

A DECADE OF TRACKING HEALTH SYSTEM CHANGE

By Paul B. Ginsburg and Cara S. Lesser

In the wake of failed government health care reform in the early 1990s, managed care emerged as the private-sector answer to skyrocketing health costs. In 1995, The Robert Wood Johnson Foundation created the Center for Studying Health System Change (HSC) to track this market-driven experiment in organizing, financing and delivering health care. In the intervening years, a great deal of change has occurred—much of it different from what was expected. The decade saw the rapid rise and hard fall of tightly managed care and a great deal of delivery system organizational change in response to both developments.

The Only Constant in Health Care is Change

In some respects, the more things change in health care, the more they stay the same. Managed care had its heyday and rapid decline. There were mergers and break-ups and an alphabet soup of new types of organizations, management strategies and payment arrangements.¹

To what end? In many respects, we're no better off than we were a decade ago. Roughly the same proportion of Americans—about 15 percent—lacks health insurance, and we've managed to hold steady only because public coverage has grown. Health care spending continues to absorb an ever-larger piece of America's overall economy, growing from 13.8 percent of gross domestic product in 1995 to 16 percent in 2004 to a projected 20 percent in 2015.

At the same time, disparities between health care “haves” and “have nots” have widened.² And, although public consciousness has been raised about serious gaps in the quality of care, progress reducing medical errors and improving

quality has been slow.³

Amid, all the change, one thing is clear—competition for the health care dollar has become intense. Hospitals and physicians have moved to increase revenues. This may well be a legacy of managed care, which spurred hospitals and physicians to offer substantial price discounts to avoid losing patients to competitors. For physicians in particular, it is also a response to continued reimbursement pressures under Medicare and Medicaid.

There is more marketing and targeted capital investment in profitable service lines. Hospitals are advertising quality and convenience and offering programs that generally healthy people might not be aware they need. Rather than ignore longstanding differences in the relative profitability of services and depending on cross subsidies to offer a full line of services, hospitals have focused capital spending on more profitable services, most often cardiovascular, orthopedic and oncological care.⁴

Physicians are attempting to make up for stagnant fee levels for professional services by investing in facilities, such as specialty hospitals and outpatient surgical centers, and introducing more ancillary services, such as imaging, into their practices.

Since most of the increased competition is aimed at increasing service volume rather than improving quality and increasing efficiency, it's highly questionable whether these developments bode well for patients and those who pay the bills—primarily employers and government. Some of the increased competitive behavior might moderate the effects of hospital consolidation, with dominant hospitals now facing competition from physicians. But a downside to this type of competition is that it threatens hospital cross subsidies, which are depended upon to provide services for the uninsured and standby capacity, such as burn and trauma units, for communities. And, as physicians add the capacity to offer more services within their practices, the risk of self-referral conflicts has increased.



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Finally, marketing services to consumers who have an insurer to pay most of the bill is certain to raise costs for those who pay for insured care. To date, purchasers have not developed effective strategies to counteract the potentially costly results of intensified competition for profitable services.

Thus, the increasingly competitive health care system has spawned new challenges for policy makers, while problems related to access, cost and quality have endured. What will it take to trigger real progress? Reflecting on the experience of the last decade, we have observed three simple lessons about what motivates and constrains change in the health care system:

- Public perception matters.
- All health care is local.
- The devil is in the details.

While none of these ideas are new, we believe that the past decade underscores their importance and that together they provide useful guidance for policy makers and health system leaders who hope to advance meaningful and lasting change.

Public Perception Matters

Ironically, during a time when many consumers felt disenfranchised by the health care system, the past decade has reinforced the importance of public perception and opinion as key impediments to and drivers of change. Politicians and policy makers were reminded of the power of public opinion with the infamous “Harry and Louise” advertising campaign that helped to quash national health reform in the early 1990s, and managed care executives were schooled in this lesson with the vehement consumer backlash against managed care that emerged a few years later. Indeed, innovation in health insurance design and management today continues to be strongly shaped by public rejection of the blunt administrative controls and restricted provider choices characteristic of tightly managed care.

The next health care backlash is already brewing, zeroing in on health care affordability. Just as the rapid expansion of managed care prompted consumers to move the health care system in a new direction, today’s rapid growth of patient cost sharing likely will again engage the public—and this time the focus will be more directly

on the need for cost control, something recently cited by President Bush in his 2006 State of the Union address. Whether new consumer-driven health insurance products and greater price and quality transparency will empower consumers to rein in health care costs on their own remains to be seen. Regardless, it seems quite certain that the increased financial responsibilities and risks associated with these and more conventional insurance products will raise public awareness about health care costs and engender greater support at least for discussion of strategies to preserve affordability.

Threats to affordability are developing on two fronts. First, consumers are feeling the pinch directly as employers continue to pass more of the cost of health benefits to employees. If health care costs continue to rise faster than workers’ incomes, a growing number of employees will find themselves priced out of health insurance. And those with coverage will spend a greater proportion of their income on premium contributions and out-of-pocket costs, including deductibles and coinsurance.

Second, Americans are confronting the affordability problem as taxpayers. Rising health care costs are hitting public-sector programs with a double-whammy: Not only are current program commitments rising more rapidly than revenues, but demand for public coverage is increasing as rising health care costs push more people out of employer-based coverage. Visibility is greatest at the state level, where rapid growth in Medicaid spending is colliding with requirements to balance state budgets. Even if Americans were amenable to tax increases, keeping pace with the current trajectory of Medicaid growth would be a formidable challenge.

On the Medicare front, the first wave of the 76 million baby boomers turns 65 in 2011, and financing of their care will begin shifting from the employment-based private insurance system to the publicly financed Medicare program. As a result, Medicare spending will accelerate sharply as more people join the program

and as per capita spending growth remains unchecked. Financing the boomers' care will severely strain the federal budget, leaving fewer resources for competing spending needs and forcing policy makers to consider tough trade-offs, such as reducing benefits, raising taxes or allowing larger deficits.

In light of these trends, increased urgency to control costs seems inevitable. For now, purchasers are pinning their hopes on consumer-driven health care and increased patient cost sharing to help slow the rapid growth of health care costs. Whether successful or not, the increased financial responsibilities patients will face may pave the way for a more candid discussion about the inherent individual and societal trade-offs involved in keeping health care affordable. Recent history shows that public perception is a critical ingredient. How health care leaders and policy makers harness public awareness of the cost problem and shape public opin-

ion about options to respond will greatly influence the direction of the health care system in the years ahead. But leaders thus far have been unwilling to acknowledge that there are no painless solutions, instead promising that popular initiatives, such as health information technology and quality reporting, will slow cost trends substantially.

All Health Care is Local

Because there are limits to how far people generally will travel for medical care, health care markets are—and likely will continue to be—local. We have repeatedly been struck by the differences in the configuration and dynamics of health systems across communities. In some communities, large multispecialty groups dominate physician practice, while in others they are non-existent. Academic medical centers are at the core in some markets, while other communities revolve around a col-

lection of community hospitals. A single Blue Cross Blue Shield plan dominates some markets, while others have a number of competing national plans. Many of these differences are longstanding, rooted in historical developments specific to individual communities rather than recent mergers and market entries.

And, it is not just the collection of players that defines a community's health care system; there also are cultural differences in the public's tolerance for high numbers of uninsured, the degree to which major stakeholders attempt to work together to solve problems and the role of government regulation. Together, these attributes result in different environments and systems of care. Indeed, while we speak of the "American health system," what we actually have is a collection of highly local health care systems—many of which are so fragmented that it is a misnomer to call them a "system" at all.

Changes in health care delivery occur market by market, with notable differences in response to what are often common drivers. Consider how managed care developed in communities across the country. Markets with established integrated delivery systems and multispecialty physician groups moved more quickly into the experiment of global capitation, while communities without this infrastructure focused more on administrative controls on access to services.

Today, there are differences in how competition for specialty services is unfolding across the country. In some places, the focus is on new specialty hospitals; in almost all markets, physicians are expanding the scope of services delivered in their offices. And the intensity of competition appears to be weaker in communities where prominent academic medical centers dominate the market and physicians are closely aligned with hospital systems.

The local nature of health care mar-

About the Center for Studying Health System Change

Founded in 1995, The Center for Studying Health System Change (HSC) is a nonpartisan policy research organization focused on trends in the cost, quality and accessibility of health care in the United States and their implications for policy. Instead of advocating for particular policies, HSC serves as an honest broker of information for policy makers, the news media, employers, health care providers, insurers and the public. HSC is funded principally by The Robert Wood Johnson Foundation and is affiliated with Mathematica Policy Research Inc., a leader in evaluating the effectiveness of local, state and federal health, human services and educational programs.

Ultimately, all health care is organized and delivered at ground level—in local communities—where HSC collects information about the changing health system. HSC's main research tool is the Community Tracking Study (CTS), which consists of national surveys of consumer households and physicians in 60 nationally representative communities across the country and intensive site visits to 12 of these communities. Led by Paul B. Ginsburg, Ph.D., a nationally known health economist and health policy expert, HSC researchers combine quantitative and qualitative research from the surveys and site visits to provide policy makers with a vibrant picture of changing health care market dynamics and the implications for health care policy.

HSC recently completed its fifth round of intensive site visits to Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County Calif.; Phoenix; Seattle; and Syracuse, N.Y. In each community, HSC researchers interview between 50 and 100 local health care leaders, including employers, physicians, hospital executives, policy makers, safety net providers and insurers.

kets not only produces different results in different communities; it also influences how change occurs. Despite diversity in configuration, most local health care markets today are comprised of a concentrated set of players—a handful of hospitals and health plans and, in some specialties, a limited number of physician practices—that must interact with each other repeatedly over time. While national and regional affiliations among plans and providers certainly help shape business strategies, recognition that success or failure is highly contingent on ongoing relationships with a small set of players is a strong force shaping health care organizations' behavior in local markets. Indeed, the increased concentration of health plans at the national level has had remarkably little impact on the way they do business in local health care markets.

In some cases, the insularity of local health care markets can obstruct change, as organizations that are so interdependent can be reluctant to press one another too hard. Take for example the experience with tiered-hospital networks. In some markets, hospitals blocked health plan efforts to create tiers based on price and quality, by refusing to accept “non-preferred” status within a network. A number of local, employer-led initiatives to collect and disseminate information on hospital cost and quality of care met a similar fate, as key institutions simply refused to participate. Higher market concentration leads to higher prices, with recent literature showing that this applies to nonprofit hospitals as well.⁵ And a longstanding problem for hospitals is their dependence on referring physicians, which encourages accommodating—and sometimes costly—behavior. “Keeping the physicians happy” is the reasoning behind many hospital decisions to invest in expensive and duplicative technology, inefficient use of operating room time and slow adoption of information technology.



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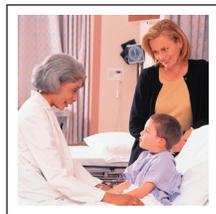
On the other hand, the interdependence of key organizations in communities' health systems can promote collaboration and produce positive results. For example, limited competition and mutual self-interest has prompted hospitals in some markets to work together to respond to emergency department crowding and related ambulance diversions. Similarly, relationships between large provider organizations and health plans in a community can facilitate agreement on uniform quality measures and reporting requirements, as has been the case with the pay-for-performance initiative in southern California.

However, national forces have sparked change in local markets. Take for example how health plans pressured hospitals and physicians in the early 1990s to cut costs and assume financial risk for patients' care. This phenomenon occurred across the country, albeit to varying degrees in different markets. What prompted health plans to suddenly act so aggressively in their local markets? Ultimately, the broader economic climate emboldened plans, as employers, many of whom compete in national or international markets, got

serious about controlling costs during a severe recession, shifting employees into managed care products that had restrictive provider networks.

Likewise, just a few years later, the economic boom of the late-1990s shifted the balance of power in favor of providers, as employers became more concerned with recruiting and retaining employees than with controlling health care costs. The resulting sharp shift in power between providers and health plans in local health care markets across the country led to a spate of plan-provider contract show-downs, when many providers threatened and some actually dropped out of health plan provider networks as they sought better contract terms and payment rates. Again, it was a change in the broader economic climate and in how employers approached health benefits that prompted local organizations to act aggressively and challenge the status quo.

Today, new physician ventures have become an important force driving change in local health care markets. Facing stagnant reimbursement rates for professional services, many physicians have turned



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to investments in specialty hospitals and outpatient surgery centers to supplement their income. These ventures have created new competition for traditional acute care hospitals and challenged longstanding relationships between hospitals and physicians.

Another driver of change is the new Medicare hospital quality initiative, which encourages hospitals to publicly report a small number of quality measures. While reporting is voluntary, hospitals must report to receive a higher inpatient payment rate update. In contrast to the numerous failed local efforts to spur quality improvement through public reporting, the Medicare initiative has been powerful enough to compel almost universal participation. And our 2005 site visits found that hospitals are focusing on improving performance on these measures to be ready for the possibility that patients, employers or plans might use the information to guide care decisions. Although it remains uncertain how extensively purchasers or consumers ultimately will use the data, providers today do not want to take a chance on an environment in which their local competitors are seen as having better quality of care.

The Devil is in the Details

Many fads have come and gone in health care over the past decade. There was a great deal of experimentation with new organizational arrangements to build integrated delivery systems and new payment methodologies in the early 1990s, aimed at giving providers the tools and incentives to control the cost of care and improve quality. As has been well documented, many of these experiments floundered as changes in managed care undermined the promise of these innovations and as many underestimated the difficulty of building successful systems.

Looking back, it was naïve to think that simply creating organizations to unite hospitals and physicians would suddenly lead them to work together in a more constructive manner. Or that physician practices would be productive when owned by either a hospital or a physician practice management company without a substantial investment in management tools to simulate the incentives of private practice. Similarly, it was unrealistic for providers to think that developing a health plan would not be a major stretch beyond their core competencies. And both providers and

plans were naïve to assume that simply by changing financial incentives, organizations would be able to rise to the challenge of managing these incentives and that they would produce the intended outcomes of higher-quality, lower-cost care.

No crystal ball could have predicted that a huge economic boom would largely unravel employers' commitment to tightly managed care as they faced tight labor markets and workers clamoring for fewer restrictions on care and broader access to providers. This cut short the time to figure out ways to get these new organizational forms and incentives to work better. Mindful of repelling workers, employers did not return to tighter models of managed care but instead passed the responsibility for containing costs to their employees through higher patient cost sharing.

One of today's most pervasive "next big ideas" is consumer-driven health care. The concept envisions empowered consumers armed with detailed cost and quality information and a significant financial stake in the cost of care playing an instrumental role in controlling costs and driving quality improvement. In the 12 local health care markets tracked intensively by HSC over the last decade, these critical ingredients of consumer-driven health care are not yet in place. And there is a danger that overselling this concept could cut short the time needed to refine it to make it more effective—much as what happened with managed care.

For example, many current products offer little effective information support for enrollees. There also has been little investment in refined benefit designs that would shield services such as accepted regimens for chronic disease management from high cost-sharing requirements, target higher cost sharing to services with limited benefit or uncertain effectiveness, and emphasize patient incentives to use



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higher-performing providers.

Another development that demonstrates the importance of getting the details right is the nascent pay-for-performance (P4P) movement. Whether P4P will turn into a passing fad or result in quality improvements and increased efficiency will rest largely on physician acceptance of the concept, which in turn will require thoughtful, manageable implementation of P4P initiatives.

Ultimately, a critical lesson from the rise and fall of managed care and the tidal wave of organizational change that accompanied it is that the devil is in the details to produce meaningful, enduring change in the organization and financing of the health care system.

Looking Back...Going Forward

Looking back, there has been tremendous change in the health system over the past decade, and while increasingly competitive, there has been little progress controlling costs or improving access and quality of care. Despite this discouraging finding, there are lessons to be learned from reflecting on the experiences of the past

decade. Looking forward, it is clear that the public will need to be actively engaged in how the health system changes, and that policy makers and health care leaders will need to develop solutions that can win the hearts and minds of the American public if they are to have real traction over time.

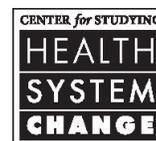
At the same time, strategies to improve health care delivery need to acknowledge the local nature of health care markets and that this affects how change occurs and the extent of its impact. And finally, while much needs to be done to improve the health system and a sense of urgency will help inspire action, there needs to be recognition that meaningful change will not happen overnight.

We need to encourage our political and health care leaders to look beyond the next election or fiscal year and to talk more frankly about real solutions to the enduring problems of high health care costs, uneven quality and inequitable access.

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Notes

1. For a review of major changes that have occurred during this period, see Ginsburg, Paul B., "Competition In Health Care: Its Evolution Over The Past Decade," *Health Affairs*, Vol. 24, No. 6 (November/December 2005).
2. Hurley, Robert E., Hoangmai H. Pham, and Gary Claxton, "A Widening Rift In Access And Quality: Growing Evidence Of Economic Disparities," *Health Affairs* Web exclusive (Dec. 6, 2005).
3. Davis, Karen, and Lucian L. Leape, "To Err is Human; to Fail to Improve is Unconscionable," The Commonwealth Fund (August 2005).
4. Ginsburg, Paul B., and Joy Grossman, "When the Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care," *Health Affairs*, Web exclusive (Aug. 9, 2005)
5. Vogt, William B., and Robert Town, "How has Hospital Consolidation Affected the Price and Quality of Hospital Care?" Research Synthesis Report No. 9, The Robert Wood Johnson Foundation, Princeton, N.J. (February 2006).



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