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Looking Ahead: IS THE HEALTHCARE WORLD FLAT?

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Thomas L. Friedman, in his book *The World Is Flat*, writes that “lightning-swift advances in technology and communications put people all over the globe in touch as never before.”

American companies outsource high-tech and low-tech jobs to India, Chinese goods find worldwide buyers, and consumer information is a mouse click away. In the dramatic transformation to a global economy, the traditional barriers separating suppliers, employees, and customers vanish. The world is increasingly a level playing field in economic terms, where all competitors have an equal opportunity, and employees can be anywhere. Companies must fundamentally alter their business models to succeed. “We are about to see creative destruction on steroids,” writes Friedman.

Can the Friedman analogy and lessons be applied to the transformations occurring in the U.S. healthcare system? Arguably, they can, but healthcare’s flattening isn’t so much about globalization overseas – fewer than one percent of 35 million hospitalizations of American citizens occur in other countries. Similarly, although radiologists in Bangalore, Switzerland, Australia, and Israel read x-rays during the wee hours for more than 500 U.S. hospitals, most Americans’ radiologic images are still made and read on this continent.

What is happening in American healthcare is that technology is a major force driving a fundamental change in the economic model for healthcare delivery. Healthcare used to be driven by the supply side, i.e., physicians, hospitals and new medical technology dictating utilization, patient referrals to providers, and prices. Now healthcare is evolving rapidly toward a demand-driven system in which individual consumers, health plans, employers, and government – aided by distance-shrinking information technology – are taking more control. This transformation will require shifts in perception and strategy if hospitals intend to remain competitive and responsive to

their communities in the new environment. Is your board ready for the transformation?

Demand-Side Changes

America’s insatiable demand for healthcare is outstripping society’s willingness and ability to pay for it. In an attempt to regain some control, society (acting through payers and government) is changing the rules of the game (i.e., its social contract with healthcare providers). With healthcare at 16 percent of the gross domestic product and climbing, society is increasingly unwilling to write blank checks to reimburse the costs of facilities, physicians and nurses, and technology to meet the growing demand.

As a result, hospital trustees will be forced to make increasingly difficult decisions throughout the next decade regarding, for example, what services to provide and for whom. Hospitals in competitive markets won’t be able to fall back on pat responses such as “we are a full-service community hospital; therefore we do everything for everybody.” Solo community providers will face tough triage challenges on what to keep and what to refer to more specialized facilities.

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On the demand side of the equation, transformation is driven by three principal factors:

1. Growing utilization. Utilization will continue to increase on both the ambulatory and (a surprise to many) the inpatient side. This growth will be driven by an increase in total U.S. population, from roughly 300 million today to 320 million in 2020, and by the aging of the baby boom generation. Because older patients consume more hospital resources, the aging population by itself will increase healthcare utilization by 1.6 percent annually, according to a study in *Health Affairs*. Clinical technology will shift some volume from inpatient to outpatient settings, but this effect will be limited since approximately 80 percent of surgery is already done on an outpatient basis.

2. Insurance coverage and the uninsured. Changes in the payment sector continue to remove providers' ability to set prices that recoup a reasonable margin. Public payers Medicare and Medicaid dictate rather than negotiate prices, and they chronically pay at or below cost. The bargaining power of private health plans is growing. Anthem

Inc.'s purchase of WellPoint Health Networks for \$16.4 billion makes it the nation's largest health insurer, with 26 million health plan members in 13 states, while UnitedHealth Group, which has agreed to buy Mid Atlantic Medical Services for \$2.95 billion, will give UnitedHealth more than 20 million members.

What about the uninsured? The universal coverage aspect of the healthcare policy debate will continue well beyond November 2008. If the Republicans retain the White House and control Congress, we can expect promotion of "market-based solutions" such as pay-for-performance and consumer-directed health plans, which will benefit primarily those who already have insurance, or could buy it if premiums were more affordable. Under this scenario, the ranks of the 47 million currently uninsured will probably increase, highlighting the need for more extensive changes in policy.

If the Democrats are in charge, we can expect the debate to focus on some form of universal coverage. However, any such program could take six to 10 years to fine-tune and implement. The biggest stumbling block: determining who will pick up the estimated \$50 to \$145 billion tab. Healthcare

doesn't exist in a vacuum; several other major issues are competing for votes and funding in this election year, including the economy, education, energy, Iraq, and homeland security. So don't expect your hospital's financial burden for treating the uninsured to decline much very soon.

3. Transparent information. The increasing availability of comparative hospital and physician information on clinical outcomes, patient safety, patient satisfaction and cost, combined with the education, affluence, and demanding nature of baby boomers, are major factors that will contribute to consumer-driven health care. But consumer-driven purchasing will be a long time coming, impeded by significant factors such as the lack of reliable information and a constrained supply of providers (see sidebar, "What's Flattening Healthcare?" on the next page). Ten years from now healthcare delivery will be much more driven by knowledgeable consumers, but over the near term, consumer-driven products will generate more heat than light.

Supply-Side Changes

Supply-side changes will be dominated by four key trends:

1. Increasing clinical technology demands. From pill-cams transmitting images of the gastrointestinal tract to minimally invasive neurosurgery via the nasal cavity, improvements in clinical technology will continue to amaze us as they improve patient care. Not too long ago the single-slice CAT scanner was considered the latest and greatest. Today patients and clinicians want 256-slice devices. Shelf lives are shorter and the capital cost to acquire this technology is substantial, but hospitals have little choice if they wish to maintain market share. Baby boomers want a 52-inch HDTV, an SUV in the garage, and the most advanced diagnostic and treatment technology when they're ill – especially when somebody else pays the bill. New technology generates an arms race among competing providers who must invest in centers of excellence just to keep pace.

2. Physician shortage. Unless something changes, we will face a growing and severe shortage that by 2020 may range as high as 200,000 physicians. But the problem hospitals face

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goes beyond a headcount. Most physicians emerging from training today don't want to be tireless entrepreneurs, hanging out an independent shingle. Instead, they expect to be good clinicians who collect a regular paycheck from their employer, and "have a life" outside the office. In addition, many physicians of all generations feel they no longer really need the hospital. Even those who do want to support their local hospital find the notion of "volunteer time" unrealistic. They are simply out of discretionary time as they cope with economic stresses in their practices and want more time for personal pursuits. Many physicians are opting for early retirement.

3. Nursing shortage. If forecasts of the physician shortage give hospitals a headache, the nursing shortage will deliver a migraine. The current predicted shortfall in 2020 is approximately 400,000 nurses. At the same time, part of the solution to the physician shortage could be using more advanced practice nurses as primary caregivers (Have you been to your nurse-staffed neighborhood clinic at Wal-Mart or Walgreen's lately?), which would make the hospital's nursing shortage even worse.

The problem is not limited to nurses; shortages are forecast in virtually every aspect of hospital employment.

4. Growing competition. In the early 1980's futurist Jeff Goldsmith wrote that healthcare was a "neighborhood business." That's no longer true. Notwithstanding the 200,000 U.S. citizens who went to places such as Bumrungrad Hospital in Thailand in 2005, most hospitals and doctors aren't subject to overseas competition. The real action will be right here at home because the old

neighborhood has changed. Today, mobile patients empowered with information on where the best care is available readily travel to hospitals, outpatient facilities, and physician specialists doing sophisticated work in their offices in the next town, county, or state. Hospitals today face a range of old and new competitors, including other hospitals, physicians, and investor-owned enterprises. Constrained facilities and capital access are often considered to be important supply-side trends. While

they clearly affect a hospital's ability to provide services, hospitals that transform themselves and align with physicians to operate efficient and high-quality enterprises will be able to generate solid margins and obtain the capital needed to build facilities and acquire new technology, thus creating a self-fulfilling cycle of success. Investment capital will be available to those whose performance merits it.

Social Contract

When the "greatest generation" returned home from the war, employer-based health insurance was already embedded in U.S. culture. The next two decades were a heady time, and the healthcare system participated in that prosperity. Hospitals were built with Hill-Burton funds, subsidies were provided to train physicians, and (some) insurance was provided for the elderly and poor through Medicare and Medicaid. At the risk of oversimplification, we can say that society contracted with healthcare providers, saying "care for us, and we'll give you our trust and respect, and we'll pay you well."

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What's FLATTENING Healthcare?

MORE POWER ON DEMAND SIDE

- ✓ Increasing utilization
- ✓ Government and health plans dictate prices and quality/regulatory requirements
- ✓ More transparent information on quality, safety, and price
- ✓ More informed consumers
- ✓ More choice of outpatient facilities and nontraditional providers

LESS POWER ON SUPPLY SIDE

- ✓ Costs of technological arms race
- ✓ More competition
- ✓ Workforce shortages
- ✓ Traditional hospital-physician separatism inhibits efficiency
- ✓ Little ability to limit demand from insured/poor payers

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Why are so many middle-aged physicians angry today? Because that contract is being rewritten – without negotiation. The new contract from society reads more like this:

- * Take care of more people, who have more complicated conditions, and increased expectations.
- * Provide more complex care with fewer resources and face increased regulatory costs.
- * In return, we'll keep a wary eye on you and let you know how much we're going to pay you when we get around to it.
- * Are we clear on this?

Many physicians feel they have about as much control of their destiny as American manufacturers facing global competition from low-cost producers. Their business no longer sustains their profession.

Implications for Boards

The trends reshaping healthcare call on boards to question traditional beliefs and practices and to change to address new economic realities. Trustees should rethink their approach in several areas, including:

The Case for Building a Hospital-Based MULTI-SPECIALTY GROUP

- ✓ Newly trained physicians prefer to be employed. We will face a seller's market for the next decade, and hospitals without a multi-specialty group (MSG) will be at a disadvantage.
- ✓ MSGs foster collegiality and a spirit of inquiry, which in turn lead to improved patient safety and quality.
- ✓ Within MSGs average family practice physician incomes are about seven percent higher (an obvious aid in recruitment) as a result of benefits of scale and cross-subsidization from specialists (who are rewarded with referrals).
- ✓ Electronic medical record development is enabled when a hospital and a MSG are sister corporations (i.e., subsidiaries of the same parent). Interoperability is in the parent company's interest, even when it means the hospital and/or MSG have to give up some aspects of their preferred, individual modality.
- ✓ When the MSG coexists as a sister corporation to the hospital, the parent company can also negotiate with "single signature" authority, focusing on the overall value to the health system, without regard to whether the medical group loses money on its piece.

1. Mission and clinical priorities. A full-service mission may no longer be what the community is asking for, AND it may not be sustainable economically. If your hospital has a lagging market share in a given service, the service area may be sending you an important message. No hospital can be the best in everything. Harvard

strategist Michael Porter advises that "... strategy is choice and trade-offs ..." meaning that strategy is about deciding what you will not do, just as much as setting priorities for what you will do. This suggests that a clear assessment of your clinical service portfolio may be in order.

2. Quality and patient safety. The current model employed by many hospitals relies on volunteer physicians for credentialing, peer review, and quality improvement. Research from the RAND Corporation and Dartmouth Atlas suggests this is a flawed model, and anecdotal field experience consistently backs up the research. Other than the smallest institutions, hospitals may need full-time, paid clinical leaders with a mix of administrative/clinical responsibilities, especially to chair large departments such as surgery and medicine.

3. Physician employment. Most physicians are currently in practices that range from one to three physicians; however, single specialty and multi-specialty groups (MSGs) are likely to be the dominant organizational structures of the future. This means trustees need to think now about the role of the hospital in building or acquiring such groups. There are a number of compelling reasons for hospitals to form their own MSG (see "The Case for Building a Hospital-Based Multi-Specialty Group").

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True, the late 1990s' experiment in physician employment was for many hospitals an abysmal failure. Times have changed. Hospitals acquiring practices needn't overpay for inflated "goodwill." A commonsense approach to practice management, such as basing physician compensation on productivity and net revenues, combined with noncompete clauses, can make hospital-owned groups viable and enable hospitals to overcome past problems.

4. Information technology. Information technology (IT) can be the "steroid" of organizational transformation when appropriately prescribed to support an organization's strategic plan. By enhancing communications among providers and with patients, IT enables providers to improve quality while simultaneously cutting costs. Paper-bound providers with legacy systems that don't talk to each other can't meet the markets' demands for efficiency and demonstrable quality. Current estimates suggest healthcare costs could be cut by a third if IT were fully implemented.

Factors Inhibiting the Move to CONSUMERISM

- ✓ Comparative information on provider quality is:
 - ✗ Limited to few conditions
 - ✗ Inconsistent and contradictory among sources
 - ✗ Not understandable to less literate segments of population
- ✓ Little useful information is available on providers' relative prices, and few consumers are incented to choose lower-cost providers
- ✓ Constrained supply: no real choice when few/no alternatives exist for a local hospital or specialist
- ✓ 70/10 Rule: 70 percent of healthcare costs are associated with 10 percent of the population
- ✓ Policy concerns: only the affluent will have access to "the best" providers
- ✓ Litigation: physicians taking legal action to prevent panel exclusion

However, the capital costs of implementing IT networks are enormous, and the near-term cultural hurdles of physician adoption are daunting. While it is theoretically possible for all the bits and bytes to talk with one another, it turns out to be quite difficult to implement interfaces among such a wide variety of legacy systems. Boards need to stay focused on IT as a core strategy and not be deterred by the operational challenges.

IT will tear down barriers to consumers' access to information. In the future "best practice" hospitals will do much more than post information on their Web sites. They will educate consumers on how to acquire, interpret, and compare reliable information. Information technology will also expand the possible locations for diagnosis and treatment. A hospital campus will be one among many venues where patient care can be provided. Other options include physician offices, ambulatory care centers, patient homes, retail stores, and even

the Internet. Hospital campuses will be redesigned to improve access to ambulatory care and also offer patients single rooms, thereby reducing infections and improving quality, productivity, and patient satisfaction.

Conclusion

As the economic model for healthcare delivery evolves over the next decade, hospital trustees will face increasingly difficult decisions. U.S. healthcare won't be flat in the global sense, but it will trend towards a buyer's market. Understanding this will be critical for both mission and margin.

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