

Business and Management Strategies in Healthcare • part 1

# Healthcare as a business

## LEARNING OBJECTIVES

- **Describe** factors contributing to the growth of healthcare spending after World War II.
- **Describe** forces leading to the emergence of managed care.
- **Define** managed care and describe types of managed care organizations.
- **Identify** changes in the healthcare industry resulting from competitive pressures.
- **Describe** current issues in managing healthcare.

*This first article in a three-part series describes the evolution toward managed healthcare and the adoption of business strategies by healthcare organizations. Topics discussed include: the postwar boom in healthcare, forces of change, the emergence of managed care, competitive pressures and current issues in managing healthcare.*

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### Postwar healthcare boom

**B**efore World War II, the major role of the physician was to provide support and ease pain for patients with serious disease. However, scientific advances made during the 1940s and 1950s led to astonishing changes in med-

ical care. Research and innovation in procedures, diagnosis and drug development resulted in the ability to treat and cure previously fatal diseases. As a result, Americans' attitudes toward healthcare changed dramatically.

During the 30 years following the war, the political and medical communities focused on providing superior care to more people. The 1960s saw the growth of federally supported healthcare programs, such as Medicare and Medicaid. The government expanded funding for biotechnological and medical research and for new physician training programs, and also provided funding to help build new hospitals and medical centers.

Physicians practicing in this climate typically selected expensive and sophisticated medicines and therapies as they were introduced. Accordingly, patients during this time expected immediate and unlimited access to all available medical resources, selecting hospitals, physicians and specialists of their choice. Physicians legitimately perceived that they would be susceptible to malpractice lawsuits if they did not provide the most up-to-date treatment for each patient.

Traditionally, medical services were delivered by independent physicians, medical centers and community hospitals within a fee-for-service system, which reimbursed physicians and hospitals for each service they provided. Services and medications were provided without regard to cost – a situation that resulted in uncontrolled spending and jeopardized quality of care.

### Forces of change

By the 1980s, health insurance rates had begun to skyrocket. The fee-for-service insurance system was rewarding physicians and hospitals financially for providing unrestricted and, in some cases, heroic or futile treatments. Patients had no reason to question the need for any treatment or incentive to shop for the best value.

The rising cost of health insurance was so formidable that it was undermining the ability of American corporations to compete in foreign markets, and preventing workers from getting significant wage increases. From 1987 to 1992, corporate healthcare costs rose an average of 15% annually. Nationally, total healthcare spending in the United States had reached \$1 trillion by 1997, accounting for 13% to 15% of the gross domestic product.

While costs were rising, healthcare analysts were reporting in the 1970s and 1980s that there were significant variations in the way medicine was being practiced in the United States. Rates for procedures such as tonsillectomies, hysterectomies and Caesarean section deliveries varied widely from one part of the country to another.

Because family physicians and specialists operated from independent practices, they faced little accountability for quality, cost or any other aspect of the care they provided. As a result, overall delivery of care was fragmented, with no set of best practices for physicians to follow.

Corporate initiatives and state-level programs provided for a shift in the delivery

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of healthcare services. The medical community adopted business strategies to reduce excessive spending on healthcare, to educate providers about the costs of the care they were delivering, and to create appropriate expectations for the costs and benefits of healthcare. These strategies resulted in a new approach to healthcare delivery called managed care.

### Emergence of managed care

*Managed care organization (MCO)* is a term frequently used to describe any healthcare delivery organization with a defined population of enrollees and healthcare providers, and a prospective (prepaid), rather than retrospective, means of provider reimbursement.

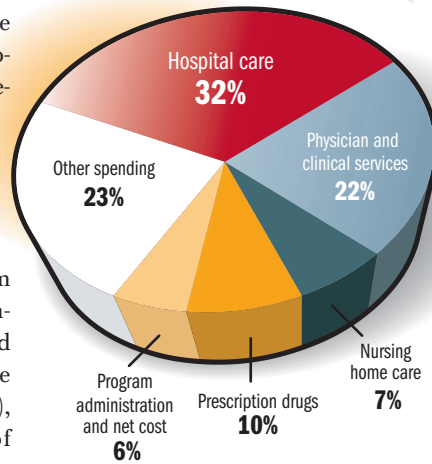
The concept of managed care rapidly gained acceptance from employers as an alternative to fee-for-service. By the mid-1990s, it was estimated that over 73% of all American employees received their healthcare through MCOs.

One of the earliest managed care designs was the health maintenance organization (HMO). Health maintenance organizations provide healthcare services to members who prepay a premium that generally covers a specified range of both inpatient and ambulatory care. Health maintenance organization administrators distribute the prepaid amount among the physicians, technicians and other service providers, who then must provide all necessary medical services to the enrollee population within this budget. The most recognizable and controversial feature of HMOs is that they are closed systems; HMO enrollees must use HMO physicians if they do not want to pay additional costs for service.

Due to the restrictiveness of HMOs, preferred provider organizations (PPOs) became very popular throughout the 1980s and 1990s. In general, a PPO is formed when several independent physicians, a hospital or both join together in a group that contracts with an insurance company or employer to provide care to subscribers for a preestablished fee schedule.

There is generally more choice in PPO plans. For example, PPO members can select

### Healthcare expenditures in the United States—2001



Source: Centers for Medicare and Medicaid Services, 2003

healthcare services from a great variety of physicians, specialists and hospitals. Members also have the option of obtaining medical services from non-PPO providers, although a larger copayment is required when services are utilized outside the PPO system.

Point-of-service (POS) plans developed in response to consumer demands for even greater choice in selecting physicians. These plans allow members to choose whether they want to use HMO benefits or fee-for-service coverage for each medical incident they experience. Most plans offer tiered payments for medications and services, so that patients can choose to pay a higher cost for access to certain drugs and services.

### Competitive pressures

As medical costs spiraled out of control, the business community reacted by pressuring MCOs. Businesses demanded price concessions, controlled utilization of services and medications, and more oversight of clinical decision making. Managed care organizations addressed these demands by introducing numerous cost-containment mechanisms, such as:

- Drug utilization review: a formal program for assessing data on drug use against explicit prospective criteria.
- Formularies: lists of preferred drugs approved by the pharmacy and therapeutics (P&T) committee from which partici-

pating physicians are encouraged or required to make their selections.

- Prior authorization: A physician must request authorization before allowing a patient to receive a restricted treatment.
- Generic substitution: Physicians are given incentives to prescribe generic alternatives whenever appropriate.
- Therapeutic substitution: a mechanism in which pharmacists are given the authority to substitute a therapeutic equivalent for a drug that is in the same pharmacological or therapeutic class as the prescribed drug.
- Pharmacoeconomic studies: studies of costs and outcomes associated with pharmaceutical programs and services.
- Pharmacy benefit management companies (PBMs): entities that administer key aspects of a healthcare organization's pharmacy benefit in an effort to control costs and utilization.

As managed care achieved dominance in the 1990s, the competition among specific MCOs became fierce, and integrated delivery systems (IDSs) began to develop. *Integrated delivery system* refers to the banding together of healthcare providers (for example, physicians, hospitals, mental health centers, nursing homes and home care providers) as a means to coordinate patient care, strengthen or broaden the range of services, expand geographic coverage, and more successfully compete for managed care contracts.

The competitive climate influenced many healthcare organizations to change to a for-profit status, which provided them more flexibility in obtaining capital. For example, for-profit organizations may acquire capital from institutional investors, insurance companies and banks, whereas nonprofits must rely on government or private grants.

The pharmaceutical industry has been greatly affected by the advent of managed care. Many managed care initiatives have been designed to restrict the purchase of more expensive pharmaceutical products in cases where other options exist. Managed care organizations have also put pressure on the pharmaceutical industry by not purchasing certain drugs, purchasing generic drugs, negotiating for substantial discounts

or, in the case of the federal government, requiring rebates to all federal programs.

In response, pharmaceutical companies have restructured themselves to become more competitive. New strategies and techniques included:

- New approaches to selling.
- Addition of value-added services.
- Development of national, regional and corporate account structures.
- Restructuring and rightsizing.
- Development of contractual arrangements with healthcare organizations.

In another development, patients and physicians found managed care to be heavy-handed and overly controlling. Consumers called for a greater emphasis on convenience and self-management. The healthcare sector responded with programs such as self-contained cancer treatment centers that focus on patient and family convenience, as well as providing skilled care. Self-management programs that teach about disease symptoms and prevention are also being developed.

### Current issues in managing healthcare

New issues are developing in healthcare management as medical costs continue to rise and the managed care paradigm continues to evolve.

While managed care curbed inflation for a few years in the mid-1990s, several factors have led to a second wave of rising medical costs. These factors include a growth in less restrictive forms of managed care and rising hospital costs (as a result of growing labor costs and increased demand for services). It is projected that healthcare spending in the United States will rise from 13% of the gross domestic product to 17% by 2011.

A comprehensive approach is needed, one that takes into account the entire cost of treating patients. In addition, patients need to be made more responsible for their healthcare and lifestyles. Healthcare administrators are utilizing several mechanisms to create such a holistic plan. These include:

- Development of clinical practice guidelines to define optimal medical practice for each disease as a whole.
- Patient-focused care, in which specific care teams are responsible for overseeing all of a patient's needs.
- Disease management, in which delivery

of care is dictated by the overall, long-term health outcome for each patient.

- Population management, which emphasizes preventive care.
- Outcomes research and management, which measures the economic, clinical and humanistic outcomes of patient care processes.

A new overall patient focus is appearing as patients are gaining substantial power in the healthcare industry. As the "baby boom" generation ages, its members are becoming increasingly knowledgeable and vocal about their medical concerns. They are viewing their physicians as partners who help them make their healthcare decisions. Because today's patients have higher expectations, health plans are putting a greater emphasis on service through greater accessibility, friendliness and responsiveness.

Dissatisfaction with managed care is resulting in national and state efforts to adopt a Patients' Bill of Rights. State versions may offer patients the right to an independent external review, the right to sue insurers (usually preempted by federal laws), performance reports on managed care plans and ombudsman programs to help managed care enrollees obtain services.

A new healthcare decision maker has emerged in the wake of the managed care era. The medical director has become the key decision maker, balancing the goals of patients, physicians and the health plan. The medical director is the corporate physician who interacts with pharmacy directors to manage the formulary, with physicians to oversee best medical practices and with administrators to ensure cost-effective delivery of care.

Medical decision-making in the managed care environment has become more definitive. Managed care organizations use clinical practice guidelines, developed from a consensus of information from medical experts, to recommend criteria for the diagnosis and treatment of specific diseases. Clinical practice guidelines, derived from actual clinical experience, are becoming more popular. These guidelines are utilized to enhance patient care, reduce inappropriate care and disseminate medical information systematically. Healthcare providers are being asked to document their practice guidelines and the outcomes resulting from

the use of these guidelines.

Disease management programs are also influencing managed care decision making. These programs focus on chronic conditions, which are often responsible for a significant percentage of a healthcare organization's expenditures in terms of emergency room visits, repeated visits to physicians and long-term use of prescription drugs. **PR**

*The next article in the series will discuss management strategies currently in use by healthcare organizations.*



### ARTICLE SUMMARY

- Before World War II, the major role of the physician was to provide support and ease pain for patients with serious disease.
- Scientific advances made during the 1940s and 1950s led to astonishing changes in medical care.
- The 1960s saw the growth of federally supported programs related to healthcare.
- Traditionally, medical services were delivered by independent physicians, medical centers and community hospitals within a fee-for-service system.
- Services and medications were provided without regard to cost, resulting in uncontrolled spending and skyrocketing insurance rates by the 1980s.
  - The rising cost of health insurance undermined the ability of American corporations to compete.
- Quality of care varied widely from one part of the country to another.
- Corporate initiatives and state-level programs provided for a shift in the delivery of healthcare services.
- A managed care organization is a healthcare delivery organization with a defined population of enrollees and healthcare providers, and a prospective means of provider reimbursement.
  - Health maintenance organizations, PPOs and POS plans are forms of MCOs.
- The business community pressured MCOs to reduce costs by using a variety of cost-containment strategies.
- Competition among specific MCOs became fierce in the 1990s.
- The pharmaceutical industry has been greatly affected by the advent of managed care.
- New issues are developing in healthcare management as medical costs continue to rise and the managed care paradigm continues to evolve.