Quarterly Report on the Status of Healthcare in the United States

報 告

Quarterly Report on the Status of Healthcare in the United States (I)

Toni Harrington[1)]

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Returning to the United States after two and one half years away, I find that health care is continuing in the same direction as I described in my lectures at St. Luke's College of Nursing. The only difference is that the process has moved further and the effects that were predicted are now becoming reality. The following are several aspects of the reforms that we are seeing.

Hospitals

The economics of managing a hospital are changing rapidly. The role of hospitals is shrinking. Doctors, patients, and money are "bleeding" away. Insurance companies have gained power in dictating when and where patients get care. Advances in medical technology have enabled patients to be treated for illnesses without sleeping in a hospital bed. For decades, hospitals were the core of the health care system. Today they are a part of medicine that is regarded as unaffordable and increasingly unnecessary. The problem is most acute in big cities where many patients are poor and uninsured and where new competition from sophisticated medical services has moved to the suburbs.

Hospitals across the US are being sold, merged and sometimes put out of business at a rapid pace.

In St. Paul, Minnesota, eight community hospitals joined into a single system called Health East in 1996. Since then, five of those hospitals have been closed and two more will be shut down by 2000. Boston's two largest academic medical centers, Massachusetts General and Brigham and Women's merged in 1994. Beth Israel and Deaconess combined last year.

Large academic centers that were once the affluent top of the health care system, are the least suited to the new times because they have the expense of training doctors and nurses and treating poor inner-city residents in an era of discount pricing.

As we spoke in Tokyo, hospital income began to decrease after 1983 with Diagnostic Related Groupings (DRG). Hospitals found that they made more money the sooner patients went home.

During the first year after DRG's the length of patients' stays in the hospital dropped from 9.5 days to 7.5 days. Now averages are in the 5-6 day range.

Layoffs continue as hospitals try to contain costs and react to the steady decrease in hospital patients. With pressures to reduce expenses, many hospitals focus on personnel costs which are typically more than half of their budgets.

In 1994, Congress rejected President Clinton's proposed health care reform plan. This left the future of the health care system increasingly in the control of market forces.

Physicians

As you are aware, in the US, most physicians are in private practice and are not employed by hospitals. For years hospitals and their physicians coexisted peacefully, but the struggle

1) George Mason University, Educational adviser of St. Luke's College of Nursing

for health-care dollars has turned hospitals and physicians into adversaries. Physicians are mobilizing to determine ways to compete with the hospital. Many are pressuring hospitals to meet their requests for new equipment for their offices in return for sending patients to the hospital. Some surgeons are building their own outpatient surgery centers.

Hospitals have tried to coax doctors into partnerships, but physicians have been moving more diagnostic tests, blood work and even surgical procedures into their own offices, creating new profit centers that challenge the hospital bottom line.

Many physicians feel that they can't be bothered with the problems of the hospital and instead must take care of themselves. They are not concerned if the hospitals are unable to survive. As the entrepreneurial planning continues, doctors are learning that they, too, will be subjected to the same scrutiny as hospitals in such areas as health-care-fraud.

The 150 year old American Medical Association is also having problems. Its membership is declining. Many feel that its House of Delegates has views far to the right of many members, especially the younger doctors. Membership in the 1960's included about 90 Percernt of doctors in private practice. Today only about 40 percent of the country's doctors are members. Many are concerned that the structure prevents the organization's ability to cope with changing times.

Report Cards

Report cards (consumer guides that rate hospitals, health plans, doctors and other medical services) have become important for Americans who are trying to understand and move through today's increasingly complicated health care maze. Researchers have documented an unexpected benefit from these guides: a significant improvement in the quality of care and range of services offered in hospitals that are publicly rated. Such improvements have included more services for expectant mothers, reduction in the number of Caesarian section deliveries, and an increase in the number of transfers of high-risk infants to specialized facilities. Hospitals whose charges were higher than average were more likely to be reviewing their charges.

The New York State Department of Health review of death rates in open heart surgery listed death rates of doctors and hospitals and has led to reforms in the medical community. The state in the last five years, a has seen a 52 percent decline in heart surgery mortality rates.

Organizations representing doctors and hospitals have resisted attempts to make this information public. Most concerns stem from fear of misunderstandings from data that could hurt medical professionals and institutions.

Medicare

The new head of the Health Care Financing Administration, the agency that runs the $300 billion Medicare and Medicaid programs, is Nancy-Ann Min DeParle. Though she came from a poor family in eastern Tennessee, she has degrees from Harvard Law School and Oxford University. Her biggest task will be opening Medicare to a number of new options including managed-care plans, developing more accurate ways to pay home healthcare providers, launching a new nationwide plan to combat fraud and abuse, and facing the problem of long-term solvency as the "baby-boomers" age.

The Clinton administration has proposed expanding Medicare to offer early retirees at age 62 and displaced workers as young as 55 the opportunity to buy coverage under Medicare. There is criticism of the plan saying that this should not be done when the long-term solvency of the entire Medicare system is in jeopardy.

Nursing

Highly creative strategies will be required to deliver quality care while reducing costs, This is

the challenge of nursing education and nursing practice. Many institutions are designing patient care with a patient-focused theme where the services will be brought to the patient rather than the patient accommodating the system. Patients and families will be the directors of their own care. Staff and families will have access to a highly sophisticated clinical information system and unit management will be within the framework of shared governance where the power is with the direct care givers and decision and policy making happens at the point closest to the patient.

Patient outcomes will be a result of a highly organized collaborative model that includes primary nursing, critical paths and case management. Partnerships between nurses and unit support staff will create skill-mix changes that allow the nurse to spend less time on non-clinical unit maintenance-type functions and more time with the patient and family. The belief is that this will have a positive financial impact as well as enhance patient satisfaction and outcomes.

Because labor costs in health care are primary targets of cost-cutting, nursing leaders in education and practice will need to be creative in developing models of care that balance the goals of managing cost and delivering high-quality care.

Ethics

Ethical issues are currently in the spotlight because of the focus on such controversial issues as organ transplantation, cloning, and the use of fertility drugs. More on this issue in the next quarterly.

Quarterly Report on the Status of Healthcare in the United States (Ⅱ)

April, 1998

This quarter I have selected several issues that are under current discussion in the United States. One is the growth of managed care and the controversy surrounding this model of healthcare delivery. Many newspapers publish articles that provide detail of the concerns that some patients have. My guess is that these concerns are from a minority, but are sensational in nature and therefore good news stories. The general feeling seems to be that the system is working and it costs the patient less. However, there are concerns because it is altering a basic American "right" of individual choice. We will continue to see how this system evolves.

Another issue is the upsurge of ethical discussion related to medical science developments. A third issue is related to hospitals and their evolving changing status – the emphasis is now on managing a business that can sustain itself. And last are some issues related to nursing practice.

These are interesting times!

Healthcare Reform – Managed Care

Managed care continues to grow, becoming the most utilized model of health care delivery. Today, over two-thirds of all Americans with private health insurance are enrolled in these plans. Health Maintenance Organizations, the most common type of managed care organization, provide a full range of health services for a fixed monthly premium or fee. Members of an HMO are required to select a primary care physician who is affiliated with the health plan. This physician is a "gatekeeper" who coordinates the patient's care by deciding when the patient should be referred to a specialist or surgeon or when they should receive expensive diagnostic tests.

Many Americans view the managed care system as restrictive, preventing them from contacting a physician directly. Yet, advocates of managed care argue that there is an advantage in having one physician take full responsibility for the care of each individual patient. Most primary care physicians are trained as general practitioners, family practice physicians, pediatricians, internists or obstetrician-gynecologists.

There are three major kinds of HMOs: the Group Model, the Staff Model, and the Independent Practice Association. Group Model HMOs contract with independent medical groups who provide care for large numbers of patients for a fixed per member fee. Staff Model HMOs employ salaried physicians and other health professionals who provide care solely for the members of one HMO. The Independent Practice Associations contract with associations of independent physicians who work in their own offices. These independent practitioners receive a per-member payment, or capitation, from the HMO to provide a full range of health services.

As managed care has emerged and gained popularity, there are still being reviewed. Many managed care organizations offer first-rate care through closely scrutinized and reasonable management of treatment. Examples of these are California's Kaiser, Utah's Intermountain Health Care, the Harvard Community Health Plan and Mayo Clinic. These plans clearly emphasize the importance of preventive care in maintaining people's health. As they see it, managed care plans coordinate each patient's care, promote preventive medicine, and carefully monitor quality.

Those who are critical of managed care characterize it as a bureaucratic system that diminishes choice for everyone and forces doctors to place more emphasis on saving money than on saving lives. Because managed care plans are all designed to decrease costs, the impact of this cost control on the quality of health care is a major point of discussion.

It is clear, however, that managed care is here to stay and it is also clear that there is a need for better tools to assess the value, quality, and availability of managed care services.

Ethical Considerations in Healthcare

There have been several new developments in medical science over the last few years that have raised new and very complex ethical issues. For example, the issue of cloning. There is much discussion about the outcome of research in this area. Should cloning experiments continue to include experiments with humans? What are all the possible problems and implications that such experimentation will bring?

Other ethical dilemmas arise relating to advances in the management of fertility. Surrogate mothers, freezing of embryos, use of frozen embryos from mothers who are no longer living, multiple births -sometimes as many as seven -all are situations that bring about ethical questions. Today's ethical crisis in reproductive medicine is the product of converging social, economic and scientific factors. Many women in the work force have delayed childbearing to the point where technological intervention offers their only hope of becoming biological mothers. New treatments are being rushed into use before they are fully proven to be safe or effective.

Another issue that has been of concern recently relates to organ donation. Often a patient is brought into the Emergency Department after an accident and his heart stops beating. If organ donation is being considered, the quality of the organ is maximized if saline can be pumped into the body quickly before the life support equipment is turned off. Many physicians and organ transplant teams are questioning how soon to begin this procedure after heart beat ceases. It becomes an ethical question because beginning the procedure too quickly will hasten death. And, sometimes the procedure is considered before permission has been obtained from the family.

Hospitals – For Profit or Nonprofit?

Over the past 10 years, more and more hospitals have merged with larger hospital chains. They have done so in order to maintain financial stability. Most of these hospitals were originally non-profit or not-for-profit hospitals. Since 1980, more than 400 nonprofit and public hospitals have been converted to for-profit institutions, prompting an argument over what happens when hospitals must respond to their stockholders as well as their patients. Physicians are concerned about the "bottom-line" way of thinking that is blamed for nursing cutbacks and low employee morale. They are so concerned that many are interested in buying back the hospitals. They feel that if they can buy them back they can return them to the original level of healthcare delivery.

At one such hospital, a Columbia/HCA hospital in Alexandria, Louisiana, an agreement has been established between the doctors and the hospital that restores control to the medical center itself instead of the national corporation. It creates a governing board with one-third of the members elected by the doctors. The hospital's administrators will work for the governing board and not directly for Columbia. The doctors believe that this is a step in the right direction, but the doctors' long term goal is still nonprofit ownership. Columbia officials say they are not interested in selling their interest in the hospital and contend that care at the hospital has never been better, noting that the hospital recently was the only one in Louisiana included on a "100 best" list by two health-consulting firms.

The "Hospitalist"

A growing number of hospitals are turning patients over to medicine's new specialty – the hospitalist. Using this concept, when a patient is hospitalized, his family physician turns over his care to a hospital physician who is principally responsible for caring for hospitalized patients only. This is not a new concept. When a patient comes to the emergency department and has no physician, they are assigned one by the hospital.

Data has shown that hospitalist programs can reduce the length of hospital stays, improve efficiency, and cut costs. The program also enables doctors who choose office-based primary care to see more patients because they no longer have to divide their time between their offices and one or more hospitals. Hospitalists maintain their expertise because of considerable experience dealing with problems that office-based doctors treat infrequently. Studies have shown that patients with heart disease or pulmonary embolism fare better if they are treated by physicians with experience in caring for patients with these problems rather than by those with limited expertise.

There are concerns among physicians who feel that they are being forced out of the hospital and therefore cannot maintain relationships with their patients. They worry that they will never know what happened to their patient while he was in the hospital. Many feel that the concept will decrease the quality of care because many physicians learn through hospital grand rounds and informal consultations.

In the past few years, hospitalist programs have opened in many cities, including Washington, San Francisco, Tampa, Richmond, Philadelphia, Baltimore, Atlanta and Chicago. Managed care organizations are strong advocates for these programs, but many feel that that the benefits and risks of hospitalists must be fully assessed before the traditional system is replaced by this new and largely untested model of care.

Nursing

Nurses are discovering the healing power of customer service. For decades, nurses have found it difficult to understand the priorities of families in the hospital setting. For example, a nurse could be working very hard to save a baby when the parents would become upset that the grandparents could not see the baby. A group of nurses in the Outpatient Surgery Department LDS Hospital in Salt Lake City, realizing that clinical

competence is only a part of medicine, pushed through a major re-engineering effort.

They felt that healthcare is about a personal enco unter— "bedside manner". Some of the reforms instituted at LDS Hospital included valet parking, free refreshments for family members, allowing no delay in surgical start times (7:30am means 7:30am and no later), drawing blood during the insertion of IVs, cutting back on X-rays and other orders that weren't specifically indicated (a process called "minimum labs"). They even did away with the no-underwear in the OR policy. There have been no issues with infection control and the patients feel much less vulnerable.

Because of these changes, the nurses noted that recovery times grew shorter, people went under anesthesia feeling better and woke up feeling better. They went home sooner. Today, the peak capacity in the OR is up more than 50% with zero increase in staff or square footage and patient satisfaction is much improved. They have found that when scarce resources create conflicting demands, the interests of the customer provide the largest space on which to seek common ground.

There are now some emergency departments that allow the family in the room during resuscitation procedures.

Nursing Shortages Again?

Many say, "what goes around, comes around" -meaning that situations and problems occur over and over again, that there are cycles. First we have shortages of nurses and then we have too many nurses. The cycle looks to be repeating itself again. As managed care has gained momentum, many nurses have left the hospital setting and are working outside the hospital in managed care and ambulatory settings. Hospitals decreased their numbers of nurses as they closed beds. However, now the hospitals have lost too many nurses and are now saying they are in another nursing shortage crisis.

Quarterly Report on the Status of Healthcare in the United States (Ⅲ)

July, 1998

Managed Care

This quarter the focus is again on managed care and the national reaction to this "new" model of care. Although managed care has been around for many years, most Americans have had traditional medical insurance and have been able to choose their physicians and health care facilities. As more and more employers have limited the kinds of health insurance that they offer their employees as a benefit, more and more Americans have elected to become a part of a managed healthcare plan. I don't think that people have thought much about the ramifications of belonging to a health plan and few realized that their choice of physicians would be so limited.

When a person is healthy, it does not matter very much which physician they choose, but when they develop a serious illness, most want the best possible care and want to choose their physician and hospital.

One state that has begun to regulate the managed care industry is Florida. The state has passed laws making it illegal for HMOs to forbid doctors to tell patients about expensive treatments. And, patients now have the right to protest to an outside board if they think their health plans improperly refused to pay for their care. Also, patients now have the right to direct access to certain types of physicians such as gynecologists and

dermatologists and emergency rooms.

Pushed by patients, doctors, hospitals, and the White House, Congress is now involved in important discussions about whether to create a set of federal "patients rights" through many of the methods Florida has already begun to employ.

The newspapers are publishing more and more articles on patient dissatisfaction with managed care. The question has become, "What kind of rights should Americans be guaranteed in a health care system where managed-care plans have gained broad powers to decide how much and what kind of treatment patients receive?" That question is becoming a major public concern and a volatile issue in Congress. As national and state political election campaigns begin, one of the strongest issues will be patient rights in managed care plans.

HMO – United Healthcare Corp – in an unusual study is examining the care provided its members and finding some disturbing news.

United's study found that many of their doctors who treat patients are not following standard guidelines for medical practice. Many of the physicians had not prescribed essential drugs and diagnostic tests for conditions ranging from heart disease to diabetes.

By next year, most of the doctors in the health plan's network will be graded to see how they rate against accepted medical norms. Once United gathers a sufficient amount of performance-related information about doctors and hospitals, it plans to make it available to the 10.4 million patients in its health plans across the US.

Doctors and hospitals are not used to being graded. And this effort will increase the distrust that already runs deep. United believes that its physicians want to do a good job, but feels that they have not set up systems to remind patients about tests or developed checklists to remind themselves to check if a patient is taking a certain medicine. Follow up mechanisms are not in place. The study concedes that reliance on computerized records of medical and pharmacy bills is not a perfect system, but in questioning physicians few disagreed with the accuracy.

United is hoping that the data will influence physicians to change their practice.

Disease Management

Another new concept being used as health care continues to undergo reform is "disease management". What is it? This concept incorporates several processes. First, a disease is identified. It can be a disease that is prevalent within a geographic area or common among a certain age group of patients. The disease usually is one that is expensive to manage. If health care providers can gain a good understanding of the disease by surveying patient demographics, developing clinical practice guidelines (clinical pathways), and performing outcome assessments, the disease becomes easier to manage.

For example, there may be many patients in a clinic that have asthma and are being hospitalized frequently. Hospitalization is expensive. Perhaps, through study of the individual cases (e.g., the population), development of clinical practice guidelines that focus on the best way to manage asthma, and evaluation of the outcomes, managing the utilization patterns can lower costs.

Four factors should be considered to determine if disease management is right for an organization:

1. The population must be large enough to promote efficiency in disease management.
2. The population database must be comprehensive and enable the organization to determine the diseases that are most common in a particular population, account for the largest amounts of inappropriate or preventable expenses, have the greatest negative impact on values such as quality of life, and be amenable to intervention.
3. Its costs must compare with national and

state averages to determine if there is room for improvement.

4. The mix of payors must be determined. Reducing fee-for-service patients will reduce revenues in the short-term period, but this loss can be made up by attracting additional fee-for-service and managed care patients. Capitated providers will gain immediately through reduced costs.

(Macstravic, Scott. *Health Care Strategic Management, April 1998*)

Top Ten Trends in Ambulatory Care: 1998-2002

Ambulatory care continues to demonstrate high growth in US healthcare. Russell Coile, in his *Health Trends*, forecasts 10 trends:

1. Access and convenience will continue to be critical success factors.
2. "Express care" services such as telephone triage will continue to be important to consumers.
3. Medical malls will provide a comprehensive range of services.
4. Satellite clinics will continue to increase in number.
5. Specialty centers will cater to specific customer groups and diseases – such as alternative medicine centers, mid-life women's centers, senior centers, diabetes centers, etc.
6. Ambulatory surgery centers will continue to see growth in volume – about 10% provide 23 hour care.
7. Alternative, or complementary, medicine will become more widely accepted.
8. A priority will be to improve financial performance in poorly managed programs.
9. Competition will center on service.
10. The growth in ambulatory care is bringing new government regulations related to patient rights.

More Health Plans Relying On Specialists as Gatekeepers

Some health plans are starting to designate specialists as principal care providers (gatekeepers) for certain chronic conditions such as renal disease, diabetes, congestive heart failure, and asthma.

This trend is driven by the recognition of consumer preference for access to a physician of their choice. When members enroll in a health plan, a questionnaire is used to assess their health status and identify those with health risks that require more intensive follow up. A physician specialist is then recommended to the patient as their primary physician so that expensive complications and hospitalizations can be avoided.

Hospitalists

Also, as discussed in last quarter's update, "hospitalists" – physicians who oversee primary care doctors' patients during the hospital stay – are gaining more popularity. It is felt that they add value to the hospital and physician network.

They can increase quality by:

1. Ensuring that patients are admitted, assessed, and treated as they need it, while freeing up primary care doctors' time for office visits.
2. Managing inpatient care against critical paths and coordinating complex cases that involve multiple specialists.
3. Communicating with family when *they* are available.

They can cut costs by:

1. Speeding patient evaluation and treatment at admission, shortening waits for admission from the ER, and assessing patient readiness for discharge early in the day.
2. Possibly supporting student resident training.
3. Avoiding a visit by the specialist (some primary care physicians may order this visit in the hospital when they can't be at the bedside).

Is hospital employment of nursing personnel declining?

Data from California's office of Statewide Health Planning and Development show that the total nursing hours worked per patient day was the

highest in 10 years in 1994 and has stayed at that level. RN hours per patient day has increased from 6 to more than 8. Licensed Vocational Nurses hours have decreased slightly and nurse aide hours have increased. RNs are being used in ancillary and ambulatory care units because their training suits them for responsibilities like case management and patient teaching.

Because acute care patients are sicker and go home sooner, they require more intense care while they are hospitalized. Also increasingly complex medical technology is utilized in the acute care setting. Both of these factors have contributed to the increased need and leveling off of the number of nurses. The number of nurses employed has decreased some, but the nurses are working longer hours.

Quarterly Report on the Status of Healthcare in the United States (Ⅳ)

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Managed Care

According to an article by Scott MacStravic in *Managed Care Quarterly*, Summer, 1998, "in managed care, the most valued customer is the one who is least likely to use the organization's services." The nature of the payment system drives this way of thinking. Health plans compete with other health plans for patients by offering the lowest price. The only way they can offer the lowest price is to avoid the high costs of chronically ill patients and those requiring long-term hospitalization. Also to hopefully prevent the high costs of serious illness, health plans use medical management strategies such as prevention, early detection of disease, improved treatment choices and self-care. If these strategies do not work, what can sometimes happen is patients who have chronic disease or serious illnesses could be encouraged to drop out of the health plan. This author suggests that the system could be changed by adjusting payment to reflect the risk level of particular customers/patients. If payments are adjusted for health status, the sicker individuals and populations would represent the best prospects precisely because they have higher risks and costs than normal, and therefore greater potential for savings.

Seniors Are Redefining Health Care

The aging baby boomers in the US will have a profound effect on health care providers. Some of these effects will be the result of demographic trends described by Russell C. Coile, Jr. in Russ Coile's Health Trends, July, 1998.

- Seniors use three to four times as much health care resources than younger adults do.
- Fewer seniors are requiring nursing home care.
- Older adults are leading longer, healthier, more productive lives. Today most seniors have not functional status limitations
- Seniors are becoming more educated in buying health care products and services.
- More and more older adults are using the Internet and searching for health-related information.
- Seniors are causing a growth in the senior housing market -such as assisted living communities.
- Long term care costs are expected to rise 200% to 400% by 2020.

The next generation of seniors in the US are younger, healthier, more active, and more fit than any previous group.

Disease Management

In *Executive Solutions for Health care*

Management, July, 1998, experts are agreeing that chronic disease management programs are producing cost-effective care. The primary reason for their success is that patients will be quick to accept advice or education that will keep them away from emergency visits and hospital stays. These programs are providing individualized care and listening, communication, and education that those outside of managed care claim is absent in health maintenance organizations.

Disease management can be as little as educational information mailed to a patient's home, computer interaction or home visits. The purpose is to educate the individual so that he can live with his disease and prevent periods of serious illness. By gathering data about specific patient populations and planning and charting the care of patients with this specific disease, their care can be better managed and serious illnesses encountered less often.

Are Primary Care Physicians Decreasing in Importance?

As we have learned, over the last several years, more and more physicians have entered primary care and turned away from specialty practice. However, more and more the literature seems to suggest that the primary care physician may be unnecessary or less important in the future. There are several reasons for this change:

1. If a patient must first go to a primary care physician before seeing a specialist, this care could be less expensive in the beginning, but more costly long term. If the patient had been seen originally by a specialist, the problem could have been more quickly resolved and at less cost.
2. Quality is better when the patient sees the specialist.
3. Gatekeeper models are beginning to allow their patients to go directly to the specialist mainly as a result of lawsuits.
4. Disease management programs are being developed and implemented by specialists and the resulting outcomes are of higher quality.
5. Through a concept called *demand management*, patients are triaged to the right physicians and therefore physician office visits are reduced.
6. As I mentioned in the last Quarterly Report, many organizations are using hospital intensivists in the care of high acuity hospitalized patients, further decreasing the role of the traditional primary care physician.

紀要第２５号訂正のお知らせ

先日、皆様にお届けいたしました紀要第２５号の９２ページ、Toni Harrington 先生による「Quarterly Report on the Status of Healthcare in the United States(Ⅲ)」“Managed Care”の項で下記の図が参考とされましたが、実際には図が掲載されていませんでした。お詫びを申し上げますとともに、図の追加をお願いいたします。

聖路加看護大学紀要委員会