

Perspective

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The Shape of Change In Healthcare



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EXECUTIVE SUMMARY

The need for change in our unsustainable US\$2.4 trillion healthcare system is clear. Equally clear is the fact that almost everything changed in September 2008: As the credit markets froze, the stock market tanked, the Department of the Treasury stepped in, and the global economy edged toward a recession. Given these challenges, many believed that President Obama would be unable to tackle the nation's healthcare issues for most, if not all, of his first term. As a result, the fact that structural change is back on the table has surprised many. Still, what remains very much uncertain are the important details for how this fundamental change will occur, though important trends are emerging that will determine the nature of the playing field, the players, and the plays in various segments of the healthcare sector.

Aside from general notions of reducing "waste," the healthcare reform proposals from both parties continue to focus strongly on the demand side of the problem—primarily on efforts to offer funding or tax credits to make insurance more available and affordable. These reforms would be certain to increase the number of covered citizens, but the resulting increases in demand and total cost would be too much for even the most optimistic reductions in cost shifting and waste to offset. To date neither political party has presented an argument for, or an outline of, major structural changes to the supply side of the healthcare system (or controls on the demand side, for that matter). Absent a vision for structural change, any hope of putting the system on a more sustainable footing is quixotic at best.

THE PLAYING FIELD

To some, the playing field in health-care suggests an industry on the brink of structural change; to others, it remains just another troubled and troubling sector of the economy with problems to be managed and minimized. Indeed, even before the downturn, things weren't looking good—except in the way that the industry's issues sounded a drumbeat militating for change:

- Healthcare costs continued their decades-long trend of exceeding the consumer price index (CPI)—often by a factor of two or more.
- The aging of the baby boom generation and alarming rises in obesity (and its accompanying chronic conditions) in people of all ages augured severe demand strains on the system.
- The long-term costs of caring for the nation's soldiers wounded in Iraq and Afghanistan became apparent. These costs will stress the U.S. Department of Veterans Affairs (VA) system and have collateral effects in the private sector for the next 40 to 50 years.
- Technological and pharmaceutical advances produced patient benefits and offered some hope of reducing the demand for and cost of treatment, but have not yet lived up to that potential.

- Potentially transformational opportunities such as evidence-based medicine (EBM) and electronic health records hold promise in terms of improving quality and reducing both demand and costs. But they require fundamental changes in the models for care delivery and financing, along with greater levels of investment, to make their potential a reality.

In short, there simply were no encouraging trends to offset the forces that would constrain and confound efforts to rationalize the healthcare system. Worse, the historical truth is clear: Even under the best of circumstances, “reforms” in healthcare always cost more money in the aggregate—at least \$1.5 trillion based on conservative estimates by the Obama administration. That money will be increasingly difficult to find, whether one looks to government, the private sector, or individuals—notwithstanding the almost \$36 billion in health information technology (HIT) stimulus funding and more than \$600 billion proposed in the budget as a “down payment on healthcare reform.”

Whatever the will of the people and the Obama administration for healthcare reform, the obstacles are huge, and in the near term the costs will far outweigh the savings. Post-meltdown fiscal constraints will

trump any political considerations. Remember that previous large, publicly funded interventions in the healthcare system, such as the Hill-Burton Act and the creation of Medicare/Medicaid, were enacted during periods of national prosperity, not recessions and credit crunches.

In addition, the other main financiers of healthcare—large employers—were nearing the end of their ropes even before the most recent financial shocks. Healthcare costs are once again getting serious scrutiny as a competitive factor in global business, and the next step may be more draconian than those seen in earlier crunches. These employers know full well they are paying for other pieces of the demand stream that don't carry their own weight—specifically, they are supplementing underpayments from Medicare and Medicaid and

making up the write-offs for the uninsured. Consumer-driven health plans with high deductibles and savings accounts have helped slow cost increases somewhat, but they can never address the cost shifting that is already priced into the system. As financial pressures mount, large employers' next move may mirror their approach to retirement benefits in the 1990s—an explicit transition to a defined-contribution healthcare benefit. This step would eliminate the overhead of plan selection, design, and administration, while making employers' costs more predictable and controllable (as that risk would be shifted to employees). Keeping large employers from moving further in this direction, and retaining their crucial role in any pluralistic solution, is perhaps the greatest challenge for policymakers. That's assuming that some large employers

don't simply toss in the towel or go into bankruptcy during the current economic crisis.

Working through the next few years will be difficult for the entire country. Of all the economy's sectors, healthcare will be perhaps the most insulated from catastrophe, but it will be challenged to do more albeit with an expanded set of resources. In many ways, the industry will continue the trends of recent years, remaining largely private and pluralistic, with no significant changes to existing incentives to encourage consumer-directed health plans and tax-advantaged savings accounts. It will be somewhat harder to find time, attention, and capital in order to innovate and experiment, but the industry will survive and winners will make key plays to position themselves for a rosier future economy.

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THE PLAYERS: PRESSURE FROM ALL SIDES

The imperative to find better ways of providing care, improving short- and long-term outcomes, and reducing costs will be strong—especially in the private sector. As more risk shifts to consumers, innovation in plan design and incentives will be accompanied by continuing pressure from large employers to rein in the rate of cost increases—even if absolute reduction remains a distant hope.

Although consumers may feel most at risk, the pressure on profits from a slow economy with unpredictable energy costs means that large employers and their healthcare-plan partners will be driving real change. In the past year or two, we have already seen large employers cutting out major chunks of risk—the Detroit Three automakers’ payments to the UAW for retiree healthcare benefits being the most dramatic example. Although the elimination of healthcare benefits or a full-scale move to a defined-contribution approach may not happen soon, they

are both likely to be on the agenda for major corporations—both as frameworks for budgeting and as long-term threats to policymakers, intended to spur change. The near-term engine driving change for the industry’s players will be the demands of an increasingly nervous corporate sector.

Health Plans

Major health plans occupy an almost governmental position in the private-sector value chain. They must navigate and mediate the ground between the principal payors (employers), the end-users and co-funders (consumers), and the suppliers (primarily hospitals, doctors, and pharmaceutical firms). As government officials have learned, it is virtually impossible to make everyone happy. Doing this job well in the future will only be harder.

The fundamentals of the near term seem clear: Corporate dollars available for healthcare benefits will not keep pace with the medical CPI; the prices

charged by an increasingly oligopolistic supply side will likely increase in real terms; and the consumer (the party that is most like a customer for the plans) will be caught in the middle. The only potential structural help could come in the form of improved hospital and doctor margins that could be repatriated or redirected—but only if there is near-term relief with expanded or subsidized insurance coverage for those who have none (or little) today. If this eases cost pressures on providers, there could be some relief for the plans, their sponsors, and consumers. However, such a safety valve is at least three or four years away—given the time it would take to set up these programs and capture the value in lower provider prices.

To the extent that public-sector initiatives arise to encourage and assist individuals and small groups in purchasing health insurance, there may be demand-side gains for the major insurers and plans. In the long term, federalizing or standardizing

insurance regulation may be a mixed blessing. Many states find themselves today with only one or two players in the industry. So, although an invigorated demand side would be good news, some insurers may encounter additional, and perhaps more nimble, competition. This is especially true because standardization (in whatever form and whatever the source) will likely begin with a less-onerous list of mandated minimum benefits. An era of more bare-bones coverage, focused on catastrophic insurance, is likely for this market. We could see a return to the “major medical” mentality more common 40 years ago, when routine costs such as those for office visits and prescriptions were much lower and consumers were mostly concerned with hospitalization costs.

Insurers and plans should focus on product innovation that produces better clinical results at lower cost; preparation for a more nimble, Web-based business model to capture the likely increase in demand from

individuals and smaller groups; and structural changes that better align incentives among payors, providers, suppliers, and patients/consumers. All these efforts should be helpful in any long-term strategic scenario short of outright nationalization. To build innovative capabilities that are outside plans’ traditional purview, technology and new partnerships are likely to be the tactics that drive successful new initiatives.

Providers

Although the past decade has been no bed of roses for providers, they have gained strength relative to other players in the healthcare system. There have been hits to some very parochial areas (e.g., office-based chemotherapy margins), but the sector as a whole has done well. Medicaid budgets and rising unemployment have put stress on the revenue side, but no major hits to the financing system have occurred. Several factors account for this success—and have important implications for the future.

First, healthcare delivery is local and personal. Consumers don't know the people who answer claims questions at their health plan, but they do know their doctors, pharmacists, therapists, and nurses. Local brands and reputations count for a lot, and many health plans learned this lesson the hard way (when they set up PPOs without key local providers, for example). And, although no one likes paying higher prices, consumers seem reluctant to vote for measures that directly reduce revenues to providers. Consider, for example, how Congress has made several 11th-hour rescissions of cuts to Medicare physician payments in recent years.

Second, demand for healthcare keeps rising. Much of this increase,

of course, is driven by population growth and aging. In addition, conditions related to behavioral factors, particularly obesity and the chronic conditions that come with it, are driving up usage rates and will likely do so for many years to come. Technological and scientific advances are also contributing to increased demand—by and large in good ways, if one ignores the costs. It is easy to forget how far medicine has come in 50 years. Treatments and tools we take for granted today simply weren't available in the 1950s: open-heart surgery, cardiac catheterization, second-generation antibiotics, keyhole surgery, chemotherapy, advanced diagnostics, and neonatal medicine, to name just a few. This portion of demand growth, although less

dramatic on a year-to-year basis than the impact of demographic changes, is nonetheless a significant factor in rising costs over time and will not go away. Finally, the exogenous factor of the soldiers wounded in Iraq and Afghanistan, which is not part of most projections, represents both a large and a long-term addition to total demand for the VA system—creating unforeseen competition with the civilian system for money and labor.

Third, supply is shrinking in many key parts of the care continuum. We are well past the years—post-World War II and post-Medicare/Medicaid—of frantically building new hospital-bed capacity, but the shortages have shifted to other care settings. Long-term-care options are hard to find in

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many markets, particularly for those of limited means. But a more insidious kind of shortage is also driving health-care costs ever upward: overall and specific labor-market imbalances.

- Physicians now practice differently, especially in primary care, where we see a splitting of office-based practices and hospitalist practices. This shift, along with physicians' desire for shorter hours and a balanced lifestyle, is driving lower productivity overall and therefore exacerbating shortages that have been endemic for at least two decades. Nothing meaningful is happening in the supply pipeline to counterbalance these factors.
- Virtually an entire generation of nurses will leave the workforce over the next 20 years. This will, of course, increase demand for new nurses and place even greater pressure on salaries. While somewhat less susceptible to generational pressure, supply in the allied health professions, such as physical therapy, is already extremely tight and salaries are skyrocketing.

- Providers have been pretty smart over the past 20 years. Although they may not have intentionally created local or regional oligopolies, leading providers in most U.S. markets have assembled sites, assets, and programs that give them considerable market power—backed up by strong branding. Contracting is a fierce business, but leading providers know they hold some strong trump cards (perceived strengths in, say, heart surgery, cancer, orthopedics, and emergency care). It is perhaps indicative of these dynamics that national rating schemes (like that of *U.S. News & World Report*) for leading hospitals do not consider cost at all.

Any doubts about the structural source of the provider sector's strength should be easy to allay: Basically, supply and demand are inexorably showing the power of the invisible hand. Looking ahead, neither the high demand for care nor its tight supply is likely to abate. For this reason, of all the players within the healthcare sector, providers may have the greatest vested interest in

maintaining the status quo. However, a recession-driven decline in net revenue, as providers fail to realize prices, and a potential increase in bad debts could put providers under cost pressure. Finding a persuasive vision of a different, perhaps draconian, future may be necessary to stir action in a new direction.

Pharma, Biotech, and Suppliers

The pharmaceutical firms and their emerging near-cousins, the biotechnology firms, hold great possibilities for improving people's health, longevity, and quality of life around the world. Although it varies in length and robustness over time, the pipeline of important compounds and agents being developed is almost always promising and a source of hope. Despite all this—and the stunning achievements of the past 30 years—industry headlines are more likely to focus on high prices; recalls and lawsuits; patent defense; generic preemption; and marketing, selling, and detailing practices.

On a more fundamental level, the traditional business model is under

great stress. The strains of globalized supply and production trying to live side by side with localized demand and pricing are beginning to show—even in the face of some instances of commendable humanitarian concessions on HIV/AIDS drugs in developing countries and similar initiatives. Specialty biotech products are only increasing the cost pressure in the market as they become a more significant share of pharmaceutical sales. The old value proposition of retailing compounds at the prices the market will bear and marketing their nuanced differences versus branded competitors and generics is wearing thin on both sides of the supply–demand divide. Pressure on the current model will only increase further: According to some estimates, by 2012 prescriptions for generics may make up 80 percent of volume as several blockbuster drugs come off patent.

Of more immediate concern, of course, is the easy target presented by

big pharma and biotech to reformers or to public-sector purchasers in light of the significant increases in year-over-year Part D premiums. Medicare Part D was generally a boon to the industry—converting mere need into true economic demand by publicly funding much of the shortfall. Although margins may have suffered a bit, top-line revenue grew significantly. But, without the vigorous bidding and pricing competition one would expect from a large purchaser (the government, essentially), Medicare Part D represents an untapped source of savings for reformers and the frugal alike. Scarier still is the prospect of possible initiatives to expand Medicare Part D into a program for more citizens (even those currently insured) and seek national-level discounts.

A new model of partnering, cooperation, and clinical rigor needs to be created—without destroying the engine that generates funds for vigorous R&D. For example, companies

could redirect today's investments in sales and marketing toward R&D—*if* they developed compounds with a clear understanding of providers', plans', and consumers' willingness to pay a premium for those products and if they had clear candidates that warranted investment with this mind-set. Alternatively, companies could direct investments to support collaborative efforts with other stakeholders to drive better outcomes.

Non-pharmaceutical suppliers will face similar pressures and are likely to be even more vulnerable to the efforts of providers (and some plan sponsors) to standardize, concentrate volume, and drive down prices. Makers of stents, pacemakers, artificial joints, and other high-ticket, high-tech products will, like their counterparts in the pharma sector, find their sales techniques challenged by a customer base that is increasingly institutional, rather than composed of individual decision makers.

THE PLAYS: A NEED FOR INNOVATION

Structural change may be coming from the top down or via mandates from the Obama administration, but that doesn't mean that industry-driven structural change is entirely out of the question for healthcare players. The existing marketplace contains all the ingredients needed to drive and reward selective strategic plays by current industry participants—and new players, as well. Some of the strategic opportunities are clear, even if the strategies for success are not yet in place.

- Costs are still rising too fast. There are some viable solutions: greater adherence to best practices; more cost-effective use of pharmaceuticals and medical technologies; identification of chronic conditions that will cost payors dearly in the future if not managed now; and incentives for consumers.
- A truly consumer-driven marketplace is missing several key structural pieces. Most notably, it needs market makers (third parties that can match clinical needs to providers based on costs, quality, and service) and advisory services to guide patients to the most efficient and effective providers. It also requires independent sources of information on treatment alternatives.
- Consumer demand for less-comprehensive health plans with an affordable cost will drive opportunities for more old-fashioned “major medical” products. Similarly, consumers who seek to limit their out-of-pocket risk will be more willing to exchange choice for affordability.

These top-line trends should drive innovation that is useful in the cur-

rent marketplace and should position leading firms for success in any subsequent wave of reform—whenever that seems affordable. Stemming from these trends, a number of plays are already emerging or should appear in the near future.

Partnerships for Best Care

Two categories of clinical need drive a disproportionate share of total expenses for health plans: chronic diseases (such as diabetes and hypertension) and their downstream acute episodes; and major interventions such as for cancer, heart surgery, and joint replacement. By and large, chronic conditions are undertreated (and patients' compliance with treatment is poor) and major acute interventions are too readily pursued (catheterization or surgery rather than medicine for certain kinds of heart disease, for example). The science surrounding these conditions continues to evolve, but best practices are generally well understood.

That said, aligning incentives to encourage best practices is a challenge. Employers are reluctant to overencourage screening and chronic disease treatment, fearing they are spending their money now just to save some other employer a big surgical bill 20 years hence. They are also aware that employees often respond badly to pressure to seek treatment. Consumers seem reluctant to change their lifestyles in the near term—and believe medicine and surgery will save them when things get really bad later. Providers have not coordinated with each other to standardize care, and care patterns can differ widely depending on geography and the strengths and weaknesses

of particular doctors and hospitals. The health plans sit in the middle of all this trying to manage the often unmanageable.

There is, however, one helpful trend that may provide a way to begin addressing this huge problem. For many years, leading hospitals and physicians have focused on developing strong local and regional brands in selected, usually high-cost, services. Heart surgery, maternity services, joint replacement, and cancer care are the most common examples. These plays are for market share and scale, but they also deliver better outcomes, according to some studies, thanks to a combination of some standardization and the value of experience and repetition. Such efforts were given additional momentum by Michael Porter and others in their recent writings encouraging highly focused clinical programs that can be branded on both cost and outcomes. The continued evolution of EBM only strengthens the argument in favor of such initiatives.

Most areas have providers who can develop and implement high-quality programs to screen for and manage chronic conditions, but relatively few will have the breadth and depth of expertise (and capital) to achieve “best care” status for heart, cancer, or major joint replacement programs. Best-care programs for chronic conditions are somewhat less demanding, but require organization, discipline, first-rate science, and, yes, capital to achieve their potential and tie into acute-care best programs (the link from successful diabetes management to avoidance of subsequent cardiac

services, for example). All sectors have a stake in successfully filling this space, and an opportunity to do so. Providers, plans, pharmaceutical firms, and funders (employers and government, most notably) can all seek to form partnerships and incentive arrangements—probably on a regional basis—to bring competitively advantaged products to market. The benefits include world-class care for patients; lower, more predictable costs for plans (and their sponsors); and increased market share for local providers.

Beyond Best Care— Prescriptive Insurance?

Making available a robust menu of programs to manage chronic disease and to treat high-cost and high-risk conditions based on the best available scientific evidence is more than an insurance or underwriting issue. If done dispassionately, it should also carry an implicit ethical component. Providers and health plans should at the very least strongly encourage patients to adhere to the regimens of best-practice programs. To do less would be to deny consumers the best care, however inadvertently.

But what is the right thing to do for patients who refuse to follow proven best-treatment protocols? The situation presents a delicate but important question: How can the industry develop incentives for patient behavior that are noncoercive, but still effective? Initially, this will be a question primarily for large plan sponsors (employers) and their health plan partners. In the long term, the issue is likely to become one of public policy.

As daunting as it may be for employers and plans to dabble in the health decisions of consumers, it is relatively minor in comparison to a public policy debate. Fortunately, we don’t yet have to decide on rules for the whole country about, say, criteria for hip replacements. Nonetheless, interesting possibilities can be explored as a later wave in the development of best-care models and the insurance features that accompany them.

It is possible to imagine a tiered approach to enrollees in a large plan with access to multiple best-care services. A plan with the most attractive benefits and features would be priced to appeal to virtually all employees. Once they were enrolled, screening would be required for chronic conditions. If appropriate, patients would be channeled into best-care disease-management programs. Enrollees who encountered major illnesses (whether related to chronic conditions or not) would be channeled into best-care programs and providers for, say, cardiac bypass.

This all sounds very tidy, but of course not everyone will choose to comply (especially, experience suggests, those in chronic disease management programs). For those who—even after counseling—continue to stay out of the best-care offerings, there would be an alternative. The alternative would be a more traditional, “major medical” type of policy that puts them at greater financial risk for their choices. The alternative would also limit the plan sponsor’s risk exposure. This may seem unthinkable, but the strategy is driven by clinical and ethical factors, not short-term financial con-

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siderations. In essence, it is a high-risk pool strategy common to other types of insurance coverage and on the same moral plane as requiring motorcyclists to wear helmets. Don't look for this to happen soon, but it represents a logical second-order implication of the best-care strategy.

Transitionally, it is likely that plans looking to best-care strategies will first turn to carrots rather than sticks. This is especially probable in consumer-directed health plans with savings accounts. Benefits that “flex up” (or premium contributions that “flex down”) could be designed—for example, further reducing any out-of-pocket expenses associated with care that conforms to the best-care protocols. One way or another, plan sponsors and health plans need to find ways to substitute EBM for their patients' use of the Yellow Pages and the gang at the watercooler as guides for their care decisions.

Fill the Structural Gaps in the Consumer-Driven Marketplace
Building consumer participation in the healthcare system is essential for

confronting costs in the most significant areas of spending. Employers recognize this and are moving health plan beneficiaries to consumer-driven formats and other types of plans with high out-of-pocket costs. But the information and tools necessary to help them make good decisions about their healthcare choices are not adequate. Without a market maker to provide these resources, the movement to greater consumer participation in healthcare might face a backlash. Independent advisors are also needed to assist patients in making important clinical decisions. Health insurers have made investments in developing these tools, but consumers tend to distrust them or find them difficult to use. Insurers have focused on negotiating rates and discounts, and they have little data about service quality and health outcomes to help patients navigate decisions about their care.

For the most part, patients trust their physicians more than they do insurance companies, which are viewed as being focused on costs rather than care. Physicians, on the

other hand, are paid by the volume of treatment they provide, not their results. In the future, many sources of transparent information are likely to arise if patients are motivated to choose the treatments and providers that offer the best value, and thus seek out the resources to do so. For example, research indicates that oncology patients who develop close relationships with case managers early in their treatment make the most appropriate use of end-of-life care.

New Players: Virtual Health Plans
If and when structural changes are made to the state-level insurance regulation regime, perhaps toward the end of the new administration's first term, new players are likely to emerge in the health plan space—those seeking a regional or national level of business. Any regulatory reform that opens the door to new modes of risk aggregation (beyond employment groups) will also open the door to a new business model for health benefits.

In the 1980s, the term “stitcher” was coined to describe intermediaries that assembled the pieces (doctor and

hospital networks, primarily) of plans being sponsored by large, multistate employers. This role continues to exist, both as a capability within large health plans themselves, and as an independent entity working with large plans. Such a stitcher role could evolve into a virtual health plan in a number of ways:

- Aggregating risk for small groups and individuals, thus finding ways to avoid the expensive community rating systems and individual underwriting of today
- Assembling networks of primary care providers, including low-cost retail clinics
- Hiring the services of best-of-breed preferred provider organizations throughout the country, giving customers access to good providers at competitive prices
- Integrating market makers and leading information providers to assist consumers in making healthcare choices and buying decisions
- Using the Internet to make the services and network available almost anywhere at almost any time—including routine tasks of adjudication and payment.

This role is available to both existing players and newer entrants that are already focused on Web-based insurance services. When the opportunity arises, the new entrants—with no concerns about cannibalizing a large core business—may be the nimblest at moving into this space.

Closed-Panel HMOs May Reemerge

People who don't have insurance today—or who strain to afford their traditional plans—may be happy to choose a restrictive, closed-panel HMO at the right price. Workers with traditional insurance in the 1980s and 1990s hated this idea, but mostly because they felt forced into it. Those without coverage today may find this sort of HMO a welcome alternative. Restrictive PPOs could also compete in this space, but they have historically proven less capable of controlling costs. Whatever the specific products end up being, they are likely to hit price points established by the new administration for subsidies and tax credits under any eventual “reform lite” set of initiatives.

Supply-Side Solution for the Uninsured and Medicaid

Expanding access to healthcare does not fix all the problems for uninsured and low-income patients who must still cope with a system that does not

reward providers for keeping patients healthy. In much the same way that best-care standards and market makers are needed in the purely private sector, these patients need to be directed to the most timely and cost-effective care. One response is the idea of a “medical home,” in which a doctor or other healthcare professional oversees the complexities of an individual patient's care. This model is based on the notion that better management of illness, particularly chronic conditions, can lead to lower costs over time and to better results for patients. The success of this model lies in efficient use of specialists and provision of the right level of care, without triggering the costly overuse of medical services. Retail clinics and allied health professionals could be used to treat routine conditions and guide strategies to manage disease and ward off expensive acute episodes.

New Customer Focus for

Pharma and Suppliers:

The Changing Face of Medicine

It is only a slight exaggeration to say that the age of the entrepreneurial physician is nearly over. Ever-increasing numbers of primary care physicians are employed by hospitals or health systems, and most new graduates assume that is the model for the future. Lifestyle issues are

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ever more important to the physician workforce, meaning that they are reluctant to take on the additional work of handling their own administrative matters—especially as these become increasingly onerous. Finally, margins on diagnostics and drugs (particularly in oncology) are eroding drastically, which is having an impact on some specialists' net income. Perhaps in a decade, the only truly independent physicians left will be plastic surgeons, ophthalmologists, a few large group practices, and a few heart surgeons.

The implications for pharmaceuticals and high-end, high-tech suppliers are clear. Targeting individual doctors (or small groups) is unlikely to remain the predominant channel and method of choice. Although such focused selling is already disappearing owing to plan-driven formulary restrictions and group purchasing organizations, it still works—witness the spotty compliance with preferred products in such categories as pacemakers, stents, and artificial joints. However, investments made to maintain the old system are probably doomed to become a rearguard action. Sales in the future will be increasingly institutional in nature (hospitals, health systems, health plans), with much higher compliance rates driven by the employment of ever-larger numbers of physicians and the continued progress of EBM and other best-practices tools. Seller beware.

CONCLUSION

There are no guarantees in life, particularly in any realm in which politics plays a major role and the economy is in crisis. Healthcare in America is certainly at a crossroads, but a political consensus is lacking and the fiscal cupboard is rapidly depleting. The healthcare system should probably take some comfort in concluding that while fundamental change is on the Obama administration's radar, critical details have yet to be defined and are not likely to be fleshed out in the near-term. The bad news, however, is that fundamental change is a lot closer than many originally believed possible in the current economic environment—and getting increasingly closer with each year that the nation delays or ignores strategies to improve the existing system.

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