

# State of the Industry 2003

Leadership and cooperation are the tools that can change healthcare for the better

by Ian R. Lazarus

Imagine you are on an international flight to a destination far away. Through some misfortune, you find yourself cramped into the middle seat in the middle section of a wide-body jet. Because luggage bins are full, your bag is under the seat in front of you; you cannot stretch your legs. Your seat back does not recline due to mechanical failure. You cannot see out the windows and have no bearing on where you are or where you are heading. You would like to use the restroom, but the seatbelt light is on and federal restrictions require you to stay in your seat anyway.

An hour of turbulence has stripped away whatever dignity you had left, but you are determined to persevere (as if you had a choice). Then there's an announcement to let you know that the flight is running just a few minutes behind but you are still scheduled to arrive on time—in 36 months. Welcome to life in the healthcare industry.

Lately, the healthcare industry has had precious few opportunities to celebrate. At times, stakeholders believe they are confined with little room for improving their lot, or on a seemingly endless flight that only could be described as a nightmare. This last year—with a weakening economy, distrust of American intentions overseas, victory in a war that continues to take American lives, and a stubborn unemployment outlook—there is just one bit-

tersweet fact for those working in healthcare: No matter what happens outside the industry, we provide a vital service that will endure whatever else society must contend with. In this respect at least, some might argue that healthcare is recession-proof.

## IT'S THE ECONOMY

Recession-proof or not, the economy continues to bite at the heels of the healthcare industry, and for some, that is an understatement. But nothing speaks louder than facts, and on paper at least, the provider side of the industry actually has enjoyed some stability. Improved revenues from managed care rate increases have effectively offset continued cost pressures from supplies, labor, insurance and pension expenses. As a result, operating margins have held firm for three years in a row, according to Fitch Ratings, an agency that tracks bond ratings in several public markets.

Industry prospects going forward, however, are not as optimistic. Managed care rate increases are expected to taper off while uncompensated care is expected to increase. If revenue growth slows as expected moving into 2004, health systems can only hope that gains in investment income might once again create some stability with respect to operating margins.

The prospect for certain individual provider sites are not so favorable. For the

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past three years since we began tracking this metric for MHE's State of the Industry Report, the ratio of downgrades to upgrades in health system bond ratings has remained just under 4 to 1. That ratio is expected to hold steady in 2003. Through the first half of the year, Fitch Ratings already has downgraded 15 health systems while upgrading only four. Fitch provides a useful overview of opportunities and risks that individual providers will face during the next 12 months (see table, below).

By comparison, managed care plans and traditional health insurers have fared much better than their provider counterparts. In its latest review of plan performance, Weiss Ratings upgraded 72 plans while downgrading only 11. But a weak economy also has impacted this segment of the industry significantly. The combined life and health insurance market witnessed a 52.6% decline in net income during 2002, resulting in the lowest level of profitability in 10 years.

"Investments are an intrinsic part of the industry's ability to maintain adequate reserves in order to deliver long-term policy commitments," says Melissa Gannon, vice president of Weiss Ratings Inc. "Substantial portfolio losses over time force companies to compensate in other ways,

such as dipping into their financial reserves." The continuing downturn in equity markets was responsible for the industry's profit decline, resulting in a staggering \$15.5 billion capital loss on the sale of invested assets. Even with such huge losses, group health products remained profitable, amassing \$2.1 billion in profit during 2002.

It should come as no surprise that overall spending increased in 2002 and is expected to show an increase again in 2003. Healthcare spending has increased approximately 10% the past two years, a rate four times greater than the overall economy. However, for the first time in five years, the increase did not extend beyond the previous year's growth. In fact, rate increases in spending definitely have slowed; during 1996 to 2001 those rates rose steadily from 2% to 10% every year, according to a recent study published by Paul Ginsburg and Bradley Strunk.

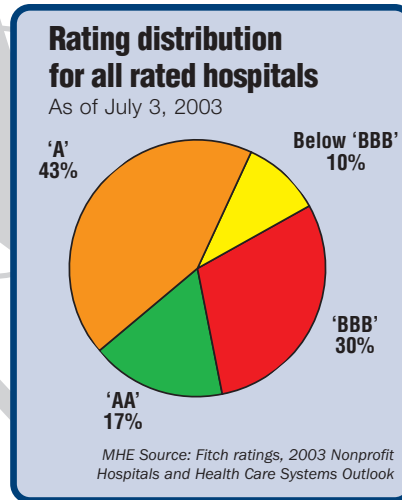
Growth in hospital spending accounted for the largest overall increase last year, 51% of the total, with hospital price inflation accounting for an even larger share of price increases than the year before. By comparison, for all the attention paid to

prescription drug costs in the media, it is worth noting that drug spending actually has decelerated three years in a row because of the expiration of patents, fewer new FDA-approved drugs coming to market, and the influence of copayment mechanisms that inevitably slow demand.

Unfortunately, whatever gains the industry can hold, few are passed on to the consumer. Health premiums continue to trend upward, with Towers Perrin reporting a 15% increase in 2003, up from 13% in 2002. Employees also are picking up more of the bill as employers are all too willing to pass it on. This has not escaped the attention of the average consumer. The Kaiser Family Foundation's recent poll indicated that Americans are more worried about healthcare costs than losing their jobs, paying their rent or mortgage, or being the victim of a terrorist attack.

This year has not been without its share of small victories, and although healthcare costs are on everybody's mind, at least the safety nets at both ends of the age spectrum appear to be tightening. Medicare+Choice saw its membership peak in 1999 at approximately 6.3 million members, but participation by the private sector has slowed along with reimbursement increases, and as of today only 5 million members still have access to coverage.

As this issue goes to press, House and Senate conferences begin deliberation on



## 2003-2004 outlook for hospitals and health systems

### Areas of opportunity

- Expansion of profitable service lines/elimination of mediocre competencies
- Utilization growth
- Cost of capital
- Revenue cycle management

### Risks

- Labor
- Government spending/health insurance coverage
- Rising supply costs
- Capital needs/access

- Competition with physician/niche competitors
- Rising insurance expenses
- Rising bad debt expense

### Areas of uncertainty

- Investment returns
- Pension funding
- Managed care reimbursement
- HIPAA
- Information technology costs
- "Swaps," "synthetic leases," and other financing derivatives

MHE Source: Fitch Ratings, 2003, Nonprofit Hospitals and Health Care Systems Outlook

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the details of a bill to strengthen the program and its prescription drug component. Sens. Charles Grassley (R-Iowa) and Bob Graham (D-Fla.) similarly promise a bill for more affordable long-term care insurance. Washington also demonstrated its ongoing commitment to the State Children's Health Insurance Program (SCHIP) by releasing \$2.7 billion in allotted federal funds to the program.

Meanwhile, the mainstream marketplace continues to experiment with innovative financing mechanisms for healthcare expenses, and as recently as June, the House passed legislation formally recognizing the benefits of Health Savings Accounts. A bill that would legislate the benefits of such accounts is expected in the near future.

### IT'S NOT US

As is typical of human behavior, any attempt to understand the challenges of working within the healthcare industry will result in much finger-pointing, but rounding up the usual suspects does little to explain the underlying complexities of the industry we have created. Just like the advertising for mutual funds, on any given day, any one constituency can come out

smelling like a rose or looking like a loser.

In the 2002 State of the Industry Report, for example, MHE outlined findings from research sponsored by the American Association of Health Plans (AAHP) and conducted by PricewaterhouseCoopers.

It found that 18% of the increase in healthcare costs, the largest category of all, resulted from increased payments to hospitals. The American Hospital Assn. (AHA) sponsored a similar study this year, also conducted by PricewaterhouseCoopers, to tell its side of the story. These studies found that the increases in growth spending from 1997 to 2001 are principally because of rising labor costs and secondarily to rising supply costs.

### IT'S HUMAN CAPITAL

It's true that human capital, or "knowledge workers," can represent a huge com-

petitive advantage in the labor-intensive industry of healthcare, and workforce shortages are threatening not only the quantity of care provided but the quality of it, according to recent studies published

by the Institute of Medicine (IOM). The Department of Health and Human Services reports that by 2020, the healthcare system will need 3 million nurses—a million more than the projected supply.

Vacancies already are at 10% or more for RNs, radiology technicians and pharmacists. Many innovative programs coming from AHA, combined with legislation for financial assistance to nursing students, are well worth examining for health systems that will face this crisis.

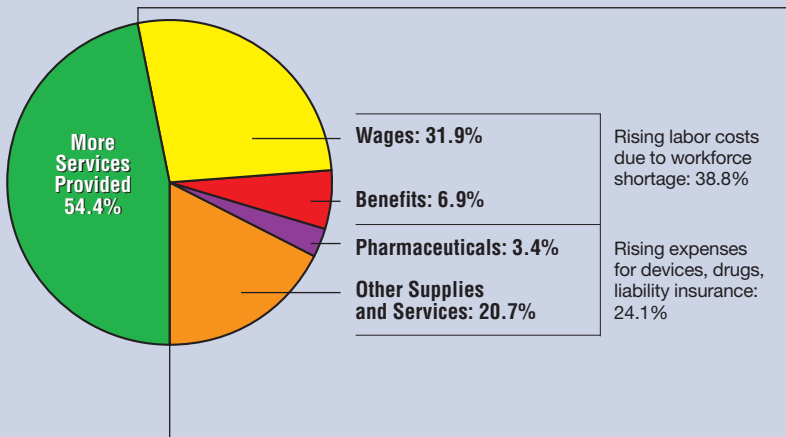
For the medical community, working in this industry has been no picnic either. Rising malpractice claims, combined with higher administrative expenses for participation in managed care, are driving more physicians from the business of health every day.

As this issue goes to print, more than 1,000 physicians in the state of Florida have signed affidavits indicating they will leave the state, change specialties or leave the profession because of the rising cost of medical malpractice insurance. Elsewhere, nearly 8,000 physicians have collectively submitted a call in the *Journal of the American Medical Assn.* for a single-payer system that they argue would allow for the expansion of Medicare while simultaneously lowering overall costs.

Whether the physicians are bluffing in threats to abandon medicine or not, their frustration is indicative of rising concern over issues regarding the cost to maintain a medical practice. Even with caps on malpractice judgments, some

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Share of growth in spending (\$83.6 billion) on hospital care 1997 - 2001



Increasing Costs to Provide Care 44.6%

\*Net of increases in efficiency

MHE Source: PricewaterhouseCoopers calculations, February 2003  
PricewaterhouseCoopers analysis, February 2003

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states report a 48% increase in premiums, according to Weiss ratings.

For its part, AAHP defends the insurers by pointing to a Government Accounting Office (GAO) study finding that it is the losses on claims, not losses on investments, that have been a principle driver of rising premiums.

## IT'S QUALITY AND ACCESS

Unfortunately, the academic cornerstones of our industry—quality, access and cost—have become so distorted over time in their relative importance to overall industry effectiveness that they no longer are given equal attention. Any improvements in our delivery system have such a reliance on affordability that one cannot examine any dimension independent of the others.

Perhaps the most comprehensive review (and indictment) of healthcare quality originally came from the 1999 IOM Report and its finding that as many as 98,000 Americans die each year because of medical errors.

In 2001, the IOM released its recommended solutions in "Crossing the Quality Chasm: A New Health System for the 21st Century." The report provides a useful blueprint for healthcare providers, payers and government on building a more reliable healthcare infrastructure, summarized by the following imperatives:

- Adopt a new set of principles to guide the redesign process for care delivery;
- Create a set of priority conditions upon which to focus initial efforts;
- Establish more effective organizational support to make change possible; and
- Implement incentives for improvement by facilitating evidence-based practice, supported by robust

technology, including appropriate payment for services, and the creation of a qualified workforce.

While all this is easier said than done, the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) is taking heed and launching various pilot projects that will not only incentivize better performance, but will publicize the results.

Programs initially are being launched in New York, Maryland and Arizona through 2004 and will focus on public reporting and financing incentives for a list of priority conditions and treatments (for more information, go to [www.cms.hhs.gov/quality/hospital/](http://www.cms.hhs.gov/quality/hospital/)). Eventually, the program will be expanded nationwide with provider results posted on the Internet and in local papers.

Finally, the shroud of secrecy under which many healthcare organizations have operated is about to be removed, and this

will almost certainly change things going forward.

It goes without saying that strong leadership is required among key constituencies in the healthcare equation to

rein in an industry with a multitude of challenges.

From the political perspective, healthcare will figure prominently among the presidential candidates' various platforms. Few have offered as controversial a program as that of Democratic presidential candidate Richard Gephardt, whose national health program would cost \$200 billion a year. The program offered by candidate Howard Dean

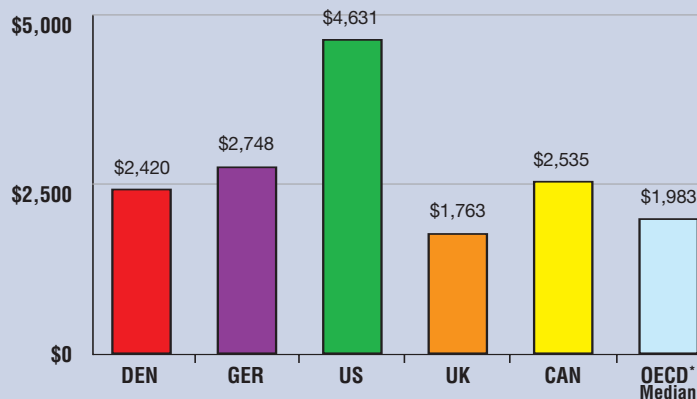
(D-Vt.) would run a paltry \$88 billion per year. As with any political solution, the best we can hope for is a compromise measure.

In his recent address to the AHA Leadership Summit in San Francisco, former New York Mayor Rudy Giuliani provided some useful insight to healthcare leaders on what they must do to lead successfully.

Giuliani advised the leaders to know what they believe in and stick to it, identify their strengths and link with others who can augment their weaknesses, have the courage to overcome their fears, and take care of the people in their organization while letting them know what's expected of them. "It's important to have people around you who'll be honest about your performance," he said.

The shroud of secrecy under which many healthcare organizations have operated is about to be removed.

Per capita national health expenditures, 2000



\*Organization for Economic Cooperation & Development

MHE Source: Anderson, et al. "It's the Prices, Stupid: Why The United States is So Different from Other Countries." *Health Affairs* (May/June 2003): 89-105

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What he did not say is how difficult such a transformation can be for the leadership of a healthcare industry that is composed of factions with objectives that are diametrically opposed to one another.

## IT'S A STATE OF MIND

Veterans of the healthcare field would be understandably weary of the continued politicking from the various constituencies, but whether defending a position or attacking it, this state of mind is not conducive to meaningful change. In her recent testimony before the Senate Appropriations Committee on Health and Human Services, Karen Davis, president of the Commonwealth Health Fund, makes a compelling case for serious introspection on the industry and its challenges.

In her testimony, Davis notes that the U.S. healthcare system, by far the most costly in the world, spends 69% more than in Germany, 83% more than in Canada, and 134% more than the average of all industrialized nations (based on 2000 data), even though our demographic profile is younger than those of the other countries.

A key difference, of course, is that the United States is the only major industrialized nation that does not offer universal health coverage, resulting in greater out-of-pocket expenses for Americans than for consumers in other countries. Contentions regarding waiting lists for care in other countries do not make a compelling case when considering the length of time Americans might wait for a physician's appointment, and the fact that emergency departments are overcrowded as a direct consequence of the swelling

ranks of uninsured and underinsured.

Do we get better value for these higher expenses? Not according to Davis. The United States has about the same mortality rate from heart disease as other industrialized nations.

In fact, on most measures of mortality, the United States has poorer performance than other countries and ranks 37th overall in the World Health Organization ranking of health system performance.

So how do we explain ourselves to ourselves, let alone to our customers?

"The Commonwealth Report makes a compelling case," notes international healthcare consultant Joseph Straus, MD, principal of Raphael Medical. "But what it does not address is the unique social fabric of the American culture and the broad-based individualism that put us in this predicament." Dr. Straus points to the heritage of American culture that results in a system in which access to healthcare is not a right, but a privilege.

**The heritage of American culture results in a system in which access to healthcare is a privilege, not a right.**

He compares this with other industrialized nations with a stronger sense of social consciousness and awareness of limited resources, where access to healthcare is indeed a right.

Dr. Straus also says, however, that the pendulum is currently swinging in both directions. While calls for universal access in the United States are gaining a larger audience, among other industrialized nations there are movements toward privatization and deregulation.

When the grass looks greener, it is to some degree because we focus primarily on what we wish to see, Dr. Straus says.

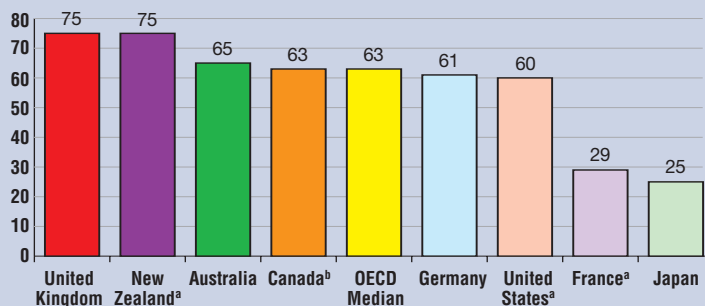
Henry John Kaiser once observed that, "problems are only opportunities in work clothes." If that statement is true, these challenges clearly have us surrounded.

Another prominent statesman, William J. Bennett, adds that, "we do not suddenly become what we do not cooperate in becoming."

Taken together, the implications for healthcare leaders are clear: Reach across the aisle—providers and payers alike—to formulate effective programs that will sustain the system and drive toward continued improvements in quality, access and cost.

Every healthcare executive must acknowledge a professional responsibility to overcome these challenges. After all, as the healthcare consumers that we are, we have created the industry that we privately wanted, for better or worse. **MHE**

**Age-standardized mortality rates for acute myocardial infarction per 100,000 population in 1999**



<sup>a</sup>1998, <sup>b</sup>1997

MHE Source: Anderson, et al. "It's the Prices, Stupid: Why The United States is So Different from Other Countries." *Health Affairs* (May/June 2003): 89-105