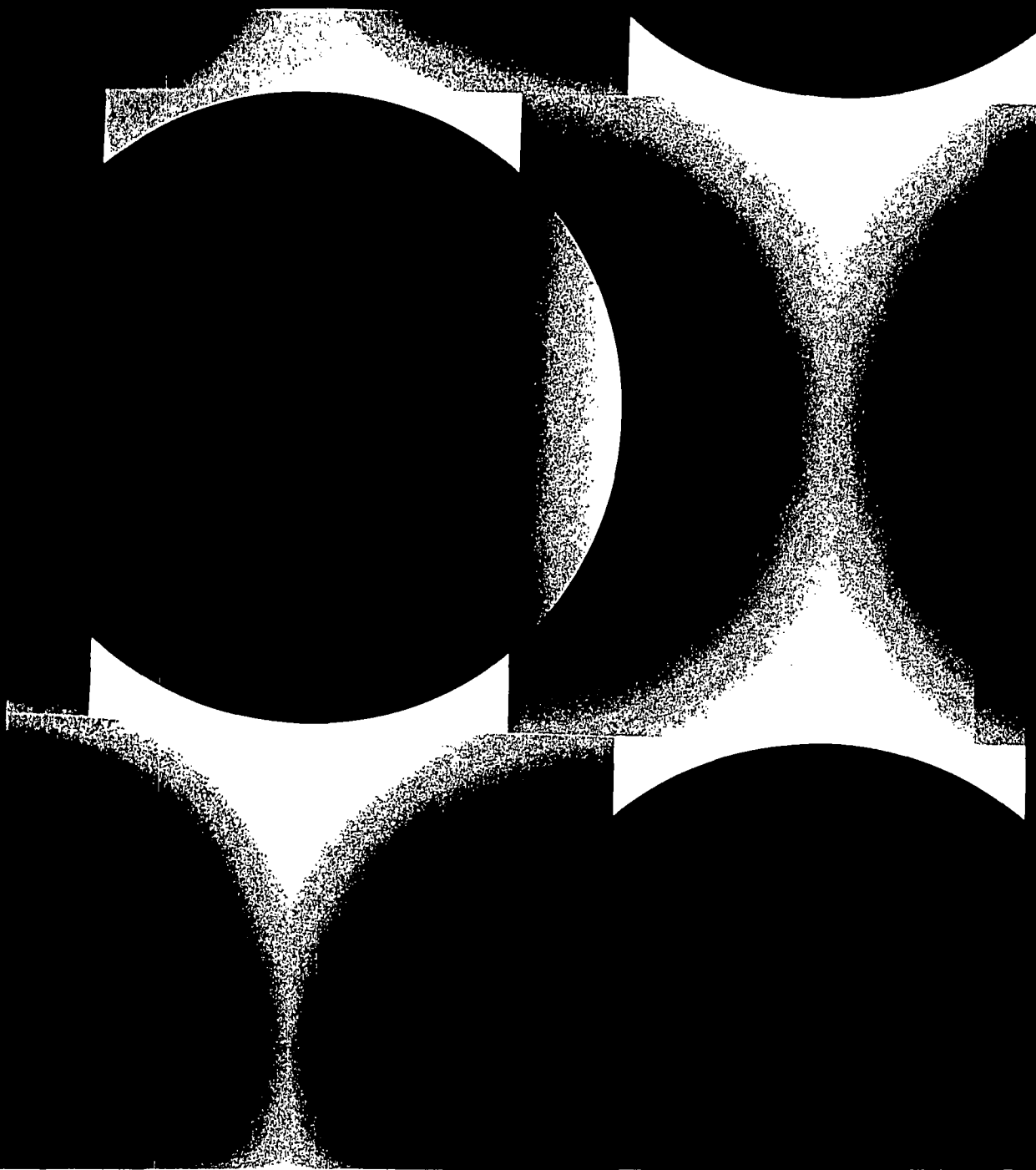


U.S. Seniors and International Medical School Graduates Entering U.S. Family Practice Residencies



Source: Association of American Medical Colleges, 1996

*Trends, Reactions, Strategies—
the Environment and Beyond*



Trends, Reactions, Strategies—the Environment and Beyond

Eight big trends

1. MANAGED CARE MARCHES ON

The influence and reach of managed care is growing rapidly at the same time it is coming under political attack, and management methods are changing:

Growth

- Health maintenance organization enrollment is swelling.
- Independent physician associations are the preferred model of organization.
- Patient satisfaction is as good as fee-for-service arrangements.

Political heat

- Federal and state legislatures are making laws limiting HMOs' abilities to control hospitalization and treatment.
- President Bill Clinton created a national commission to promote consumer protections, health care quality and access.
- The media is focusing on "the managed care problem" in this country.

Managerial evolution

- Consumers are demanding more choice and rebelling against limitations, which is leading to growth of open-choice plans.
- Population-specific risk assessment and demand management are increasingly forcing physicians to consider the business impacts of medical treatment, which is changing the traditional patient-physician relationship.

Trend outlook: Continued cost reduction, quality improvement, high consumer satisfaction and expanded choice of hospitals and physicians will drive even greater enrollment in managed care plans. Managed care is becoming entrenched.

2. CHANGING GOVERNMENT ROLES

The government's influence over health care is increasing:

Size

- Government health programs are growing faster than private-sector plans, increasing their impact as a payer.

Cost containment

- The government is emphasizing managed care plans to bring government health program costs in line with the private sector.
- To forestall Medicare bankruptcy, short-term payment reductions are essential.

Regulation

- New federal and state laws are placing more requirements on managed care organizations.
- Standards for quality and consumer protection are being established.

Trend outlook: Despite election-year rhetoric, significant reforms are in store for Medicare, especially incremental reforms that address the problems of the uninsured.

3. COST REDUCTION

Competition and payer pressures are driving costs down:

Inflation

- Providers have brought health-cost inflation in line with the general economy.

Delivery

- Industrywide efforts to redesign and re-engineer the delivery process make further cost reductions all but certain.

Trend outlook: Clinical efforts to reduce the variation in medical practice and to adopt practice guidelines will proliferate.

4. CONSOLIDATION

All sectors of the health care industry continue to consolidate rapidly:

Capacity reduction

- Mergers, acquisitions and network affiliations drive out excess capacity and seek economic efficiencies.

Trend outlook: Consolidation will continue, especially on the demand side and among small employers and coalitions that will unite for greater bargaining power.

5. CONSUMER INVOLVEMENT

Barriers to consumer information and participation in decision-making are lowering:

Customer demands

- Providers and payers are responding to customer demands for choice, convenience and affordability.
- Access to electronic information systems and the global Internet is empowering individuals.
- Individuals and communities want improved outcomes and better quality of life.

Trend outlook: Alternatives to traditional medical care and self-help strategies will lead to more demand for prevention and status improvements.

6. NEW ROLES FOR PHYSICIANS

Physicians face greater complexity and a wide range of new options as health care organizations of all types vie for their attention and loyalty:

Physicians are:

- seeing their incomes stagnate or go down
- finding security in groups
- looking for capital partners to give them more resources and autonomy
- affiliating with hospital providers

Management and training

- Opportunities abound for physicians seeking an executive or management role in new developing health care organizations.
- The public policy debate rages as to the number and type of health care professionals to educate and train.

Trend outlook: Physicians' roles will become increasingly important in health care management and government health care policy-making. At the same time, physician organizations will proliferate and become stronger.

7. DEFINING AND DEMONSTRATING QUALITY

The demand for outcomes measures has led to a host of new reporting tools available to payers, but no consensus has emerged on the best tools or methods to use:

Real-world outcomes

- Progressive organizations are developing their own measurement systems to improve internal operational performance.
- These systems are focusing on community health issues

Trend outlook: The government will ultimately define quality and outcomes measures as it determines what it expects for its growing investment in health care. Providers will work with payers to determine the most appropriate outcomes.

8. INFORMATION TECHNOLOGY

New information technologies are reorienting the structures of health care organizations.

What health care needs:

- to automate the basic business and care processes
- to track patients and populations across various settings through the continuum of care
- a comprehensive system to serve all these needs
- systems to handle the unique needs of managed care
- systemwide information technology standards that allow the effective sharing of information

Trend outlook: Substantial investment in information technology will continue. Health care organizations will patchwork their systems together until better integrated solutions are found. Health care businesses will begin to leverage the popularity and broad reach of the Internet.

From the field: seven health-system responses

As it approaches the millennium, the American health care industry has begun to look and act like other mature industries:

- Growth of services is declining, particularly high-cost hospital care.
- Customers are increasingly price-sensitive.
- Providers are responding by reducing their prices.

Health insurers and managed care plans have become powerful negotiators. They know that most providers have excess capacity and are willing to trade prices for volume, and that many must consolidate to remain in business.

This is the context for an industry that will account for \$1 trillion in goods and services this year—a staggering one-seventh of the nation's gross domestic product. With stakes this high in a market that is constantly rearranging, both current and potential players are searching for ways to gain as much of the market as possible. Seven distinct strategies emerge:

1. HEALTH CARE ORGANIZATIONS FOCUS ON CUTTING COSTS AND INTEGRATION

Health care organizations are experiencing steady declines in demand for inpatient services, and most markets have excess capacity. At the same time, competition is heating up, both from traditional competitors as well as new entrants.

Cost-cutting

- To remain competitive, health care organizations have reduced costs, primarily by improving the efficiency of their operational functions and programs.

Integration

- Horizontal integration is going on briskly industrywide, with health care organization networks emerging in key markets to develop economies of scale and/or contract more aggressively with employers and payers.
- Through mergers, joint ventures and acquisitions, the consolidation of health care organization is accelerating.

2. HEALTH CARE ORGANIZATIONS FORGE NEW LINKS WITH PHYSICIANS

Health care organizations are investing in physician-related ventures as never before:

Hospital-physician connections

- management service organizations
- independent physician associations
- physician-hospital organizations
- purchasing physician practices
- employing physicians

While there are little data indicating these relationships have increased business for either party, the consensus is that health care organizations and physicians are laying the groundwork for more future integration.

3. PHYSICIANS PURSUE NEW OPTIONS

As a group, physicians are acting much like hospitals. They are:

- consolidating
- merging
- developing partnerships with other physicians, health care organizations and health plans

The reason

- Physician real income has been stagnant for the past five years, when adjusted for inflation.
- Government pricing regulations and health plan contracts are restraining physicians' earnings.
- Most markets have a significant surplus of specialists.

Investor-owned physician practice companies

- These didn't exist a decade ago, but are expected to grow significantly by the end of the century.
- Most focus on mainstream health services, but a few concentrate on specialty services, such as oncology and cardiovascular care.

Finances and capital

- The stock market has been generous to investor-owned physician-practice companies, but the sector is quite volatile.
- Several organizations have changed ownership over the past few years, others have merged and a few have had disappointing financial results.

4. MANAGED CARE: LEARNING TO DIVEST

Health plans are still consolidating, though the pace of mergers and acquisitions has slowed:

Health maintenance organizations

- HMOs are performing well in most markets.
- Medicare and Medicaid are expected to continue offering HMO options to their enrollees, which means enrollment will keep growing.

For-profit HMOs

- For-profit HMOs have had better financial performance because they've kept their medical loss ratios lower than not-for-profit HMOs.
- Because of their good financial performance, purchasers in some states, such as California, are calling for HMO rate reductions.
- Concern over the quality of health care provided by for-profit HMOs is increasing.

Access and choice

- Staff- and group-model HMOs have traditionally been the most successful, but customers are opting for improved access whenever possible.
- Independent physician associations, which offer more access and choice, have quickly become popular among consumers.
- HMOs have learned it's more cost-effective to contract for physician and hospital services than to own them.

Divestiture

- Several HMOs are divesting their integrated systems.
- Kaiser Health Plan, for the first time, has developed network arrangements and point-of-service products.
- Other traditionally integrated plans have elected to divest their hospitals and physician groups and concentrate on the insurance business.

5. INTEGRATED DELIVERY SYSTEMS RE-EVALUATED

Successful integrated delivery systems, such as Kaiser Health Plan and Henry Ford Health Care Systems, have been noted for their ability to deliver high-quality health care services at reasonable prices by successfully combining:

- health care organizations
- physicians
- health plans

In some markets, though, integration has lost its luster. The IPA-model health plans in California have been able to:

- match the performance of many integrated delivery systems
- manage utilization effectively while maintaining a comparable level of customer satisfaction
- offer a much wider choice of physicians and practice models
- grow quickly, given their comparable prices and quality and greater access to providers

Traditional integrated delivery systems at a disadvantage

- Many integrated delivery systems have made major investments in facilities and personnel, which give them high fixed costs and make them susceptible to disappointing operating performance.
- As a result, “virtual integration,” which strives to keep costs variable rather than fixed, is becoming the integration model of choice.

6. ACADEMIC HEALTH CENTERS: THE TIDE TURNS

Over the past two decades, the source of revenue for teaching facilities has shifted from tuition and research grants to clinical services:

Where they are is what they are

- Many teaching health centers are in inner cities.
- Some facilities focus their clinical services on their communities, which are often heavily indigent and elderly.

Traditional roles

- Teaching health centers continue to provide highly complex care.
- They have traditionally received a “teaching differential”—a higher payment for their services because of their status as teaching institutions.
- These facilities have produced a steady stream of highly trained physicians.

Times have changed

- Indigent and elderly patients are being increasingly enrolled in Medicare and Medicaid managed care plans that tend to avoid teaching centers because of their high costs.
- For highly complex services best provided by academic facilities, health plans contract only on an as-needed basis.

The results?

- Demand for the clinical expertise of teaching hospitals is declining.
- Congress is questioning the value of paying teaching differentials.
- The federal government is suing to recover payments for clinical services that were provided by some teaching programs but were billed separately by the faculty.

7. NICHE PROVIDERS EMERGE

Managed care plans have successfully reduced hospital utilization by relying on alternative delivery programs to deliver care:

- urgent care centers
- home health services
- home infusion
- ambulatory surgery centers

Demand and supply

- Although many of these services were developed by hospitals, the fastest-growing source of alternative delivery programs is small, specialty health care organizations.
- Demand for alternative delivery programs is growing.

Management and capital

- Negotiating and tracking the various public and private payer requirements demand a high level of management skills, and many small firms are unable to acquire or afford this expertise.
- As with other health care sectors, the niche market is consolidating and looking toward the public markets to finance its capital needs.

Five Strategic Initiatives

This book has examined both the driving environmental trends and reactions of health care organizations to those trends. The final fundamental question is: So what? What does all this mean for health care organizations in planning for the near term?

Here are five strategic initiatives based on this environmental assessment to use as a guide for health care planning for the rest of this decade and into the next millennium:

1. CREATE VALUE AND DEMONSTRATE ACCOUNTABILITY

- value-added products and services that deliver measurable outcomes will differentiate the leaders in every market

2. INSIST ON A COMMUNITY FOCUS

- join with other community partners to invest in healthy communities and improve health status

3. BE DRIVEN BY CUSTOMER NEEDS AND EXPECTATIONS

- meet needs and exceed expectations every time—treat the customer as the last judge of quality

4. PARTICIPATE IN THE REDESIGN OF THE PUBLIC FINANCING SYSTEM

- join with elected officials in identifying and implementing the best approaches to managed Medicare and Medicaid

5. MAINTAIN FLEXIBILITY—WELCOME CONTINUING CHANGE

- develop a responsive health care organization that adapts to new and very different forces—no matter what the future brings

The Institute for Medicare Practice

of Mount Sinai School of Medicine



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The Political Economy Of Medicare

Medicare reform requires political reform.

by Bruce C. Vladeck

ABSTRACT: Medicare spends more than \$200 billion a year; the politics surrounding the Medicare program cannot be fully understood without an adequate appreciation of that fact. An understanding of the political economy of Medicare is perhaps best achieved by thinking along three dimensions: (1) Medicare as redistributive politics; (2) Medicare as special-interest politics; and (3) Medicare as distributive politics. Seeing the extent to which Medicare policies flow from these political processes makes clear that Medicare reform and broader political reform are, at some level, inseparable and indistinguishable.

22

MEDICARE
POLITICS

MY EPIPHANY, MY FLASH OF INSIGHT: An evening in August 1996, riding from the airport into Pittsburgh, prior to a seminar at the University of Pittsburgh the following morning. Few cities have so theatrical an entrance: If you're coming in from the airport, through the Fort Pitt tunnel, you emerge from the tunnel with all of downtown, across the river, laid out before you. At night especially, the taillights from the elevated expressway on the bluff above the river's north bank add motion to the more vertical tableau of the skyscrapers behind.

In the past, when the steel mills were operating, the view was even more spectacular. Lining both banks of the Monongahela, beginning just east of the Golden Triangle at the confluence with the Allegheny and extending miles upstream, stood the great industry that provided Pittsburgh its identity. During World War II, it is said, the mills on the Monongahela produced more steel than all of Germany's; Hitler and Tojo were defeated by western Pennsylvania. If you've never seen an operating open-hearth mill at night, it's difficult to imagine the orange-red brightness of the flames or the volume of smoke or the simple inhuman size of everything, with hard-hatted workers dwarfed by their tools.

By the mid-1980s the mills were all shut, made obsolete by mini-

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Prescription Drug Coverage, Utilization, And Spending Among Medicare Beneficiaries

As the cost and use of prescription drugs move to the forefront of Medicare policy discussions, new survey data shed light on recent trends.

by Margaret Davis, John Poisal, George Chulis, Carlos Zarabozo, and Barbara Cooper

ABSTRACT: Outpatient prescription drugs are not a covered benefit under Medicare. There have been proposals in the past to expand Medicare benefits to include drug coverage, and current discussions dealing with "modernizing" the Medicare benefit package have raised the issue again. Using data from the 1995 Medicare Current Beneficiary Survey (MCBS), we describe the sources and extent of drug coverage among Medicare beneficiaries. The data show that 65 percent of Medicare beneficiaries have some level of drug coverage—a figure much higher than previous published numbers—and that 95 percent of Medicare health maintenance organization (HMO) enrollees have drug coverage. The data provide a baseline to observe future changes in the level of coverage, particularly among Medicare managed care plans.

DATAWATCH

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PRESCRIPTION DRUGS PLAY AN essential role in the treatment of disease, particularly among the elderly and the chronically ill. Innovations in drug therapies have led to improved health outcomes and quality of life for persons living with chronic conditions such as heart disease, hypertension, diabetes, arthritis, and depression, which are common among the elderly. Yet providing these therapies can be costly, and drug prices have been rising rapidly. In the six years between 1990 and 1995, national spending on prescription drugs increased 51 percent, an average of more than 8 percent per year.¹ The rise in spending reflects both the increasingly

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The Problem Isn't Payment: Medicare and the Reform of End-of-Life Care

By Bruce C. Vladeck

Of the roughly 2.4 million Americans who die each year, approximately 75 percent are insured by Medicare at the time of their death. Death in America is now something that happens primarily to older people, and Medicare is the primary source of health insurance for almost all Americans over the age of 65.

Medicare spends more than \$50 billion annually on beneficiaries who are in their last year of life, determined retrospectively (Lubitz and Riley, 1993). That phenomenon, in turn, is consistent with a pattern in which Medicare, like most health insurers, spends the great majority of its funds on the relatively small minority of beneficiaries who have disproportionately high expenses.

The management of terminal illnesses and the dying process is the source of considerable dissatisfaction among growing numbers of Americans, as this issue of *Generations* so well reflects. Dying people are routinely subjected to unwanted and ineffective high-technology interventions; the inertia of the healthcare sys-

*The forces
that have produced
our current disaffection
with the process of dying
are much more fundamental
and less tractable.*

tem appears to run roughshod over the preferences of patients, their families, and their caregivers, both volunteer and professional; the most intimate and difficult of personal experiences are bureaucratized and dehumanized. The growing recognition of these problems, in conjunction with widespread perceptions and misconceptions about how Medicare works, has focused increasing attention on the idea of chang-

ing Medicare policies in order to remedy some of the worst problems now confronted in the dying process. In order to permit the delivery system to treat dying patients more humanely and more compassionately, the syllogism runs, changes must be made in the way Medicare operates (Last Acts, 1998).

The problem with this syllogism is that it is wrong. Medicare is not the problem, nor is it central to the solution. Implementation of "optimal" programs or systems for care of dying patients may require relatively minor tweaks in the ways in which Medicare operates, but those are secondary problems in the design and man-

agement of such systems. The forces that have produced our current disaffection with the process of dying are much more fundamental and less tractable than issues of Medicare policy and are therefore much harder to change. In that sense, it is too bad that Medicare is so tangential a part of the problem; if it were a larger part, the problem would be easier to fix. But so long as those concerned with improving the process of dying in the United States remain preoccupied with Medicare financing and reimbursement, attention will be diverted from the more basic, and more difficult, issues.

WHAT MEDICARE DOES— AND DOESN'T DO

Medicare is so large and pervasive a part of our healthcare system that it may seem only natural for health professionals and policy analysts to ascribe near-magical powers to it, but in fact there are two fundamental reasons that the influence of Medicare on phenomena like the care of dying patients tends to be exaggerated. First, the increasing hegemony of economic modes of thinking, not only in policy analysis but other aspects of public discourse, has led to widespread confusion about the effects of economic incentives on behavior. Most of economic reality takes place on the margins: It is true that, if the price of hogs rises relative to that of cattle, farmers will breed relatively more pigs and fewer cows, but cattle ranching will not cease to exist altogether, nor will even the most aggressive and entrepreneurial farmers seek to turn their cows into pigs. If economic incentives were the only determinant of human behavior, then we would have neither pediatricians nor geriatricians.

In addition, the relative naivete of most health professionals regarding financial matters often produces confusion about the difference between an economic incentive, like those embodied, intentionally or not, in practices Medicare permits or encourages, and a requirement or prohibition made by an authoritative body, Medicare rules and regulations being a prime example. Thus, in the early days of the prospective payment system, many health professionals believed that Medicare would "not permit" inpatient stays greater than the geometric mean for a particular diagnosis-related group, when

the fact was that Medicare policy permitted longer stays but made stays shorter than the mean relatively more profitable for the hospital—an incentive, not a requirement (Vladeck, 1991). On the other hand, failure to comply with a patient's advance directive is a flat-out violation of Medicare rules that, in principle, puts a hospital at risk of losing all its Medicare reimbursement. And even that requirement, it appears, is honored primarily in the breach (Teno et al., 1997).

The fact is—and it is one in which I think we should all take considerable comfort—that health professionals tend to do what health professionals do, and large healthcare institutions tend to do what large institutions do. Changes in Medicare policy—whether through payment incentives or disincentives or direct requirements or prohibitions—have been demonstrated to affect such behaviors *at the margin* but rarely ever change them in more fundamental ways. Medicare policies tend to work best when they reinforce behaviors health professionals are already inclined to adopt, such as reducing inpatient lengths of stay, and work least well when they run counter to strong patterns of professional behavior, as with the care of dying patients.

Second, while the original statutory prohibition of any Medicare "interference with the practice of medicine" was understood to be primarily rhetorical even at the time it was enacted, Medicare has generally operated—and its managers have generally sought to operate it—as an insurance program purchasing services from an exogenously determined healthcare system, rather than as a manager of that system (National Academy of Social Insurance, 1998). Thus, Medicare policy concerning the coverage of new technologies has always required that the technology become accepted practice—or, in the case of drugs and devices, be approved by the Food and Drug Administration—before Medicare would consider paying for it. Similarly, Medicare's regulations for institutional providers have almost unfailingly deferred to state professional licensure and scope-of-practice laws.

Indeed, Medicare is often criticized for being slow to respond to innovations in healthcare delivery or the healthcare marketplace. On the

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other hand, a strong case can be made that those areas in which Medicare has moved too far out ahead of established professional consensus or norms have been precisely those in which the program has encountered some of its worst problems of fraud and abuse—as in the case of partial hospitalization for the chronically mentally ill or even in the very rapid expansion of homecare after 1981 (U.S. General Accounting Office, 1996; U.S. Department of Health and Human Services Office of the Inspector General, 1998).

The history of the development of hospice services in the United States may be relevant here: A movement that had already established a strong rationale and track record, but had not yet become a routine part of the healthcare system in most communities, was diverted and perhaps permanently damaged, it might be argued, by the too-rapid adoption of a too-rigid Medicare coverage and regulatory policy (National Hospice Organization, 1998).

What Medicare really does—and does rather well by any comparative standard, I would argue—is pay hospitals and doctors and clinical laboratories and outpatient clinics for the services they provide to elderly and disabled beneficiaries; and Medicare does this most effectively and most efficiently when those are the same hospitals and doctors and so forth providing pretty much the same services to Medicare beneficiaries as to their other patients. While it may be true, in some argumentative sense, to say that existing patterns of Medicare payment and Medicare policy support a system of care that is wholly inadequate to the needs of older patients, essentially the same Medicare policies could support a superb system of care to elderly patients if anyone was out there providing one.

Over the past fifteen years or so, in fact, Medicare has sought to move away from payment policies that encourage or discourage particular treatment modes to methods that encourage more efficient patterns of resource utilization in caring for particular illnesses or conditions. Thus, the prospective payment system for inpatient hospital care pays essentially the same amount for care of a terminal cancer patient whether that care is very high-tech or invasive or more supportive and palliative. Anal-

ogous prospective payment systems are in the process of being implemented for Medicare-covered skilled nursing facility, rehabilitation, and homecare services, with much of the explicit impetus for such systems arising from the belief that payment systems should be neutral as to specific patterns of care, provided they are appropriate to the patients being treated and of at least minimal quality.

On the other hand, it is true that the area in which Medicare has made the least progress toward development of a clinically neutral payment system is the physician fee schedule, and my own experience is that the shortcomings of that system, being most visible to practicing physicians, have contributed disproportionately to the perceptions about Medicare incentives. While the system implemented since 1992 has shifted billions of dollars away from invasive procedures toward cognitive services, and thus from surgeons and medical specialists to primary care practitioners (Physician Payment Review Commission, 1997), the woeful inadequacies of the system through which evaluation and management services are classified for reimbursement fail to adequately reflect the amount of time or emotional energy a physician must devote to caring effectively for a dying patient with complex familial or emotional problems. On the other hand, efforts to adjust the fee schedule to encourage other kinds of especially complex or challenging cognitive services, such as case management of homecare patients, have produced substantial expenditure increases with no apparent change in patterns of actual physician practice (U.S. General Accounting Office, 1996).

Thirty-three years of experience with operation of the Medicare program have thus left experienced program administrators with what can only be described as a sense of deep-seated humility—along with a not inconsiderable degree of cynicism—about their ability to effect change in the actual delivery of health services to Medicare beneficiaries. Patterns of medical care for the elderly have, of course, changed enormously over the past two decades, and Medicare has been critically connected to those changes, but the number of instances in which specific changes can be linked to specific efforts

to bring them about through Medicare policy are remarkably few.

Further evidence of the limitations of Medicare's effects on the healthcare system is provided by recent data about patterns of dying among Medicare beneficiaries. Among Medicare patients, all of whom present essentially the same financial incentives to doctors, hospitals, and other caregivers, the likelihood of dying in a hospital varies by more than twofold from one region of the country to another. This variation appears to be unrelated to patient preferences but is strongly correlated with various characteristics of local healthcare delivery systems (Pritchard et al., 1998).

THE PROBLEM OF UNCERTAINTY IN CARE OF THE TERMINALLY ILL

The public perception may be that Medicare spends vast amounts of money on aggressive treatment provided to patients known to be facing imminent death, when palliative care would be less expensive and more appropriate. However, of the 27 percent of Medicare expenditures that involve services to beneficiaries who are in their last year of life, only a relatively small fraction involve beneficiaries for whom death is believed to be imminent at the time those expenditures are incurred (Lubitz and Riley, 1993). Most of those expenditures involve efforts either to prevent or significantly postpone death in instances in which such efforts are not entirely delusional; efforts to treat one illness, but the patient soon dies of another; or efforts to reduce diagnostic or prognostic uncertainty. Nor is it clear, in many instances, that palliative care is any less resource-intensive or expensive than aggressive treatment (Emanuel and Emanuel, 1994).

The fact is that most clinicians have far less prognostic confidence on issues of imminent mortality than the general public probably believes. The limitations of medical knowledge and the infinite variability of individual human beings interact with an unconscious reluctance to arrive at unpleasant conclusions. Contemporary American medical practice is undoubtedly characterized by a strong bias toward treatment in all sorts of situations—a bias that is no doubt reinforced by reimbursement incentives,

but one that causes ethical or social problems, it seems to me, only to the extent that it is acted on contrary to patients' wishes. And even the putative economic disadvantages of such a bias must be considered in light of the continued desire of people to create and reinforce systems of health insurance precisely in order to permit such a bias to continue to operate.

The difficulty of making exact prognoses in many cases of terminal illnesses is often emphasized, appropriately, by advocates for hospice in criticizing Medicare's eligibility rules for the hospice benefit, which require a physician certification that the patient is not expected to survive more than six months. Those advocates are often less open in acknowledging that there are many instances in which a physician may believe with reasonable certainty that he can predict a remaining life span of less than six months but is reluctant to tell that to the patient or the patient's family. But while it is hard enough to provide optimal care for terminally ill patients when all involved—clinicians, the patients, family members—share a set of clear expectations about the patient's future, far more common are situations in which not everyone is on the same page, or at least will admit to being on the same page.

Medicare's rules about hospice eligibility, however much they discourage beneficiaries from taking advantage of what could be a valuable benefit, do highlight a more generic problem in the discussion of the relationship between payment systems and care of the dying. As a matter of principle, all patients, whether they are dying or not, whether they are Medicare beneficiaries or not, should be treated respectfully, humanely, and compassionately. Dying patients may have different needs from other patients, but in fact they are reasonably heterogeneous themselves. So if one wants to talk sensibly at all about special services or payments or accommodations for only those patients who are dying, then one is back into the realm of thresholds and categorization. And since mortality is in fact something that eventually affects us all, some notion of imminence needs to be part of that definition. But then we're back where we started from: If dying patients should somehow be treated differently, by insurers as

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well as clinicians, then someone has to acknowledge that they're dying, and soon.

More basically, the observational data would seem to suggest that most physicians, nurses, and other clinicians are not very comfortable dealing with dying patients, and most of the rest of us are even less comfortable. Nor is it entirely clear that such discomfort is altogether a bad thing—although it may often produce horrendous outcomes in particular cases. But to expect that fiddling with the rules or practices of a health insurance program could overcome that basic reality strikes me as, at best, an unrealistic notion.

CODA—MEDICARE AND THE POLITICS OF DYING

Shortly after the Supreme Court upheld the ability of states to regulate physician-assisted suicide, the Office of the Administrator of the Health Care Financing Administration (HCFA) was inundated with thousands of nearly identical letters, each inquiring whether physician-assisted suicide was a covered benefit under Medicare. It turned out that the sample text for such a letter, along with the HCFA administrator's address, had been posted on the Web site of at least one major right-to-life advocacy organization. In order to respond to these inquiries, the Office of General Counsel of HCFA drafted a rather elegant, if terse, reply, pointing out that Medicare benefits were available only for the treatment of illness or the prevention of injury or loss of a body part; that physician-assisted suicide did not meet such a definition and was thus not a covered service.

While that specific issue was thus rather effectively addressed, the letter-writing campaign was in fact symptomatic of a much broader and deeper political phenomenon. Thousands of Americans, most visibly associated with the right-to-life movement, appear to believe that forces within our society are seeking to solve the long-term financial problems of Medicare and Social Security by encouraging the euthanization of the elderly. In that alleged plot, by the way, physician-assisted suicide was only a secondary threat compared to the broader efforts to accomplish such euthanization by the promotion of Medicare managed care. That is

where the notion of a "private fee-for-service plan," as contained in the Medicare + Choice provisions of the Balanced Budget Act, comes from, and the influence of the National Right to Life Committee on congressional Republicans is why such plans are in the Balanced Budget Act.

While the typical reader of *Generations* may find these beliefs rather far-fetched, the fact is that the broad-based consensus in the medical and academic communities about care of the dying is not universally shared throughout this society. Many people still believe that society has an interest in how terminally ill patients are cared for even when that interest conflicts with the patient's own wishes or desires. And that absence of consensus provides even more reason to be wary of seeking to change patterns of care for the dying by modifying Medicare or any other government program. There are many issues of considerable emotional and ethical content for which, our experience would suggest, this heterogeneous and pluralistic society is best served when the government stays as far away as possible. We have enough problems trying to improve care of dying patients. The last thing we need is for it to become a political issue. ☪

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The Institute for Medicare Practice

of Mount Sinai School of Medicine

in doing nothing, the Medicare commission produced the best currently attainable outcome.

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Sounding Board

PLENTY OF NOTHING — A REPORT FROM THE MEDICARE COMMISSION

THE National Bipartisan Commission on the Future of Medicare, which began its work to great fanfare just over a year ago, held its last meeting on March 16. The commission, established by the Balanced Budget Act of 1997, had 17 members. The act required 11 affirmative votes for the adoption of any recommendations, a provision interpreted by the commission's cochairs, Senator John Breaux (D-La.) and Representative Bill Thomas (R-Calif.), as requiring 11 votes for any action, even issuing a report. Thus, when on March 16 a package of proposals assembled by the chairs commanded only 10 "yeas," the commission concluded its existence having produced literally nothing. (I, for reasons that will become apparent, was one of the seven "no" votes.)

In keeping with the Hippocratic principle of first doing no harm, the absence of a product of the commission's work should not be assumed to be a bad outcome, but the lack of consensus revealed by that process has some broader, and more distressing, implications. Medicare, this nation's largest and most important health insurance program, does indeed have a number of important problems, which are likely to worsen over time if not addressed. Yet members of the commission could not even reach consensus among themselves as to what those problems are, or in what priority they should be addressed. A number of analysts of the U.S. political system have recently observed, in the context of the extraordinary events surrounding the impeachment and trial of the President for sexual indiscretions and their sequelae, that this nation's political institutions are more polarized, more partisan, and more ideological than at any time in the past century; that "sound bites" and rhetoric have largely driven substantive conversation out of political discourse; that the Washington, D.C., representatives of the mass media are at least as out of touch with the public outside the Beltway as the politicians are; and that the American people, as a result, are more alienated from and dissatisfied with the political system than they have been in many years. The experience of the Medicare commission is entirely consistent with that picture.

A FIGHT OVER FINANCING

The apparent cause of the commission's failure to reach consensus was a fight about money. Medicare costs, like most health care costs, have historically grown faster than the economy as a whole — a pattern that is expected to continue into the future. In

the case of Medicare, however, the economic and fiscal effects of that growth will be substantially heightened by the extraordinary increase in the number of beneficiaries that will result from the aging of the baby boomers born between 1945 and 1965. Today, there are roughly 38 million Medicare beneficiaries; by 2030, when the last of the baby boomers will turn 65, that number will have doubled. The costs of benefits for that many people will almost certainly exceed the capacity of Medicare's current sources of financing — primarily payroll taxes, income taxes, and premiums paid by beneficiaries. All other things being equal (which of course they never are, but which is an inevitable and perhaps unavoidable assumption in government budgeting), Medicare will also consume an ever-larger share of the federal budget, thus diminishing the funds available for other purposes. So the primary task given the commission in the Balanced Budget Act of 1997 was to address long-term financing.

For a majority of commission members, however, the injection of additional revenues into Medicare was, if not literally inconceivable, then certainly something one should not talk about in public. How much additional revenue Medicare will require in the future depends, of course, on what happens to the growth of medical costs as well as on demographic change, and no one on the commission disagreed with the proposition that everyone's interests are best served by having Medicare work as efficiently and cost effectively as possible. Although most of the commissioners supported the position that Congress should adopt a number of Medicare "reforms" in order to save money, the majority then sought to defer any further discussion of revenues, although the commission's own, wildly optimistic staff analyses demonstrated that even those largely hypothetical savings would not be enough. Most of the Democrats on the commission, however, encouraged by the President's proposal to allocate 15 percent of the current and anticipated federal surplus to Medicare, refused to support a package that did not include at least that much new money.

The discussion of Medicare financing in the commission was further complicated by the increasing unreality that characterizes most federal budget debates. The unprecedented magnitude and duration of the current economic boom was not anticipated by most economic forecasters, and certainly not by those who make the official government projections. For at least the previous 15 years, domestic politics had revolved primarily around issues related to the federal budget deficit — issues sufficiently compelling that politicians of all stripes were able to compromise on the Balanced Budget Act of 1997, including substantial changes in Medicare policy, such as the expansion of managed care and the largest reductions in payments to providers in the program's history.

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No sooner was the budget enacted, however, than the economic forecasts on which it was based turned out to have been far too pessimistic. Just 18 months later, the federal treasury is awash in revenues. Political leaders are having a hard time adjusting to this new reality; their instinctive response is to deny that it exists.

Thus, just two weeks after the commission went out of business, the trustees of the Medicare program reported that, thanks to the strength of the economy and the effects of the Balanced Budget Act of 1997, Medicare was in fact in far better financial shape than anyone had previously thought — although the trustees then gave the inevitable lip service to the continuing need for “reform.” But this recent experience raises questions not only about the urgency of doing anything about Medicare, but also about the extent to which policy changes that might have far-reaching consequences for millions of beneficiaries and thousands of providers ought to be made on the basis of long-term forecasting models that have been so wildly inaccurate in the recent past.

Disagreements about money split the commission in other ways as well. How to pay, over time, for Medicare benefits is not the only problem facing the program; at least as important is the fact that the current benefit structure is so inadequate. On average, Medicare now pays barely half the total costs of health care for an average beneficiary, and out-of-pocket costs for premiums, supplemental insurance, and noncovered services are growing faster than overall health care costs, and much faster than beneficiaries’ incomes. The most glaring deficiency in the benefit package, in the current environment, is the absence of coverage for outpatient prescription drugs, which are continuously becoming both more expensive and more necessary for the optimal treatment of the most common illnesses of the elderly. Most of the Democrats on the commission decided, early in the process, that they would not support any package of recommendations that did not provide some realistic method of coverage for at least some part of prescription-drug expenses; most of the Republicans on the commission refused to support any proposal to add new government spending for that purpose.

A PROPOSAL FOR “PREMIUM SUPPORT”

In order to resolve the contradictions between the need to improve Medicare’s long-term financial outlook and opposition to new revenues, and between the demands for a prescription-drug benefit and opposition to new government financing, the commission’s cochairs concentrated, from an early stage in the proceedings, on a proposal to redesign the entire Medicare program around the theory of “premium support.” Initially proposed by Henry Aaron and Robert Reischauer,¹ and ostensibly modeled on the Federal Employees Health Benefits Program, premium support would require private plans, and the ex-

isting Medicare fee-for-service program, to submit annual bids to supply the existing Medicare benefit package and possibly additional benefits as well. An average bid, weighted for the plan’s enrollment and adjusted to reflect a part of regional cost variations, would then be calculated, and the government “contribution” would then be fixed at some proportion of the weighted average bid, with beneficiaries required to contribute the balance. In theory, such a process would encourage beneficiaries to select lower-cost plans and, over time, would drive down the aggregate rate of growth in Medicare costs. It would thus at least partially address the financing problem without any new tax dollars and possibly even create the opportunity for efficient plans to offer expanded benefits, such as prescription-drug coverage.

FROM THEORY TO PRACTICE

As applied to Medicare, of course, premium support is still purely a theory, and a pretty elastic one at that. Many of the details of what became the proposal voted on by the commission were in flux until the night before the commission meeting. It is also a theory with many substantial holes in it, some of which may not be able to be repaired. Briefly, some of the issues to be resolved are the problems of managing risk selection and risk adjustment; accounting for cost variations among geographic regions; methods of preventing various forms of “gaming” and cheating in the bidding process; ensuring adequate levels of performance by participating plans; and protecting rural, low-income, and severely ill beneficiaries and the communities in which they reside. But a proposal for premium support might still have commanded 11 — or even 12 or 13 — votes, had the commission been able to solve either the financing or the prescription-drug problem.

Since no one has ever seen a premium-support system operated along the lines proposed to the commission, no one really knows whether it would save any money at all. The commission staff produced estimates of enormous savings, but those were based on assumptions so questionable that they were not taken seriously by any other experts; indeed, economists on the commission expressed some skepticism about whether premium support might ever produce any savings. Probably the most objective estimates were those of the chief actuary of the Health Care Financing Administration (HCFA), who estimated that, over a period of 30 years, premium support might reduce total Medicare spending by perhaps 2.5 percent — a substantial sum of money, to be sure, but far short of what is needed to solve the long-term financing problem, and only a fraction of the savings attained by such crude, “traditional” policies as those contained in the Balanced Budget Act of 1997. Perhaps more tellingly, at least from the perspective of this commissioner, the HCFA actuary at-

tributed most of the savings premium support would accomplish in its first 10 years to increasing costs to beneficiaries — savings, in other words, attained not by increasing efficiency but by shifting costs to people with relatively low incomes.

As a means of providing a cost-free way to provide a prescription-drug benefit, premium support does even worse. Much of the rhetoric in favor of premium support during the commission’s discussions involved the notion that encouraging the participation of many private insurance plans would create the opportunity for innovation and expansion of the Medicare benefit package. After the actuaries and economists began to analyze the potential effects of adverse risk selection on a premium-support program, however, and to look more closely at the actual experience in the Federal Employees Health Benefits Program, it became apparent that premium support would probably actually increase total Medicare expenditures, unless the ability of plans to provide any variation from the basic benefit package was severely constrained, or even eliminated. In fact, the proposal voted on in March would probably have had the effect of forcing many health maintenance organizations that now offer limited prescription-drug coverage to their Medicare beneficiaries to discontinue it. In other words, premium support could not provide a free lunch; if beneficiaries were to get a prescription-drug benefit, someone would have to pay for it.

But premium support still got 10 votes on the commission, remains the heart of the legislation that the commission’s cochairs intend to introduce in Congress, and lies implicitly at the heart of the fiscal-year 2000 budget resolutions adopted by both houses of Congress along largely partisan lines. In Washington, D.C., no bad idea ever truly dies. Since the economic rationale for premium support is so shaky, it is important to understand why the concept has so much political staying power.

To begin with, many Republican members of Congress, including some in key leadership positions, simply cannot abide the notion of a large, government-operated, redistributive health insurance program. In 1995, they voted overwhelmingly to transform Medicare into a voucher program with a defined government contribution, but the perceived electoral consequences of that decision were so fearsome that it is no longer politic to take such a position openly. Medicare, as it is now constituted, remains enormously popular with the American people, beneficiaries and younger citizens alike. Proponents of premium support will vehemently deny that theirs is a defined-contribution program and insist that they seek to preserve Medicare’s existing benefits, but the forebears of premium support are unmistakable, and one does not have to be paranoid to imagine how easily some future Congress could convert a system

of premium support into a purely arbitrary defined government contribution.

In the current political and intellectual climate, even many people who are not hostile to the basic principle of Medicare share the prevailing conventional wisdom that, because it is a government program, Medicare must by definition be less efficient and more costly than the same benefits provided by private insurers. The evidence to the contrary is overwhelming but largely irrelevant to the political process. Thus, both moderate Republicans and many “new Democrats,” such as Senator Breaux and many senior Clinton administration officials, are attracted to premium support because they like the ideas of privatization, increased competition within government programs, and other efforts to recast New Deal and Great Society programs into what appear to be more contemporary forms. In these preferences, they are supported by the hegemony of classical microeconomic analysis in think tanks and policy-analysis centers; despite the clear, and repeatedly demonstrated, inapplicability of neoclassical economic models to health services and health insurance, theirs continues to be the only intellectually respectable game in town.

In fact, the more closely one looks, the more premium support appears to resemble not so much the defined-contribution approach of the Republican Congress’s Contract with America, but the “managed competition” theory of the Clinton administration’s 1993–1994 health reform proposals. It is ironic, but hardly surprising, that many of the same political leaders who so aggressively attacked the Health Security Act as excessively bureaucratic and unworkable when it was proposed as a means to ensure universal coverage are now willing to apply a very similar approach to Medicare benefits.

FIRST, DO NO HARM

Any wise physician knows that the most prudent, and probably most effective, response to some medical problems is to do nothing, but for elected politicians, professional pundits, or academic policy analysts, acknowledging the wisdom of such an approach creates the danger of unemployment. At the moment, the Medicare program is in its best financial shape in decades; the U.S. health care system in which Medicare plays such a central role is experiencing an unprecedented level of disequilibrium, and only the most foolhardy have any certainty as to what the future may hold. The consensus of leading economic forecasters has, as the old Wall Street cliché puts it, predicted five of the last two recessions. Our political system is increasingly conflict-ridden and dysfunctional, and most of the so-called experts, including most of the members of the Medicare commission and its staff, have only the foggiest idea of how Medicare actually works. It may turn out that,