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Top 10 health industry issues in 2010: Squeezing the juice out of healthcare

PricewaterhouseCoopers’ Health Research Institute

At a glance

The push for health reform is stirring up the industry, organizations are crawling out of the recession and the government is becoming more active.

Success will hinge on squeezing the most value out of new and current relationships, impending regulatory changes and consumer demands.

Each organization will have to understand new interdependencies and redefine its role as the health industry converges.

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Last year, external forces put health organizations in a reactive mode, but 2010 will present an opportunity to step ahead of the changes. Success will hinge on squeezing the most value out of new and current relationships, impending health reform and regulatory changes, and consumer demands.

In 2010, the emphasis on cost continues. The government is taking a more active role in demanding quality and managing costs, the recession has pinched budgets, and both new and existing players are examining the value they bring to consumers. The potential for savings multiplies as the industry converges, squeezing out inefficiencies and duplication. Health leaders must look beyond their own organizations and figure out how they can benefit by reducing costs elsewhere in the value chain. As the industry addresses an increased emphasis on cost, the reductions could domino from one sector to another.

Whether it's increasing community-based collaborations to address wellness, using technology to deliver care, or connecting data to provide better information, providers, payers, pharmaceutical companies and employers will have to redefine their roles.

Recommendations for health industry organizations to stay ahead of the changes:

Understand rewards, rules and data

- Look for pilots and grant programs that test new ways to bring value to patients and the community.
- Stay on top of government rewards and take advantage of the incentives before they turn into penalties.
- Increase rigor around regulation compliance to avoid mistakes and fraud liability.
- Use data infrastructure to support information reporting, analysis and predictive business planning.

Engage consumers, partners and new players

- Understand how consumers use new media and social networks for health education and treatment.
- Establish new ways to relate to each other and to patients as care delivery channels evolve.
- Find innovative ways to contribute to patient outcomes, especially as new players continue to change the structure of the health industry.

Plan, stay flexible and find the right partnerships

- Redesign workflows to align with increased electronic-enabled health delivery and new interdependencies.
- Develop a comprehensive, strategic approach to educate employees on health and wellness, including, flu prevention, care and containment.
- Re-evaluate existing relationships and consider new partnerships for outcomes-based care delivery.
- Consider nontraditional arrangements to support healthcare innovation and sustainability.

1. The aftermath of health reform: Get ready for a regulatory spin cycle

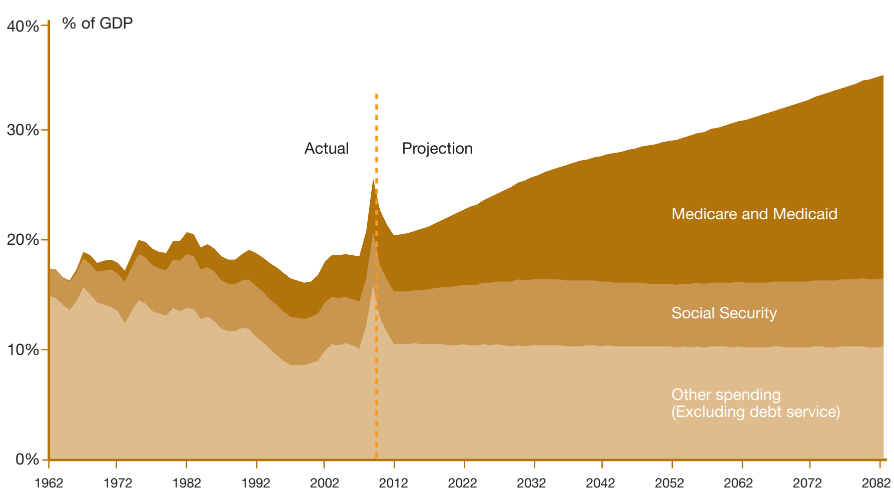
Even though President Obama campaigned on the prospect of change, no one knew exactly how it would play out, where alliances would be forged or fail, and how long the process would take. The administration's three healthcare goals have been clear from the beginning: expand insurance coverage, modernize the health system, and increase prevention and wellness. On all three, work began in 2009 and will continue in 2010. The expansion of the State Children's Health Insurance Program (SCHIP) provided coverage to more children, and the stimulus invested in health IT and prevention. Providers, payers, employers and pharmaceutical companies will be busy absorbing these changes in 2010. However, that's just the start if any part of health reform passes. Within the almost 4,000 pages of the bills in Congress are major insurance market and payment reforms and dozens of new agencies and grant programs.

All reform will be in the context of future spending, particularly in light of Medicare and Medicaid absorbing an increasingly large part of GDP (see Figure 1). With that type of financial burden in the future, the trend in the U.S. could mirror that of European countries in which major reform initiatives—and their concomitant regulations—are a more recurring process.

Implications:

- Providers will face increasing reimbursement pressure and physician practice models will begin to adapt to those payment changes.
- Seeing the primary care shortages in Massachusetts, some states may step up education and training programs.
- Payers will grapple with a leveling of Medicare Advantage reimbursement, possible increase of industry fees and taxes, and decisions on how to approach a public option in national and state insurance exchanges.
- Pharma will face continued restrictions in marketing activities and data usage, financing of prescription drug use to fill the Medicare coverage gap, rebate changes and maintaining its overall 10-year, $80 billion contribution agreement with the Obama administration.
- Employers will need to manage new mandates, changing tax implications and the potential cost shift from Medicaid and SCHIP expansion.

Figure 1: Federal spending as percent of GDP, 1962 – 2082



Source: Congressional Budget Office Analysis, June 2009

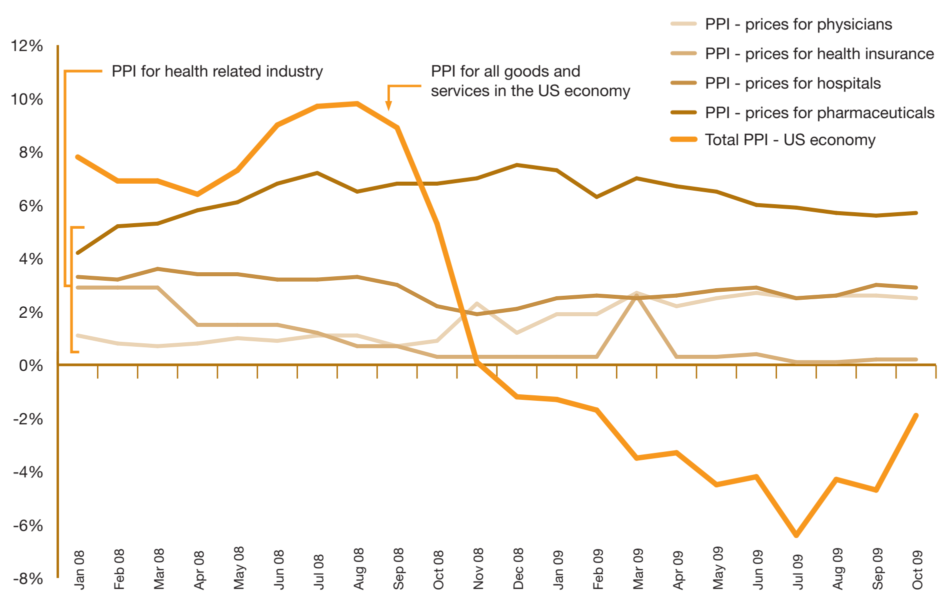
Economists expected health spending to grow at 5.5% in 2009 compared to a drop in GDP of 0.2%, the largest one-year increase in the health share of GDP ever.

2. Managing through the recession: getting more for less

Flat is the new growth for many industries outside of healthcare. Consumers and businesses have less money to spend on everything, including medical care and treatments. The recession crushed prices throughout the economy—with the exception of healthcare (see Figure 2). Economists expected health spending to grow at 5.5% in 2009 compared to a drop in GDP of 0.2%, the largest one-year increase in the health share of GDP ever. Historically, the health industry has been much less closely aligned with the business cycle and the impact tends to show up with a lag of a year or more. That could mean increased pricing pressure in 2010. Cost reduction efforts are under way in the following areas:

Figure 2: Producer price indices

Percentage change in prices for medical goods and services compared to all other goods and services



Source: PwC analysis of Bureau of Labor Statistics; Total PPI is seasonally adjusted. Hospital, physicians' offices and health insurance PPI are not available on a seasonally adjusted basis. May 2009 – Oct 2009 are preliminary values for Hospitals, Physicians, Insurance Carriers and Pharmaceuticals

Devices and pharma: Hospitals see the potential of cost savings in cardiology, spine, vascular, plastics, minimally invasive and orthopedic implants and products. Mergers among device makers and single source agreements could yield big savings. According to a 2009 Goldman Sachs' survey, hospital purchasing managers reported an 18% average price discount after consolidation among cardiology and orthopedic device makers.[1]

Other industry estimates are as high as 55%, depending on the level of standardization, utilization management and net discounts off current list prices. Newer and more aggressive approaches base pricing on outcomes. For example, total knees that increase patient post-op mobility would affect overall length of stay and patients' ability return to activities of daily living.

Another factor that could affect medical product purchasing decisions is the proposed Physician Payments Sunshine Act, which would require pharma and device companies to disclose consulting fees paid to physicians, health insurers, pharmacists and others. This national expanded transparency requirement was proposed by MedPAC, the agency that advises Congress on Medicare issues. Currently, six states and the District of Columbia require that drug companies report as little as $25 in consulting fees to physicians. Some companies have already begun reporting compensation to physicians and others say they will voluntarily begin disclosing these financial relationships in 2010.

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Nonlabor costs: Nonlabor costs can make up almost half of most hospitals' expenses. Hospital executives said they're scrutinizing non-traditional purchased services such as biomedical engineering, energy management, security and parking. Food and nutrition services are a significant part of the "big three" non-labor spending; environmental services and laundry/linen services are the other two. Nutrition costs during a hospital stay range from $22 to $70 per person per day. Organizations that have tightened up contracts with food and beverage vendors report savings up to 15%, which

[1] The Goldman Sachs Group, Inc., "The squeeze is on: winners and losers of rising hospital pricing power," October 14, 2009.

As employers shed jobs, payers battle decreased enrollment and are looking to reduce benefit-related administrative costs.

translates to approximately $500,000 to $4 million, depending on the system's size.

Employer dependent audits: Employers are increasingly hiring experts to check whether their employees' dependents should be insured under their benefit plans. With 3% to 8% of people failing to produce dependent verification and a $1,900 average annual cost per dependent, savings can range in the millions of dollars. For example, plans with 3% ineligibility per 10,000 dependents, can see savings of $570,000 and those with 8% ineligibility can see about $1.5 million.[2] In 2010, demand for these audits is expected to increase.

Payer administrative costs: As employers shed jobs, payers battle decreased enrollment and are looking to reduce benefit-related administrative costs. Payers are also experiencing an increase in medical costs as members rush to incur claims before termination and providers improve coding practices to focus on higher priced procedures.

Implications:

- Conflict of interest disclosures for surgeons using certain implants and devices is prompting some doctors to enter gain sharing or service line cost management agreements that reward high quality outcomes through utilization and technology management.
- Hospitals will revisit high-cost implantable devices as a part of evidence-based resource management that aligns cost with reimbursement and quality outcomes.
- Pharma and device companies need to prepare for national transparency laws, including developing a master repository containing single customer profiles that can track individual transactions. The value of certain sales and marketing activities need to be evaluated against potentially onerous collection and reporting.

[2] Society for Human Resource Management, "Health Care Savings with Dependent Eligibility Audits," April 14, 2009. http://www.shrm.org/hrdisciplines/benefits/Articles/Pages/dependentaudits.aspx

3. Government reimbursement moves to carrots and sticks

The government is moving from volume-based payments to value-based purchasing (VBP). VBP is a pivot from process to quality measures. And, it is tied to reimbursement withholds (5%) that can be retracted through quality ratings against peers that compete with one another. Healthcare organizations who have not taken advantage of incentive programs need to gear up quickly before those carrots turn into sticks. For example, 2010 is a double bonus year for physicians who adopt both e-prescribing and electronic health records (EHR).

A PwC survey found that less than half of providers have fully implemented all but the most basic EHR functions.[3] Only 1.5% of the 63% hospitals surveyed by the New England Journal of Medicine have a comprehensive EHR system.[4]

The HITECH Act of 2009, which was a part of the stimulus bill, provides a scale of incentive payments to providers to establish meaningful use of an EHR system (see Figure 3). These payments decrease each year until 2015 when penalties kick in. In addition to monetary support, providers will have access to technical assistance through a collaborative consortium of HIT Regional Extension Centers, which will offer providers help in the selection, acquisition, implementation and meaningful use of an EHR system.[5]

Congress approved the Medicare e-prescribing incentives, hoping to broaden the current 20% (120,000) of office-based physicians who use electronic methods to prescribe medication.[6] Physicians can earn a

Figure 3: PwC modeling of incentive payments for a 500-bed hospital if it achieves meaningful usage in 2011, 2012 or 2013

Incentive	Year 1	Year 2	Year 3	Year 4	Total incentive
Transition factor	100%	75%	50%	25%	
Base Incentive	$2,000,000	$2,000,000	$2,000,000	$2,000,000	
Variable incentive based on Medicare volume and charity care ratio	$1,665,800	$1,665,800	$1,665,800	$1,665,800	
Total incentive per year when multiplied by Medicare share and transition factors	**$2,428,000**	**$1,821,000**	**$1,214,000**	**$607,000**	**$6,070,000**

Source: PricewaterhouseCoopers' analysis, 2009 based on 500-599 Bed Hospital Data from Solucient

1.5%

of the 63% hospitals surveyed by the New England Journal of Medicine have a comprehensive EHR system.

[3] PricewaterhouseCoopers, "Transforming Healthcare through Secondary Use of Data," September 29, 2009.

[4] Jha, Ashish et al., "Use of Electronic Health Records in U.S. Hospitals," April 16, 2009, New England Journal of Medicine, 360; 16:1628-38.

[5] Department of Health and Human Services, "HIT Extension Program: Regional Centers Cooperative Agreement Program," November 23, 2009, Funding Opportunity Announcement.

[6] The Henry J. Kaiser Family Foundation, "Special Health IT Report: Electronic Prescribing Increasing Despite Glitches," June 29, 2009. http://www.kaiserhealthnews.org/Stories/2009/June/29/eprescribe.aspx

The government is moving from volume-based payments to value-based purchasing (VBP). VBP is a pivot from process to quality measures.

bonus of 2% of the total estimated allowed charges for professional services covered by Medicare Part B. The incentive drops to 1% in 2011 and 2012 and then to 0.5% in 2013. While e-prescribing activity started out strongly a few years ago, implementation and adoption have been difficult. Pockets of success stories, such as the one in Massachusetts that found a savings of $845,000 for 100,000 patients per year, show the savings potential if broad adoption is achieved. Physicians face barriers such as prohibitions against e-prescribing of controlled substances. And many have encountered resistance from some Medicare beneficiaries who still want paper prescriptions that they can shop to different pharmacies to find the lowest prices.

CMS' new model of rewards and penalties for interoperable EHRs signals a more assertive future of government pushing the industry to connect better to deliver care. This signals a shift in CMS' attitude from a "passive payer" to an "active buyer" of healthcare services.

Implications:

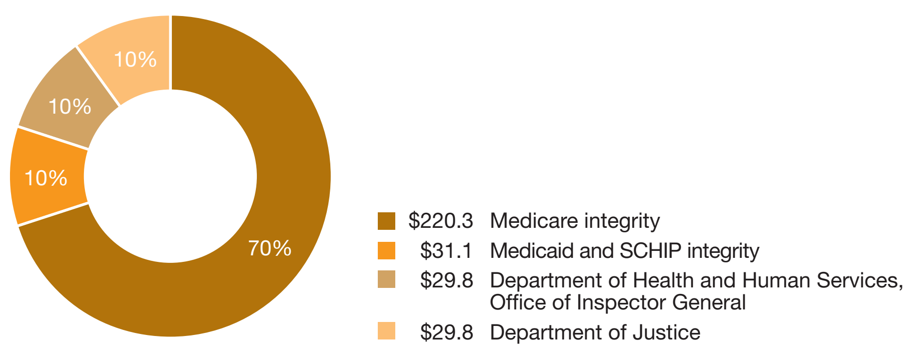
- Large providers with legacy systems will require adequate planning for enterprise-wide EHRs or risk missing out on new funding dollars.
- Workflows need to be thoughtfully redesigned to accommodate changes related to electronic-enabled care delivery.
- Privacy and security strategies related to electronic information exchange need to be established or revisited.

4. The fine line between fraud and mistakes

Healthcare executives could face jail time in addition to fines if they break the rules in 2010. For example, recent court activity, using the US Park Doctrine as precedence, has held pharma executives liable for violations, such as off-label marketing. Some executives have paid out $75,000 in individual civil penalties and have been sentenced to six to 10 years in prison. Corporate penalties have been as high as $2 billion.

Losses to fraud are estimated to cost more than $68 billion annually.[7] Medicare fee-for-service error rates in 2009 (7.8% – $24.1 billion) are double that of the previous year (3.6%), while the increase in Medicare Advantage error rates translated into $12 billion in improper payments. The Obama administration has boosted its fraud and abuse budget for 2010 by 50% over the previous year[8] (see Figure 4). Nearly one-tenth of the FY2010 budget is designated for Department of Justice (DOJ) for prosecution and enforcement. The budget proposes using national coding and technology to ensure appropriate Medicare payments and address financial conflicts of interest in physician-owned specialty hospitals.[9] The Health Care Fraud Prevention and Enforcement Action Team (HEAT) leverages the expertise of law enforcement agents, prosecutors and staff members from HHS and DOJ to step up enforcement activity.[10] HEAT is even turning to consumers to report suspected problems with Medicare summary notices and medical bills. CMS is educating beneficiaries through its website about how to protect themselves and stop fraud.

Figure 4: FY 2010 Healthcare Fraud and Abuse Budget (in millions)



Source: White House, Office of Management and Budget. http://www.whitehouse.gov/omb/budget/fy2010/assets/hhs.pdf

[7] National Healthcare Anti-Fraud Association, "Consumer Alert: The Impact of Health Care Fraud on You!" http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centr&wpscode=TheProblemOfHCFraud

[8] The Advisory Board, "New Task Force Aims to Address Medicare, Medicaid Fraud," American Health Line May 21, 2009. http://www.americanhealthline.com/article.aspx?s=47551

[9] American Health Care Association, "Summary of Federal Government Medicare/Medicaid Integrity Programs and Fraud Investigations Affecting Long Term Care (LTC) Providers," August 2009.

[10] U.S. Department of Health and Human Services and U.S. Deptartment of Justice, HEAT Task Force Success. http://www.stopmedicarefraud.gov/heatsuccess/index.html

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Providers also will feel the pressure from CMS's Recovery Audit Contractor (RAC) program, which has focused on clawing back Medicare overpayments. The program has concentrated on certain regions but will spread nationwide in 2010. On the payer side, Medicare Advantage (MA) plans, already hit with a 4% drop in payments, could see payments reduced further through the government's risk adjustment data validation audits (RADV). The audits review underlying medical records to determine if coding associated with encounters justifies higher risk adjusted payments to MA plans. Continuing ICD-10 implementation efforts will also present an opening for improved coding education and fraud prevention.

Health reform is banking on the savings from fraud prevention and recovery to bend the curve on cost growth, and technology could make the rewards larger than ever. Fraud and abuse savings from the current health reform bills are estimated to be $1 billion to $1.6 billion.[11]

Historically, the government has used labor-intensive audits, leading to lengthy investigations to chase down suspected fraud perpetrators. However, the move towards sophisticated technology that can detect fraud earlier makes it a much different process for providers and payers.

50%

is how much the Obama administration has boosted its fraud and abuse budget for 2010, over the previous year.

Implications:

- Internal controls need to be tightened and staff educated on the ramifications of fraud and abuse.
- Program integrity units need to shift more toward fraud prevention. Some pharma companies have already started certification programs to maintain awareness and accountability.
- Businesses need to be more vigilant about using funding for unproven fraud detection solutions.
- Secondary health data sources can help pharma companies be more proactive and predictive. For example, claims data will increasingly be used to identify geographic hot spots for products with increased off-label use potential.

[11] PricewaterhouseCoopers analysis of CBO estimates from America's Healthy Future Act and the Affordable Health Care for America Act, November 2009.

5. Message received: Telecom companies integrate into health delivery

Telecommunications corporations are capitalizing on the growing use of their products in the healthcare industry. For example, Verizon is unveiling a Telehealth Collaboration Services initiative in 2010, which will provide remote consultation, technology for continuing medical education, and virtual encounters between management of hospitals, physician practices, laboratories and government agencies. AT&T announced an alignment with Microsoft and Covisint to create what they describe as the first nationwide health information exchange zone, which stemmed from its initial work with the state of Tennessee. GE Healthcare and Sprint have partnered with San Antonio's Methodist Healthcare to create a wireless infrastructure for anytime communication among providers and access to patient vitals. With increased focus on technology connecting patients to different modes of care and the push for interoperable electronic health systems, these companies are positioned to strengthen their share of the healthcare business. The Continua Alliance, a nonprofit consortium of technology and IT firms, has gained momentum as it continues to certify personal health devices, such as pulse oximeters and Bluetooth blood pressure cuffs.

The convergence among telecommunications, technology and healthcare organizations stems from the need for proven communication channels to deliver specialized IT capabilities, as well as from the lack of dominant IT innovators within the health industry. The trend got a huge boost from the 2009 stimulus package, including $7 billion in broadband funding, $598 million for the establishment of regional health information technology extension centers and a national Health Information Technology Research Center, and $564 million for health information exchanges. The first grant for the extension centers will be awarded in 2010.[12]

The convergence trend among telecommunications, technology and healthcare got a huge boost from the 2009 stimulus package.

Implications:

- Current players need to understand how consumers use new media and social networks for education on health treatments and resources.
- Technology and telecommunications companies may become key players in setting new regulatory rules versus just playing by existing ones.
- New players will continue to change the structure of the industry, the basis for competition, and the way health services are delivered.

[12] U.S. Department of Health and Human Services, Recovery Programs: Hitech Priority Grant Items. http://www.hhs.gov/recovery/programs/hitech/index.html

Pharma companies are also working with the retail sector to drive wellness and awareness programs for at-risk populations.

6. Manufacturing health: Pharma extends into patient care delivery

Faced with a revenue growth rate that has dropped from 9.9% in 1997 to 1.3% in 2008, pharmaceutical companies are shifting toward a more comprehensive patient-centered approach. They are addressing education, clinical effectiveness, product safety, total care costs, consumer out-of-pocket costs, compliance with treatment regimens and employer wellness.[13] Such a shift will be disruptive as life sciences companies converge with other players to address patient outcomes rather than lab-based scientific results.

For example, Merck and CIGNA have entered into a performance-based contract designed to realign incentives to produce better results for patients, insurers and pharma. The plan is to place two diabetes treatment drugs on a preferred tier in the insurer's formulary. As patient adherence and glucose control increases, Cigna will receive additional rebates. With demonstrated improvement in patient outcomes (A1C levels), Merck will increase its sales volume.

Pharma companies are also working with the retail sector to drive wellness and awareness programs for at-risk populations. For example, Walgreens is offering free diabetes testing through a program sponsored by Novo Nordisk and Bayer. In addition, Wellness Inc. provides skilled healthcare education and screening services at Walgreens locations.

Bayer Health Care is connecting directly with some of its customers—hemophilia patients. Through web-based programs geared towards patients and their caregivers, the company provides help with the daily challenges they face.[14] For example, Life's Little Essentials introduces parents of children with hemophilia to helpful resources and networks. Living Fit! provides physical therapy recommendations for strength and resistance training for children from ages 7-17. Bayer Health Care also offers a self-infusion training program to help patients gain independence from having to frequent infusion centers.

Implications:

- By supporting care delivery innovations, pharmaceutical companies will rebuild trust among consumers and be seen as a strong partner in delivering effective healthcare.
- The need for consumer engagement at all points of care will open up opportunities for pharma to partner with providers and insurers to increase the value of health spend and effectively manage at-risk populations.
- Pharma will increasingly adopt formal collaborations with other stakeholders within and outside the health industry to positively affect patient outcomes.
- Alignment of incentives between pharmaceutical companies and payers ultimately helps to control costs, redefine product value and improves patient utilization of treatment.

[13] IMS Health, "U.S. Pharmaceutical Market Trends: Tremendous Slowdown," July 2009. http://www.imshealth.com/portal/site/imshealth/menuitem.a46c6d4df3db4b3d88f611019418c22a/?vgnextoid=bd34c71e81a32210VgnVCM100000ed152ca2RCRD&vgnextchannel=ad97a7a4fa712210VgnVCM100000ed152ca2RCRD&vgnextfmt=default#

[14] Bayer Health Care Pharmaceuticals, Inc.,"Life's Little Essentials" and "Living Fit!" http://www.livingwithhaemophilia.com/default.jsp

7. P-H Harmony: Physician groups rejoining with health systems

Physicians are looking for stability, while hospitals are trying to manage rising costs. Decreasing reimbursement for physician-owned diagnostic imaging and ambulatory procedures, declining physician professional fees, gain-sharing and under arrangement limits, and CMS' move to coordinated care (bundled and global) payments are bringing physicians and health systems closer together. One indicator of the growing trend is physician employment by hospitals, which has nearly doubled since 1994, whereas other physician affiliation models have remained flat or decreased (see Figure 7).

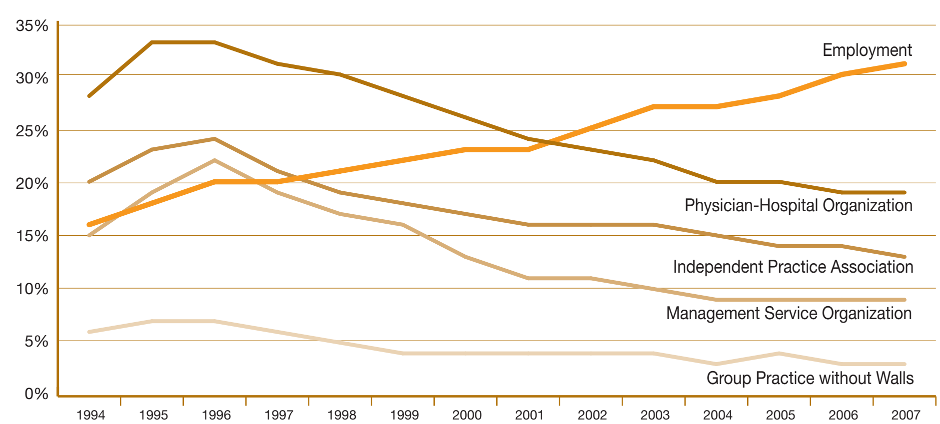
MedPAC has recommended combining hospital and physician payments for episodes of care to encourage all parties to re-engineer processes to improve effectiveness and patient outcomes. The theory will play out over the next three years through Acute Care Episode (ACE) demonstration projects in four states.[15]

Dozens of healthcare systems have voiced interest in newer models of physician alignment, called accountable care organizations (ACOs). The most effective ACO design will enable healthcare providers to control costs and improve quality by working together with other providers and payers under a structure that effectively accepts and redistributes global payments.

Implications:

- Providers will re-evaluate their relationships and consider all aspects of new partnerships including their strategic direction, operational infrastructure, various affiliations, payer contracting and overall funding.
- Comprehensive collaborative planning is a necessity and lining up the right incentives can renew current relationships.
- Hospitals that have poor relationships with their physicians may have to devise a strategy that repairs trust and garners buy-in.

Figure 7: Percentage of hospitals with physician affiliations, 1994 – 2007



Source: American Hospital Association, 2009

[15] Centers for Medicare and Medicaid Services Office of Research Development and Information, "ACE Fact Sheet," August 17, 2009.

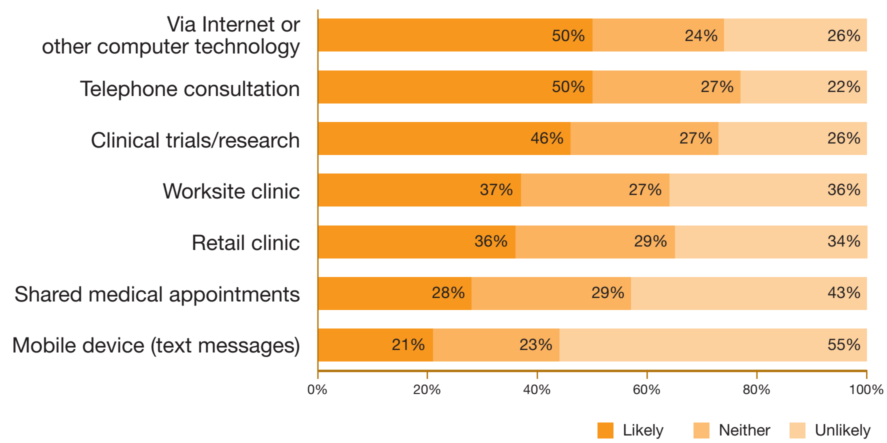
Patients want better access to care, and jams in the delivery system are prompting them to seek quicker and more convenient treatment outside physicians' offices and hospitals.

8. Care delivery continues to move out of traditional venues

Patients want better access to care, and jams in the delivery system are prompting them to seek quicker and more convenient treatment outside physicians' offices and hospitals. These traditional care venues are being augmented with more choices, and providers of medical services are exploring alternative means for care delivery. The growth rate of the home healthcare and disease management markets are expected to increase to 25% 2010 and to remain steady over the following five years.[16] Retail health clinics have increased nearly 20 fold since 2005 and are beginning to expand the scope of their services to include management of chronic diseases such as asthma, osteoporosis and diabetes.[17] CVS MinuteClinic and Walgreen's Take Care Clinic have already piloted disease management programs.[18]

With venue shifts, use of nonphysician providers such as advanced practice nurses, physician assistants, physical/occupational therapists and pharmacists, will expand. Community/retail pharmacies are focusing more on patient-centered care by taking advantage of their frequent personal contact. For example, Walgreens is increasingly using pharmacists to counsel patients, and CVS is studying the effects of e-prescribing on patient compliance.

Figure 8: Consumers' willingness to utilize alternative methods of accessing healthcare



Source: PwC Consumer Access Survey, 2009

According to PwC, consumers are open to other ways of receiving care outside of traditional venues (see Figure 8). Approximately 50% of respondents said they would be willing to use telephone consultations or computer and Internet technology to access

[16] Frost & Sullivan, "North American Home Health Care and Disease Management Markets for Remote Patient Monitoring," June 2009, N5BA-56, p. I-7.

[17] Merchant Medicine, Graph: "Retail Clinics in the United States," February - April 2009 Data. http://www.merchantmedicine.com/Home.cfm?view=Retail

[18] Wall Street Journal, "Retail Health Clinics Move to Treat More Complex Illness, Rankling Doctors," September 10, 2009. http://online.wsj.com/article/SB125253798506197499.html#

healthcare. E-mail consultations topped the list of preferred methods to access care, followed by online consultations.[19] Insurers such as the Hawaii Medical Services Association, Aetna and Cigna reimburse for e-consults (telephone/online consultations), and this trend is expected to grow.

Both the home healthcare and disease management markets already leverage remote patient monitoring technology. Homecare agencies typically use IT to automate clinical referrals, scheduling, billing and claims management. Technology vendors who work with homecare agencies offer tools to document telephone correspondence, e-prescribing, real-time web-based outcomes data, and electronic medical record integration. Intel and Microsoft have conducted remote patient monitoring pilots in cooperation with leading healthcare organizations including the Veterans Affairs Rural Resource Center Western Region, Memorial Hospital and Health System in South Bend, Indiana, and Nightingale Home Healthcare of Indiana, Inc.[20]

Implications:

- Increased availability of remote patient monitoring systems will complement disease management and home health care to engage consumers with constant feedback on their health.
- Hospitals, especially those with nonemergent ED cases, have an opportunity to understand and educate patients on alternative means of care such as community retail clinics and online consultations.
- Healthcare organizations need to connect to each other outside hospital settings to help patients stay healthy or recover from illnesses.

E-mail consultations topped the list of preferred methods to access care, followed by online consultations.

20x

Retail health clinics have increased nearly 20 fold since 2005

[19] PricewaterhouseCoopers, "Jammed Access: Widening the Front Door to Healthcare," July 2009, p. 20, 23.

[20] Dunbrack, Lynne et al., "Intel and Microsoft's Remote Patient Monitoring Announcements: Are They Dual or Dueling Efforts?" Health Industry Insights, 2008.

In fall 2009, the flu dominated the news, giving the industry a real-life test of its readiness for a major public health crisis.

9. Battling the flu

In fall 2009, the flu dominated the news, giving the industry a real-life test of its readiness for a major public health crisis. Experts believe that flu will intensify in 2010 with another wave of H1N1. At the height of a flu season, hospitals could exhaust their bed capacity in 15 states, and beds in 22 other states could reach 75% capacity, according to Trust for America's Health, a nonprofit health advocacy organization.[21]

Though the CDC recommends that all healthcare workers get immunized for flu, only one-third typically follow through. Because of the severity of 2009's flu outbreak, several states are taking extra measures. For example, Massachusetts extended vaccination administration to dentists, pharmacists and paramedics. New York passed a law requiring all healthcare workers to get both the seasonal and H1N1 vaccines.

CDC officials are also advising about the importance of nonpharmaceutical interventions, such as social distancing and infection control in a surge situation. When the numbers and needs intensify, no single prevention or care element will carry the system. Communities will depend on a connected safety net, where businesses and the healthcare community have established communication channels, proper contingency plans for resources, and the right funding mechanisms.

Instead of waiting for regulatory directives, employers need to establish early and consistent channels of communication that include clearly defined sick leave policies. Fifteen states have proposals for sick leave mandates on the table. Many employers have already scheduled onsite flu clinics and education for employees. Hospitals and physicians need to ensure that their own workers are immunized so that they can be an effective vehicle for care delivery. Insurers can develop policies for rendering care during outbreaks and offer guidance to members, employers and brokers.

Pharmaceutical companies can help not only through research, development and deployment of vaccines, but also use of existing media relation channels to educate the general public.

Implications:

- Organizations need to develop comprehensive, strategic approaches to educating employees on flu prevention, care and containment.
- Businesses need to engage in proactive business continuity planning that includes putting the proper communications in place, understanding the impact of workforce fluctuations and proper budgeting. Most payers have already included potential flu impacts in their financial forecasts.
- Formal collaboration within communities will enable more people to receive care during heightened flu seasons regardless of flu-strain combinations.

[21] Trust for America's Health, "H1N1 Challenges Ahead," October 2009.

10. Money in the neighborhood: Reinvigorating population health

In 2010, a new social responsibility will emerge as community health is rewarded by government programs. Increases in the coordination of community-oriented health services and consumer access to information for healthy living will encourage personal responsibility. The Communities Putting Prevention to Work program, a stimulus-backed effort, provides approximately $642 million for regions to combat leading chronic diseases through evidenced-based prevention and healthcare strategies."[22]

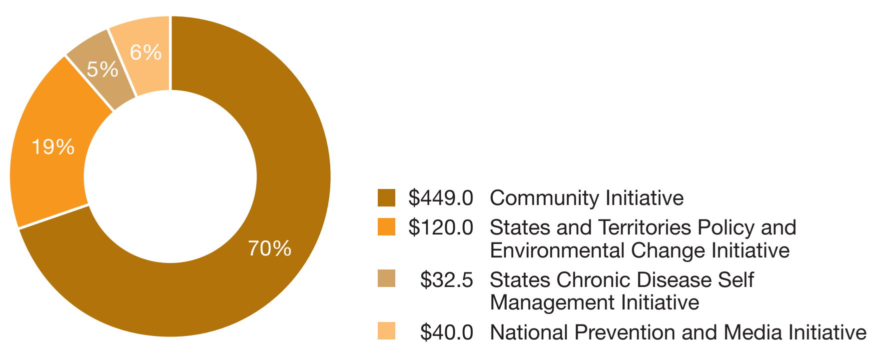
In 2010, a new social responsibility will emerge as community health is rewarded by government programs.

The program will award grants in four areas (see Figure 10): Community Initiative ($449 million); States and Territories Policy and Environmental Change Initiative ($120 million); States Chronic Disease Self Management Initiative ($32.5 million) and; National Prevention and Media Initiative ($40 million).

The $120 million allotted for the States and Territories Policy and Environmental Change Initiative aims to "support states and territories in promoting wellness and preventing chronic disease through state-wide policy and environmental change for chronic disease prevention and to increase tobacco cessation through expanded quit lines and tobacco cessation media."

For example, Indiana Tobacco Prevention and Cessation group collaborated with more than 130 partners, including 85 local

Figure 10: Funding for Communities Putting Prevention to Work initiative (in millions)



Source: PwC analysis of data published on CDC website available at http://www.cdc.gov/nccdphp/recovery/

[22] Centers for Disease Control and Prevention (CDC), "Recovery Act Communities Putting Prevention to Work." http://www.cdc.gov/nccdphp/recovery/

Healthcare stakeholders may get a boost in support for new health and wellness programs. The key will be figuring out sustainable ways to engage individuals in these programs.

community coalitions, 13 statewide partner agencies and six VOICE youth hubs, to develop the Indiana Tobacco Control 2015 Strategic Plan. The strategic plan cites a CDC recommendation for the state of Indiana to invest $78.8 million towards implementation of a thorough, evidence-based tobacco control program.[23]

In the small, Midwestern town of Albert Lea, Minn., the AARP/Blue Zones Vitality project sought to improve the longevity of each resident by at least two years through a collective commitment to living a healthier lifestyle. Sponsored by the United Health Foundation, the town developed several initiatives designed to "transform the town into a blue zone ("blue zones" are areas of the world with the longest living populations), by changing the way residents eat, work, exercise and play." This initiative created walking groups, community gardens and cooking classes for longevity-promoting foods.[24]

Implications:

- Healthcare stakeholders may get a boost in support for new health and wellness programs. The key will be figuring out sustainable ways to engage individuals in these programs.
- By partnering with community initiatives, healthcare leaders will augment their corporate responsibility and community benefit plans.
- Increased public-private partnerships may create new and nontraditional arrangements to support innovation and sustainability in the healthcare delivery system.

[23] Indiana Tobacco Prevention and Cessation (ITPC), "Indiana Tobacco Control 2015 Strategic Plan," August 2009.

[24] AARP et al., Vitality Project. http://www.aarpmagazine.org/health/vitality_national/week6/daily_dispatch_friday.html

About PricewaterhouseCoopers

PricewaterhouseCoopers provides industry-focused assurance, tax, and advisory services to build public trust and enhance value for its clients and their stakeholders. More than 155,000 people in 153 countries across our network share their thinking, experience and solutions to develop fresh perspectives and practical advice.

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PricewaterhouseCoopers' Health Research Institute provides new intelligence, perspectives, and analysis on trends affecting all health-related industries, including healthcare providers, pharmaceuticals, health and life sciences, and payers. The Institute helps executive decision-makers and stakeholders navigate change through a process of fact-based research and collaborative exchange that draws on a network of more than 3,000 professionals with day-to-day experience in the health industries. The Institute is part of PricewaterhouseCoopers' larger initiative for the health-related industries that brings together expertise and allows collaboration across all sectors in the health continuum.

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