"The American Hospital: What Does the Future Hold?"

Rotunda Room
Ronald Reagan Building and International Trade Center
Washington, DC
April 21, 2003

Abstracts

Please note: sessions from "The American Hospital: What Does the Future Hold?" will be webcast by kaisernetwork.org, a free service of the Kaiser Family Foundation, and will be available after 9:00 a.m. ET, **Wednesday**, April 23, at http://www.kaisernetwork.org/healthcast/fah/21apr03. Along with the webcast, a transcript and related resources also will be available.

Is The Past Prologue?

Jeff Goldsmith, President, Health Futures, Inc. and Associate Professor of Medical Education, School of Medicine, The University of Virginia

Dr. Goldsmith will examine the way in which hospitals have responded to strategic threats to the hospital environment over the last 20 years. Specifically, he will discuss how effectively hospitals have co-opted emerging technologies. He also will outline strategic and tactical challenges that hospitals will face in the future, and how they may respond.

Future Demand: Demographics And Patient Care

Stuart Altman, Chairman, Council on Health Care Economics and Policy, Sol C. Chaikin Professor of National Health Policy, Heller School for Social Policy & Management, Brandeis University; David Shactman, Director, Council on Health Care Economics and Policy, Brandeis University; Kenneth E. Thorpe, Robert W. Woodruff Professor and Chair, Emory University-Rollins School of Public Health; Efrat Eilat, Research Associate, Brandeis University.

Hospital utilization and spending increased significantly in 2001 and 2002, reversing a long-term trend. Many analysts predict that this trend will be short-lived and that the current rate of spending growth will not be maintained. In this paper we contend that the forces driving current hospital expenditures are more likely to continue than they are to abate. We project that real hospital spending per capita will increase by 65 percent between 2002 and 2012, with 26 percent of that increase explained by population growth and population aging. A number of forces will contribute to the current trend. We maintain that technology, the chief driver of hospital spending is likely to remain cost-increasing. We also find that hospital spending by baby boomers grew faster than that of the elderly, a change in trend that could indicate a higher propensity to consume as this cohort transitions in to higher spending age groups.

Uwe E. Reinhardt, James Madison Professor of Political Economy and Professor of Economics and Public Affairs, Princeton University

"How Much Does Aging *Per Se* Drive Health Spending?"

> According to a long-run trend line for constant-dollar health spending per capita over the period 1965-2000, the American health sector each year expects to be fed 4.5 percent in real purchasing power per American than it got the year before. Although there are year to year wiggles around this trend and sometimes somewhat wider deviations—e.g., during 1988-1998—an amateur can become an actuary simply by projecting health spending along that line. The aging of the population is frequently cited as a major driver of total spending in the past and, especially, in the years past 2010, when the first Baby Boomers will reach retirement age. One easily succumbs to that theory when one contemplates graphs depicting average per-capita health spending by age group. These data show that health spending per elderly persons is three to five times that for persons aged 35-45. This presentation attempts to show, however, that the aging of the population *per se* is only a minor driver of the annual growth in health spending. The annual growth of the population is slightly more important. Both factors are dwarfed, however, by annual increases in health spending for all age groups. If Americans are really interested in controlling future health spending, they should stop looking at uncontrollable demography as the main culprit and seriously explore the cost-effectiveness of this nation's health spending. If that is too delicate a task—because one's person's health spending is another's income—the Americans will have no choice but to keep allocating an ever rising share of their GDP to health care—somewhere in excess of 40 percent by mid-century.

Future Supply: Capital And Technology

Richard L. Clarke, President and Chief Executive Officer, Healthcare Financial Management Association (HFMA); Frederick E. "Rick" Wolfert, President and Chief Executive Officer, GE Capital Healthcare Financial Services

"Evaluating Capital Needs and Opportunities in an Era of Profitless Growth and Cashless Utilization"

> Executives of hospitals and health systems are being presented with worthy proposals for new facilities, increased services, and technology upgrades at the same time that many of them are struggling to find the cash or credit to underwrite these projects. Effective allocation of scarce capital dollars will be critical to the success of hospitals now, and into the foreseeable future.
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> Many needs for which hospitals must expend capital are beyond the hospitals' control, and hospitals are experiencing additional financial pressures that add to the capital expenditure burden. Operating budgets in many hospitals are

increasing as well, with no proportional expansion of operating revenue. Construction of new capacity, and purchases of information technology and medical technology are fueling the need for capital dollars, and operating budgets are strained by inadequate payment, the growing number of uninsured patients, salary costs, pharmaceutical costs, and liability insurance premiums.

With revenue and cost pressures straining liquidity, hospitals are compelled to turn to financing to fund their operating and capital cash needs. Based on experiences of senior healthcare financial executives, the following key strategies are needed to improve capital access and allocation:

- Integrate strategic, financial, and capital plans;
- Develop a strategic operational plan;
- Understand the available capital spending pool;
- Analyze capital access options;
- Gather and assign capital requests to capital budget categories;
- Judge each project according to identified criteria;
- Determine how to handle potentially profitless projects;
- Develop a strategic plan of finance for ventures requiring significant capital; and
- Establish and maintain close communication with capital market constituencies.

Future Supply: The Hospital Workforce

Peter I. Buerhaus, Valere Potter Professor of Nursing and Senior Associate Dean for Research, Vanderbilt University School of Nursing

Dr. Peter Buerhaus will provide an overview of the hospital workforce, including current vacancies of various professionals and technicians and the impact on hospitals. He will then summarize trends in pharmacy and the debate over whether a new shortage of physicians is in the making. Because registered nurses comprise the largest component of the hospital workforce, Dr. Buerhaus will focus the rest of his remarks on the RN workforce, beginning with a description of the causes of the current shortage of RNs, present forecasts of the future supply of RNs, describe what is known about the relationship between hospital nurse staffing and quality of care, and discuss implications for hospitals. Dr. Buerhaus will conclude by offering recommendations to strengthen the future hospital workforce.

Integration

Harold S. Luft, Caldwell B. Esselstyn Professor of Health Policy and Health Economics and Director of the Institute for Health Policy Studies, University of California, San Francisco; R. Adams Dudley, M.D., Associate Professor, Institute for Health Policy Studies, Department of Medicine and the Department of Epidemiology and Biostatistics,

University of California, San Francisco; Peter M. Broadhead, Harkness Fellow in Health Care Policy (Australia), Institute for Health Policy Studies, University of California San Francisco

> In theory, integrating hospital care with community-based care offers tremendous potential for clinical improvement, as improved communication and cooperation among providers allow patients to receive the best care available in the setting most able to meet their needs with minimal duplication of effort among providers. While some organizations that historically have been integrated, such as group/staff model HMOs, have had some clinical success and have survived financially, the historical experience with the integration of pre-existing hospitals and medical groups has been that the practically achievable clinical or economic benefits were nowhere near the theoretical advantages. In fact, the marketplace is now moving away from integration, with declining use of capitation and other funding mechanisms that bundle care across settings and encourage providers to work in a coordinated fashion.
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> What has it been about prior attempts to integrate health care vertically that has led the market away from integration, despite its theoretical advantages? Are there alternative approaches to integration that might be more effective than prior initiatives? Do funding strategies exist that could make this feasible? Or should integration be abandoned altogether? In this paper we address the potential of and barriers to integration, describe the prior U.S. experience with it, and offer a strategy that may increase the probability that future attempts at integration reap more of the clinical benefits while creating less administrative friction.

Hospitals, Physicians And Patients

Lawton R. Burns, The James Jo-Jin Kim Professor and Professor of Health Care Systems and of Management, The Wharton School, University of Pennsylvania and Director of the Wharton Center for Health Management & Economics; David Nash, M.D., The Dr. Raymond C. and Doris N. Grandon Professor of Health Policy, Office of Health Policy & Clinical Outcomes, Thomas Jefferson University

"Patients As The New Third Party In Physician-Hospital Relationships"

> Physician-hospital relationships have been the subject of continued research inquiry over the past forty years. Interest in the topic has waxed and waned with various developments such as the Prospective Payment System (PPS), managed care and integrated healthcare, and physician practice management companies (PPMCs). More recently, there has been some interest to consider the role of the patient in these relationships, particularly with the development of open-access model health plans, the rise of consumerism in healthcare, and the consumer-driven health plans offered by insurers. That is, what happens when a dyadic exchange between physicians and hospitals becomes more explicitly a triadic relationship that includes patients?

In this paper, we describe the trajectory of the relationships between physicians and hospitals, and the recent inclusion of patients in them. We argue that patients are the latest in a series of third parties to these physician-hospital exchanges. To help us describe the exchanges and the revolving set of third parties and their roles, we draw on the concept of "triads" by the sociologist Georg Simmel.

Paying For Patient Care and Sources Of Financing For Hospitals

Hugh W. Long, Professor of Health Systems Management, School of Public Health & Tropical Medicine, Tulane University

"The Future of Hospital Payment in the United States – Getting to 2011"

Payment to hospitals in this decade will continue to reflect current trends in the nature and role of the hospital institution. Aggregate hospital payment will experience further shrinkage as a proportion of national health expenditures. The mix of services provided by hospitals, and hence their payment, will continue to shift away from inpatient care to outpatient/ambulatory services.

Most payment to hospitals will remain solidly linked to the philosophy that payment should focus on covering the cost of resources consumed in delivering care. Whether that payment is tied to episodes of care or is made on a per capita basis, there will be continuing efforts to slow cost growth, reduce lags in recognizing the costs of new techniques/technology, and more closely match variation in payment and variation in expected patient resource use (risk adjustment).

The next wave of payment evolution, primarily from the private sector, will begin to address relating payment to the value of the care delivered (or the benefit created by the care delivered), rather than merely to the costs of that care. Challenges include adequate measurement of quality and other benefits, the reallocation of risk, patient contributions to payment, and dealing with classic externalities, particularly those extending over substantial periods of time.

Catherine McLaughlin, Professor, Department of Health Management and Policy and Director of the Economic Research Initiative on the Uninsured (ERIU), The University of Michigan; Karoline Mortensen, The University of Michigan

"Who Walks Through the Door?: The Effect of the Uninsured"

The combination of increasing numbers of unemployed workers, high and rising health insurance premiums, and tightening state budgets has led many analysts to predict an increase in the number of people without private or public health insurance. All health care providers are understandably concerned about the

implications of an increase in the number of uninsured persons for their financial viability.

Using 1999 MEPS data, we calculate what percent of hospital visits are accounted for by uninsured persons at present and predict how those shares would change under three different possible scenarios. We look not only at inpatient stays (IP) and emergency department visits (ED), but also at outpatient visits, which represent an increasing percent of revenues for many hospitals. Outpatient department (OPD) revenues are approaching 50 percent of total revenues for many hospitals.

The separation of IP from OPD shares is important for the analysis. While the likelihood of having an inpatient stay was statistically the same for nonelderly, nondisabled, nonpregnant individuals whether they had full year coverage or were without insurance the entire year, both the likelihood of having an outpatient visit and the average number of outpatient visits in a year were statistically higher for those with insurance coverage. Consistent with economic theory, hospital admission decisions are not strongly influenced by insurance coverage status, but decisions to use outpatient services are.

In 1999, 11 percent of the population was uninsured all year; an additional 11 percent was uninsured part of the year. Those without coverage the entire year accounted for, on average, 5 percent of IP visits, 10 percent of ED visits and 2 percent of OPD visits. We estimated that a 40 percent increase in the size of that pool would result in increasing those average shares to 7 percent, 14 percent, and less than 3 percent. However, these numbers may mask variation among hospitals. The burden of predicted increases in the number of uninsured persons depends on an individual hospital's current share of uninsured patients, its mix of IP and OPD revenues, and the marginal cost of treating those uninsured patients.