

HB

47

HOUSE COMMITTEE REPORT

(7)

Date Referred: January 9, 1989

FURTHER REFERRALS: LABOR & COMMERCE
FINANCE

Date of Committee Action: 4/1/90

The HEALTH, EDUCATION & SOCIAL SERVICES Committee recommends that:

HOUSE BILL NO. 47 [CATASTROPHIC ILLNESS INSURANCE]
"An Act relating to catastrophic illness insurance; and providing for an effective date."

[] be replaced with _____ [] the same title
[] a new title

[] have attached amendment(s)

- [] do pass
- [] do not pass
- [X] no recommendation
- [] individual recommendations
- [] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(S):

- [] fiscal impact
- [] zero fiscal note
- [X] zero with analysis

APPROVES PREVIOUS:

- [] fiscal note(s) published: _____
- [] zero fiscal notes(s) published: _____

SIGNING DO PASS:

Peter Jones

SIGNING OTHER THAN DO PASS:
(Do Not Pass, No Recommendation, Amend)

W. Furnace no rec.
W. Krenberg no rec.
Scott no rec.
Mark no rec.

P. J. Ellis
Chairman's signature

FISCAL NOTE

REQUEST:

Revision Date: _____ Agency Affected: _____
 Title: Relating to BRU: _____
 Catastrophic Illness
 Sponsor: Rep. Koponen Components: _____
 Requestor: (H) HESS

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL						
---------	--	--	--	--	--	--

REVENUE						
---------	--	--	--	--	--	--

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

Division of Insurance will present a fiscal note upon
hearing HB 47 in the House Labor & Commerce Committee

Prepared by: Jim Nordlund *Jim Nordlund* Phone: 465-3759
 Division: House HESS Committee Date: 4/5/90

Approved by Commissioner: _____ Date: _____
 Agency: _____

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SPONSOR STATEMENT

HB47

HB 47 is identical to SSHB 410 which I introduced in the 15th Legislature to act as a working draft for a solution for uninsured and underinsured Alaskans. We all know of relatives, friends, or friends of friends who have found themselves in the unfortunate position of desperately needing medical care and not being able to pay for it. An estimated 7-10% of Alaskans are uninsured. Alaskans are like most other Americans - most of those who are uninsured are employed. 40% of the uninsured are children.

There are several concepts behind HB 47 which distinguish it from some other current bills dealing with the issue of access to health care. HB 47 includes a single pool concept, which would allow for good planning and shared risk. It has a deductible (of \$5,000). It is capped on a per person, lifetime basis. It would be funded by utilizing a portion of income of the Permanent Fund and would provide a nontaxable benefit to Permanent Fund recipients. I believe it would also reduce the hold harmless paid by the State to the federal government for Alaska welfare recipients and as a universal access program should lower the cost of workers' compensation.

Entrepreneurialism ran rampant and forgot sound management principles.

The Failed Revolution in Health Care — The Role of Management

by Regina E. Herzlinger

The American health care industry is sick. Its huge fraction of our GNP—one out of every eight dollars—is double that of Japan and at least 50% higher than that of other developed countries. Because it is growing at rates 50% higher than the GNP, the industry's cost hampers control of our disastrous trade deficit.

Even so, despite the sums they spend on health care, many Americans cannot get the services they need or want. Plagued by the ubiquitous ailments that reduce their productivity, like backaches, sore feet, and digestive difficulties, Americans find services to be fragmented, impersonal, inconveniently located, and offered at unsuitable times. Then there is the quality of the care itself, which is notoriously erratic. Although our health care system excels in heroic procedures that save lives, more common procedures are less expertly provided. For example, most experts concede that only a fraction of the 700,000 hysterectomies performed every year can be medically justified.

Regina E. Herzlinger, holder of the Nancy R. McPherson chair at the Harvard Business School, is a member of the control faculty who also teaches a course in health care management. This is her sixth HBR article on this subject, beginning with "Can We Control Health Care Costs?" (March-April 1978).

In response to demand and to the perceived inadequacies of the system, new organizations sprang up in the 1970s to deliver more efficient service, new organizations to upgrade the quality and accessibility of care, and new organizations to exploit the extraor-

Entrepreneurs saw a big opportunity in the health care industry.

dinary advances of molecular biology and computer science. They were the forebears of a revolution that in the 1980s was supposed to transform the health care

New organizations were not like the hospitals, medical suppliers, and the care providers of an earlier era that grew slowly and cautiously to become fixtures on the landscape. Often launched by entrepreneurs, these were upstarts—HMOs, nursing home chains, health-related businesses—that looked to the financial markets for nourishment. And the financial community fell in love with their prospects and tapped the spigots that let billions of dollars flow. One securities analyst giddily predicted that virtu-

ally all Americans would eventually be enrolled in new health care organizations. After U.S. Healthcare's initial public offering in 1983, the price soared to 7.4 times earnings.

The entrepreneurs were well rewarded. The fabled Abe Gosman, a skilled real estate developer and banker, began Mediplex, a nursing home chain, in 1983, took it public in 1984, and sold the company to Avon for \$300 million in 1986, netting more than \$100 million. Like him, the entrepreneurs who entered the industry were challenged by the prospect of transforming the sluggish giant—filled with business-as-usual administrators and detail men—into a sleek machine delivering efficient, convenient, and technologically advanced services and products. They recognized the importance of the cause, health care, they thought, is nobler than Pringle's.

Abetting the revolution were two powerful sectors: government and large private employers, allied in this case by their alarm over skyrocketing costs. By 1985, the health care costs of the average big company were growing so fast that they would equal its net income by 1993.¹ Uncle Sam quailed at the prospect of paying to maintain the well-being of a surprisingly resilient and fast-growing elderly population. A shot of good, old-fashioned competition—as just the medicine the government wanted. That, of course, was business's natural inclination as well.

Business and government used their enormous purchasing power—paying for more than 80% of health care bills—to push and prod the system to respond. When the federal government started limiting its hospital payments to a fixed price for the service rendered (through so-called diagnosis-related groups, or DRGs) in the early 1980s and the private sector initiated a host of audit techniques to review health care providers, the stage was set for the revolution.

But the revolution failed. Despite the ability of the entrepreneurs, the enthusiasm of its powerful backers, the billions of dollars spent to fuel its engines, the nobility of the cause, and the clarity of the mandate, it failed. Despite the vaunted efficiencies to be created by new services and competition, costs proved intractable. Services remained inconvenient and variable in quality. The scientific breakthroughs that pioneers have created have yet to be reaped as effective medical technologies.

What went wrong? I claim that the failure was almost entirely that of management, not of strategy, that the creators of these new organizations were so blinded by the vision of the dazzling new world they hoped to forge that they neglected the details of management that would breathe life into their vision. My purpose in this article is to reorient the revolution to

a second stage that will be guided by those who believe that in management, as in architecture, God is in the details.

The Altered Scene

The revolution grew out of profound changes in technology, in population characteristics, and in social expectations of what health care should be.

We are most familiar with the technological changes. Laser and microsurgery, pharmacological miracles, ultrasonics, magnetic resonance imagers (MRIs), and other computer diagnostics, transplants, and artificial joints and organs—all these innovations increasingly enable health care providers to do what was once unimaginable.

And the promise is breathtaking. Genetic engineering itself not only will offer better, more specific, and safer therapies for sick people but also may permit actual prevention of disease by correcting genetic defects that cause it. The increasing cost-effectiveness and user-friendliness of computers promise instruments that vastly expand our ability to diagnose, monitor, cure, and account for the cost of disease. These instruments may eventually replace one or another of the five senses; hearing has already been restored in some completely deaf people through electromechanical ear implants.

In the last decade or so, entrepreneurial "techie" have created hundreds of companies, ranging from the biotech miniatures that surround most major medical schools to the giants that make big, computerized diagnostic equipment like MRIs and CAT scanners, to the aggressive ventures marketing clinical and management information systems.

The aging of the population is the most important demographic phenomenon; it has prompted the rise of a whole subindustry of geriatric care. Also significant is the altered status of women, the largest consumers of health care and the prime agents for their families' purchases. Their rising income, declining free time, and growing dissatisfaction with traditional health care have shaped enterprises aimed solely at them, including birthing centers and no-appointment-needed neighborhood emergency care providers.

The new status of women also affected the supply of services. The trend toward a corporate practice of medicine, with physicians working under the direction of a manager who was to help them establish more efficient, standardized service, was facilitated by the growth in the number of female MDs from virtually none in 1969 to nearly 25% of the total by

decades later. Many of them and their spouses (particularly the ones with young children) were willing to trade the independence and high income of the fee-for-service doctor for the more limited responsibilities of a salaried employee.

But the dependably subservient army of women health workers—nurses, technicians, aides, and dieticians—increasingly found more rewarding and more lucrative opportunities elsewhere. By 1986, for the first time, the number of female college freshmen interested in becoming doctors exceeded those interested in nursing.

Meanwhile, Americans' expectations of the care delivery system were changing; people were increasingly charging it with keeping them healthy instead of just treating their diseases. Better educated and more self-sufficient than their forebears, they considered themselves the best instruments for health maintenance, and acted accordingly. The remarkable drop in the incidence of cardiovascular disease, for example, was greatly leveraged by individuals who reduced their cholesterol intake, stopped smoking, and pursued fitness regimens. To serve them, fitness clubs, weight-reduction emporiums, and other health-promoting enterprises sprang up.

An overriding concern during this time of upheaval was the cost of health care. Even doctors overwhelmingly rated costs as their number one worry about the system. Groups formed to "manage" care spread quickly. The most popular were HMOs (health maintenance organizations), which combined insurance with care delivery functions—thus offering an incentive to limit the cost of care to the price of the insurance—and PPOs (preferred provider organizations), in which the "preferred" physicians and hospitals discounted their fees.

Many hospitals integrated vertically to supply comprehensive services, ranging from health insurance to community-based outpatient care, and integrated horizontally into chains to obtain economies of scale. Nursing homes, medical equipment suppliers and manufacturers, distributors, and pharmaceutical companies also sought to integrate for the sake of scale and product-line efficiencies.

Health care quality became a universal concern. Doctors, insurance companies, the federal government, and consumer groups

questioned the necessity for some procedures and called attention to the great variability in utilization pattern—across the medical profession and around the country. Organizations to monitor the quality of care emerged, as did national health care chains that promised to furnish consistent and appropriate levels of service. As knowledge of the ills of the system grew, attention began to shift toward measures to rebuild and reinvigorate. They added up to a promise of more responsive, less expensive care, committed to maintaining health as well as healing the sick.

What Went Wrong?

The promise has given way to discouragement and stagnation. Costs have not only continued to climb at staggering rates—50% higher than the CPI in 1988—but also have become so unpredictable that insurance companies cannot price their packages correctly. They lost about \$7 billion in 1987 alone.¹ In a survey I conducted last year of all publicly listed companies, 70% of the CEOs complained about the rise in health care costs and nearly 50% felt they could not control them.

Evidence of continued serious quality problems abounds. When half the surveyed doctors do not know the American Cancer Society's guidelines for cancer checkup, how good is the advice they give their patients?² Coronary angiography, widely used to detect coronary circulatory problems, was shown to



be inappropriate in 17% of cases studied.' There is considerable doubt about the need for the astonishingly high number of Caesarean birth procedures performed (nearly one million in 1987). In a poignant description of a hospital's treatment of his infant granddaughter, one physician asked, "Is Brutality Now Our Standard of Care?"¹⁵

To be sure, this decade has seen important surgical innovations that permit many patients to shorten their hospital stays or to avoid them altogether. And there have been impressive gains in heroic procedures like transplantation of hearts and other organs. Moreover, of course, many care providers continue to give dedicated, excellent service.

But the new organizations have almost universally failed to meet their promise. A glance at the stock market tables says a lot: Hospital Corporation of America (HCA), a high of \$57 in 1983, priced at \$43 at this writing; U.S. Healthcare, an HMO, high of \$23 in 1986, now at \$6; Manor Care, a nursing home chain, high of \$26 in 1986, now at \$14; Cetus, a biotech company, high of \$42 in 1983, now at \$11. Many of the biotechnology concerns are financially precarious. Most of the HMOs and hospital and nursing home chains have posted losses or seen severe curtailment of their earnings growth. Many companies that invested in health care enterprises in the early 1980s are sorry they did. Avon Products, for one, just wrote off hundreds of millions in losses.

Entrepreneurs were obsessed with growth and single-mindedly focused on marketing.

The usual reason for failure: the entrepreneur's obsession with financing and fixation on marketing. Although a fledgling enterprise understandably must attend to securing its capital and its place in the market, the health care entrepreneurs gave too little thought to how the organization should be run.

Just like any other business, such organizations require, for example, excellent accounting systems for tracking costs. Technologically innovative companies need organizational frameworks that enhance the research function and control systems that balance the technologists' creative activity with the company's financial resources. Moreover, every new enterprise needs to be guided by a philosophy about centralization of power that reflects appropriately the circumstances of the business and its growth potential. When a company is run well, earnings growth should take care of itself.

But financing fixes to "create" growth were a standard part of the scene, especially among hospital chains. They usually involved restructuring of sources of capital and optimistic accounting to generate high returns on invested capital. The chains' practice was to buy hospitals, revalue the assets, and borrow up to 80% of the purchase price. The resulting leverage lifted return on equity into the stratosphere—enabling, for example, one company to achieve a 24% ROE in 1985, though its return on sales amounted to a more modest 10%.

When hospital utilization dropped, new financing fixes emerged and Wall Street continued to fund them. Some chains formed ESOPs that "bought" their lower performance hospitals, with junk bonds as the vehicle. In one stroke, they got rid of a drag on earnings and posted a gain on the sale! Later, when the market seemed to turn sour on their newly fixed earnings, they turned to yet another approach and sought to go private.

The nation's 6,000 nonprofit hospitals, beset by the same empty-bed problem, also used financial fixes extensively. Many restructured into holding companies with for-profit and nonprofit subsidiaries. The lower costs produced by their tax exemptions enabled the nonprofits to underprice the tax-paying businesses with which they increasingly competed.

Certain entrepreneurs could not resist the temptation to indulge in creative accounting to impress their bankers. Many HMOs held constant their "reserves for contingent liabilities for claims incurred but not yet filed," while revenues climbed dramatically. In other words, they understated expenses. The nonprofit holding companies usually provided financial statements only for their money-losing hospitals, to maintain their tax exemptions and to keep donations coming, while obscuring any favorable results of their for-profit units.

Some entrepreneurs were particularly clever as financiers. The head of Health Stop, the nation's largest chain of ambulatory care centers, got much of his financing from hospitals that paid \$250,000 to \$1 million each for the right to put their names on the centers' doors. Although the hospitals were sure that the centers would create new patient bases for them, the credibility of a hospital's name on the door probably created a patient flow for the Health Stops they would not otherwise have had.

Where was Wall Street while these financial machinations were going on? The financial community restricted its criticism to the attire of these new entrepreneurs, snickering at their "la la" look and open shirts.

The biotechnology companies are also preoccupied with financing; but for them it reflects the

unfortunate realities of the U.S. capital markets. Although their research has been very productive, the hundreds of millions of dollars needed to bring a drug to market through clinical trials to determine efficacy and safety are beyond the resources of nearly all biotech companies—at least since October 19, 1987. So the entrepreneurs are forced to give away much of their technology through contingent licensing and joint-venture agreements with established pharmaceuticals. Will their techie creativity survive these bear hugs?

The marketing efforts of health service entrepreneurs often held out a promise that the actual delivery of the service could not meet. For example, the widely touted “women’s programs,” created in response to women’s complaints about inadequate services, are usually no more than a referral source to traditional care providers. One hospital’s ignorance led it to trumpet its PMS (premenstrual stress) program as dealing with women’s *postmenstrual stress syndrome*.

Instead of sound cost-accounting systems, the new managers looked for financing fixes.

For hospitals, buildings and building additions are an important part of marketing: they signal solidity and promise modernity and new services. So, while thousands of hospital beds lie empty, hospital construction proceeds at a swift rate, with \$2 billion in investment in 1986.

Technology-based companies sometimes fall into a trap of confusing market glamour for product fit (another responsibility of management). There is the case of the talented former Digital Equipment engineers who started Computers in Medicine to sell an integrated clinical and management information system to the fast-growing doctors’ group-practice market. It was a technological marvel, complete with touch-screen and voice-recognition capabilities to appeal to the computer-leery doctor. The engineers positioned the system as the Mercedes of its class, a beautiful \$100,000 machine.

But Mercedes-driving doctors turned out to be very hard-nosed when buying computers. Technology held no magic for them, especially when offered by a company with no history. They wanted service assurances that the company could not provide. Computers in Medicine failed.

Like this advanced information system, the much-touted expert systems have made little headway

with medical practitioners. The brilliant MDs designing these systems have trouble empathizing with the mass of physicians who are uncomfortable with computers or unwilling to abdicate their decision making to a machine. User-friendly expert systems that support doctors’ decision making, instead of supplanting it, have yet to be designed.

The biotechnology companies have also had difficulty selling advanced concepts to their conservative, wary clientele. A case in point is the largest of them, Genentech, which, after surmounting many regulatory hurdles, finally brought its long-awaited clot-dissolving drug, t-PA, to market. But 1988 sales fell far short of expectations because the company did not foresee the difficulty of convincing doctors of the efficacy or cost-effectiveness of the innovative cardiological therapy that t-PA represents.

Similar marketing misperceptions have also bogged down health promotion companies. No question there’s a market out there: 50 million Americans smoke, 23 million are drug abusers, 18 million are problem drinkers, and 10% of adults are so obese that they jeopardize their lives. But health is customarily promoted by true believers who cannot empathize with the destructive life-styles of those who most need their services. So in aerobics classes you see athletes with 20-inch waists or necks working out, while the potbellied, hard-breathing smokers who most need the exercise are elsewhere because the instructor has not tailored the program to their needs and abilities.

Missed Opportunities

While the entrepreneurs were busy devising financing and marketing schemes, they missed opportunities to improve the quality and efficiency of health care in four key areas: administration of operations, management of human resources, management control systems, and the formation of a management philosophy.

Operational Administration. The health care system too often delivers service in inconvenient settings, in ways that are inconsistent if they are subject to the individual preferences of physicians, and in ways that demonstrate too little regard for patients or clients.

Everybody has heard a horror story about a hospital stay that reflects the depersonalization felt there. (Professional staff, for instance, may refer to patients not by their names but by their illness or the procedure used, like “the cabbage in 312” — a cabbage being a coronary artery bypass graft.)

The entrepreneurs who started Nutritional Management offered help to morbidly obese people who weigh two or three times their ideal weight and have high risk of illness and premature death. Their protocol of fasting, tailored exercise plans, and behavior modification regimens held great promise. The key to the program was the support given these seriously ill and depressed individuals in transforming eating and exercise habits so they could maintain weight loss. But the support included only 20 minutes a week with their counselors and 10 minutes a month with their physicians. Not surprisingly, the company folded.

The women's program at the Charles River Hospital in Massachusetts, in contrast, represents sensible operational administration. Instead of simply relying on traditional therapy, the psychiatric hospital studied its clients' needs. It identified the importance of close personal relationships in women's perceptions and structured a program consistent with that view, in the therapy sessions and also in the world they would reenter following their hospital stays. After discovering that some patient problems, like sexual abuse, were so repugnant that the staff avoided dealing with them, Charles River also offered therapy to staff members.⁵

Many emergency health care centers exhibit a wide gap between concept and actual operation.

What distinguished one psychiatric hospital's program for women was its study of the clientele's needs before starting the therapy service.

Created to supply no-appointment, no-wait service to working parents and people with medical emergencies, they have become instead as slow in service as any hospital emergency room. Patients often have to wait an hour or more. Many centers have failed to give their doctors (who are salaried) clinical guidance or managerial training, or to motivate them. Consequently, the centers have suffered from high physician turnover rates, frustrating their avowed aims of continuity of service, friendly atmosphere, and physician involvement.

Compare this situation with Health Stop's policy. It rewards doctors directly for building volume and delivering the efficient, patient-centered service that makes people want to return when they next need treatment. Each center is now divided into two entities: one, Health Stop, for the delivery of care, which

is owned by the physicians; the other, Wellesley Medical Management, for administrative services like accounting, maintenance, and billing, which is owned by management. The doctors' equity stake influences them to look at their place of employment differently. They learn, for example, to schedule employees' work in a cost-effective way and to look for ways to shorten patients' visit time. Yet they become mindful of the benefits of having a satisfied clientele; a clue is the fact that they often telephone patients to inquire about their progress.

Human Resources. In many segments of the health care industry, those employees who are at the most critical point in fulfilling the purpose of the organization—that is, in close and frequent contact with the "customer"—are often given the lowest pay and the lowest status. In nursing homes they are the aides, denigrated by their very job title. Mismanagement of this worker group has undermined the delivery of new services to the elderly. Few are the organizations, for-profit or nonprofit, that have ignored stereotypes of income or career paths and have carved out satisfactory roles for nursing home aides and workers of similar status.

The shortage of nurses is a case study of human resource mismanagement in the health care industry. Although nurses are the backbone of hospital service, their career prospects are limited. Their salary scale is compacted to a \$24,000 range between the base salary of a staff nurse and that of the director of nursing services (depending on the section of the country), peaking at an average of \$39,000 for the director of critical care nursing—a small increment for a 20- to 40-year career.⁷ Only 6% of supervisory nurses got incentive payments in 1986.⁸

Moreover, their work has become increasingly difficult: while hospital patients became "sicker and left quicker," institutions' support staff numbers shrank and left the nurses with more paperwork and tasks not directly connected with caring for patients. More important, the role of hospital nurses has become rather unclear as they have specialized—*are they allies or competitors of the doctors?* Lingering sexism compounds this problem, as some doctors cannot deal with the financial demands and independence shown by the once subservient nursing profession, 97% of which is female.

A program at Boston's Brigham and Women's Hospital is a notable attempt to manage this problem. In an effort to establish a distinct professional identity and to reinforce nurses' self-esteem, the hospital encourages them to spend a great deal of time articulating what they do. To enhance patients' and nurses' satisfaction, patients are assigned "primary nurses" who are responsible for all their hospital care and for

all subsequent visits. The hospital looks for ways to foster physicians' respect for the nursing staff. In one seemingly trivial change (but significant to all concerned), nurses are entering their observations directly in the patient's medical record, next to the doctor's note, rather than in the back of the record, as in the past.

Nurses are also encouraged to explore various career options, like research. The results have been rewarding. When a nurse group's study of premature infants' care, for example, found that the practice of tying their limbs to the four corners of the bed (so they wouldn't dislodge their support tubes) stunted their growth, Brigham and Women's nurses designed a womb-like environment in which the preemie's fetal position stimulated rapid growth. The hospital provides intense career counseling, supported by heavy doses of training and internal public relations. These measures have eased the impact of the nursing shortage in the hospital and have helped the hospital's nurses grow professionally.

Control Systems. Managerial control systems to track costs and establish the organizational basis for operations are a critical component of any for-profit or nonprofit entity. These systems consist of a structure, which divides the organization into the units responsible for carrying out the work, and an accounting system that continuously evaluates their performance.

Many health care organizations lack either aspect of a managerial control system. Some HMOs even lack accounting systems. One fast-growing HMO had no CFO or controller during a period when it was entering into fixed-price contracts to deliver its services. Not surprisingly, it later suffered heavy losses. It is no secret that healthy young adults dominate the rosters of HMOs. As these members age, however, the absence of a firm fix on costs imposed by a good managerial control system may prove fatal; clever marketing cannot substitute for it.

Some entrepreneurial companies providing patient-centered health care have remained traditionally organized—that is, by the doctors' specialties, not the patients' needs. This structure is akin to organizing an auto manufacturer by its suppliers of wheels, batteries, and steel rather than by the components of the car—engine, chassis, and so on. Although the traditional organization gives the physicians a peer group, it also sets up a barrier for the many patients with cross-specialty needs, like those with back problems or chronic pain, and undermines assignment of responsibility for an outcome—because no one person is accountable.

This functional structure makes it difficult to identify the costs of a service and the relationship



Physician	1985	1986	1987
B	22	10	7
C			
D	12	10	8
E			
F	9	10	9
G			
H	12	10	5
I			
J	11	11	12

Source: Mediquip Systems, Inc.

between cost and price. Because the dispensing of a service usually cuts a loss many functions, cost accounting and billing become horrendously complicated. The absence of accurate cost-accounting data forced the federal government to derive its DRG system through econometric analysis.

The Cleveland Clinic Foundation has one of the few institutions with enough cost-accounting and control competence to permit it to quote fixed prices for 17 procedures, including all physician and hospital costs. Virtually no other hospital can quote a fully bundled price. The clinic's concentration in certain medical specialties such as cardiology simplifies its cost accounting. While a few other hospitals are also specialized, like Shouldice Surgery near Toronto that treats only hernias (and tracks work requiring correction to the surgeon involved), most are multifunctional and so cannot derive the economies and other managerial benefits of concentration.

Having good cost-accounting data can cut costs. For example, Cardinal Distribution, a successful regional wholesaler located in Ohio, developed a PC-based inventory control system for its client pharmacies. The system tripled inventory turnover and reduced the necessary number of employees for purchasing and billing.

Having good clinical data can significantly improve patient care. The table shows the results when a hospital installed a quality monitoring system. Over a two-year period, the incidence of illness, after treatment for heart failure and shock, in the patients of the ten staff physicians declined generally, and in several instances dropped sharply.

Control difficulties can plague biotechnology companies that are organized according to scientists'

specialties, like molecular biology, rather than by product line or disease category. This structure inhibits product development. Sometimes it appears to exist mainly to help a fledgling company dazzle potential investors with seductive but cryptic displays of scientific wonders. Many of these startups lack the cost-accounting ability to control their cash "burn rate," so they can fail if the equity market collapses.

Management Philosophy: Some health care entrepreneurs, especially those in service delivery, are sheepish about their business status—perhaps because of the academic doctors' frequent attacks on the "medical-industrial complex." Typical is the attitude of Keith Brodie, a psychiatrist who is president of Duke University. In a lecture he lambasted "the bete noire of rampant entrepreneurialism" in health care.¹ Such scorn leads to denigration of a business focus and a sensible managerial viewpoint.

Some health care executives proudly declare that they embrace a philosophy: they are decentralized. But their espousal may represent an easy out of the tough job of managing (or a bow to pop management), not a thoughtful response to the organization's needs. Often they lack the management control systems that make decentralization work. One large hospital chain I studied operated on a decentralized basis, but its "model" information system could not identify the key group of doctors who admitted more than 40% of its patients.

Tight centralization, however, was the philosophy of David Jones, who built Humana to the point where at one time the company earned nearly as much from its 80 hospitals as its largest rival, HCA, did from its 350. Humana boasted excellent management control systems. Jones, a CPA, pored over minutely detailed reports and created probing internal competitive devices such as a monthly ranking of all hospitals according to profit margins, receivables turnover ratios, and bad debt rates. When utilization fell, the chain used its information system to help it design new insurance products whose price was based on the low marginal cost of a day in a Humana hospital.

It would be gratifying to be able to report that Humana had reaped its just rewards. But it lost nearly a quarter of a billion dollars from its insurance products. The centralization philosophy left too little room for development of managers capable of running the new business, and Humana's top managers could not respond appropriately to the needs of the fast-growing, dispersed markets they had entered. Maxicare, an HMO, ran into the same problem. Its carefully crafted centralized management system could not keep up with the company's growth, and Maxicare too had no bench of management stars to

Ideas for Future Health Care Entrepreneurs

Category	New Technologies	New Consumers
Cost	Assemble and assemble services (e.g., foot and hand monitoring)	Widespread health care (stationary, lower back pain management, hypertension control, care for sick children, elder care)
Efficiency	Use unmonitored devices to monitor health (e.g., for hypertension control)	Focused facilities (foot care, back pain, breast care, headaches)
Quality	Use unmonitored devices to monitor health (e.g., for hypertension control)	Adopt a "granola" approach
Access	Use unmonitored devices to monitor health (e.g., for hypertension control)	Pharmaceuticals from the home (e.g., for hypertension control)
Marketing	Use unmonitored devices to monitor health (e.g., for hypertension control)	Home health care TV shopping network

Author's note: I have compiled this table with the help of many enterprising colleagues, businesspeople, venture capitalists, and students.

offset the systems' limitations. Maxicare is teetering on the brink of bankruptcy.

Regional cost variances in health care compounded these companies' difficulties. Per capita expenses in New England, for instance, exceed those of the Mountain states by 40% for hospital service and 50% for nursing home care.² Operating a closely centralized organization in such an environment, particularly during a time of fast growth, is difficult. Recognizing this truth, Humana eventually scaled back to the few regions in which it owned hospitals and to a level at which its centralized systems could comfortably operate. The company has posted big earnings gains in the last two years.

Author's note: I am grateful to Jane Newman for her assistance in the preparation of this article.

A few health care companies have benefited from decentralization. Bristol-Myers' notably graceful acquisition of many companies over the years was made possible by a management philosophy that enabled each new unit to maintain those features central to its success. So, in 1986, when Bristol-Myers spent \$300 million to buy Genetic Systems, a biotech company, Wall Street did not view the investment as particularly risky, despite the ostensible handicap that the company's only assets, its scientists, were not owned.

Bristol's philosophy recognizes that its many businesses, spanning hair care products to cancer drugs to Bufferin, require quite different management styles. This is a notion that even much smaller health care concerns have not recognized. The consequences have not always been advantageous to the business, as the case of Beverly Hospital shows.

To distinguish itself from other small community hospitals north of Boston, Beverly Hospital decided to diversify. A part of this successful program was a birthing center that featured a supportive environment for mothers delivering naturally, without medication. Running the center was a team of nurse-midwives whose clinical training and shared counterculture values made them ideal supervisors of this alternative birthing site.

But the hospital's administration did not see eye to eye with the nurse-midwives. Management's insistence on a hierarchy, despite the nurses' view of themselves as equal partners in a flat organization, sparked an irreconcilable conflict. Finally, the senior nurse-midwife in charge (also a founder) resigned, "protesting the encroachment of hospital standards" on midwives' services.¹¹

The Second Stage

The American health care system still offers great opportunity for innovation—possibly as much today as in the recent past. As one starting point for future adventurous health care entrepreneurs, the second table lists some suggestions. Blossoming innovation

that improves productivity and cuts costs is timely, for the cost of caring for the rising number of the elderly and catastrophically ill is expected to shoot up to as much as 15% to 20% of GNP.

The next wave of entrepreneurial enterprises may learn from the painful experiences of their predecessors. If so, they will be more focused and more businesslike in managing their organizations. Like Humana, they will exert strong financial controls. Like Health Stop, they will share power and rewards with employees. Like Brigham and Women's Hospital, they will recognize the importance of employees' professional and personal development.

The new generation of entrepreneurial managers, one hopes, will resist the seductive temptation to buoy earnings temporarily with financing and marketing schemes and instead will aim for substance, carefully building a sound structure. In the second wave of the health care revolution, the rewards will come to those who structure operations that can deliver what the marketing message promises, to those who create comprehensive control systems, and to those who put into effect managerial philosophies that reflect organizational purposes.

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