

Healthcare in the U.S. Waiting for Dr. Toyota

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Public healthcare

Medicare and Medicaid are U.S. government-sponsored healthcare programs. Medicare is a federal health insurance program for people age 65 and over, certain younger disabled people, and people with kidney failure. The program is administered by the Health Care Financing Administration, an agency of the U.S. Department of Health and Human Services. Medicaid is a federal-state partnership, with state laws, state regulations, federally approved state waivers, and approved "state plans" - all creating significant variations from state to state.

By the year 2000, Medicare expenditures alone are expected to reach 13.8% of GDP. In 1997, the US spent 1,092 billion (1.09 trillion) in healthcare, a 4.8% increase over 1996 expenditures, which peaked between 1990 and 1996.

Private healthcare costs have been traditionally lower than Medicare. But higher overall Medicare costs have grown at a slower pace than in previous years. The average growth expected from 1997 through 2005 is 3.3%, compared to an average growth rate of 4.8% from 1973-1993 and of 6.4% from 1993-1997. Notwithstanding, a gap continues to exist in excess medical prices, or the difference between medical costs and inflation.

The gap between costs and income after the Balanced Budget Act (BBA) is estimated to be in the range of 9-14% (higher costs). By the year 2005, Medicare costs are expected to near \$200 billion, while Medicaid is expected to reach over \$100 billion. The number of Medicaid recipients was stable, at 22 million, until 1986, but is expected to increase to 12 billion by 2005.

Today, 39 million Americans are covered by Medicare. By 2002, all beneficiaries will be able to choose between a managed care plan or continue under the fee-for-service plan. However, opting out of managed care will mean limited services. Beneficiaries will have the first 6 months of the year to change their plan of choice, after which time they will be locked-in. The full spectrum of choices will include Preferred Provider Organizations (PPOs), Provider Services Organization (PSOs), private Fee For Services (FFSs), Medical Savings Accounts (MSAs) and religious or fraternal organizations.

The public system in the U.S. faces issues similar to those in other countries of the Americas, issues of equity vs. equality. The government needs to carefully define a set of benefits that it can and will pay for; a package that will most likely include - albeit with limits - prescription drugs.

Health insurance costs and coverage

Health insurance costs were at their lowest in 1996, but have been increasing moderately ever since at a rate of 3-4%/yr. However, costs are expected to increase much faster in 1999 and beyond. The increase will be partly driven by a forecasted 14-15% increase in prescription drugs costs, and by narrowing profit margins, which will make it imperative for companies to widen their customer base. The price of insurance usually adjusts to inflation after two years, which means that prices are due to increase in 1999 to catch-up to the higher costs of 1997 and 1998.

Today, it is estimated that only 38% of Americans could chose (or could afford) indemnity plans. In 1988, 71% of Americans were covered under such a traditional plan. By 1998, that number had decreased to 12%, the remainder covered by a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) or Point of Service (POS) plan., with PPOs increasing at the fastest rate. Faster growing plans are curiously not those with higher customer satisfaction, where Kaiser, a staff-model, rates the highest.

The average cost of health plans per person peaked in 1995 at \$138, but decreased in 1998 to \$123. That same year 62% of Americans paid a \$10 co-payment per visit under their HMO plan, and 42% of HMOs required use of generic drugs. Plans are using less and less pre-existing condition clauses. In California, HMOs show the highest reduction at 50%, followed by PPOs at 28%, and POSs at 20%. In the next couple of years, it is expected that plans will focus on reducing the cost of prescription drugs.

Today, 150 million Americans receive healthcare through their employer. Of them, 62.3% are 69 years old and younger. Employer-based plans covering that age group is increasing, after bottoming in 1993. On the other hand, the number of uninsured over 65 is increasing. In 1987, 14.5% of Americans were not covered, compared to 18% in 1997, a trend that is blamed on decreasing real incomes, since insurance coverage and income inequality go hand in hand. Flexible benefits plans (Flex Plans) are considered a burden on low-wage workers and can only work for wealthy companies/employees.

Quality of care

Healthcare lags behind other industries when comparing dollars spent on true quality management. Studies show that in 3 out of 100 cases, errors that caused temporary or permanent disability or death were preventable. That relation increased to 11 in 100 cases where non-optimal care was provided.

Healthcare lacks warning mechanisms, and the industry needs to learn how to motivate to improve quality. A system to qualify or rate plans according to quality standards has been proposed, as well as the creation of quality improvement pools. Hospitals and groups would bid for moneys in the pool, awarded depending on quality and optimization of care achieved. Such mechanism would be built into the contract between providers and health plans. Quality could be measured by whether the right/wrong drug was prescribed, whether the wrong treatment was given altogether, or whether the patient got better or did not respond to treatment.

Secretly, employers are waiting for a system that would provide excellent quality, reliability and outcomes, at an affordable price. In other words what Toyota did for the automobile industry. It is

believed that such efficiencies can only be attained with purchasing coalitions and quality accountability at the provider level.

Business needs for healthcare organizations

Any healthcare organization depends on predictability, stability, and understanding the comparability of markets.

There are many problems facing the US marketplace. Among the most salient are:

- The uninsured and issues of inequality.
- The degree of change, the speed at which change is happening and ignorance about what the system will look like in the future.
- Inability of the marketplace to assimilate decisions at the same speed decisions are and need to be made.
- Fast pace of technological change, which puts increasing pressure on price increases.
- Projected Medicare expenditures are not sustainable given forecasted income.
- Lack of comprehensive and feasible options for long-term care, particularly for the elderly, an increasing segment of the population.

Overcoming these problems is going to depend on:

- Flexibility of the private sector.
- What will be paid for (or not paid for) by plans and by government-sponsored programs (limited services).
- How government will tackle paying for almost 50% of all healthcare costs and the need for government to continue financing these costs.
- Whether or not -and how well- Medicare will be privatized.

Market mechanisms are indeed different for healthcare, a non-commodity. Commodity prices are based on what people want to buy and how much of it they will buy. Healthcare analysis cannot simulate that of regular commodities.

Impact of technology, information and market changes on healthcare

Technology is rapidly changing healthcare, and the backbone of this change is access, particularly access to information. Such access is more than ever before fast, simple, inexpensive and secure. The widespread access to healthcare information is considered a fundamental element of social changes, which we are beginning to experience and will continue to experience in the next century.

The information age has gone through three stages of development:

<u>Stage I</u>	<u>Stage II</u>	<u>Stage III</u>
Before 1984 Information at manager's desk, based on data systems, only professional data managers can make changes.	After 1984 The power is at the hand of consumers of technology, people can manipulate information from their desktop.	Now Internet computing is prevalent Information is shared over the network User are at the interface level Information is easily accessible and easy to use
Lack of integration.	Limited integration. Just-on-time manufacturing and inventory.	Applications talk to each other and the consumer is not bothered by the technology or technologies behind the screen Third parties administer the information and the technology Cross-over and interconnectedness of information, databases and systems, all possible through systems integration. The Future Extension of just-on-time processes beyond manufacturing Market is fully consumer-driven Technology to be used strategically Selection of technology needs to be based on what is realistic to meet business objectives Integration achieved through the internet.

Besides technology, a key element of the new marketplace is the role and responsibilities of the physician. Physician cooperation is and will continue to be a defining factor in healthcare economics and high quality orientation and demand. Depending on who it will be and how this leadership role develops, the information broker will also play a fundamental role. This role is still not clearly defined in the U.S., and it is not yet evident whether physicians, the hospital, the managed care company or the government will fulfill it. What is obvious is the trend toward market disintermediation and a reinvention and metamorphosis of traditional service roles.

With the growth of HMOs, healthcare became closer to a commodity-based industry, but this is not sustainable. Subsequently, HMOs acquired strategies of retail organizations. However, the changes described in the above paragraphs are giving way to a client-based industry focusing not on disease, but on the individual customer. This trend will continue to be emphasized by new biotechnology and therapies such as gene therapy, and other trends such as self-diagnosis, e-commerce, and non-profit driven healthcare, among others.

New strategies of healthcare companies will focus on creating and maintaining customer loyalty since profitability is highly dependent on a broad customer base. Such a strategy will include:

- Creating the right branding.
- Making information available and accessible to customers.
- Augmenting the speed at which information and services get to the marketplace.
- Incorporating electronic business.
- Redefining and extending the geographical customer base.
- Changing the corporate culture to create a real passion for the consumer.
- Establishing non-traditional partnerships, often across industries.
- Segmenting the market in non-traditional ways, based on new criteria, replacing outwardly descriptive categories with individual patterns, tastes and choices.

Healthcare companies in particular are faced with tremendous challenges. In addition to the above strategies, they need to accurately and carefully manage their revenue cycle, which involves increasingly sophisticated analysis of costs, revenues, and risk management. Companies will need to devise a cost structure more in line with revenues, and have a proper capitalization and organizational structure that allows the company to act with agility to the demands of the market. More than ever, healthcare companies need to have a clearly defined strategy which will be non-global and increasingly segmented, with well-defined product lines and pricing. The most difficult challenge to overcome will be optimizing the value placed on particular or specific customer segments while maximizing profits.

What will the next millenium bring? Many are still dreaming of Dr. Toyota, an efficient, sustainable, affordable, and accessible healthcare system. Child and family life-style care will most likely be emphasized, as well as quality healthcare, preventive and corrective at its core. An industry expert recently stated “we will come to view illness as a failure of the pharmaceutical industry.” And way before him someone else said “there are no illnesses, only ill people.” Perhaps there will be no “ill people” once we have the tools to make what is flawed whole. But with such wonder comes a redefinition of medicine and continued debate on its ethics.

A good portion of the information contained in this article was gathered at a conference on Healthcare Trends in the U.S. organized by the UC Irvine Graduate School of Management, Irvine, California in February, 1999.