The Future of Healthcare Delivery: A Contrarian's View
by DAVID CASSAK, Editor
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Five years after its publication, Jeff Goldsmith's Can Hospitals Survive? *seems more a description than a prophecy of the problems and challenges that have befallen the U.S. hospital industry in the 1980s. With is prediction of the shift to outpatient services of the growth* of *alternative delivery systems. and of a shrinking inpatient service bases - this before the implementation of prospective payment - the book has proven to he an uncannily accurate chronicle of what has happened to healthcare in this country. v. Through his book. and through scores of articles and lectures delivered throughout this country before groups* of *hospitals. physicians. and suppliers. Goldsmith has established himself as one* of *the country's brightest and Most refreshing thinkers about health policy anti practice.*

While he argues for continued change in the healthcare delivery system during the second half of *the 1980s. Goldsmith's vision represents a more traditional. inure conservative vision for the future of this volatile industry than do man analysts today While he argues for the growth of multi-hospitals systems and health maintenance organizations and, for a shift in the balance of power from providers to purchasers of care. he also believes in the viability of private practice physician services and, more fundamentally, in a healthcare delivery system that holds certain values such as the patient / physician relationship. In many respects, his is a true contrarian view.*

We went recently to Chicago to visit with Jeff Goldsmith to talk about the future of' healthcare and healthcare delivery. Goldsmith earned his undergraduate degree at Reed College and his M. A. and his Ph. D. in sociology at the University of *Chicago, where he still teaches courses in marketing and healthcare public policy at the Business school. In addition, Goldsmith serves Ernst & Whinney the national accounting firm. as a technical advisor and heads his own consulting firm. Health Futures. Inc. With clients ranging from Hospital Corporation of America to America Hospital Supply to Presbyterian-St. Luke's Health System. Goldsmith's views on healthcare are becoming more prescriptive than descriptive of the changes coming in healthcare and his influence, contrarian nonetheless, is significant.*

Health Industry Today: In your book, *Can Hospitals Survive,* you argued that the healthcare industry was following the model described by Alfred Chandler in his analysis of what happens to a company or industry as it matures. Chandler said that a company or industry moves through four stages. Stage I is an initial expansion and accumulation of resources. usually through forward and backward integration. Stage 2 is an internal rationalization and consolidation of growth. Stage 3 is a diversification into

new products and new markets. and Stage 4 is the development of a decentralized, multidivisional form of corporate organization.

In 1980. you said that healthcare was somewhere between the first and second stages. between initial expansion and integration on the one hand. and a rationalization of resources on the other. Where is the healthcare industry in that model five years later?

Jeff Goldsmith: An interesting thing happened to the healthcare industry over the past five years. Healthcare managers have leaped over the stage of rationalization of resources and moved directly from expansion and integration into diversification into new products and new markets. What they really haven't done yet is to develop the discipline to use the resources they have accumulated to control healthcare costs. That's the central challenge the healthcare industry faces right now.

It's going to take much longer than most healthcare managers think to create an integrated system of care that uses all the component parts of the system to save purchasers money and to improve the quality of the care and services ices offered. Right now we're in the conglomerate or acquisition stage of diversification. People are experimenting with a lot of different businesses, but no one has found the glue to put it all together. In other words, though we're seeing a lot of acquisition activity, the integration is notably absent. No one is really focusing on how the cost of care can be lowered by being in a number of health-related businesses because there is no one leveraging the cost savings. And I don't think anyone has really looked at how the quality of patient care can he improved as a result of having all of those pieces. That, to me, is the cutting point of whether vertical integration is going to work in healthcare - if it doesn't result in lower prices to the purchaser and if the patient doesn't notice a difference in the quality of the clinical experience, then it isn't going to be a viable strategy.

HIT: What's driving the mania toward acquisition and merger? Is it market share considerations? Cost considerations? Patient care considerations?

Goldsmith: People are basically saving, “My core business isn't going to be viable in the future so I've got to get into some other businesses.” I don't think it is much more sophisticated than that.

HIT: One of the assumptions behind *Can Hospitals Survive* is that hospitals are at the center of the healthcare delivery system. Is that still it valid assumption? Or have hospitals become just one more component of the healthcare system, neither more nor less important than the other parts?

Goldsmith: I think the hospital is clearly still central to the healthcare system. The sickest patients and the most complex medicine will continue to be found in hospitals. The real question is whether the financial resources necessary to

provide the care that is rendered in the hospital are going to be sufficient for the hospital to be a going concern. And I'm not certain they are. Hospitals have done spectacularly well under the first two years of prospective payment. but we haven't yet moved to a national price. which will certainly be difficult for some hospitals. We also don't know what impact a more competitive healthcare system will have on hospitals because we're not yet, I think, in a purely competitive healthcare system.

HIT: You don't think the healthcare system can accurately be described as a competitive system today?

Goldsmith: No. I don't think there is yet price elasticity for demand for hospital care. In other words. I don't think that just I because the hospital raises its rates. it can count on a diminution of business. We're still five years away from that in most places.

HIT: Yet most hospital officials describe the current business environment as very competitive.

Goldsmith: What they are really talking about is a decline in business because of things such as a reduction in admissions and a shift of more services to outpatient settings. The thing that has produced the downturn in business for the hospitals has not been price competition. It has been the growing role of the patient in patient cost sharing - the patient staying away from the system because of the increased cost of care to them - and aggressive utilization control. not just by health maintenance organizations, but by commercial insurance companies and self-funded employers as well. There has also been a shift in the structure of the market itself, as I described in *Can Hospitals Survive*, in the growth of cost-effective alternatives to inpatient care. If you took at the scenario I painted in that book, where are you seeing 15, 20, 25 percent growth rates right now? You're seeing them in things like ambulatory surgery and home healthcare - precisely where our model predicted growth would be.

There is an identifiable market for health services, and the healthcare system is likely over the next five years to evolve to the point where the price of care -whether it is for a day in the hospital or a package of services provided to employees over a year - will make a difference in terms of whether people will buy the service or not. I just don't think we're there yet.

HIT: Is there a chance that true price competition won't come to healthcare? Is there anything that will mitigate against price ever being as important a factor in healthcare as it is in, say, automobile sales?

Goldsmith: The only thing that could do it is if we have a sustained 5- to 10-year period of dis-inflation. If the mechanism that people are using now to contain healthcare costs are sufficient to bring health benefits costs and Medicare

program costs down to the rate of general inflation and keep them there. we may not move as aggressively toward a price competitive world as we will if inflation re-ignites or if there is a significant downturn in business that will force employers to take the next step in cost containment. Whether we move as quickly toward price competition as we have in the automobile industry or the airlines industry will be a function of what happens in the general economy. Right now - and this is something that people haven't really focused on - healthcare spending as a percent of Gross National Product is lower than it was two years ago, and it has essentially been dead level for the past four years. In other words, the percentage of the total economy's resources that the healthcare system is consuming has not been growing as it was in the past.

HIT: How much of that is a matter of social policy? Someone like Uwe Reinhardt of Princeton would argue that there is nothing that says that healthcare spending at 10 or 11 percent of GNP is a magic number, that it can be 15 percent of 33 percent if that is what we, as a society. want. Can a shift in social policy change the direction the healthcare system is currently taking?

Goldsmith: It's not a matter of social policy, it's market dynamics. Uwe is right - there isn't any magic to 9, 10, 11 percent of G N P being spent for healthcare. But I don't think our society made a "social policy" decision that growth in healthcare spending ought to come to a halt at 10.7 percent or wherever it peaked. What happened was, the Federal government said, "We can't afford to increase Medicare outlays," State governments said, "We can't afford to increase Medicaid outlays," and employers said, "We can't afford to have a 25 to 30 percent increase in our healthcare costs each year for the same amount of coverage." Each of them took different approaches to solve the problem. That's not a social policy model, is it? That's a market model. Each sought to make more efficient use of their healthcare dollars and to exert a countervailing influence over the pressures that have driven up their healthcare costs. Employers have redesigned health benefit packages, the Federal Government has moved toward prospective payment for hospital services, State Medicaid programs have capped rates and encouraged people to move into HMOs. Everyone has taken a different strategy, but they all have the common element of people shifting economic risk back on to providers.

HIT: Let me ask you about one aspect of public policy, though - Peer Review Organizations. What do you think of PROs, especially given their emphasis on utilization review?

Goldsmith: They are a major force, unlike PSROs, they are already having a significant impact on the system. And they are also being encouraged to sell private review services to business, so that's another potential area of impact.

HIT: Will they have a one-time impact, a cleaning up of the system? Or will they continue to drive down utilization levels year after year?

Goldsmith: What's happening is that there is a quality assurance dimension emerging for PROs that is really going to he important. PROs are ratcheting down on utilization: to make sure that the quality of patient care has not deteriorated. I think that there is a legitimate role of the PROs to begin to monitor quality of care. That role will become more important as cost is wrung out of the system. I don't view the PRO as merely a containment vehicle.

HIT: In a recent article in *Health Affairs,* you described a shift in power from the providers of care to the purchasers of care. Are purchasers yet beginning to shape the delivery of care or are they just exercising greater negotiating strength?

Goldsmith: I don't think they're yet shaping it, but I think we've now got something very close to a Mexican standoff rather than a rout. The idea of countervailing influence doesn't I presume that anyone is dominating the system. But that physicians and other providers of care are clearly no longer in control of the system, that much I think we *can* say.

HIT: Some people, particularly the multi-hospital systems today, are saying that the centerpiece of any future healthcare delivery system has to be the merger of finance and delivery. Do you agree?

Goldsmith: No. I certainly don't see it as an inevitable development. In fact, I don't even see it as a necessary development. You really don't need to merge financing and delivery for market pressure to be brought to bear upon those who provide care. In fact, one could argue that it is somewhat more efficient to have a large number of potential purchasers and a large number of potential providers interacting. You get a much more vigorous market that way. The merger of finance and delivery is only going to make sense if it saves purchasers of care money, and it's not clear yet that it does. I don't think there is any magic in the integration of financing and delivery, and I emphatically disagree with Paul Elwood and others who have predicted that this industry will be dominated by a handful of large firms [who merge financing and delivery of care]. I think there are actually dis-economics of scale in healthcare.

HIT: When we were talking in Chicago last month. you said that you don't think that the strategy that the for-profit multi-hospital systems are taking in setting up their own *HMOs* and insurance companies is going to be successful for them. Why do you believe that?

Goldsmith: They've missed the market. They were five years too late. The time to get into the HMO business was when Maxicare and U.S. Health Care took off. not at the point where price earning multiples for H MO's are at 25 or 30. The present value for HMO acquisitions are no bargain. The multi-hospital systems are also dealing with a main frame that is private practice-based. They built their systems by saying to doctors, "We will supply the capital and you go practice medicine. Do the best job that you can: we're going to leave you alone." For them to turn on their heels in the mid-1980s and say,

“We're going to manage the cost of healthcare" is a chance of signals to those doctors and is going to be very difficult for them to get through their system. It isn't just a question of managing a bunch of buildings. What they're saying now is that they want to manage a healthcare system. The problem is they don't have a real healthcare system. They have some buildings and independent medical staffs. Creating an integrated system is going to be much more complex than just going out into the marketplace with a lot of money and trying to buy HMOs.

HIT: You also mentioned that you don't see it as an effective strategy for filling hospital beds.

Goldsmith: I don't think you get into the insurance business to fill hospital beds. There's an inherent conflict of interest there. Aetna and Metroplitan Life don't have a lot of empty beds to fill. They don't have a vested interest in leveraging a mass of concrete. That's the difference. What I've been telling my provider clients - they haven't necessarily been listening to me - but what I've been telling them is that until they can get up in the morning, look at themselves in the mirror, and say, "I want to save that employer money more than I want to fill my empty beds, they're going to have a hell of a problem competing in the insurance market.

HIT: Some see the same inherent conflict in physician and hospital joint ventures - that there is a collision of interests between doctors who stress ambulatory care and hospitals who need to fill beds.

Goldsmith: Yes, it's a somewhat related issue, though it's the same issue.

HIT: One of the premises of *Can Hospitals Survive* is that as more care shifts to outpatient settings, there is a potential conflict between the interests of physicians and those of hospitals, both on economic grounds and on patient care grounds. Some people in the doctor community are saying that hospitals are not necessarily their best joint venture partners because the goals of the two groups are not compatible. Do you agree with them?

Goldsmith: The key is that the hospital's goals are going to have to change. If the hospital's goal is to fill empty beds and the physician's goal is to increase his patient population and to improve his margins, you're right, their goals are not compatible. But the hospitals' objectives are changing. They are beginning to realize that filling beds isn't going to be the sole criterion for success for a healthcare organization. Indeed, if they are an integrated healthcare company, they're probably going to he hurting themselves by filling beds because they are increasing their costs. They want to be able to leverage lower cost products and services to the maximum extent they can if they are at risk for the cost of care under insurance.

For physicians, I don't necessarily think hospitals are bad joint venture partners. It depends entirely on the management philosophy of the corporation or multi-hospital system they are dealing with. There are a few multi-hospital systems that are saving to

themselves. 'I don't want to absorb the physician's risk. I don't want a lot of oarsmen driving my boat. I want them out there on their own. I want to support private practice - That's been a big theme of mine. I tell my hospital clients not to absorb the physician into their system. All they're doing is guaranteeing the physicians' income at a time when the market value of the physician's time is failing. That's not a very good business to be in. I tell my clients to keep the physician at risk. Let him stay out there on his own. but do everything you can to help him to compete by providing capital, management expertise, and systems.

Private practice is a vigorous institution. People will fight a lot harder to remain free and autonomous than they will to further the objectives of some giant corporation. That's why the independent insurance agent has been such a viable force - he's an independent, entrepreneurial businessman and the industry has been well served by him. I think that the private practice physician is going to work a lot harder to stay free and to be viable economically than he would if he were sitting there punching a time clock.

I think fee-for-service physicians have responded with alacrity to the incentives are already in place, even the indirect ones... The idea that the only way you can control the doctor is to put him on salary is an illusion.

HIT: Doesn't autonomous private practice work against the interests of a managed healthcare system, though?

Goldsmith: You don't have to salary a doctor to create incentives for him to be productive. Right now, health insurance plans are saying to doctors, “Here are the rules, here's what we’re going to pay for." That's working very well. The idea that the only way you can control the doctor is by putting him on salary is an illusion. You are also increasing your risk when you do that.

HIT: One of the hallmarks of independent physician practice has been fee-for-service reimbursement. There is a big push in public policy today toward capitation. especially among those who argue that fee-for-service is structurally or inherently wasteful and inefficient and capitation inherently cost-effective. What future do you see for both capitation and fee-for-service? Is fee-for-service worth preserving?

Goldsmith: I think the reason capitation is so popular right now is that people have assumed that physicians wouldn't change their behavior unless the financial incentives offered them were totally changed. That's what capitation does. It reduces per-incidence income of the physician the more services the physician provides.

Capitation advocates assume that fee-for-service is inherently uneconomical. and that is where I part company with them. There are 20 million people in HMOs today. That means that there are 220 million not in HMOs. So what is fee-for-service's share of the marketplace today? It has gone down a percentage point or two in the last few years, but it is still in the 90s. I don't see fee-for-service as a threatened institution. I see it as a

challenged institution. I think it is a viable, vital force in our health economy. Simply by virtue of the way it is organized, the more doctors there are, the more competitive fee-for-service will become. The real problem with the fee-for-service system has been the absence of a prudent purchaser. That's been a consistent thread in all of the arguments of the pro-competition petition people the absence of a prudent purchaser has been at least as much responsible for the growth of the cost of care as irresponsible providers of care. If you have a prudent purchaser. the fee-for-service market is going to work very well indeed. It's a matter of payers setting the ground rules about what they will pay for and how much they are going, to pay. After that. the practitioner has to decide whether he wants to play by that payer's rules or whether he wants to find a payer who isn't going to be such a prudent purchaser.

I think fee-for-service physicians have responded with alacrity to the incentives that are already in place. even the indirect ones. Fee-for-service decisions. for instance, have been responsible for the shift to ambulatory surgery. That's been a voluntary decision driven by market incentives. Look at physician response to prospective payment -the sharp drop in the length of stay and the surprising drop in admissions of Medicare patients are a function of the fee-for-service physician saying. "Maybe some services aren't medically necessary. Maybe it's not good for the patient to be in a hospital for 10 days or two weeks if I can get them out earlier."

HIT: You also don't agree with someone like Paul Elwood who sees HMOs or capitated healthcare plans as cornerstones of a competitive healthcare system?

Goldsmith: No, I don't. I think the people who have assumed that you have to have an HMO to have a competitive system did so because they believe that physicians won't change the way they behave or that you can't exert sufficient influence over their behavior without making them part of an integrated system stem. I don't believe that, and that is where Elwood and I differ.

HIT: What about Preferred Provider Organizations? Are you optimistic about the role or impact that they will have?

Goldsmith: No. I think healthcare is going to be dominated by commercial health insurance based on negotiated rates and utilization control, not by groups of providers. The insurance companies are going to the market leaders. They already are.

HIT: Yet in the *Health Affairs* article, you argued that commercial insurers are in trouble now in their health insurance policies.

Goldsmith: They were in trouble. They're not in trouble any more.

HIT: But aren't they always susceptible to the problems that plagued them? You argued that they got into trouble for reasons outside of their control - a shift toward self-insurance by large employers and the costs of marketing a high cost product.

Goldsmith: Commercial insurers turned profitable early in 1984 and they've have two very good years since. So has Blue Cross for that matter. But commercial insurers, in particular, have been doing well. In fact, they've been taking market share away from Blue Cross during this decade. As far as self-funding is concerned, that has been dead level during the 80s. It leveled off quickly when inflation subsided.

HIT: Who do you see as the major companies to watch in commercial insurance?

Goldsmith: The big companies – CIGNA, Prudential, Aetna, Metropolitan Life, John Hancock.

HIT: What do you think of the new Aetna/VHA joint venture? Does that seem to you a necessary strategy for insurers to pursue - allying with a large provider group? Isn't that in argument for the merger of financing and delivery? That's what the VHA is saying is the rationale for the partnership.

Goldsmith: But the VHA isn't an integrated healthcare delivery system. It's an alliance of hospitals. I think it was a smart business decision for Aetna and the VHA to work together. It is an extraordinarily risky venture, and they're late as well. This health insurance market has a tremendous amount of momentum behind it, and it's going to he tough to come in in 1986 and take market share away from companies that already have found solutions to the healthcare cost problems.

One of the biggest opportunities I see in health insurance is in the claims trail. That claims trail is a real gold mine of information about how people are using healthcare and the differential in cost among providers. People are now beginning to use what they're learning from the trail of claims to help manage healthcare spending. That's a very important development. There is an information systems revolution going on in health insurance right now. People are installing sophisticated computer-based information management systems to help monitor costs, to report to the employer what is happening to his healthcare spending, and to throw off the indicators that will help him to manage more effectively.

One of the other positive trends for commercial health insurance is that for years, commercial insurers were handicapped competitively because only Blue Cross had enough market leverage to be able to negotiate discounts with providers. Now virtually anyone with a patient population to deliver can negotiate a discount with providers.

HIT: How large does that population have to be?

Goldsmith: I would say in most markets, no more than five percent of the market. The key issue is whether you can shift those patients to those providers. That's a big question mark. We don't know how moveable the patient population is yet. There are indications that patient can be moved if there is a significant difference in the out-of-pocket costs for care.

HIT: But don't you think Preferred Provider Organizations are central to that effort? That's their main selling point - that they move patients from one provider to another in exchange for lower cost care. Metropolitan Life is shifting a lot of people from one hospital to another in Miami through its PIRO.

Goldsmith: True. I just don't know about PPOs yet. This Is probably a quibble. but I don't see Metropolitan Life's negotiated rate insurance product as an organization of providers. They have a slightly smaller group of hospitals involved and they've negotiated somewhat more favorable rates. But it's not an organization of providers, it's more like Blue Cross, an insurance plan that has a contract with hospitals.

I think that what we're going to see is negotiated rate insurance, and I don't think that is a PPO. I think that the provider-organized PPOs are not, for reasons that we've already discussed, going to be a significant market force. I just don't think that employers are likely yet to put aside five to ten years of blaming providers for cost increases and welcome those providers as the solution to the cost containment problem. That's a tough sell.

HIT: Let me ask you, though. about one aspect of the PPO that some people see as crucial and valuable -their efforts to select out of a general pool of providers those who are most cost effective and most willing to compromise on costs. Doesn't that make PPOs a valuable vehicle in today's healthcare cost environment?

Goldsmith: Most of the PPOs have been founded on the basis of a discounted per diem. They've negotiated a 15 percent discount and then the provider has quietly raised his rates. I don't think a negotiated per diem rate is the way you control healthcare costs. DRGs have demonstrated that per case or per admission is a better framework for controlling costs and H MOs have demonstrated that per capita is even better than that because you have the opportunity to avoid admitting people to the hospital by managing their care. PPOs that are based on discounting and that do not get at the utilization of care really aren't going to he competitive factors in the future. And if your goal is to control utilization of services as well as to reduce costs. then you're pretty close to being an HMO anyway, aren't you?

You can't just make promises. What does the employer really want? Does he care about a bunch of empty beds' No. He wants his healthcare costs to behave. to be predictable. Ultimately. the key to cost containment is not making the First sale. it's having two. five. ten years of consistent results in keeping healthcare costs under control. You're not going to do that by a sort of singles-bar liaison organization and that's what I think a lot of PPOs are at this point.

Ultimately, the key to cost containment is not making the first sale, it's having two, five, ten years of consistent results in keeping healthcare costs under control. You're not going to do that by a sort of singles-bar liaison organization, and that's what I think a lot of PPOs are at this point.

HIT: I was interested to note that in the *Health Affairs* article, you pointed to the studies that John Wennberg of Dartmouth is doing in variations in medical practice patterns as crucial to bringing the system under the kinds of utilization control you mentioned by using information management systems. Can you elaborate on what impact medical practice variation studies will have on healthcare delivery in the future?

Goldsmith: There's a lot of gold to be mined there. There are real questions raised by the fact that incidence rates for particular procedures may vary three- or four-fold from community to community with no underlying epidemiological explanation for the variations. That suggests that there is a tremendous amount of wiggle in physician decision-making and. in particular. how physicians use hospitals. As insurers and payers, in general, get a better grasp of this information. they're going to be able to begin... I wouldn't say dictating. but demanding greater accountability. I think we'll see more uniform standards of care in this country as a result.

HIT- Do you think it will necessarily lead to a reduction in the number of services delivered? Some doctors are arguing that even if we know that a given procedure is done 30 percent of the time in one community and 80 percent of the time in another, we really don't know that the 80 percent level isn't more appropriate than the 30 percent level.

Goldsmith: They have a fair argument. I guess I would argue in response that if there is compelling evidence to suggest that the people in the community where it is go percent aren't healthier by double over the community where it is 30 percent. you've got over-utilization. I think we're going to see a convergence around the norm rather than a convergence on the lowest common denominator. That was the objective of the DRG system - to pull lengths of stay and per case costs down to a national average not to seek the lowest level But we do know that we have a lot of over-utilization that has to be looked at. In our planning, we always assumed that 400 days of hospital care per 1,000 population was about the bottom limit that you really couldn't push an average slice of the U.S. population below that level of hospital utilization without encountering some serious problems. I'm hearing from some of the more mature HMOs that there is a lot of water in that 400 days per 1,000 figure, that it can be even lower than that, particularly if you have a lot of alternative services to leverage such as an effective home healthcare service.

HIT: What happens to capacity within that scenario? We're now at 4.5 hospital beds per 1.000 people and 2.2 doctors. Some people argue that we can get by with half of that.

Goldsmith: I agree. I think we've got enough hospital beds in this country to treat a population of half a billion.

HIT: Do we, then, have to shrink the system? The argument is that if we don't shrink the system, then either hospitals and doctors continue to order more services

or their costs go through the roof because they have the same overhead costs to spread over fewer patients. That's always the argument for closing hospital beds.

Goldsmith: My friends in the hospital management firms have a marvelous saving, which is that there is no such thing as a fixed cost. Get past debt service and what have you got? There are a lot of costs that behave as if they are fixed, but if Humana can break even at 26 percent occupancy, there is a lot of flexibility, isn't there, in how much capacity actually costs.

The real question is. How do you shrink capacity? In the steel industry, capacity shrunk not because Ronald Reagan came in and said, "You've got to shut down X percent of steel-making capacity," but because the steel industry ran into a market that wouldn't support their previous output. That's the direction I think we're moving in in healthcare. As part of their strategic planning, healthcare planners are going to ask how many hospital beds they need to deliver care to a given population and, more importantly, how much bed cost and capital cost their product can support without their losing money. It's at that point that those planners will begin to shrink capacity - that they'll decide not to replace beds and to close facilities that they control. I think we're going to see a lot of that.

HIT: Let me, then quote from *Can Hospitals Survive:* "As costs increase, competitive pressures within the hospital industry will intensify to the point where many hospitals, perhaps hundreds, will be forced to close and as many as several thousand may be absorbed by large hospital management firms. Yet the evidence is that hospitals are not closing.

Goldsmith: Yes, but remember, hospitals got a tremendous bonus from the Federal government for liquidating their Medicare franchises. In effect, the government created a financial cushion that has kept a lot of hospitals afloat. I think we are going to see hundreds of hospitals close, but not necessarily in areas where beds are in excess supply. They're going to close in inner cities. where there aren't enough hospital beds, they're going to close in rural areas where the local health economy can't support them. There are hundreds and hundreds of small Hill-Burton hospitals that are hanging by a thread. I think we could see a large number close in the next several years.

HIT: Would political or social pressures work against that? Will the government step in at that point to help keep those kinds of hospitals from closing?

Goldsmith: Have they done so already? Not obviously. I haven't seen a rural hospital bail-out bill pass Congress or billions of dollars allocated for replacing those facilities. The problem is that those hospitals are antiques. They're fully depreciated and unable to keep up with the standards of care people expect. When they get seriously ill, many patients in small rural communities migrate to an urban center to get their care. The typical rural community will see 40 percent of its population or better travel to an urban center to get care. In effect, these people have voted with their feet. What they are saving is, "We want a hospital in our community, but if I have to have open heart surgery or to

be in the intensive care ward, it's not going to be in a 40-bed hospital." That's a market decision people are making, and what you wind up with in many of these hospitals is people who aren't really acutely ill - they're somewhere between acutely ill and the skilled nursing level of acuity.

HIT: Where, then, do you see hospital occupancy levels and hospital bed sizes in the future? Ken Abramowitz of Sanford Bernstein has predicted that as many as 20 percent of all hospital beds will close by 1990 as the entire healthcare system shrinks and healthcare spending as a percent of G NP goes down to 9 percent. What do you think of Ken's view?

Goldsmith: I think that healthcare as 9 percent of GNP is much too low. Ken's being a little apocalyptic on that. We'll be lucky to keep it under 12 percent by the year 2000 given the growing elderly population. I don't really see it going down very much. Of course, some would argue that given the trend of the previous 15 years, to hold the level of healthcare spending dead even will be a major victory.

HIT: In the second half of the passage I quoted, you argued that for-profit multi-hospital systems would absorb thousands of other hospitals - you predicted that as many as 1.500 hospitals would be absorbed. That now seems overly optimistic. Why didn't that occur?

Goldsmith: Actually. I didn't mean just for-profits. I meant all multi-hospital systems. But I do think that we've already seen a plateauing of growth for multi-hospitals systems. that consolidation of the hospital industry is just about over. That's also a contrarian view. I also think a lot of systems are going to get out of the business of contract management of facilities that aren't viable over the long term. There will be modest growth in equity positions in hospitals. but look at what has already happened - Humana hasn't bought any hospitals for a number of years. HCA didn't buy any hospitals this year and won't buy any next year NMF isn't buying any either. The major for-profit companies have essentially put acquisitions on hold. If you can't earn a market rate of return on future capital I investments, the price of hospital beds is going to have to fall a ways before people get back in the business of buying again. I really don't think we're going to see more than 40 percent of the hospitals in this country in systems, either for-profit or not-for-profit.

HIT: That is a contrarian view. Some people are predicting that nearly all hospitals will be in some sort of system in the future as a result of competition. If you look at a very competitive community like Minneapolis, there are no freestanding hospitals: everyone is in one system or another.

Goldsmith: But I don't know what that means. In Chicago, 80 percent of the hospitals are free-standing, and this is a very competitive market. Minneapolis is not a good model for the future of our healthcare system. It is an unusual community. I don't think you can look at Minneapolis and say that's the way Atlanta or Austin, Texas is going to turn out.

HIT: Let's go back to the for-profit companies. For years people said that they would fire the best in the new healthcare environment because of their management expertise. Yet after reports of flat earnings this year and next. HCA's stock recently took an enormous nose dive. from the mid-40s to the upper 20s. Is that a warning about the future of the for-profit industry? Or is a nervous reaction peculiar to one company?

Goldsmith: I think the market over-reacted. HCA stock at 28 was an outrageous buy. The problem doesn't lie with HCA, it lies with the Financial analysts. The earnings declines shouldn't have surprised anyone. I mean I really don't understand how analysts honestly couldn't see that two years of single digit revenue growth would nor eventually lead to single digit earnings growth as well. That's basically happened to HCA. and analysts shouldn't have been surprised, HCA is not without its problems, but the company itself is basically a strong company. It has the best cadre of young hospital administrators in the business. They are extraordinary young people in their late 20s and early 30s who didn't want to take 15 or 20 years to rise to the top of another organization. HCA also has the best franchises among all of the hospital management companies – they've made spectacular development decisions.

HIT: But didn't it suggest to you that people had inflated the opportunity for for-profit companies - that they had placed too much faith in their ability to more effectively manage in the new environment, and the downturn was a correction of that view?

Goldsmith: The whole investor-owned sector has its challenges. which is how to manage their costs. The for-profit systems have acquired aggressively over the past several years and now they have to manage all of those assets. But the firms that can do that effectively that can increase productivity and manage their markets are going to do great. At the same time, to presume that just by making a lot of acquisitions and being a big company is going to be a recipe for endless double digit earnings growth is unrealistic.

HIT: What do you think of the future of the not-for-profit systems such as Voluntary Hospitals of America (VHA) and American Healthcare Systems (AHS)? Do you think those two consortia represent a different type of healthcare system? Or are they a typical not-for-profit system, but on a larger, national scale?

Goldsmith: I reserve the word "system" for something that has inter-dependent parts in which the strategic agendas of those parts is subordinated to the strategic agenda of the whole organization. By that definition of the word. neither the VHA nor AHS are systems. They are alliances of powerful, wealthy, quality hospitals, and there is a tremendous amount of leverage to be exerted in those alliances. But to argue that those hospitals have re-arranged their strategic priorities to be a part of those larger systems would, I think, be inaccurate.

HIT: So granted that, your contrarian view of the growth of multi-hospital systems comes from the fact that you believe that hospitals can exist as "free-standing"

because the systems they define for themselves operate on a much more local basis and include ambulatory care, nursing home and home healthcare, HMOs. etc.

Goldsmith: What I mean by a multi-hospital system is owned, merged assets. That's not V H A or A H S. There is a tremendous base of local identification and, in effect, community ownership of those facilities. The question for the alliance is, can they exert enough leverage at the national level for it to make a difference in the local market that one of the hospitals is a member of VHA or AHS? That's their test.

HIT: You said in your book. "Though hospital planners have enthusiastically encouraged the development of multi-hospital systems to promote cost containment, there is yet to be conclusive evidence that these systems actually save money."

Goldsmith: And five years later, I think that statement is just as true as it was in 1980. The jury is still out on that question. In fact, some people think the jury has fallen asleep.

HIT: Can't we conclude that if the jury hasn't found that evidence in the past five years, it never will?

Goldsmith: The time to test the theory that multi-hospital systems lead to economics of scale is just coming now. The question is, How do multi-hospital systems perform under real cost containment pressures? To argue that there were economics of scale in a cost-based reimbursement environment is ridiculous because there was no incentive to save money. And during the first years of DRGs, everyone was rolling in money. Hospitals weren't exactly hurting financially and no one was asking the kinds of questions that would result in seeking economies of scale. I'm not arguing that the economies aren't there. I'm just arguing that we haven't seen them yet. You need management systems to produce them and you need to change the way in which patient care is provided.

HIT: Well, if they haven't proven themselves as cost savers, what about as vehicles for competition? Is that the real role for multi-hospital systems? What benefit do they have for the healthcare industry overall and for the individual providers in promoting competition? Can we ask the same question about other alliances of providers such as HMOs and PPOs - whether and to what extent their real value lies in promoting competition rather than saving money?

Goldsmith: But you can't make that distinction. Their ability to compete is directly related to their ability to reduce costs. On what other basis would they compete? The purpose of competition is to save money and improve quality for those who purchase care by adding value to the service offered. None of these alliances, whether they are multi-hospital systems or HMOs or PPOs, are going to make any difference if they don't save money and add value. They have to do more than just create large conglomerates that market provider services. They have to ask what the market really wants and what it wants - what any purchaser wants - is lower costs and better value.

HIT: So many of these discussions revolve around the notion of a system. You described what you mean by a system before. Could you elaborate on that and give an example of a healthcare system that you think fills your criteria today?

Goldsmith: For many years, the traditional example of a healthcare system was Kaiser - that's a mature integrated finance and delivery mechanism. It contracts to deliver services it can't deliver under ownership, and it has a patient management function. I think Kaiser is the closest we've got to a system, but it's not a hospital system, it's more of a health insurance system that owns and manages hospitals and physicians.

I'm not certain that those entities we call multi-hospital systems are operating as systems. The test is. is the product different" Does it cost less' Is it of higher quality" Is it delivered more efficiently as a result of there being all of those pieces'! I think except for Kaiser and some integrated group practices. such as Lovelace (in Albuquerque. New Mexico] and Geisinger Clinic [in Danville, Pennsylvania, which have their own hospitals and HMOs. we don't really have many systems of care right now. We have portfolios of healthcare services. but not many systems.

HIT: Picking up on that portfolio notion. in Can Hospitals Survive, you talked about t he need for hospitals to integrate forward into areas such free-standing emergency care and ambulatory surgery and to integrate backward into things such as home healthcare and nursing home care. We've seen immense activity in all of these areas in recent years, not just for hospitals, but for others as well. Some people think the opportunities here are beginning to close down. Do you agree? Or do you see the opportunities, especially for hospitals, as wide open still?

Goldsmith: I think those segments will see a shakeout. That shakeout is already underway in some of them. We've seen a lot of failures and a lot of acquisitions.

HIT: Home healthcare. in particular. has re2liv been booming. What future do you see for that segment?

Goldsmith: What happens in home healthcare will he a function of what the Federal government does in reimbursement policy. Lately, they've been clamping down on home healthcare reimbursement. The other factor that will determine home healthcare's future is whether private insurers will expand or contract their coverage for home care services, and there is some evidence that they are beginning to contract it. Those two things could slow the growth of home healthcare.

HIT: In *Can Hospitals Survive,* in talking about multi-hospital systems, you said. "The ultimate battle for control of our healthcare market will be at the local level since there is no national market for health services." If you still believe that, then you really do, as you said earlier, fundamentally disagree with Paul Elwood and his concept of the SuperMed. [For more on SuperMeds, see the November 1985 issue of *Health IndustryToday.]*

Goldsmith: Yes. I do. This isn't the electronics industry, or the computer industry where you have experience curve pricing. The heart of healthcare is a face-co-face relationship between a doctor and a patient. What's national about that? And what can a national entity do to change the economics of that relationship? That's the real question. Healthcare is local and regional, it's not national. Most metropolitan areas are 99.5 percent self-sufficient for health services. If you look at the Mayo Clinic, the Cleveland Clinic, the Ochsner Clinic - the major regional clinics - they share at least one common characteristic, which is that they are becoming less national and more regional.

HIT: But the Mayo Clinic just announced plans to open facilities in Scottsdale and Jacksonville.

Goldsmith: Yes, but wait a minute. That's by branching. People aren't flying in record numbers to Rochester, Minnesota anymore to get care. That's why Mayo is going to Scottsdale and Jacksonville.

HIT: What advantages, then, are there for hospitals to join one of the national systems? Might we see in a healthcare environment that is less volatile a trend toward re-alignment into systems that are more regional in structure?

Goldsmith: The principal advantage for hospitals in belonging to a national system lie in access to a pool of management. I don't think access to capital is going to be that important in the future because hospitals aren't going to be doing a lot of capital spending. Group purchasing? You know all about that - my belief is that an aggressive single large freestanding hospital can get as good a deal as any of those alliances can. So purchasing isn't that important.

Some hospitals look at the advantages of belonging to a national system as the sort of Richard-Nixon-Opening-to-China illusion: “If we could just get every Chinese person to buy a six-pack of Pepsi we’d be in great shape.” The current analog to that in healthcare is “If we could just sell IBM our . . . I don’t think the healthcare market is going to work that way. The vast majority of employees are in locally-based., locally managed small businesses. Figuring out how to solve that small business manager's healthcare cost problem is where the real opportunities lie.

HIT: In *Can Hospitals Survive* you said that you didn't think hospitals will get into the medical supply business: “The risks of integrating backwards into the medical supply business seem to far outweigh the benefits.” Do you still believe that?

Goldsmith: Yes.

HIT: What's your view, then, of an organization like VHA supply?

Goldsmith: I'm baffled by it. I don't understand why they've done it. This is an intensely competitive business in which margins have virtually disappeared for significant parts of the business. I don't understand the rationale for what the V H A is doing.

HIT: What impact do you think the Baxter Travenol/ American Hospital Supply merger will have on the medical supply industry?

Goldsmith: Honore de Balzac, a noted cynic once said. -The small are difficult to crush because they lie so flat beneath the foot." The combination of Baxter and American will be a tremendous management challenge. They're going to have to restore morale and to create a unified sales force and divisional structures that work. That's a 3 to 5 year job. There are a lot of market opportunities for other suppliers while this giant gets its act together. I don't think they're just going to steamroller the rest of the supply industry. As is the market for health services. the market for medical supplies is a local and regional market. and the people who can respond to the product needs and services of hospitals and physicians on a local and regional_level are going to be successful. Size isn't going_to be an issue as much as who meets the needs of the customer best. If you can get along on lower cost of sales relative to a large organization, as most of your readers can, if you can live with lower margins for a while, the shakeout, or so-called shakeout or consolidation of the medical supply industry that some people have predicted could take a long, long time.

HIT: Let's turn, finally, to doctors. Some people see the current oversupply of physicians as a crucial factor in driving where physician practice is going. How serious is the glut? And what impact is it likely to have on the marketplace?

Goldsmith: What glut? You don't really have a surplus in any market until the price goes down, and that hasn't really begun to happen yet. When it does come, the principal impact of the oversupply will be to reduce the market value of the physician's time. That’s the bottom line. When there are more providers out there than the market can bear. office patient volumes will continue to fall and it is going to be hard for the individual physician to raise his prices. For physicians, the most serious impact will be to reduce his earnings.

I'm not certain we're at that point yet, but I do think we've reached the point where physicians no longer have unlimited power to increase their incomes. I also think there is an enormous opportunity for suppliers here - and this is relevant to your readers - because the people who can help physicians to offset the declining market value of their time are going to do very well. You see this now in the extraordinary market for desk top analyzers and the other diagnostic products that are making their way into the physician's office. That's a torrid market in an otherwise …..?

anyone who can provide him with the technology and the framework for increasing his market is going to do great because the physician still make a lot of the healthcare decisions. Those decisions are being hedged by employers and insurance companies who are insisting on pre-admission review or mandatory ambulatory surgery for some procedures, but the physician is still managing the patient's healthcare needs.

H IT: One of the biggest trends in recent years has been the trend toward physician group practices. In 1980, you wrote, “Recent research has undercut the claim that large group practices provide significant economies of scale." Yet that segment is booming. Why? Have doctors suddenly found those economies?

Goldsmith: The economies of scale for physician groups sort of peak around the level of 6 or 7 group members rather than 100 or so, which is where the really significant growth in groups is occurring. Group practices face a crucial problem today: how to keep productivity high and improving. Right now, tailing per- physician-productivity is the soft underbelly of physician group practices.

HIT: Okay. Stages 3 and 4 of the Chandler model are diversification into new products and markets and then development of a decentralized, multi-divisional form of corporate organization. Are we at Stage 3 and going into Stage 4? You’ve already said that you don't agree with the SuperMed theory. Will we ever get to 4and what will it look like?

Goldsmith: I think we're now at Stage 3 and people have been stretched thin. management-wise. by that movement into 3. 1 think we're going to have to go back into Stage 2. a rationali7ation of resources. because we never really got to that stage before. People are beginning to get into that rationali7ation with the installation of industry-like cost accounting and productivity systems. That's a very good sign.

As far as moving on to the multi-divisional structure of Stage 4. I'm not sure we're ever going to get there. You have to have market share growth for the industry and consolidation of the system in order to get to Stage4. I'm not sure that growth or consolidation are necessarily going to happen in healthcare. Chandler himself believed that the model didn't always happen the same way in every industry. Certainly if costs aren’t reduced or value added as a result of consolidation. that consolidation won't take place. Chandler’s model assumes that you have no more than 5 or 10 or 12 actors in a given market, which is what happened in the steel and auto industries. I don’t think that is going to happen in healthcare. I think healthcare is going to remain a tremendously fragmented industry.