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Understanding the Velocity of Change in Health Care

By Ian Morrison **March 06, 2012**

Elements of change have different half-lives.

The key drivers of health care have different rates of change. Coverage expansion is on a two-to-three-year timeline. Reimbursement reform is on a 10-year timeline. Cultural transformation of institutions is on a 30-year timeline. Yet, there are many aspects of health care that are on a short fuse. Budget cuts at the federal level can happen almost immediately. Network changes or contracts can occur in a year. Some new technologies can have immediate impacts, while others take decades to reach full deployment.

Understanding the different half-lives of health care is crucial to preparing for the future. Too many actors conflate these forces into a blur of change moving at the same speed, causing big strategic problems.

The Half-Life of Health Care

Half-life is a term from radioactive physics referring to the time it takes for a substance to decay by half; it measures the rate of change in radioactive decay. Similarly in health care, different dimensions of the future move at different rates. We may understand this intellectually, but as actors in an unfolding game, we have difficulty judging the pace of change. My old mentor, Roy Amara, who headed the Institute for the Future for 20 years, taught us a basic principle about the future that we codified as Amara's law: "There is a natural human tendency to overestimate the impact of phenomena in the short run, and underestimate it in the long run."

Another eminent IFTF colleague, Paul Saffo, had a brilliant insight about the pace of the unfolding future: "Never confuse a clear view with a short distance" — a phenomenon I dubbed "premature extrapolation."

We imagine that many important changes are close, even though logic suggests otherwise. For example, the aging of the baby boom as a driver of health care utilization has been hyped for as long as I have been in the futures business, which is more than 30 years. And yet the very first baby boomers, those born in 1947, became eligible for Medicare only this year! We have been so enthusiastic about their arrival in Medicare, this major demographic trend is old news.

We are eager to see positive changes happen fast, and we celebrate their progress even though they may be imperceptibly slow. One of my basic principles in analyzing future trends is that if something is going to be a big deal in the future, it has to start sometime. And it needs to show meaningful progress year over year.

While we have a tendency to overestimate in the short run and underestimate in the long run, that is not the whole story. Some things can move faster than you think. Look at the sting of the recession, its impact on credit availability for hospitals and the way it lowered demand for elective health care services; or a change in the law that allowed coverage of 26-year-olds. And there may be more rude short-term shocks in our future, which I will highlight.

So, it is important to sort out the rate of change for each of the factors that are causing changes in health care and weave them into a plausible unfolding reality.

Short Half-Life

Some drivers of change can happen pretty quickly (in the next one to two years):

Budget cuts. Perhaps the fastest change that could happen in health care is significant cuts in public programs, particularly Medicare and Medicaid, within the next 12 to 24 months. The deficits at both the federal and state levels (even though states cannot really run them) may force significant action, much in the way austerity measures have swept the European economies. Piled on top of the existing reimbursement cuts in the Patient Protection and Affordable Care Act, the sting of program cuts could hit the field before the benefits of expanded coverage take hold.

Cost shifting. A related impact is the immediate potential for providers to cost shift — to make up for the shortfall in public payment by increasing prices to commercial payers. In turn, employers can simply cost shift (or as they call it, cost share) with their employees. This has been the game for the last decade and has meant that the typical American household is in a PPO with a $1,000 family deductible.

Lansky's short fuse. My friend David Lansky who leads the Pacific Business Group on Health gave me the basic idea for this column when he told me that he believes employers now have a short fuse. I took this to mean that employers' patience with inexorably rising costs and cost shifting is wearing pretty thin. It also explains the speculation that employers may prefer a future in which they are off the hook for health care and they can send their employees to the new health insurance exchanges. (I would argue that employer exit on a massive scale has a longer half-life, maybe in 2018 when exchanges are up and running and the Cadillac tax kicks in, because by then everyone will be driving Cadillacs.)

Network contract changes. Large employers can make big changes in their employee benefits plans two years out. Small employers can switch insurers each year. Providers can find themselves excluded from a narrow network in a year or two. I have run into a significant number of hospitals, large and small, that are caught flat-footed by a sudden change in their preferred provider status as payers (plans and large employers in concert) move to skinny networks.

Mergers and acquisitions. Hospital leaders can merge institutions on short notice and buy medical groups even faster. Witness the rapid contractual integration of hospitals and physicians taking place across the country. (I say contractual integration because that has a short half-life, in contrast to true clinical integration and the related cultural shift toward accountability and quality, which may take decades to fully accomplish.)

Supreme Court decisions. The Supreme Court will rule in the summer whether the PPACA is constitutional and, no matter what the ruling, it will have a big and immediate impact. At one extreme, if PPACA is overturned, anticipate less coverage expansion in the future (although the delivery system changes under way likely will continue). At the other extreme, if the law is upheld, states like Florida will have to scramble to set up a health insurance exchange in six months (that will be fun to watch).

Medium Half-Life

Some aspects of change have a half-life that is two to five years out:

Coverage expansion. The major provisions for coverage expansion happen in 2014, a deadline that may drag out if states are unprepared to operate health insurance exchanges or rapidly expand Medicaid coverage.

Meaningful use. Meaningful use of computers got a major stimulus in the Stimulus Bill (pardon the pun), and relatively rapid progress is being made in deploying electronic health records. Interoperability with effective health information exchanges may take a lot longer.

Value-based purchasing. AHA analysts estimate that approximately 9 percent of Medicare reimbursement to hospitals will be "at risk" of quality penalties and incentives by 2015, because of value purchasing and readmission reimbursement provisions.

Large group-practice formation. Large multispecialty group practices will be formed through a variety of models over the next five years. But we should learn from all the high-functioning medical groups that have taken 30 years to become an overnight success. Culture takes time.

Long Half-Life

Some changes take a very long time, perhaps a decade or more:

Reimbursement reform. Some reimbursement reforms like DRGs can be implemented to make significant short-term changes in incentives that have a major impact. The proposed reimbursement reforms in both the public and private sectors are moving slowly (but inexorably) toward a new future. Pilots must take off and become mainstream. That usually takes time.

Cultural transformation. Some organizations like Virginia Mason Medical Center in Seattle have shown that leadership and commitment can change the culture, but these are exceptions. Most high-performing cultures take a long time to build. Patience, persistence and passion are needed to overcome the cultural inertia in most organizations.

Medical education reform. Medical education needs to change to reinforce the broader transformation agenda, but it takes a very long time to affect the stock and flow of doctors and other advanced practitioners. Most of the people who will be practicing 10 years from now are practicing today (do the math). And academic medicine is not often described as nimble, market-sensitive or change-oriented. There are notable exceptions such as UCLA, which is pursuing a rapid and aggressive innovation agenda but, in the main, it is hard to turn the academic medicine battleship.

Half-Life in Action

Here are some key examples of the half-life phenomena to watch for:

Medicare. The future of Medicare will be an enormous issue in an election year. Medicare must be changed, but how much, how fast and for whom? Proposals to shift Medicare to a voucher plan for those who are today 55 or younger is a long half-life proposal. (It won't save in the short run, but will have big impacts in the long run.) Cutting the Medicare budget in 2013 has a short half-life. Bending the trend through reimbursement and delivery system reform could take a very long time, maybe forever.

ACOs. Accountable care is a megatrend. While an ACO does not necessarily adhere to the formal Centers for Medicare & Medicaid Services pilot programs, the general idea is that integrated systems of care are being formed to provide accountable care to the population they serve. You can buy the doctors tomorrow, but managing the half-life of payment reform and business model migration is tricky stuff.

Health information technology infrastructure. We are seeing relatively rapid deployment of health information technology and real progress toward meaningful use. But we must keep the pressure on, building an infrastructure to support the vision of a high-performing health system. Finding faster pathways to interoperability will be required, because health information exchanges are moving slowly.

My advice to leaders is to discipline yourselves to parse the future and use the half-life concept to understand the pace of each individual element of change. If you conflate the future and see all the big changes as clear *and* close, you may have trouble developing a sensible strategy, sequenced to meet the unfolding future. Conversely, try to find ways to shorten the half-life of change for such elements as clinical redesign and cultural transformation that are key to meaningful change. I am very encouraged because, on my travels, I see front-line providers stepping up to change clinical processes to make them better, safer and high performing, and they are doing this rapidly. The best way to have a better future is to speed up the good parts.