Applying Economics In An Uncertain World

THE CHARTIS GROUP
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Overview

In 1995, prevailing healthcare strategy embraced four fundamental beliefs: That markets were over-bedded; that payers would drive cost management and economic alignment via capitation and hyper-managed care; that there would be an oversupply of physicians in most markets; and that hospital system formation would rationalize use of resources. However, the realities of 2005 reflect a decade that, in many ways, advanced along countervailing lines: hospitals are adding beds at a rapid pace; capitation has ebbed as a market force; physicians represent an increasingly complex strategic challenge as their dual nature as hospital supplier and competitor becomes increasingly pronounced amidst AMA projections of alarming physician shortages by 2015; and, many health systems are struggling to achieve the optimal balance between scale and consolidation and local agility.

Some providers navigated these uncertain currents with marked success while others found that their strategies led them into turbulent waters of distracting low return initiatives, poor market position, questionable investments and asset portfolios, and less than fruitful relationships.

The distinguishing characteristic of those organizations that advanced in their markets was their profound understanding of the underlying economics of their markets. Their strategies were based upon more than the physician, payer, and competitor trends of the moment—rather, their strategies were shaped by true comprehension of where markets would head based upon ultimate and prevailing economic forces.

Developing potent strategies for the decade ahead will require even greater understanding of formative healthcare economics. Changing demographics and accelerating clinical technologies are driving both rapidly growing demand and a decreasing proportionate supply of dollars and human resources. At the same time, increasing migration of care to outpatient settings and the shifting of payment from third party insurers to the consumer will influence market leverage and control of the traditional "healthcare dollar" in new and unforeseen ways.

In our experience, deep understanding of the underlying economics of an organization and its market is essential to a well constructed strategy. Such an understanding must be grounded in incisive assessment, rigorous analysis, and robust econometric forecasting. While there are many economic principles at play, we have found that there are five key economic constructs which have the greatest impact:

1. The Economics of Demand and Supply
2. The Economics of Market Leverage
3. The Economics of Agency
4. The Economics of Utility
5. The Economics of Scale

These economic dimensions are often the most overlooked and misinterpreted aspects of provider planning. But those organizations that incorporate and test their strategies against these economic tenets have the greatest success against their objectives and returns on invested resources.

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1. The Economics of Demand and Supply: There is no greater challenge to healthcare delivery in the United States than the countervailing trends of healthcare demand and supply. An aging population, clinical advances that are expanding the scope and scale of treatable conditions, and a financing super-structure that remains oriented towards episodic treatment as opposed to wellness and health status all contribute to materially significant demand growth. In addition, the nature of demand is evolving as care continues to migrate to new settings, disease states emerge in new primacies, and rapid advances in research result in new treatment protocols.

Concurrently, there is a decreasing supply of resources to accommodate escalating demand. The cost of delivery continues to rise; federal and state funding is diminishing for the growing Medicare, Medicaid, and uninsured populations; third party payers are covering a shrinking portion of healthcare expenditures; and significant physician, nursing, and clinical staff shortages are expected to continue far into the future.

The past decade and a half has witnessed its share of providers embark upon strategies where either current and future supply and demand were not well understood, or these strategies were undertaken with a "build it and they will come" mentality, as if supply and demand trends could be counter-acted. The results in these instances have included poor return on capital, under-utilized facilities, over-extended geographic footprints, asset divesture, financially challenging patient payer mixes, and costly employed physician models—none of which could justify the respective dedication of resources.

The strategic planning challenge is to avoid the canards that are so easily assumed to be true:

1. **That supply and demand trends are static linear functions that are largely independent.** When in most cases the two directly shape each other and are both influenced by the actions and reactions of the physicians, payers, providers, consumers, and technologies they represent.

2. **That supply and demand trends can be easily shifted.** This belief is seemingly antithetical to the first assumption—which is why it is a trap that is so easily sprung. Supply and demand trends are not static, but they are strong. Supply and demand can be and are shaped by collective market activity—BUT very seldom by a single activity of a single player in a market.

As most providers consider the future in the face of increasing demand and even more scarce supply, growing profitable volume is a core strategic imperative. Doing so will require a precise grasp both of demographic and service demand and of supply requirements to meet such demand.

Accurate understanding of marketplace supply and demand is a critical element of strategic planning. Without it, organizations plan in an uncertain environment where the costs of missteps are high.

2. The Economics of Market Leverage: In a market comprised of payers, providers, physicians and consumers, *market leverage* is one player's ability to actively exert influence over other players to control or grow its share of the 'healthcare dollar'. Understanding where true leverage resides in a market and how it can be altered is a function of four factors:

1. **Supply and Demand:** The respective supply of providers, payers and physicians versus the demand for their services;

2. **Consolidation:** The degree of consolidation and share of the major players e.g. dominant payers, large provider systems, large single and multi-specialty practices;

3. **Organization:** The state of organization of each of the market players e.g. providers systems, physicians groups, purchasing cooperatives, and their ability to respond to or create changes in the market;

4. **Differentiation:** The extent to which players can credibly differentiate themselves via a relevant value proposition (quality, service, cost)

Mapping out which players have achieved degrees of leverage, and the basis by which they have done so, can have significant implications in strategy development.

For instance, developing an effective payer contracting strategy must begin with an assessment of current payer market leverage in order to inform a strategic response. It is worth noting that in many markets across the country, the formation of health systems was unable to materially shift the balance of payer market leverage either because the required provider scale was under-estimated or the necessary steps to take advantage of acquired scale was misunderstood and mis-implemented.

When redefining leverage in a marketplace, there are vast challenges in strategy design and implementation that must be tested. There is danger in assuming a single set of actions can turn the tide. Too often, such one-dimensional efforts result in conducting a set of costly and ultimately distracting initiatives that never serve to reframe the market. Effective strategies require a significant commitment of resources and superior execution focused upon a defined market leverage tipping point.

3. The Economics of Agency: Private markets are constructed around the economic principal of 'agency' that ensures a level of equilibrium where entities essentially cannot "spend more than that which they have."

Healthcare consumption economics however has largely turned traditional private market agency on its head. Patients, who directly drive resource demand and consumption, are not directly responsible for paying for services received—payment is left to governmental and private third party mechanisms. Physicians, who drive hospital resource utilization, are not responsible for the costs associated with their treatments—instead hospitals bear the costs of physician choices and practices. On the revenue side of the equation, physicians who drive top-line hospital growth often have little responsibility for covering hospital capital expenditures. These dis-agencies, resulting from an underlying lack of economic alignment, contribute to under-managed utilization, rapidly growing costs, and poor returns on capital investments.

In our experience, efforts at alignment have often been ineffective or unsustainable because they were too narrow in definition. Economically and strategically meaningful alignment must be constructed along two concurrent dimensions:

- *It must financially align the players: providers, physicians, consumers and payers, around a common set of resources*

- *It must economically align the players with a business model that enables "all boats to rise" instead of creating a zero-sum premium-dollar rivalry.*

Strategies that do not achieve alignment across both fronts are compromised from the start in terms of player behaviors and actions not playing out against the strategic script written for them. Successful planning factors into the outcome an understanding that all behaviors and actions are driven by economic rationale—and that strategies are only effective if they are under-girded by aligned economics that recognize and reinforce the interdependencies of all players.

4. The Economics of Utility: Individuals want choice—and are willing to pay for it. The utility, or benefit, a patient receives from using a provider of choice knows little bounds. Financially and politically, consumers have demonstrated the potency of their preferences. Individuals, being driven by utility, have demonstrated that healthcare demand is highly inelastic. Perceived utility is so high that irrespective of price, demand continues to grow. Healthcare expenditures as a percentage of total individual income continue to rise annually.

The challenge this forces upon provider strategic planning is in answering the question "What is the greatest utility that we can offer the consumer?" Few organizations ask this question with sufficient gravity. Either its importance is underestimated in deference to current market trends and external financial/competitive events or the answer is assumed to be implied in the organization's mission or core activities. In both cases, the result for many has been a reactive strategy that ultimately aims by default to hold the center of the market, but is less capable of growing along the leading edge.

The providers who have experienced the greatest growth over the past decade have been those who have successfully defined and established a unique and differentiating value proposition to offer both consumers and physicians. Providers, applying laser-like focus on consumer and physician demand, have distinguished themselves in competitive markets by maximizing the utility they offer to defined segments in terms of clinical quality, customer service, or operational ease of use. As healthcare expenditures move towards greater and greater use of individual discretionary income, emphasis on the economics of utility will only grow in importance.

5. The Economics of Scale. Over the past 15 years, achieving economies of scale has been one of the more sought after goals in healthcare delivery. In many cases, attaining material economies of scale has been a principal rationale for Integrated Delivery System formation, medical group consolidation, and provider mergers.

The challenge in many of these cases has been that while attractive in theory, realizing economies of scale has been far more difficult in practice. Some success has been found in "back office" functions—but seldom to the degree or as easily as expected. Furthermore, clinical and administrative efficiencies and associated cost savings have been far more elusive than projected in planning efforts. The primary reason for this is that "Economies of Scale" is a concept derived in a manufacturing setting of static inputs and outputs. However, achieving economies of scale in healthcare mergers, consolidations, and joint ventures requires integrating highly variable human resources with unique behaviors, cultures, objectives, agendas, preferences, practices, and positions.

There are numerous examples of health systems that responded to organizational and operational demands during formation by creating greater layers and spans of administration than existed when the entities were independent. For many, once established, this new administrative infrastructure often proved far more difficult to dismantle.

Realizing clinical economies of scale through consolidation of clinical activity has been challenging due to the local nature of healthcare demand, physician preferences, the lack of geographic transportability of physician referral channels, patient and family preferences, and clinical treatment migration trends.

It is critical in the planning process to analyze actions predicated upon realizing economies of scale—in terms of whether “real life” human variables and behaviors will enable achievement of projected efficiencies or whether as a function of unaligned objectives, “agency” or “utility”, they in fact run counter to it.

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Each of the five constructs are powerful in their own right, however the true potency lies in the interaction among them. For example, understanding and planning around influencing market leverage takes on advanced implications and potency in the context of a market’s supply and demand dynamics and the utility that the organization can offer.

Conclusion

The past decade is replete with examples in healthcare and outside it, where strategic planning and major investment decisions have occurred under the premise that markets had evolved into “new economies” and that the basic laws of economics had been suspended. History has gone on to show that markets advance, but underlying them are timeless economic constructs that must be appreciated and incorporated into strategy. Few industries have the complex and misaligned economics that characterize healthcare. With demand rocketing and the supply of resources becoming increasingly scarce, understanding market and organizational economics as a key element of strategic planning is critical.

About The Chartis Group

The Chartis Group was formed in 2001 with the distinct mission of providing unequaled management consulting services, applied research, and program management to leading healthcare organizations as they face and successfully meet their greatest challenges. With practices in Boston, Chicago, New York, and San Francisco, The Chartis Group offers its clients unstinting service, intellectual leadership in pursuit of superior outcomes, and our standard of hiring, retaining, and offering our clients the best and most experienced professionals in the industry.

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