Top Business Issues for Today's Health Care Organizations

Achieving High Performance in Health Care

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Businesses in the United States have faced serious challenges in recent years—the fear of terrorism and national security threats, the war in Iraq, a struggling economic recovery, a record budget deficit, and a deeply divided political landscape. The health care industry was affected by these events and experienced its own unique set of issues, including the large number of uninsured, the burden of escalating health care and drug costs, and the degree to which the private sector can provide adequately for other public health needs (such as flu vaccines).

What lies ahead for the health care industry? How can health organizations achieve high performance—and consistently outperform competitors? Based on Accenture's experience, industry insights and research, here is our forecast of issues that will have a major impact on the industry in the coming months—and strategies for anticipating the resulting changes.

Recurring issues

Many of the most pressing issues likely to confront health executives in the coming months are not necessarily new. Rather, they are perennial concerns caused by aging demographics, federal and state policies and budget pressures, progress in medical research and technology, and the state of the overall economy. Acute **financial pressures** have plagued health executives year after year. These are not going to subside in the near future. Medical costs will remain a major concern for individual health organizations as well as the nation as a whole.

For hospitals, **profitability concerns** will remain paramount. One-third of the nation's 5,000 hospitals are losing money, and another third are just breaking even, according to the American Hospital Association. In a recent report, Moody's Investors Service reinforced a negative outlook for the not-for-profit health care sector based on minimal volume growth, declines in the growth rate of reimbursement from governmental and nongovernmental payers, increasing expense pressures, unfunded capital needs, and the uncertainties associated with management turnover.

As a result of such forecasts, some hospitals will have more difficulty **accessing capital markets**. The strongest hospitals will still be able to float bonds and attract donations, but for others there will be limited ability to meet debt payments for new capital expenditures, acquire new technology or access needed skills. **Competition** between hospitals continues to be fierce in many markets, especially those in which certificate of need laws were abolished, and general hospitals will continue to face "cherry picking" from single-specialty facilities. In some markets, hospital systems have sufficient market presence to remain strong competitors, but even some of those hospitals face strong competition from free-standing outpatient surgery centers as well as single-specialty hospitals.[1]

Hospitals and other health care facilities will continue to face **staffing pressures** and a shortage of nursing, clinical and IT professionals, in particular. According to the American College of Healthcare Executives (ACHE), more than 70 percent of hospitals are experiencing a nursing shortage. Competition for clinical professionals, especially nurses, has required hospitals to continually increase compensation, exercise flexibility in scheduling, and be creative in their recruiting efforts, all of which increase personnel costs.

As a result of these financial issues, all sectors of the health industry will continue to undergo **consolidation**. Small, independent hospitals will align with larger health systems. Some health plans will seek to enhance their financial performance through structural changes such as **mergers, acquisitions, or conversion** from public to private status. After a several-year lull in which such activities declined for a variety of reasons, 2004 saw an increase in acquisitions. Most industry analysts predict more such mergers and acquisitions in the near term. Other industry sectors, including suppliers, group purchasing organizations, consultants, and vendors will consolidate as well.

[1] The Medicare Modernization Act (MMA) placed an 18-month moratorium on the building of new single-specialty hospitals, but it is not known if this moratorium will be extended when it expires, if any new restrictions will be placed on single-specialty hospitals, or if they will once again be allowed to build new facilities.

While the national spotlight has been focused on quality for many years, recent reports indicate that there is still much room to improve **patient safety**. It has been several years since the Institute of Medicine estimated that as many as 98,000 people die from preventable medical errors in the United States each year. Earlier this year, Health Grades issued a report more than doubling those figures. The Leapfrog Group, a coalition of large employers looking to contain health care costs by reducing errors, recently released a study showing that only 21 percent of hospitals are fully compliant with safety practices developed by the National Quality Forum. More than half of those recently surveyed by the Kaiser Family Foundation said they are dissatisfied with the quality of health care, up from 44 percent in 2000. At the same time, 92 percent said that the reporting of medical errors should be mandatory.

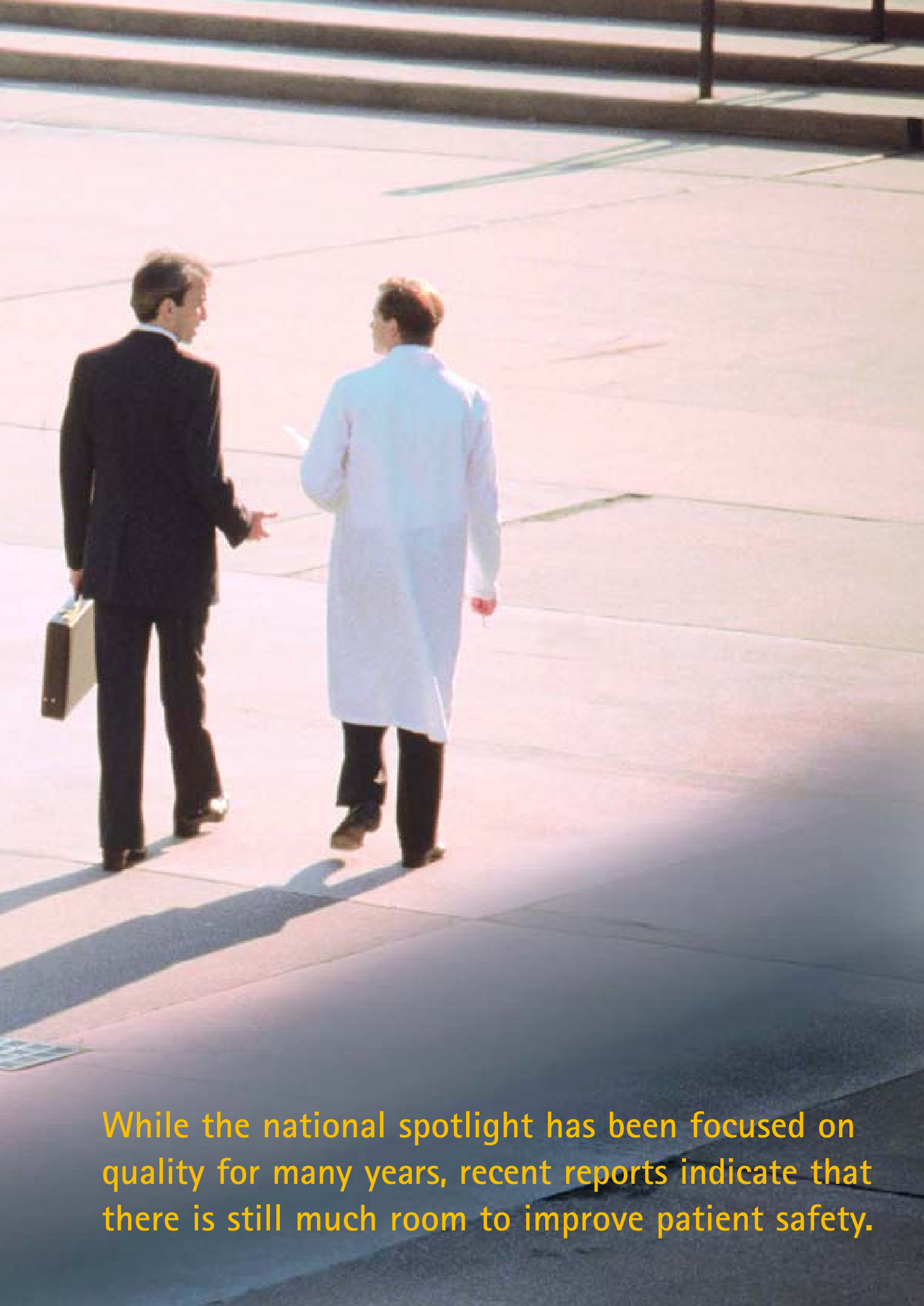
Many health plans have recently seen improvement in their financial performance as a result of higher premiums and an easing in the speed of medical cost growth. Despite the improvement, the majority still have narrow operating margins; the industry's profit margin was 3.8 percent in 2003 (according to Weiss Ratings), and averaged 5 percent among the top 17 publicly traded health plans (according to CBS MarketWatch). In the coming year, health plans will still face **rising medical costs** (though at perhaps a slightly lower rate than in the past few years) and constant pressure to improve their administrative efficiency through process and technology changes.

Employers can expect to see continued **premium growth** well in excess of overall inflation, though the rate of growth has slowed (to 7.5 percent in 2004, according to Mercer Human Resource Consulting) as a result of employers shifting more of the cost onto their employees and changing the kinds of plans they offer. Hewitt Associates is projecting that premiums will grow an average of 11.3 percent in the next year. Hospital inpatient and outpatient procedures and drug costs continue to experience annual growth rates in the double digits. One of the biggest cost drivers continues to be drugs, which are experiencing annual growth rates of about 15 percent.

Cost sharing through higher deductibles and copays, new consumer-directed health plans, and health savings accounts will continue to grow, with employees paying about 19 percent of the total overall cost in 2005, a 15 percent increase from the year before. This represents a reversal of a trend that has been in place for the last quarter of a century: Health care costs have continued to rise, and the percentage of that total paid by consumers out-of-pocket has steadily declined although the actual dollars paid by consumers has increased. Nevertheless, in the commercial sector, employers continue to shoulder the lion's share of the cost of health coverage.

Despite the recent modest economic upswing, the **uninsured** will remain an issue given the lack of a national policy and rising costs that cause small employers in particular to drop coverage for their workers. Provider and payer organizations alike face problems in dealing with a growing uninsured population, estimated at 45 million in 2004. Hospitals will continue to face the issue of how to handle uncompensated care, and its impact on their bottom line.

Hospitals, health plans and pharmaceutical companies will face increased **government scrutiny** of their governance practices. Executives from all sectors of the health industry will be very much aware of the attention that the government puts on their pricing, sales, and charity policies (in the case of not-for-profit organizations). In a few markets, zealous state or federal officials such as attorneys general or regulators have taken a highly activist position in challenging the health care industry with lawsuits and exhaustive audits. With investigations ranging from pharmaceutical drug pricing to insurance broker activities to hospitals' amount of charity care and their corporate accounting practices, no segment of the industry is or will be impervious to public scrutiny.



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The focus in the next year

The financial pressures noted on the preceding pages have plagued the industry for years. What is different now is the mix of issues on which the industry is focusing. Some of these issues are more pertinent to health plans, some to providers; but even though the two segments appear to operate fundamentally different businesses, they are inextricably linked to each other.

Both payer and provider organizations are poised to use technology as never before, and there is increased pressure on **greater use of information technology in health care**. Industry analysts are predicting that the level of IT spending as a proportion of total revenue (historically only 2 to 3 percent in health care) will reach that of other industries (5 percent or higher). Hospitals and health plans are integrating technology across their organizations and into their core business processes.

What is also new is the degree to which technology will be used to influence not just administrative practices, but clinical care delivery as well. Health organizations are leveraging technology to support **data-driven clinical care**. From well-understood systems such as computerized physician order entry programs to digitized radiology systems to major IT clinical support systems, hospitals are increasing their investments in IT to leverage the efficient delivery of clinical care. Health organizations are under continued pressure to have information available at the point of need. Though wireless devices traditionally have not been a major spending area, health organizations are beginning to adopt selected technologies where the up-front costs are manageable and the immediate return on investment is clear. Payers are beginning to experiment with **pay-for-performance** systems that reward providers for defined clinical and patient satisfaction outcomes, not simply cost outcomes.

With medical costs continuing to rise, health organizations are taking a new view of care management. They are instituting new **advanced disease management** programs. These new programs are using advanced predictive modeling techniques to identify "at risk" patients who are about to incur large claims. Technology enables prioritized outreach to these people to encourage them to modify their behavior, to prevent complications and avoid costly hospitalizations or procedures down the road. Combined with a horizontal approach to coordinating the care of patients with multiple chronic conditions (who are by far the most expensive patients to care for), new disease management programs are showing impressive gains in clinical and financial outcomes.

Additionally, providers are **leveraging evidence-based medicine**—leading practices for treating specific medical conditions—through clinical information systems that help to ensure that the most current medical knowledge informs treatment decisions, and variations from accepted practice will be based on the patients' specific circumstances and risks. Such systems, while not generally in use in private physicians' offices, are beginning to become more available to practitioners, particularly in large groups or institutional settings.

Public concerns about patient safety are one of the factors fueling an interest in information systems and **electronic health records** (EHRs). In his 2004 State of the Union address, President Bush stated, "By computerizing health records, we can avoid dangerous medical mistakes, reduce costs and improve care." The Department of Health and Human Services (DHHS) has estimated that a national health information network can save about $140 billion per year through improved care and reduced duplication of medical tests. The fact that the United States ranks 47th in the world in life expectancy underscores the need for improvement, particularly as the United Kingdom, Canada, and many other developed nations are undertaking government-sponsored efforts to develop EHRs.

Many issues remain to be resolved before shared electronic health records are widely adopted. The capital costs are significant, and many health executives are concerned about funding. Regulatory barriers to disseminating information technology (such as the Stark legislation) must be addressed. Technical standards for interoperability must be developed, and the debate over use of universal patient identifiers resolved. Technology must be disseminated beyond the acute inpatient environment and adopted by ambulatory care facilities and physician office practices. The government may encourage health organizations to take action through financial incentives, but ultimately widespread adoption will require that it mandate or pay for shared electronic health records. Given the barriers and unresolved issues, this will likely be more of an issue for discussion and debate than an action item in the coming year.[2]

[2] For a more full discussion of the challenges and opportunities for the electronic health record, see Accenture's reports "Health Information Technology and the Electronic Health Record—Implications for Achieving High Performance in US Health Care" and "Electronic Health Records Survey," both available at www.accenture.com.

Priorities for action

According to Accenture research on high-performance health organizations, those leading the industry commit to continuous performance improvement in administrative costs, medical management and technology infrastructure. Specifically, the top strategies the industry will focus on in the coming year include:

Implementing "pay-for-performance." New thinking around how to pay health care providers is evolving. Pay-for-performance programs use incentives to encourage evidence-based practices that promote better outcomes and ultimately transform the health care system. Simply stated, they are an attempt to directly link reimbursement and quality. The use of pay-for-performance in health care is being driven principally by the purchasers of health care services, including health plans, large employers and government agencies. The growing availability of clinical information technology is starting to make it possible for health organizations to gather the clinical data necessary to administer sophisticated pay-for-performance programs.

Enhancing quality and outcomes reporting. The increased attention on quality will place new demands on health organizations' staff and management talent, increasing the need for process-related training (such as Six Sigma). Health organizations will need business intelligence tools that are integrated with existing information systems and can help them capture, store, retrieve and report quality information. Payers will need information to support their new pay-for-performance programs. Providers will compete for contracts that have elements of quality metrics. As a result, providers will need to be able to measure their clinical performance against industry standards and benchmarks, and health plans will need to be able to compare and evaluate providers. Payers will also need to provide employers with customized data to assist them in managing their health costs. The new consumer-directed health plans (CDHPs) and health savings accounts require that payers provide information on health care quality and costs to assist consumers in making better-informed decisions.

Accelerating technology implementation. With vendor applications growing more complex, implementation time frames have grown. It can take several years for a health organization to implement core administrative processing or clinical information systems. Health executives have begun to recognize that their total cost of ownership far exceeds the capital technology costs. Studies have shown that the majority—roughly two-thirds—of the cost of ownership is labor. In an effort to deliver technology solutions more cost-effectively, health executives are searching for faster ways to incorporate design decisions into the implemented process. Health organizations can accelerate the implementation process by using computer systems to configure vendor products and automate coding, mapping and crosswalks. They will begin to embrace rapid implementation methods that help them focus on reaching their destination, rather than getting lost in the journey.

Evolving toward electronic health records. The vast majority (88 percent) of health executives responding to a recent Accenture survey[3] indicated that their organizations have either already begun to take concrete steps to address the adoption of EHRs, or expect to do so within the next six months. More than 70 percent of the respondents believe that EHRs will have a positive financial effect on their organizations over time. Clinical information systems will be a major area for technology investment in the near future. Many providers will likely adopt electronic prescribing in the coming year, with financial assistance from payers who stand to benefit from enhanced formulary compliance and generic drug usage. The federal government is encouraging the use of electronic prescribing as a way to reduce medication errors. Given their financial pressures and limited access to capital, health executives will demand a business case to justify major investments, and look for a demonstrable payback. The move toward fully functional, shared EHRs will be slow—particularly in more fragmented markets where market share is distributed across numerous payers and providers. But in more consolidated markets and where a significant proportion of the population is covered in capitated insurance arrangements, some progress can be expected in 2005.

Leveraging the Web to empower consumers. In response to the consumer movement and patients' desires to be more involved in their care, health executives are seeing an increased demand for systems to allow consumers to access their medical information online. Many health plans are developing advanced self-service portals that allow consumers to perform administrative functions (enrollment, eligibility, registration, claims, etc.) to improve efficiency and lower costs. By shifting customers toward self-service portals, payers can reconfigure and reduce the costs of their call centers. In the case of CDHPs, providing consumers with information to help them better manage their benefits, including integrating the various funds, has now become a requirement of the market. Some of the more innovative provider and payer organizations are exploring the potential to allow patients and caregivers to manage chronic diseases electronically, monitoring vital statistics and other clinical information through clinical portals.[4]

Finding new solutions to old problems through collaboration. Recognizing that their own independent initiatives have limited benefits, payers and providers

[3] Accenture's report "Electronic Health Records Survey" describes the survey findings. It can be found at www.accenture.com.

[4] Accenture's report "How Health Plans Are Using the Internet to Reach Customers" details the functionality offered by payer websites. It can be found at www.accenture.com.

will begin to work together to improve administrative efficiency, customer service, and clinical outcomes. They will establish more efficient linkages for eligibility, enrollment, denial management, registration and scheduling processes to reduce time and administrative costs. Just as critical, they will both change their business processes through collaborative efforts. For example, by working together, they can help reduce denials and speed reimbursements, thus reducing administrative costs for both. Connectivity and collaboration can bring payers, providers and life science vendors together to share data with each other and with local, state and federal governments, facilitating development of electronic health records.

Savvy executives are using outsourcing as a strategic tool to deliver talent, tools and solutions to significantly raise overall business performance.

Consolidating back-office functions to reduce overhead. Heightened financial pressures and industry consolidation will necessitate that health care organizations scrutinize all areas of their operations for any opportunities to minimize costs. Health plans will attempt to achieve greater economies of scale in back-office functions through IT-supported improvements in efficiencies, growth and additional mergers. They will integrate and modernize their legacy systems across previously siloed business functions. Driven by continued declines in health insurance coverage for employees, providers will implement tighter front-end identification of co-payments and deductibles to address patients' financial responsibility earlier in the revenue cycle. Some will take a holistic view of their revenue and expense management, looking at their revenue cycle and supply chain processes in an integrated manner—from the moment supplies are purchased until an item is used and billed to a patient—for performance improvement opportunities.

Managing capacity. For hospitals, capacity challenges affect service availability and limit revenue growth. Nearly six in 10 hospitals are experiencing a capacity crunch, according to a survey of health executives conducted by the ACHE. Increasing demand and per case reimbursement create strong financial incentives for hospitals to improve the flow of patients within their facilities and across the continuum of care. Hospitals will look at creative capacity management solutions to reduce lengths of stay, service delays, and hours on diversions, and free capacity to provide room for service growth.

Addressing new markets. For payers, passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) introduces the most significant changes to Medicare since its inception in the 1960s, and will cause some payer organizations to consider re-entering the Medicare market. Additionally, many payers find themselves with a need to address consumer demands for more empowerment and employer demands for more cost controls by developing CDHPs that include health reimbursement accounts, tiered benefits, and customizable services. These new markets will require payers to extend their technology focus from administrative efficiency to customer outreach.

Leveraging strategic outsourcing. Accenture research shows that outsourcing can be critical for becoming a high-performance organization: one that consistently outperforms its peers over a sustained time frame. Because outsourcing is more important than ever, health plan executives need to understand how to exploit the value opportunities beyond saving in labor costs—to further drive cost savings and achieve performance outcomes that endure. Savvy executives are using outsourcing as a strategic tool to deliver talent, tools and solutions to significantly raise overall business performance.

A future of high performance

The challenges that face the health industry today will lead to transformation in the near future. Change will be lead by industry players that Accenture has identified as high-performance health organizations. Some of the hallmarks of these organizations: They share a relentless focus on business insight, continuous performance improvement and growth. They empower their organizations with critical business information and anticipate and respond to market shifts, enabling a greater focus on producers, segments and customers. The end result: high-performance health care for plans, providers, payers and—most importantly—patients.

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About Accenture

Accenture is a global management consulting, technology services and outsourcing company. Committed to delivering innovation, Accenture collaborates with its clients to help them become high-performance businesses and governments. With deep industry and business process expertise, broad global resources and a proven track record, Accenture can mobilize the right people, skills and technologies to help clients improve their performance. With more than 115,000 people in 48 countries, the company generated net revenues of US $13.67 billion for the fiscal year ended August 31, 2004. Its home page is www.accenture.com.

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