

# CAN HEALTH CARE CURE OHIO'S ECONOMIC ILLS?

Since the end of World War II, health care has mushroomed into a giant industry. But will it continue to grow fast enough and big enough to help ease the loss of all those steel, rubber, and other heavy manufacturing jobs in the state?

There's no question that the health care industry is a giant in Ohio. It's one of our top two industries, listing annual revenues of \$7 billion in hospital care alone.

But size takes second place to historic growth patterns. Health industry growth since World War II has been phenomenal. In 1950 it represented just 4.4 percent of the gross national product (GIMP). But now it's hovering around 11.7 percent of GNP nationally, "and about the same in the state," says David Engler, Ph.D., the director of data services for the Ohio Hospital Assn.

So it's not surprising that many have pinned their hopes on this growing giant of an industry to help ease the economic shock caused by the loss of steel, rubber, and heavy manufacturing jobs in Ohio.

But is the health care industry sturdy enough to provide major support for an economic turnaround in the years ahead? The facts are slippery, as the industry turns volatile in a transition year.

Estimates are always fair game for critics. Dr. Enrico Garter of the Office of Health Technology Assessment in Maryland cites the projections that preceded end-stage renal disease (ESRD) legislation, to provide funds for kidney dialysis.

"Everyone predicted that the worst case scenario, somewhere down the road, would cost \$60 million to \$70 million. But in 1977, the first calendar year of ESRD, the actual cost was \$228 million, and now, ten years later, it's 2.25 billion. Assumptions that go into projections may reflect

half-truths, a lot of baloney, and a little bit of spice," Dr. Carter says.

But Dr. Carter's wise prescription of skepticism for all crystal-ball gazers hasn't slowed the generation of economic "guesstimates" and projections, based on best available information.

For example; the Ohio Bureau of Employment Services' Labor Market Information Division (LMID) is currently engaged in a massive project to estimate future employment patterns among all industries in the state.

Dixie Sommers, director of LMID, says the 1995 projections were derived by analyzing the historical employment trends in Ohio in each industry, compared to national trends and projections. Ohio's population trends, particularly the growth of older age groups, were factored into the projections for health-related industries (See table).

Even so, she explains, "The health services sector is particularly difficult to project, given the recent changes in health care financing which have had significant effects on employment in hospitals and other service providers."

The preliminary figures released by LMID show an expected total increase of 86,600 new jobs in the state, encompassing all areas of the health care industry, between 1985 and 1995. Since two years of that projection have already passed, the estimate of increase between 1987 and 1995 would be somewhat lower.

To realistically measure the economic impact of these new jobs, one must recognize that all but 3,900 are in trade and service areas, which traditionally offer lower pay than the manufacturing jobs Ohio has lost.

Some of the figures need further explaining. For example, the great leap in employment in offices of osteopathic physicians, as well as the somewhat smaller growth in offices of dentists and physicians, is due in part to the trend of these health care professions to incorporate their practices for more favorable tax treatment. Self-employed practitioners are not included in the LMID studies, so when an existing professional office becomes a corporation, the growth figures are distorted.

However, the actual number of physicians in the state will rise dramatically. In 1982, the Ohio Board of Regents predicted a 71.2 percent increase in number of physicians in Ohio by the year 2000. "The population in that time is supposed to go up by 4.5

<b>OHIO'S HEALTH CARE JOBS</b>			
SEGMENT	1985 JOBS	1995 JOBS	PERCENT CHANGE
<b>Outpatient facilities</b>	<b>10,200</b>	<b>18,000</b>	<b>76.5</b>
ether health services	5,500	9,200	67.3
<b>Osteopathic offices</b>	<b>3,800</b>	<b>6,200</b>	<b>63.2</b>
Other practitioner	7,800	11,600	48.7
<b>Dentist's offices</b>	<b>19,900</b>	<b>28,700</b>	<b>44.2</b>
Physician's offices	40,800	55,400	35.8
<b>Manufacturing</b>	<b>11,400</b>	<b>15,300</b>	<b>34.2</b>
Nursing & personas care	71,500	93,800	' 31.2
<b>Labs</b>	<b>4,100</b>	<b>5,000</b>	<b>22.0</b>
Insurance	7,500	8,800	17.3
<b>Distribution</b>	<b>33,300</b>	<b>37,200</b>	<b>11.7</b>
<b>Hospitals</b>	<b>199,600</b>	<b>212,806.6</b>	
<i>Source: Ohio Bureau of Employment Services, preliminary projections. Does not include self-employed practitioners.</i>			

percent," says Kevin Sexton, senior vice president for strategic planning at Cleveland Metropolitan General Hospital. "It's changing the way physicians practice. There will be many more in groups and on salaries than in private practice," he says.

The 6.6 percent job increase projected for hospitals, compared to the 76.5 percent increase in outpatient care facilities, is a reflection of the first major dynamic in the health industry transition: cost management.

Cost management came about when business and government, dismayed by the soaring cost of health care in the 1960s and 1970s, quit writing blank checks to providers for whatever services physicians and hospitals deemed necessary.

A change was made to so-called "prospective payment," typified by the federally mandated Diagnosis Related Groupings (DRGs) for Medicare payments.

Under the DRG system, hospitals are paid a fixed sum for a particular diagnosis. This sum may be more than the hospital expended in service charges, in which case it makes a profit. But if the hospital spends more in services than the set price, it loses money.

With some exceptions, there's a general agreement that prospective payment systems -which now include state-sponsored Medicaid programs and other cost management systems such as health management organizations (HMOs) and preferred provider organizations (PPOs) -motivate the hospitals to keep costs low. They have accomplished this by cutting back sup

ply inventories (which has affected some suppliers) and reducing both the number of admissions and the number of days patients stay in the hospital.

Engler says Ohio Hospital Assn. members have reduced about one million patient days.

Sexton says a survey of five northeast Ohio counties shows a drop of 15 percent to 20 percent in patient days utilized. And of Cleveland Metropolitan General, he says, "We do over one-third of our surgical cases on an outpatient basis. That's two or three times as high as five years ago."

The shrinkage has brought about extreme competition among hospitals, especially in urban areas. Many of these hospitals had expanded in the previous decade, and thus are burdened with high debt costs that must be met even as patient-days decline.

Thus prospective payment plans, in addition to fostering the booming trend to outpatient care, have spurred growth of other services being offered by hospitals including hospice care, nursing home units, rehabilitation services, alcohol treatment and employee assistance programs, birthing centers, cancer screening, and geriatric assessment.

In spite of the hospitals' new emphasis on marketing and cost-effective treatment, many experts predict a shakeout. A recent survey by the accounting firm of Touche, Ross & Co. states that 47 percent of hospitals surveyed nationwide feel at risk of failure in the next five years. The Ohio respondents were a bit more optimistic -only 36 percent of the 52 Ohio hospitals survived fear failure.

But that doesn't stop knowledgeable people such as Lawrence Weier, vice president and secretary of the state's largest health insurer, Community Mutual Blue Cross/Blue Shield, Cincinnati, from believing that utilization of hospital services will continue to drop. "When HMOs and PPOs are fully operational, inpatient days will decrease more. At some point in time, hospital boards and trustees will have to bite the bullet." He anticipates 1,000 hospital closings, nationwide, in the next five or six years.

Engler disagrees, saying there's only so much length of stay reduction that can be achieved without affecting quality of care. He sees the situation as stabilizing and perhaps even improving slightly, because hospitals are now servicing sicker patients. "I think Ohio's hospitals are fairly sound, financially. I don't think too many communities will let their hospitals fail. In the urban areas, they're vying for market share, but I see no weakness."

Those empty beds are not likely to be filled again, in Engler's opinion. "Once you've established a practice of medicine which has learned to live with shorter length of stays and fewer admissions, using outpatient facilities instead, it probably won't go back to the way it was."

Community Mutual's Weier sees these cost management programs as the bread and butter of his company. "We think in five years, as much as 50 percent of our business will be in PPOs, and 25 percent in HMOs. The balance of 25 percent will be in so called traditional insurance."

The income that is expected to be funneled into Community Mutual from its diversifications will be used to hold premium costs down, Weier explains, and help the company stay competitive.

At Day International (formerly Dayco Corp.) in Dayton, Ralph Zimmerman, president of the company's Beneplan Strategies subsidiary, says that although employment at Beneplan is low today, he expects continuous growth.

Beneplan is a cost containment service, or third party administrator (TPA) for companies that seek to reduce health care benefit costs. Zimmerman says it has a track record of 20 percent cost savings, with 10 percent coming from plan design, and another 10 percent from claims administration.

"Health care is a very dynamic industry," he says. "We're probably seeing the pendulum effect, with the industry swinging from one area to another in terms of growth."

Most of the growing areas in health care are driven by the aging of the population. The fastest-growing population group is the "old-old," those 75 years and older. They are prime candidates for nursing home care and home care services.

But even here, there's no sizable impact on Ohio's employment picture. Paul Ormond, president of Health Care and Retirement Corp. of America (HCRA), a wholly owned subsidiary of Owens-Illinois Inc. in Toledo, says his company has invested half a billion dollars in high-quality nursing homes in 19 states during the last two years.

Though many of those nursing homes are located in Ohio, he says, "We're probably not creating a lot of jobs here. This is an industry that's moving from a 'ma and pa', or locally managed basis, to becoming professionally managed. The demand growth is in excess of five percent a year. By the year 2000 there might be twice as many nursing home beds in Ohio alone, but that still isn't going to revolutionize the state."

Rob Vogt, vice president of Kenneth Danter & Co., a market research firm in Columbus, concurs. His firm recently analyzed the growth of retirement centers and congregate care facilities, many of which contain health care components. "I think growth is going to start tapering off," he says. "Vacancies are starting to increase state-wide. Two years ago, the Ohio Housing Finance Agency was financing two or three of these projects a month. But now they have a moratorium on financing."

The increase of some home care services will continue, but other related businesses have been pinched by changes in government funding. Les Inglis, president and CEO of Vortec Corp. in Cincinnati, which has a health care division specializing in oxygen equipment rental, is particularly vocal in his disapproval of the new payment methods. Medicare recently instituted rent-purchase rules that he feels are patently unfair and are forcing out dealers in durable medical equipment (DME).

"These poorly thought out attempts to solve Medicare funding problems by eliminating longer-term equipment rentals have caused problems for patients and the entire DME industry."

There is no more health policy in this country's government; there is only budget policy," Inglis told stockholders.

In manufacturing, the outlook is a bit more optimistic. Lucy Olwell, a research analyst for Merrill Lynch Pierce, Fenner & Smith Inc., New York, says "Currently, manufacturers are doing quite well. Most of their product usage is tied to surgical procedures, and surgeries are increasing."

The hospital supply companies went through a rough period in 1983-1984, when they were faced with Diagnosis Related Groupings and declining occupancy rates. Hospitals slashed inventories. In response, hospital suppliers "permanently, drastically, lowered their cost structure," says Olwell. Once the inventory reduction was over, basic demand remained. "Hospital suppliers began to see only modest top-line growth, but based on what they'd done to cut their cost, they saw tremendous bottom-line growth. So hospital suppliers have been among the best-performing industries," she says.

Unfortunately, Ohio is not one of the big health care manufacturing states. Altogether, there are 450 manufacturers registered with the FDA here, but many of the plants are small.

Merit Kimball of the Hospital Industry Manufacturer's Assn. in Washington, D.C., says there are very few headquarters here, although the state does boast Procter and Gamble Co.'s paper products division in Cincinnati; Invacare Corp., the Cleveland-based maker of wheelchairs; and drug companies such as Merrell Dow Pharmaceuticals in Cincinnati and Abbott Laboratories's Ross Laboratories Division in Columbus.

Gary Delisio's new company, Clinical Connections Inc. (CCI), Orrville, is one of those exceptions. CCI was formed in a management buyout of Norton Companies Health Products Division last spring. Its primary products are disposable monitoring and specialty intravenous items.

"The business is in transition," Delisio says. "There was a long period of time when business sense wasn't necessarily important. You didn't have to be cost effective, you just needed to be able to get to the right person within the hospital to sell your product."

Today, companies that are cost conscious can still grow at rates up to 18 percent annually, Delisio claims. "But companies that can't do that, or are working on too thin a margin, aren't seeing a lot of growth . . . maybe no growth at all."

He sees disposables becoming commodity items, with less R&D going on, and more copying. He also expects that large for-profit hospitals will work with manufacturers that produce devices under the hospital's name. "These large organizations will start dictating down through their ranks to use their products. They'll bring large purchasing strength. It's going to drive price down, and also the cost of manufacturing and distribution," Delisio adds.

Peter Halter, president of Biomedical Business International, in California, argues the point that new technologies could drive a substantial wave of growth in the health care industry. The idea, he says, is to come up with a new technology "which would enable you to treat patients outside the hospital rather than inside, or would reduce the length of stay in the hospital."

He says the specialty part of the health care supply business will flourish, and cites examples like the \$700-per-procedure technology that now replaces heart drug administration.

Halter also mentions the lithotripter, an external system that disintegrates kidney stones without surgery, and costs about \$2 million per installation. "There is a whole slew of these technologies coming in that will help treat patients in the least invasive way, to help get a patient out of the hospital early or eliminate the need for admission," he says. "That's where the action is."

Paul Rogers, president of U.S. Medical Corp., Cincinnati, agrees wholeheartedly. His company distributes laser equipment and trains hospital staffs in their use. "Ohio is a good place to be in this business," he says. "It's amazingly forward in medical areas."

He lists many new technologies, including new suturing materials and stapling devices for surgery, suction devices for plastic surgery, and laser technology used in outpatient settings for sports medicine and gynecology, among many other applications.

As an example, the laser industry is expected to grow 50 percent a year for the next ten years, Rogers claims.

"Doctors are doing things they haven't done before. I think we may be looking at a two-tiered system, where some of the higher-technology equipment and practices may not be reimbursed . . . where, if you have enough money or health insurance, you'll get things that are quite expensive, and if not, you won't. But that's more a product of the capitalistic system than it is anything intentional in the health care business," Rogers says.

Although Rogers believes the building of huge major hospitals has come to an end, he thinks those hospitals will still be willing to invest in major new technologies, such as nuclear magnetic resonance equipment, even when they require expensive additional facilities.

"The hospitals that will succeed are those that are flexible enough not to be locked into what medicine was ten years ago, but are open to what it is going to be," he says.

And for those who are looking to the health care industry as a savior of jobs in Ohio...don't hold your breath.