The Volatile Healthcare Environment

If you think health care is expensive now, wait until you see what it costs when it's free.
—P. J. O'Rourke

CHAPTER OBJECTIVES

- Develop an awareness of the major changes that have occurred in healthcare delivery over the recent several decades.
- Address the introduction of managed care and review its history up to the present.
- Review the impact of the Balanced Budget Act of 1997.
- Examine the advent and present status of active marketing of healthcare services.
- Identify the various settings in which present-day health care is delivered.
- Briefly review the presence and effects of external regulatory pressure on the healthcare industry.
- Address the changes that are occurring and continue to occur in the healthcare environment and examine the likely effects of these changes on the role of the healthcare supervisor.
- Provide a brief overview of the Patient Protection and Affordable Care Act (PPACA, or "Healthcare Reform") and its status and long-term implications.

FOR CONSIDERATION: PREDICTIONS ARE STRANGE PHENOMENA

No one really knows with certainty what will come to pass in the future (unless, of course, the "future" under consideration consists of only the next few minutes). Nevertheless, the uncertainty of the future seems not to prevent many people from offering pronouncements about what is to come.

These few comments do not refer to the "off-the-wall" predictions that are offered minus a seemingly sound basis in the present, such as the end of the world "according to the Mayan calendar" or the imminent collision of planets. Rather, the predictions referred to here are extrapolations upon some known circumstances that have factual foundations in the knowledge of the "present" (meaning the time when the predictor is predicting). Consider a scant few examples:

- "The abdomen, the chest, and the brain will forever be shut from the intrusion of the wise and humane surgeon." *Sir John Erickson, Surgeon Extraordinary to Queen Victoria, 1873.*

- "I have traveled the length and breadth of this country and talked with the best people and I can assure you that data processing is a fad that won't last out the year." *An editor of business books, 1957.*
- "Everything that can be invented has been invented." Charles H. Duell, Commissioner, U. S. Patent Office, 1899, calling for the closure of that office.
- And, although not exactly a prediction: "For the majority of people, smoking has a beneficial effect." *A physician quoted in* Newsweek, *November 1963.*

There are many more such examples available, but the basis for the point has been established. These and many other such predictions were offered not by ignorant or ill-informed individuals; rather they were voiced by educated and intelligent individuals many of whom could point to extraordinary accomplishments and advancements in their fields.

In the way of an informal exercise, describe one or two such instances in which someone's "prediction" was far off the mark. Try also to advance one or more possible reasons why intelligent and well-educated people can be so drastically wrong in their predictions. (Reasons are addressed later in the chapter.)

People who have some knowledge of the state of the U.S. healthcare system of not-too-many decades ago—say particularly in the late 1960s and early 1970s—may well recall the naysayers, including physicians, hospital executives, insurers, and many others, who predicted that the concept of managed care, as embodied in the health maintenance organization (HMO), would fail. A few interested factions were so strongly anti-HMO that some of the states went so far as to pass laws that impeded or blocked altogether the establishment of HMOs. But managed care arose in spite of all the early negativity heaped upon it.

THE MANAGED CARE "SOLUTION"

The Beginning of Restricted Access

Aside from technological advances, most of what has occurred in recent years in the organization of healthcare delivery and payment has been driven by concern for costs. Changes have been driven by the desire to stem alarming cost increases and, in some instances, to reduce costs overall. These efforts have been variously focused. Government and insurers have acted on health care's money supply, essentially forcing providers to find ways of operating on less money than they feel they require. Provider organizations have taken steps to adjust expenditures to fall within the financial limitations they face. These steps have included closures, downsizing, formation of systems to take advantage of economies of scale, and otherwise seeking ways of delivering care more economically and efficiently. It was in this cost-conscious environment that managed care evolved.

Managed care, consisting of a number of practices intended to reduce costs and improve quality, seemed, at least in concept, to offer workable solutions to the problem of providing reasonable access to high-quality care at an

affordable cost. Managed care included economic incentives for physicians and patients, programs for reviewing the medical necessity of specific services, increased beneficiary cost sharing, controls on hospital inpatient admissions and lengths of stay, cost-sharing incentives for outpatient surgery, selective contracting with providers, and management of high-cost cases.

The most commonly encountered form of managed care is the health maintenance organization. The HMO concept was initially proposed in the 1960s when healthcare costs began to increase out of proportion to other costs and so-called "normal" inflation at about the time of the introduction of Medicare and Medicaid. The HMO was formally promoted as a remedy for rising healthcare costs by the Health Maintenance Organization Act of 1973. The full title of this legislation is "An Act to amend the Public Health Service Act to provide assistance and encouragement for the establishment and expansion of health maintenance organizations, and for other purposes."

The HMO Act provided for grants and loans to be used for starting or expanding HMOs. This law preempted state restrictions on the establishment and operation of federally qualified HMOs, and it required employers with 25 or more employees to offer federally certified HMO options if they already offered traditional health insurance to employees. (It did not require employers to offer health insurance if they did not already do so.) To become federally certified an HMO had to offer a comprehensive package of specific benefits, be available to a broadly representative population on an equitable basis, be available at the same or lower cost than traditional insurance coverage, and provide for increased participation by consumers. Portions of the HMO Act have been amended several times since its initial passage, most recently by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Specifically, an HMO is a managed care plan that incorporates financing and delivery of a defined set of healthcare services to persons who are enrolled in a service network.

The introduction of managed care placed, for the first time in the history of American health care, significant restrictions on the use of services. The public was introduced to the concept of the primary care physician as the "gatekeeper" to control access to specialists and various other services. Formerly, an insured individual could go to a specialist at will and insurance would usually pay for the service. But with the gatekeeper in place, a subscriber's visits to a specialist were covered only if the patient was properly referred by the primary care physician. Subscribers who went to specialists without referral suddenly found themselves billed for the entire costs of specialists.

By placing restrictions on the services that would be paid for and under what circumstances they could be accessed, managed care plans exerted control over some health insurance premium costs for employers and subscribers. In return for controlled costs, users had to accept limitations on their choice of physicians, having to choose from among those who agreed to participate in a given plan and accept that plan's payments, accept limitations on what services would be available to them, and, in most instances, agree to pay specified deductibles and copayments.

Managed care organizations and governmental payers brought pressure to bear on hospitals as well. Hospitals and physicians were encouraged to reduce the length of hospital stays, to reduce the use of most ancillary services, and to

meet more medical needs on an outpatient basis. Review processes were established, and hospitals were penalized financially if their costs were determined to be "too high" or their inpatient stays "too long." Eventually, payment became linked to a standard or target length of stay so that a given diagnosis was compensated at a predetermined amount regardless of how long the patient was hospitalized.

As managed care organizations grew larger and stronger they began to negotiate with hospitals concerning the use of their services. Various plans negotiated contracts with hospitals that would provide the best price breaks for the plan's patients, and price competition between and among providers became a reality.

During late 1998 and early 1999 approximately 160 million Americans were enrolled in managed care plans, encompassing what may well have been the majority of people who were suitable for managed care. In-and-out participation of some groups, such as the younger aging and Medicaid patients, was anticipated. However, the bulk of people on whom managed care plans could best make their money were supposedly already enrolled. But managed care continued to grow in a manner essentially consistent with the growth of the population overall. According to the trade association America's Health Insurance Plans, by 2007 approximately 90% of insured Americans were enrolled in plans with some form of managed care.[1] Total participation today continues at or near this 90% level.

Much of the movement into managed care was driven by corporate employers attempting to contain healthcare benefit costs. However, during this same period of growing managed care enrollment, the number of managed care plans experiencing financial problems also increased steadily.

It appears that managed care was able to slow the rate of health insurance premium increases throughout most of the 1990s. However, early in the first decade of the new century the cost of insurance coverage again began climbing at an alarming rate. The increase continued; it was reported in 2005 that health insurance premiums would increase in some areas by more than 12% for 2006, making 2006 the fifth straight year of double-digit premium increases for many.[2] This grim prediction for 2006 was fulfilled, and the trend has continued; increases for 2011 and 2012 averaged in excess of 10%.

By the end of the 1990s it appeared that the majority of average middle-class subscribers had reached a negative consensus about managed care. This caused some damage to the political viability of for-profit managed care and it hurt managed care overall. Indeed, it seemed increasingly likely that managed care might not be financially affordable in the long run.

The year 2000 was especially grim for the relationship between managed care plans and Medicare. As a result of decisions made during the year, on January 1, 2001, nearly a million beneficiaries in 464 counties of 34 states lost their coverage when 118 HMOs withdrew from Medicare. In addition, many of the plans that remained in Medicare increased premiums and reduced benefits, in response to what were described as continually rising costs and the effects of cuts in reimbursement rates. In December 2000 Congress voted for billions of additional dollars for Medicare HMOs, supposedly to reduce premiums or increase benefits to subscribers. However, wording of the legislation also allowed HMOs to pay more to their networks of hospitals and doctors,

thus consuming the majority of the additional funds. As a result, only 4 of the 118 HMOs that withdrew returned to Medicare.

It is reasonable to say that although managed care provided cost-saving benefits at least for a time, it is evident that managed care plans have not been able to sustain their promises of delivering efficient and cost-effective care. An aging population, newer and more expensive technologies, newer and higher priced prescription drugs, new federal and state mandates, and pressure from healthcare providers for higher fees have essentially wiped out the savings from managed care for employers and subscribers alike. It is likely, however, that without managed care, costs and cost increases would be even more pronounced than at present.

THE BALANCED BUDGET ACT OF 1997

Major Cuts Affect Medicare Providers

The Balanced Budget Act (BBA) of 1997 was adopted in part because of the increased fiscal pressure caused by the growth of Medicare payments, concern over Medicare over-payments, the desire for more rational payment methods, and a stated wish to offer beneficiaries greater choice. By mandating that federal revenues and federal expenditures be balanced each fiscal year, the BBA fundamentally altered the rules of fiscal policy-making in the United States.[3] (It perhaps need not be said that the mandate to balance the federal budget has been dramatically overridden in recent years.) A balanced budget would of course be sensible, but it was the manner in which budget balancing was implemented that forced disproportionate reductions in healthcare reimbursement. In terms of its overall effects, the BBA became the most significant piece of healthcare legislation since Medicare and Medicaid were established in 1965.[4]

The reductions required to balance the budget were not taken uniformly from all elements of the budget. More than half of the federal budget—specifically the very large piece of the budget including Department of Defense spending, Social Security, and interest on the federal debt—was insulated from cuts, meaning that the entire balancing reduction would have to come from the remaining less-than-half of the budget. Medicare had some time earlier attained the position of the nation's largest third-party payer for healthcare services. As a direct result of the BBA, drastic cuts occurred in Medicare reimbursement, therefore affecting the income of healthcare providers. The BBA required $122 billion in spending cuts over a 5-year period beginning with 1998, with the overwhelming majority of reductions—95% or $116 billion—coming from one single source: Medicare. And most of the reductions were attained by eliminating or reducing payments to actual providers of health care.[5]

Widespread Hardship

The elements of the healthcare system most affected by the BBA were a matter of opinion, specifically the opinion rendered according to where one was situated in the provider population. According to some sources, the reductions of the BBA clearly targeted postacute care services, especially skilled

nursing facilities and home health agencies.[6] Certainly a number of healthcare professionals were affected by the BBA, including physical therapists, occupational therapists, and speech pathologists whose reimbursement was severely capped. The BBA cap on combined rehabilitation services, effective January 1, 1999, had the effect of dramatically reducing the number of rehabilitation professionals employed in long-term care facilities and also resulted in the closing of some facilities.[7]

Those in postacute care who felt specifically targeted were not alone; persons responsible for operating a great many hospitals likewise felt singled out for significant reductions in reimbursement. For most hospitals, Medicare had much earlier become a significant source of income; for a great many, it had become their largest third-party payer. Depending on various reimbursement systems in place in some states, for years Medicare had been the single significant payer that essentially contributed the full cost of care and helped these institutions remain financially viable. However, the BBA's arbitrary reimbursement reductions forced many acute care institutions into the red, increased pressures for cost reductions, brought about closures, and prompted an increased number of mergers and other affiliations.

Some degree of relief from the BBA arrived in the form of the Balanced Budget Refinement Act (BBRA) of 1999, arising perhaps out of recognition that the act itself went too far in reducing reimbursements. The BBRA became law in November 1999, and it suspended the cap that had been placed on outpatient rehabilitation services and paved the way for the design of a new payment mechanism. Also contributing some relief for providers was Congress's December 2000 infusion of cash in recognition of many managed care plans' abandonment of Medicare participation. Regardless of these positive steps, however, the BBA brought some irreversible consequences to healthcare providers.

MARKETING HEALTH CARE

Opinions concerning the place of marketing in health care run the gamut from complete acceptance to total rejection. The range of attitudes perhaps exists in part because there are many people who continue to see "marketing" as simply "advertising" or "selling," and for many years the principal professions, especially the health professions, did not advertise. True marketing, of course, consists of more than advertising, but to a significant portion of the population these terms are likely to remain synonymous.

The marketing process essentially encourages potential clients or customers to differentiate the organization's products and services from those of competing organizations. Accepting this as a thumbnail definition of marketing, we might then proceed to ask: Is this sort of differentiation necessary in health care? At one time in the recent past many would have said that such differentiation was not particularly necessary. Today, however, marketing is a fact of business life for many if not most healthcare organizations. As health care becomes more volatile, as medical practice continues to change and some providers strive to fill unused capacity, as payment mechanisms and forms of provider organizations proliferate, competition will continue to intensify between and among elements of the healthcare system.

Competition in health care essentially involves three major areas of concern: access, cost, and service quality. What becomes complex is the consideration of who is being courted for their favor at any given time. Patients are the ultimate consumers of health care; it is for them that the system exists. However, because most patients neither select their own health care nor directly pay for their care, a number of different relationships enter the marketing equation, including the following:

- Physicians admit patients to hospitals, so hospitals have a stake in getting a certain number and kind of physicians on their admitting staffs.
- The diminishing use of inpatient hospitalization has brought some hospitals into direct competition with each other as unused capacity grows.
- Hospitals supply patients to rehabilitation and long-term care facilities, which thus have an interest in cultivating relationships with hospitals.
- Managed care plans (HMOs, etc.) and traditional insurance plans, both for-profit and not-for-profit, attempt to sell themselves to employers, individuals, and care providers. Providers, in turn, endeavor to sell themselves to the plans they feel will best serve their needs.
- An increasing number of medical group practices, freestanding surgical centers, clinics, and the like, most being products of the recent 3 decades, vie with each other for patients either directly or through physician referrals.
- Pharmaceutical companies vigorously promote their products with the physicians who prescribe medications for patients. Since the late 1990s pharmaceutical companies have also engaged in widespread advertising aimed at encouraging patients—those ultimate consumers—to ask their physicians for specific medications.

All of the preceding circumstances suggest that marketing is becoming increasingly important to the healthcare organization and that the rapidity of change occurring within health care is subjecting providers to the same uncertainties that most other industries face in the normal course of business. Today's healthcare organization cannot afford to go forward without the benefit of a well-thought-out and regularly updated marketing plan.

HEALTHCARE SETTINGS

Earlier in this chapter it was suggested that at one time there were few healthcare organizations except for hospitals, and that these were little more than places where the terminally ill, mostly poor or disadvantaged, were maintained until they died. At that time there were but two or three other kinds of healthcare organizations. There were private clinics, mostly small and usually associated with the practices of one or more physicians and available to persons who could afford to pay for their care. There were institutions known primarily as asylums, publicly or religiously operated, that did little more for the mentally ill and seriously impaired than keep them contained, often in fairly grim circumstances. And there were other organizations, again publicly or religiously operated, whose mission was the housing and supervision of older persons and the infirm. These were usually known as homes of various kinds (rest home, county home, church home, etc.).

Many of the examples used throughout this text are drawn from the hospital setting, but other settings are referred to as well. The modern acute-care hospital uses the broadest range of healthcare occupations of any specific healthcare setting. Hospitals continue to employ the greatest percentage of healthcare workers of most occupations, but this percentage has been shrinking steadily as healthcare workers are able to find employment in a growing number of other settings. In addition to both general and specialty hospitals, largely not-for-profit but some for-profit, privately, governmentally, or religiously operated organizations, we find healthcare workers today employed in the following:

- Long-term care facilities, including nursing homes, and a range of designations generally indicating the levels of care provided or the kinds of populations served
- Rehabilitation facilities, sometimes freestanding (for example, a physical therapy practice) as well as often part of acute-care or long-term care organizations (for example, a hospital's cardiac rehabilitation program)
- Medical and dental practices, ranging from solo practices to large groups that may be either generalized (family practice, internal medicine, etc.) or specialized (obstetrics/gynecology, prosthodontics, etc.)
- Freestanding surgical centers, where an increasing number of surgical procedures are being accomplished without hospitalization
- Walk-in clinics, urgent care centers, and other designations, essentially freestanding medical practices that patients use without appointments
- Health centers, collections of medical practices and ancillary services sharing location and clientele
- Home health agencies, both privately and governmentally operated, using an increasing number of nursing and rehabilitation personnel as home-based healthcare services proliferate
- Free-standing clinical laboratories, including commercial, governmental, and shared not-for-profit entities
- Hospice programs, caring specifically for the terminally ill, both as free-standing and palliative care units of larger entities
- Insurance companies, managed care plans, professional medical review organizations, and government agencies (health departments and other regulatory bodies), all of which employ some health professionals
- Suppliers to healthcare providers and their patients, including pharmacies, pharmaceutical manufacturers, equipment manufacturers, medical transportation companies, and numerous others that provide the materials and services that keep health care functioning

The style of management one might employ may well differ from one setting to another depending on the nature, size, and how a particular function happens to be organized. However, it should be clear at this point that most of health care tends strongly toward Rensis Likert's *cooperative motivation system* and that most healthcare management will necessarily be people centered rather than production centered.

FOR CONSIDERATION: PREDICTIONS

Examples of predictions that turned out to be dramatically incorrect are numerous. To add just three more to those cited earlier:

- "There is no reason why anyone would want a computer in the home." *President of Digital Equipment Company, 1977.*
- "Heavier-than-air flying machines are impossible." *Lord Kelvin, Royal Society, 1895.*
- "Airplanes are interesting toys but they have no military value." *Maréchal Ferdinand Foch, Professor of Strategy.*

As noted earlier, these and many other such predictions were made by educated and intelligent individuals many of whom were highly accomplished in their fields. How can such intelligent and well-educated people can be so drastically wrong in their predictions? Perhaps there is at work in some people a sort of intellectual arrogance suggesting that what they already know is at or near the limit of useful knowledge of a particular subject. It is sometimes the educated, intelligent, and accomplished individual who is unable to—to use the expression that has earned cliché status—"think outside the box." It is not unusual for such persons to behave in a manner suggesting that the boundaries of "the box" are essentially defined by what they already know. Thus anything that is not already in "the box" of their knowledge either does not exist or is of little consequence, or, as is the case with so many predictions, is simply not possible.

Why this brief diversion concerning predictions? Because the present healthcare environment in the United States is anything but stable, predictions concerning the short- and long-term picture of American health care abound, and a great many of such predictions are at odds with each other. A major case in point is managed care; the majority of predictions concerning managed care were pessimistic, predicting that managed care would not prevail. This perhaps suggests that no matter how knowledgeable and educated we may be, we seldom know what the future holds until the future becomes the present.

EXTERNAL PRESSURE: AN AREA OF CONTINUING CONCERN

The "health-care-is-different, period" argument generally does not succeed in differentiating health care from other lines of endeavor. However, there are some legitimate differences that are more visible in health care than in other fields. These differences have come in the form of pressure from sources outside of the healthcare organization. This is not to claim that health care has a monopoly on external pressure.

Every work organization that serves people in any way experiences pressure from outside, even if that pressure is as basic as competition from others in the same business. We will not even claim for health care the burden of maximum external regulation. Although health care, or at least health care's hospital sector, may well be the most strictly regulated business in the country, other businesses such as insurance, banking, and public utilities are highly

regulated as well. However, very few businesses overall are as highly regulated as those just mentioned, and factors in addition to regulation conspire to make health care considerably different in some ways.

Growing regulatory intrusion, increasing financial constraints, and mounting public attention to healthcare costs have combined to create a unique, frequently high-pressure work environment for the supervisor. A product of recent decades, this high-pressure environment will likely prevail into the distant future.

The healthcare organization understandably has a strong interest in maintaining the level of income necessary to provide its services and remain solvent. However, healthcare costs continue to increase at a rate exceeding the overall inflation rate. In recent years, nonhealth businesses' major concern with health care has been with ways of slowing the growth of the amount paid for health insurance coverage. Thus healthcare management has been caught in a rather elemental squeeze between external limitations on income and the need to pay open-market prices for the products and labor needed to continue delivering service.

Some undeniable forces have entered the healthcare system and are reshaping the way that supervisors do their jobs:

- Healthcare costs are being capped in several ways in a continuing effort to prevent them from growing unchecked.
- Competition, once a negligible factor in health care, has become a way of life.
- Continued high-quality health care will be demanded despite constant pressure to contain or reduce costs.

Again, no particular form of external pressure is the province of health care alone. However, virtually every form of external regulation and intrusion is present in health care, making health care one of the country's most regulated activities. This places pressure on the manager to continually strive to produce more with less, and because the healthcare organization tends toward Rensis Likert's cooperative motivation system with its dependence on individual employee enthusiasm and motivation to keep the work progressing, it means that every supervisor must inspire the employees to willingly work under increasing pressure while conserving scarce resources.

Some have claimed that a preponderance of rules and regulations should make management easier; one has only to follow what is prescribed. To the contrary, burgeoning rules and regulations have made healthcare management considerably more difficult, because they mean that health care's desired outcomes—high-quality service with fiscal viability—come only through creatively finding a way through the obstacles.

THE CHANGING FACE OF HEALTHCARE MANAGEMENT

The Only Constant

We are continually reminded that the only constant in this life is change. Change is inevitable; sometimes it accrues slowly, so minimally perceptible that we become impatient. More often, however, and especially in the working

world of the healthcare supervisor, change seems to proliferate at a dizzying pace that leaves us figuratively out of breath and forever at least a little bit behind.

Change in the management of activities in any particular industry is a function of the interrelationship of three sets of determinants:

- Changes within the industry, usually in products, services, processes, etc.
- Universal changes in management practice
- Changes in the values and beliefs of society overall

Specific to health care, many of the changes occurring within the industry are technological. Although technology is advancing rapidly in all areas of human endeavor, health care remains near the forefront of activities that are most subject to technological turnover. Also, significant social changes have created financial pressures that continue to bear on the industry with increasing intensity.

The role of the supervisor is undoubtedly changing in every environment, but in few environments is it changing more rapidly than in health care. As the industry changes so must management within the industry change, so the role of the supervisor is forced to change. In terms of the effects of change, health care is in some ways similar to other activities but in some ways is remarkably different.

Managing in Health Care: How Different?

Health Care as an Industry

An age-old argument concerns supposed differences between health care and "industry," with "industry" bearing an unfavorable connotation and generally understood to refer to manufacturing and factory settings. For more than half of the 20th century, some significant and proven management practices and techniques were denied application in health care simply because they had originated in "industry."

Any number of readily available dictionaries tell us that an "industry" is a branch of the production and sale of goods and services, as in, for example, the automobile industry (goods), the steel industry (goods), the financial planning industry (services)—and the healthcare industry (services). Overall, health care as an organized endeavor is one of the largest employers in the United States, which fact alone should identify health care as not just an industry but an industry of significant proportions. Health care is by definition the second largest service industry in the country (the largest being government).

The Source of Real Differences

There are, however, legitimate differences in how various kinds of organizations are managed. But these differences are not dictated by industry definition or determined by industry characteristics. Rather, these differences are determined by the kinds of work that must be done and by the ways in which it is most effective to organize the accomplishment of work. Two opposing systems of management were postulated by Rensis Likert in *New Patterns of Management*: the *job organization system* and the *cooperative motivation*

system. Because the job organization system depends largely on economic motives and the cooperative motivation system depends mostly on individual enthusiasm and motivation, it stands to reason that management style may differ from one setting to the other.

It should be evident to most people working in health care that a typical healthcare organization, and especially a hospital, is primarily describable by the cooperative motivation system. However, few if any pure extremes exist among organizations of any appreciable size. For example, a hospital's food service tray assembly line is a classic example of the job organization system found within an organization that is perhaps more than 90% describable by the cooperative motivation system.

After decades of what was essentially isolationism, health care began to import management practices from elsewhere. Resistance gave way gradually, and eventually healthcare management practices began to resemble the people-management practices of other industries. Because health care is largely characterized by the cooperative motivation system, and because management in this kind of system is people centered rather than production centered, a variety of people-management approaches have proven appropriate for health care although coming from a number of other settings.

Determinants of Style and Approach

In a well-ordered production-centered operation, the system will continue to function reasonably well as people come and go. However, in a strongly people-centered operation system functioning fluctuates as people come and go. Consider the primary difference between the two kinds of systems as fundamental as the difference between a moving sidewalk and a stationary sidewalk. The job organization system is the sidewalk that keeps moving while people step onto and off of it; the cooperative-motivation system is that stationary sidewalk which takes no one anywhere unless the person steps out and walks.

In addition to being people centered in its management needs, health care is a business characterized by close customer contact. This very hands-on nature of the business is often used to claim that health care is different because it *is* health care. The true differences from other activities, however, lie not in the supposed importance of health care but in the closeness of service to the customer. It is *immediacy of contact* with customers—the closeness in time and space between provider and user, quite literally the hands-on character of much service—that influences much of the way such organizations are managed. Thus much of management in health care consists of managing the *people* providing the service rather than managing the *means* of providing the service.

Determinants of Management Style

Therefore, the determinants of management style vary not according to "industry" but according to the kinds of organizational systems that apply. These determinants and their applicability to health care are:

- *Immediacy of contact with consumers.* In health care this contact is immediate, literally hands on in many instances.
- *Predictability of outputs.* Outputs are not highly predictable and therefore cannot readily be scheduled and accomplished as predetermined.

- *Professionalism of employees.* This can be significant in health care, with management complicated by the presence of employees ranging from unskilled to highly skilled in the same organization and often in the same department.
- *Job structure.* Most of the jobs in health care are not highly structured, that is, they cannot be supplied with definitive job descriptions that reliably capture all possible tasks that will be encountered.
- *Employee mobility.* The more employees legitimately move about in performing their work, the more they must be relied upon to perform individually. Many healthcare employees are moderately to highly mobile.
- *Variability of work.* Within health care the work is considerably more variable than repetitive.
- *Quality required.* The hands-on nature of health care and the individual importance of a person's health essentially dictate a level of quality superior to that of many other settings.

The ways in which the foregoing characteristics are manifested in health care suggest a need for people-centered styles of management. The foreseeable future will likely see even stronger indications—for example, more immediacy of contact, more and greater levels of professionalism and thus less job structure, less predictability of output, etc.—of the need to be far more people centered than production centered.

Health Care Then and Now

The introduction of Medicare and Medicaid in the mid-1960s was a significant force in launching the country's healthcare system on the track it has followed ever since: cost escalation and thus cost containment, managed care and the advent of rationing, and dramatic structural changes in what had hitherto been a cottage industry. In the late 1960s healthcare cost inflation became painfully evident, and in various parts of the country initial steps were taken to attempt to control costs.

The 60s and 70s, especially the latter, also gave rise to the *professionalization* of healthcare (primarily hospital) management that prevails today. Consider, for example, the changes in one particular multicounty region of the country from 1969 to 1999. In 1969 this region was served by 25 hospitals. The chief executive officers (then simply "administrators") of these hospitals included two medical doctors, four registered nurses, three accountants, one physical therapist and one laboratory technician, seven people of a variety of other educational backgrounds, and seven professional hospital administrators (educated at the master's level in hospital or health services administration). By contrast, in 2009 this same region, with a considerably expanded population, was served by 19 hospitals *all* of which were headed by professional hospital executives.

In the not-too-distant past healthcare organizations were decades behind their nonhealth counterparts in a number of respects. For most of the country the Fair Labor Standards Act (FLSA) had been in effect since the mid-1930s. However, it was not until 1967 that hospitals were brought under the

minimum wage and overtime provisions of the FLSA. Before 1967 it was common to find subminimum wages in hospitals.

From minimal initial impact, *regulation* of healthcare activities began to expand in the late 1960s and continues to grow. Whether from accrediting organizations or state or federal government agencies, regulatory pressures have become significant to the extent of absorbing the full-time attention of some staff in many healthcare organizations.

The stage was set for significant changes in the *unionization* of healthcare employees with the 1974 amendments to the National Labor Relations Act (NLRA). These amendments brought hospitals under the coverage of the NLRA where previously they were addressed only in the labor laws that may have existed in some states. This change made hospitals more susceptible to labor organizing, a susceptibility that continues today with union membership expanding in the healthcare workforce while it declines in the American workforce overall.

Also, advances in medicine and medical *technology* have given healthcare managers more methods, processes, procedures, and even more healthcare occupations to contend with. With little effort it is possible to name several now-common healthcare occupations that did not exist in the 1960s or 1970s.

Changes in People Management

Evolution of Employee Relations

Considering what has occurred in the past in how management relates to employees, and what changes have occurred and continue to occur, there appear to be three overlapping but distinctly identifiable phases in employee relations:

1. *Authoritarianism,* dating from the time when one person first employed another and ending—at least legally, if not factually—in the early 1960s.
2. *Legalism,* the reliance on laws, rules, and regulations that still constitutes much of today's approach.
3. *Humanism,* an emerging trend and the likely direction of the future, in which each person is regarded as a whole person and not simply as a producer of output.

There is nothing clear-cut about these phases of employee relations. Although in the very early 20th century and even before that time there were undoubtedly some humanistic employers, the majority of work organizations were run in authoritarian fashion by autocratic leaders. Autocratic leadership ran the gamut from purely exploitative (the "Attila-the-Hun" school of management) to the solidly benevolent (the "father-knows-best" approach), but the operative beliefs remained the same: The boss calls the shots, and the boss is always right; period, no argument.

Some pockets of authoritarianism can still be found. Yet genuine humanism, although not at all widespread, is taking hold in more and more organizations. For the greatest part we probably remain rooted in the legalistic phase. We can describe this phase as having been fully launched with the passage of the

Civil Rights Act of 1964, although earlier labor laws and wage-and-hour laws put some of legalism's foundations in place during the 1930s, 1940s, and 1950s.

Before 1964, individual managers had far more freedom to act as they may have seen fit in any particular situation. Not so at present; there are many rules to be followed. Why legalistic? Do we not behave well toward employees because we *want* to treat them humanely? Or are we simply following rules because we fear the consequence of not doing so?

In the past, deliberate discrimination was not always at the heart of most managers' actions concerning employees. It is much more likely that a significant proportion of unjust personnel actions stemmed from thoughtlessness, carelessness, and inconsistency on the part of managers. Many managers' actions tended to be loose and inconsistent because there were no external pressures on the organization to encourage managers to behave in any other way.

Much of what makes the present phase of employee relations legalistic is a matter of management attitude. Far too many managers and personnel practitioners behave as they do today not because of humanistic beliefs or tendencies but because they wish to keep their organizations and themselves out of legal trouble. It is common for managers to behave in certain ways because they fear the possibility of complaints from external agencies or they do not wish to inspire lawsuits, or simply because they are mindful of following the organization's policies.

Genuine and willingly dispensed humane treatment cannot be legally mandated; it requires long-term change within people. However, fair and consistent terms and conditions of employment *can* be legally mandated, and this is exactly what has been happening since 1964. Both new and amended laws affecting terms and conditions of employment have been raining down on business in general for more than 4 decades, continuing to alter the requirements of people management.

Visible Employment Trends

Once it was universally believed that a college education in just about anything would lead to a well-paying position on a secure career path. Presently, however, the simple fact of a college degree is often not enough, as attested to by the numbers of college graduates who have been unable to connect with desirable employment.

Decades ago it was also felt that those who seemed unsuited for higher education could secure their futures through factory employment with any of a number of major corporations. This, too, is no longer the case.

Employment security is more and more becoming an elusive notion. Where once an individual could seemingly secure his or her future by going to work for any of a number of major employers and performing as expected, now even the best of performers can find their employers dramatically affected by conditions largely beyond their control. Accelerating technological and social change are compressing organizational and industry life cycles such that a specific employer can arise, grow, peak, shrink, and vanish in less time than one person's normal career span.

Where a worker of the not-too-distant past could by choice spend an entire career with one employer, the worker entering the workforce today is likely to experience a career spread across two, three, or more employments. This certainly applies to managers as well as nonmanagers, so today's healthcare supervisor will likely subscribe to a different concept of loyalty than the supervisor of 3 decades ago. Perceiving that today's organization is not particularly loyal to employees, today's manager becomes in turn less loyal to an employer. Today's managers are far more likely to extend loyalty to their occupations and to themselves than to their employers.

The Supervisor's Two Essential Hats

The supervisor in health care is obliged to wear two hats, the hat of the functional specialist—that is, the worker in some specific field—and the hat of the manager. Except for managers at the highest organizational levels, the person who manages the work that other people do must also do some of that work and must certainly be able to apply knowledge of how the work is done. Many of the problems experienced by working supervisors arise from the fact that they are thoroughly prepared to wear the hat of the worker but much less prepared to wear the hat of the supervisor.

One becomes a specialist in any occupation through education, training, and perhaps experience. This is especially true of the health professions; these require sometimes extensive education. However, one usually becomes a supervisor with little or no specific preparation, then proceeds to "manage" uncomfortably, perhaps even awkwardly, while resisting, often unconsciously, many of the management tasks that produce discomfort.

The vast majority who find themselves in this two-hat situation automatically tend to favor the hat that fits best. Thus a great many supervisors tend to favor their primary occupation over their management role because they simply are not as comfortable functioning as managers.

In the months and years ahead it is going to be all the more important for supervisors to be able to balance the two hats, wearing the hat of the manager with equal facility as the hat of the functional specialist. The healthcare supervisor's role is simply expanding too rapidly for one to continue taking refuge within a working specialty. Management is becoming, quite literally, a second career for some, a career that will eventually take precedence over what one may have considered one's primary career.

Healthcare Management's Apparent Directions

Same as Before, but More

Rapid technological change in medicine continues, making a strong technical orientation all the more important for the individual supervisor. More than ever the supervisor will have to strive to stay current technologically as well as managerially. The two hats will remain equally important, and because of changes on both sides of the job—structural, organizational, and functional changes affecting the management role, as well as technological changes affecting the specialist role—the supervisor will experience intensifying pressure on both sides.

Health care will likely continue to get most of its new managers by promotion from the ranks of working specialists and professionals. However, we are seeing more specialists and professionals who experience at least some limited formal preparation for management before assuming that role. Fewer supervisors today are just "thrown in" and left to learn as they go along, although this is still exactly what happens to far too many who are promoted from within.

Anecdotal evidence suggests that the majority of managers in health care, whether first-line supervisors or middle managers, tend to identify more strongly with a profession or occupation than they do with management. However, the tendency to identify strongly with management as well appears to be increasing. Still, it is fully understandable that many who manage at the caregiving level will identify in the long run more strongly with a profession (nursing, physical therapy, respiratory therapy, etc.) than with management until such time as they may move up to general management positions (responsible for multiple functions).

The pace of activity in many branches of health care, for some time now increasingly hectic if not frantic, can be expected to intensify. It is becoming increasingly necessary for today's healthcare managers to adapt to rising levels of stress, an accelerating pace, and an ever-expanding variety of tasks. Thus there will be increasing hazards for those who by nature internalize, who tend to personalize stresses and assume the discomforts of others, as the potential for burnout continues to grow.

There will of course be continuing growth in the individual healthcare manager's level of accountability. This is a natural consequence of the organizational restructuring and flattening of the hierarchical structure that are giving managers larger areas of responsibility and greater numbers of employees.

Good Employees Remain Hard to Find

It is relatively certain that shortages of specific kinds of specialized labor will continue for the foreseeable future. There will, of course, be fluctuations of personnel available in various specialties, and these fluctuations will include periods during which the supplies of particular specialties will be adequate. Cycles are evident in the supplies of various kinds of trained personnel. Supplies of personnel in a number of health specialties will ebb and flow, whereas a few—including, in many parts of the country, registered pharmacists, physical therapists, and occupational therapists—may remain in a shortage situation. These, too, however, can be subject to cycles in supply.

Managers may find themselves digging deeper into the walk-in applicant pool in search of entry-level help. This practice has been evident for some time now, as managers have proceeded to take more chances with applicants who are relatively uneducated or who exhibit work records that are less than completely satisfactory. In many instances orientation procedures have been strengthened to attempt to compensate for entry deficiencies, and managers have accepted the fact of increased turnover as an increasing percentage of those hired fail to work out.

Beyond strengthened orientation procedures lies the emerging need to provide basic remedial education for many entry-level employees. Organizations that once would never have considered doing so may do for many job applicants

and new employees the job that was not done by schools and families. And beyond providing practical education in basic skills such as reading and simple mathematics, managers will find themselves involved in attempting to instill the basic work ethic and elementary sense of responsibility that are needed in the employees who remain in the organization's workforce. Although much remedial education will doubtless be undertaken centrally in most organizations, some of this remedial education and essentially all of the necessary on-the-job training will take place within individual departments.

The role of instructor has always been a significant part of the supervisor's job. Because of the growing need to put forth extra effort to ensure the employability of a larger part of the walk-in applicant pool, the coming years will bring increasing emphasis on the supervisor as an instructor.

What the Healthcare Supervisor Can Expect

To summarize the implications of the preceding sections and insert brief consideration of some additional forces and their effects, in the coming several years the healthcare supervisor is likely to experience:

- Continued difficulty in filling essential jobs
- Increasing staffing and scheduling difficulties that will be addressed in part by greater reliance on alternative scheduling practices (part-timers, flex-time, job sharing, telecommuting, etc.)
- Increasing sensitivity to employee rights, as legislation governing the employment relationship continues to expand
- More legislative-driven changes in employee benefits affecting all organizational levels (especially involving health insurance and retirement)

Overall, what the healthcare supervisor of the near future can expect is an increasing amount of challenge and thus significant opportunity for learning and growth and for a greatly increased sense of accomplishment.

Critical: Self-Motivated Self-Starters Needed

It has been suggested by many sources that an individual who would presume to manage others and their work must first become proficient at the management of self. For the healthcare supervisor working during the coming several years, increased proficiency at self-management will involve close attention to the following:

- *Self-motivation.* Recognize that all of the sources of true motivation exist in the form of opportunities and are inherent in the work itself. To succeed at managing within health care it is necessary to like the work and to enjoy regularly working with people. The self-motivated supervisor is one who willingly responds to the *opportunity* to assume responsibility, do meaningful, interesting, and challenging work, learn and grow, and to help others succeed.
- *Initiative.* In the presently developing environment it is more than ever necessary for the healthcare supervisor to be proactive. The first-line manager of the past, with perhaps little decision-making authority and a

narrow scope of responsibility, could often afford to be reactive, moving when pushed by circumstances. However, the more generously empowered supervisor of today and tomorrow will find that he or she *must* step out and make the needed decisions because they are no longer cushioned by additional layers of management.

- *Organization.* People will of course differ in the extent to which they need to organize their time and space and materials. However, coping with an increased span of control and increased overall responsibility generally requires an increased ability to organize for effectiveness and especially to incorporate a certain amount of personal *planning* into determining how each hour will be spent.
- *Management of time.* The management of time goes well beyond matters of simple efficiency; i.e., doing a particular task acceptably in the least possible amount of time. It also incorporates the concept of effectiveness, ensuring that what is done at any given time is exactly the right thing to do. Activity is not necessarily productivity, and it is increasingly important to live by the principle of *doing right things right the first time.* In the increasingly hectic healthcare management environment you have but a single choice—control your time, or, by default, it will control *you.*
- *Refined sense of priority.* The healthcare supervisor's job is growing. Span of control and amount of responsibility are increasing, and you can easily find yourself covering the territory formerly addressed by more than a single manager. Can you possibly perform every distinct task that was formerly performed by two or three people? Not likely. Therefore, it becomes critically important for the manager to develop a keen sense of priority, to learn how to quickly zero in on priorities in this vastly expanded role and allow matters of lesser importance to await their turn or fall by the wayside.

Every management role in every working environment is subject to a certain amount of change. Health care simply happens to be in a period during which change is outpacing change occurring in many other environments. The pace of change may moderate during the career span of many presently at work in health care, but yet again it may not. The best we can do is to individually become as flexible and adaptable as possible under the circumstances, and go where the currents of change take us.

HEALTHCARE REFORM: THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

The Patient Protection and Affordable Care Act (PPACA, or more simply referred to as ACA) became law on March 23, 2010. It was immediately amended by the Health Care and Education Act of 2010, signed into law 7 days after the signing of the ACA. The ACA is of course the presently controversial healthcare reform legislation, a major undertaking of the Obama administration. It is the most significant and far-reaching federal legislation affecting health care since the creation of Medicare and Medicaid in 1965. Its conditions are meant to: increase health insurance coverage and affordability for more people; require insurers to cover all applicants with new minimum

standards and offer the same rates regardless of preexisting conditions; and reduce costs and improve healthcare outcomes by moving the system toward quality over quantity through increased competition, regulation, and incentives to streamline the delivery of health care.

The ACA includes numerous provisions taking effect between 2010 and 2020. Significant reforms, many of which were initially set to take effect by January 1, 2014, include the following:

- Requiring guaranteed issue, forbidding insurers to deny coverage because of preexisting conditions, and a partial community rating requiring insurers to offer the same premium price to all applicants of the same age and in the same geographic area.
- Establishing minimum standards for health insurance policies.
- Requiring all individuals not covered by an employer's plan, Medicare, Medicaid, or public insurance program to buy an approved private-insurance plan or pay a penalty.
- Opening up health insurance exchanges in every state to serve as an online marketplace where individuals and small businesses can compare policies and buy insurance.
- Providing federal subsidies for low-income individuals and families to buy insurance through the exchanges.
- Expanding Medicaid eligibility to include individuals and families up to 133% of the federal poverty level.
- Reforming the Medicare payment system to promote greater efficiency by restructuring reimbursements from fee-for-service to bundled payments.
- Mandating that businesses of 50 or more employees that do not offer health insurance to full-time employees whose health care is subsidized through tax deductions or others means be assessed a tax penalty (in July 2013 this provision was delayed for 1 year).

Passage of the PPACA did not stem the continuing controversy over how the country should address its widespread problems with health insurance cost and availability. If anything, controversy increased as the law came under criticism from several directions and some in Congress and elsewhere began advocating its repeal. Controversy and criticism continue as of this writing.

Some of the changes called for during the first year of enactment (2010–2011) included the following: insurance companies were barred from dropping people from coverage because of illness, young adults could remain on their parents' plans until age 26, coverage was made possible for uninsured adults with preexisting conditions, and a number of changes were made that affected Medicare. Changes scheduled for 2011 included Medicare bonus payments to primary care physicians and general surgeons, Medicare coverage of annual wellness visits, and other changes to Medicare and Medicaid.

The legislation stipulated that additional reforms would be implemented annually between 2012 and 2015. Some new requirements are scheduled for 2018. One extremely controversial feature scheduled for implementation in 2014 is the requirement for most people to obtain health insurance coverage or pay a penalty if they do not do so.

The PPACA will affect most healthcare managers in two ways. First, the manager may be affected as a participant in the employer's health insurance plan. Depending on the nature of the plan and its features, there could be changes that affect coverage for all employees including the manager. Second, the individual supervisor is likely to be asked questions by employees who want to know how their plan's changes will affect them and what will happen to their present coverage. The supervisor will need to be sufficiently knowledgeable to respond to general questions and to know where to go for more complete answers. For the most part, however, the interpretation of the features and effects of healthcare reform on the organization's health insurance plan will reside with the benefits-management staff in the human resources department.

At this juncture it is difficult to say much of anything definite about the long-term effects of the PPACA. The final quarter of 2013 saw a great deal of confusion and increased criticism as the government's insurance sign-up processes experienced major difficulties and the scheduled implementation of several major provisions was postponed. And of course essentially everyone is aware that the President's promise that people who were satisfied with their present health plans could keep those plans fell through when large numbers of people began receiving cancellation notices because their plans did not meet the minimum requirements of the PPACA.

Although we do not yet know how everything concerning the PPACA will play out in the long run, we can nevertheless look at some significant features and short-term results that are or will be problematic.

The Single-Party Effect

The PPACA is essentially a product of one political party. It was driven by a Democratic president and the Democratic party and strongly disputed by the majority of Republicans in Congress. Some times in the past when new legislation was controversial while under development, Congress managed to come together in mutual support once it became the law of the land. For the most part this support is lacking for the PPACA; elements of the Republican party, having seemingly been denied much of a role in the law's development, continue to resist the new law and call for its repeal. When such a major piece of legislation goes forth with only one party's approval, there are bound to be problems that linger and new issues that surface.

The Move to Part Time

The PPACA requires employers to provide health insurance for full-time employees, defining "full-time" as 30 or more hours per week. Many employers have responded by cutting some employees' hours to less than 30 per week and by concentrating on part-time employees in their hiring. Some estimates suggest that as many as three out of every four jobs created during 2013 are part-time positions. Some businesses that are hiring at a steady pace but hiring part-timers only are seeking to avoid the PPACA mandate. The result could be a largely part-time workforce for many businesses and a workforce in which many people are working multiple jobs.

Accountable Care Organizations

Accountable Care Organizations (ACOs) are a significant feature of the PPACA. The stated aim of the ACOs is to control healthcare costs, enhance quality in health care, and improve population health. Controversy has arisen concerning the true meaning of "improving population health." The section of the law that created the Medicare Shared Savings ACO Program states that this program promotes accountability for a patient population. This implies that it is the health of the Medicare beneficiaries attributed to a particular provider organization, not the health of all people living in the ACOs geographic area, although some interpretations have latched onto the broader meaning. This will likely continue to be troublesome unless some effort is made to clearly define the "population" referred to in "population health."

Effects on Costs

A number of studies on insurance premiums have suggested, given the subsidies offered under ACA, that more people will pay less than they did prior to reform than those who will pay more and that the premiums paid will be more stable because of regulations on insurance. About half of the people who buy insurance on their own will be eligible for subsidies. All of this, however, remains to be seen.

It is clear, however, that increasing healthcare costs will place considerable pressure on the federal budget during the coming decades. In the judgment of the Congressional Budget Office (CBO), this new legislation does not substantially reduce that pressure. It is further suggested that putting the federal budget on a sustainable path would almost certainly require a significant reduction in the growth of federal healthcare spending, a reduction that seems unlikely to arise from current legislation.

QUESTIONS FOR REVIEW AND DISCUSSION

1. How is competition affecting the delivery of some forms of health care?
2. What was the principal effect of the Balanced Budget Act of 1997?
3. See how many of this chapter's "healthcare settings" you can list—without referring to that section of the chapter.
4. Concerning the supervisor's management of time, what is meant by the claim that activity is not necessarily productivity?
5. How would you define a health maintenance organization (HMO)?
6. In what manner do managed care plans exert control over some health insurance premium costs for employers and subscribers?
7. Why is it that managed care plans overall have not been able to sustain their promises of delivering efficient and cost-effective care?
8. State whether you believe health care is or is not an "industry" and provide the rationale for your answer.

9. What is the stated aim of an accountable care organization (ACO)?
10. Why do many supervisors, especially those who are newer to supervision, tend to favor their primary occupations over their management role?
11. What are the two principal ways in which the Patient Protection and Affordable Care Act is likely to affect most healthcare supervisors?
12. In health care today, what appears to be the primary purpose of marketing endeavors?
13. What are the factors or forces that have essentially wiped out the savings gained from managed care for employers and subscribers alike?
14. What is meant when we speak of the supervisor's "two hats?"
15. What is a "health insurance exchange?"

EXERCISE: RESPONDING TO EXTERNAL PRESSURE

"Due to concerns over quality and access to care, the move to shorter (inpatient) stays is being monitored by patient-advocacy groups and legislators. It is imperative that facilities turn their attention to tighter control over the cost of ancillary services to meet the expectations for controlling the costs of health care."[8(p.4)]

Exercise Questions

1. Why do you believe ancillary services might be specifically targeted for cost reduction?
2. In your view, what impact will the significant reduction in the use of ancillary services have on the quality of care? Why?

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