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Lancaster City & County Medical Society

Section 2

Lancaster City & County Medical Society Celebrates 150 Years



Chapter 20
150th Anniversary Speeches

*The Lancaster City & County
Medical Society*

Celebrates 150 Years

Friday, October 7, 1994

Show Room
Lancaster Host Resort

The Medical Society acknowledges a major grant
from the Louise von Hess Foundation for Medical Education

Welcome	John H. Garofola, M.D. President
Invocation	Joseph A. Knepper, M.D.
Dinner	Menu: Shrimp Bisque Caesar Salad Prime Rib, Au Jus Grilled Supreme of Salmon Baked Stuffed Potato Green Beans with Mushrooms New York Cheesecake
Program	What is Lancaster Medicine Going to be Like in 1997? It's Going to be Different! Robert G. Doe, M.D.—Moderator Speakers: Ms. Patricia Nazemetz William J. (Terry) Kane, M.D.
Questions and Answers	

The 150th Anniversary Banquet Speeches

What is Medicine Going to be Like in 1997?

Health Link - Strategies of a Corporation to Manage Health Care

Abstracted from an address by Patricia M. Nazemetz, M.A.

Xerox was forced to reevaluate the way it managed its health care benefits when increases in health care spending became unacceptable to the corporation. The company had successfully utilized quality management in other areas of its business and so the benefits team was given the mandate to use these strategies in the area of health care purchasing.

The Xerox benefits team began by defining the current state of their health benefits system. Their fee-for-service system was provider-centered, subject to increasing levels of interference, expensive, fragmented and without focus. Consumers were not well informed and there was no linkage between systems. Utilizing this information, the benefits team defined the desired state for its health care benefits. They wanted a more focused purchasing of efficient and effective systems which met their customer requirements. Furthermore, they wanted a comprehensive system that would provide quality health care, helping to improve the health status of the consumer. In answer to the problems they felt inherent in their current system, the Xerox team stated its goals of an integrated, consumer-focused and centered, accessible, accountable, innovative and continuously improving system.

After the team defined the necessary changes, they determined the best way to go about effecting these changes. First, they determined that because of their size and geographically diverse population they would buy their own health care. They set about finding the right partners - those with a shared vision, common goals, a commitment to quality and a customer focus. The benefits team determined that the role of its health partners would be to help set performance standards and to measure and manage to these standards. In addition, these health partners would need to be consumer advocates and help to facilitate administrative tasks. Through these partnerships, Xerox expected to provide their employees with a health care system that would deliver effective and efficient medically necessary and appropriate health care, resulting in the highest levels of consumer satisfaction and improved health status.

The result is Health Link. Benchmark pricing is used to help reinforce competition on the basis of cost and quality. One of the major tenets of Health Link is continual improvement. To achieve this, measurement tools are used. Accreditation is one tool. It is used as an entrance requirement and also as a

means of identifying areas for improvement. Another measurement tool is information/reporting. This is an area which helps establish performance improvement opportunities, manage program performance, and serve as a basis for consumer reporting. The most important part of the Health Link system is the consumer. Consumer satisfaction requires outreach, shared responsibility for health, effective communication, and constant consumer input and feedback. The Xerox team feels that the importance of the health care purchaser will diminish as they achieve their goals of consumer centeredness, effective measurement and effective communication tools. The role of the corporate purchaser should evolve to one providing marketplace intelligence, education, communication and financial assistance. Ultimately, Xerox hopes to achieve a consumer centered system with high quality, consumer friendly, information such that consumers can help steer and improve the system without the need for large purchaser intervention.

Patricia M. Nazemetz received a B.A. in Mathematics from Fordham University in 1971. She completed her Masters Degree in Philosophy, also from Fordham, in 1980. She has successfully completed numerous courses in the areas of Employee Benefits, Pensions, and risk Management at the College of Insurance.

Ms. Nazemetz served as the Assistant to Manager, Corporate Insurance for Macmillan, Inc. and also as Benefits Advisor for W. R. Grace Co., both in New York City. She has been with Xerox Corporation in Stamford, Connecticut since 1977. At Xerox, she has held several positions in the benefits department before assuming her present position of Director, Benefits, in 1988.

Ms. Nazemetz serves as a director on the boards of the Kaiser Health Plan of New York, the Matthew Thornton Health Plan, and the Washington Business Group on Health. She chairs the National Committee for Quality Assurance. She is also a Commissioner on the Physicians Payment Review Commission and past president of the Corporate Board of the International Foundation of Employee Benefit Plans. She is a member of the Academy of Women Achievers of the YWCA of New York City.



Managed Health Care

Abstracted from an address by William J. Kane, M.D.

The changes in the delivery of health care will be influenced by government and industry driven competitive markets, with the latter being the dominant force. As the many managed health care options develop, it becomes apparent that there are too many physicians in general and far too many specialists in particular. Estimates of physician requirements under a market driven organized health care delivery system indicate a need to decrease the present physician supply by at least 15% with an average reduction of 42% in the surgical specialties, a 46% reduction in internal medicine specialties and a 25% reduction in pediatric specialties.

A recent national survey of hospitals reveals an average of 3.7 inpatient hospital beds per 1000 population with a 66.1% occupancy rate (884 hospital days per 1000 population annually). Through managed care, California has reduced inpatient hospital days per 1000 by 33%, resulting in the elimination of one million jobs and eventually the closing or reduction in size of many hospitals. The evolution of managed care, starting with unfettered fee-for-service, has progressed to a significant amount of light managed care, i.e., independent practice associations, preferred provider organizations, etc., and some heavily managed, deeply capitated health maintenance organizations. Payment by all health delivery systems will eventually be based on clinical performance.

In traditional indemnity there are no provider panels, there is total freedom in choice of providers, the benefit structure has varied coverages and the cost is "high." Conversely, in heavily managed care there are staff providers, the choice of provider is locked in, the benefit structure is comprehensive and the cost is "low."

The "good old days" in a managed care continuum will give way to an Integrated Health Care System - defined as a process in which the elements needed to provide all aspects of health care services to a population of people are brought together in a coordinated and accountable fashion. This system will be market driven, population based and characterized by a single management structure. Community based planning, a part of the integrated system, is based on the assumption of all care for one million population in a capitated health care system with an average age and sex distribution. The requirements in this planning include 584 primary physicians, 324 specialist physicians, 2.8 million primary care visits per year and 960,000 specialist visits per year. Additional projections include a need for 920 hospital beds, 100 post-surgical recovery beds and the anticipation of 20,800 births each year, 70% (16,000) in birthing centers and 30% (4,800) in hospitals. Ninety operating rooms will be needed - 60 outpatient (70 procedures/1000 population) and 30 inpatient (40 procedures/1000 population).

Today's health care delivery, described as fee-for-service cottage industry, is fragmented, externally controlled, micro-managed, adverse to risk-taking, and revenue is profit driven. Health care delivery in the future will be coordinated, internally controlled, prospective and risk based. In addition, tomorrow's health care will be characterized by cost centers (per member per month) and multispecialty group practices.

Currently, medical staffs are large with a diverse membership that is specialty dominated. These staffs have no business function and are unable to take risks. Medical groups of the future will have a defined membership with an appropriate balance between primary care and specialty physicians, a structured management and the necessity to take risks. There are barriers to this form of partnership such as revenue versus cost culture, specialty controlled medical staffs, weak primary care leadership, ignorance of the business of medicine, lack of trust, primary physician time constraints, lack of board understanding and conflicting economics between hospitals, specialists, primary care physicians and ancillaries. These barriers also present many opportunities as well as challenges:

- the ability to work with physicians in multiple practice
- the evaluation and management of physician/group practice productivity, flexibility and profit margin
- the integration of education, health promotion, home care and case management
- the efficient administration of marketing, information systems, claims, physician recruitment/retention and contracting
- shared services that include urgent care, specialty coverage, occupational medicine and worker's compensation - quality control via outcomes measurement.
- governance to be controlled by managed care forums and board representation

The health care system of the 90's will be patient focused with a controlled balance between primary care and specialty physicians and will be geographically decentralized with multiple convenient outlets, able to take care of large groups, communities or populations. This system will provide comprehensive risk assessment, health promotion and complete knowledge of all health care expenditures through sophisticated information management. Risk will be assumed through capitation (the ultimate partnership), controls will be adequate without access barriers and there will be systems in place to monitor utilization of services, outcomes (cost and quality) and patient satisfaction.

The impact on physicians will be the most significant in the history of medicine. Jack Welch, the CEO of General Electric, has faced many challenges in his career and through his experiences has formulated a set of guidelines

for revitalizing a company. It might be appropriate for physicians to review these guidelines:

- Face reality as it is, not as it was or as you wish it were.
- Change it before you have to.
- If you don't have a competitive advantage in a given area, don't compete.
- Control your destiny or someone else will.

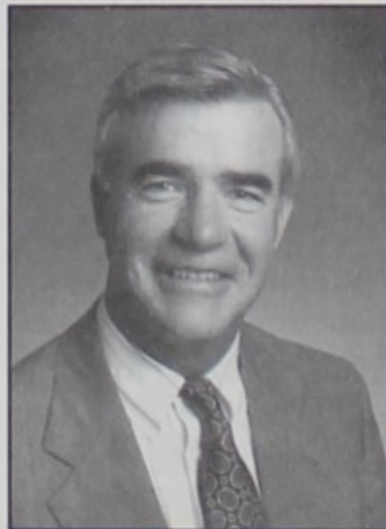
The impending changes in health care will impact physicians in many ways that will require patience, understanding and the ability to adapt. Physicians must realign themselves as part of an integrated health care system that competes successfully for contracts to manage the health of a given population. Income will be based on the efficiency and success of the Health Plans, and physicians will bear financial risk. Physicians will join medical groups and increasingly accept salaried positions. Primary care physicians will assume "Gatekeeper/Care Manager" roles and enjoy financial rewards for effective patient care and prevention. Many specialty physicians will evaluate personal and professional career options—some will retire and some will retrain themselves in primary care skills. Clinical judgment will be increasingly supported by outcomes-based (and computer assisted) clinical data and guidelines.

"Who the gods want to destroy they send 40 years of success."

Peter Drucker, *Wall Street Journal*, February 2, 1993

William J. Kane, M.D. graduated cum laude from the University of Scranton in 1965. He received his Medical Degree with honors from Temple University in 1969. He completed his residency in Family Medicine at the University of Rochester and Highland Hospital in Rochester, NY.

Dr. Kane has served as Chief of the Division of Family Medicine at Duke University Medical Center and Director of the Duke-Watts Family Medicine Residency Program. He has also served as President of U.S. Healthcare/NY, where he directed the development and expansion of the New Jersey and



New York affiliates of U.S. Healthcare. He acted as Executive Vice President and Corporate Medical Director for Cigna Healthplan, Inc. in Bloomfield, Connecticut. He held the position of Senior Vice President, Medical Affairs at Independence Blue Cross in Philadelphia. He is currently employed as Executive Vice President, Community Care at Share HealthCare in San Diego. He also serves as Clinical Associate Professor in the Department of Family Medicine at the Robert Wood Johnson Medical School in New Brunswick, New Jersey. He is married with a son and three daughters.