FALL 2025

MEDISCENE™

TRENDS IMPACTING HEALTH & HEALTHCARE DELIVERY

HEALTHCARE MANAGEMENT THE RINER GROUP INC. CONSULTING

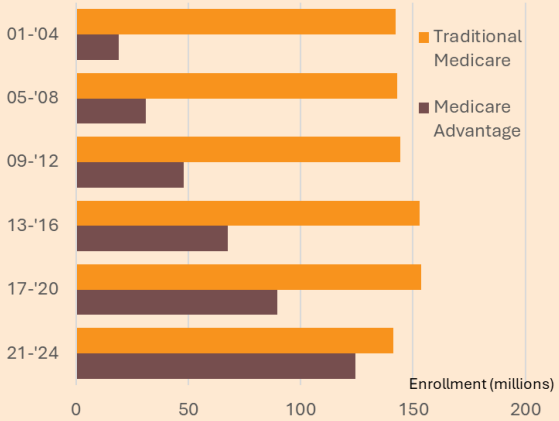
"Change your opinions, keep to your principles; change your leaves, keep intact your roots." – Victor Hugo

Medicare & Medicare Advantage - Evolution and Challenges

To receive Medicare benefits, eligible individuals select either traditional Medicare or Medicare Advantage (MA) – options that differ significantly in cost, benefits, and financial arrangements including who pays claims, with beneficiaries being able to select their preferred option during annual open enrollment periods. In contrast to what happened in earlier years, many beneficiaries now enroll in MA, not traditional Medicare and both the number and proportion of beneficiaries in traditional Medicare continue to decline. The graph below summarizes enrollment data that captures the significant growth in MA and report findings in MA. However, recent reports on upcoding, inappropriate favorable selection, and flaws in the MA quality bonus program and the high use of prior authorization approval formats are contributing to concern for continued MA growth, identifying reform options, and rebalance of traditional Medicare, and MA.

The History: After the Affordable Care Act, payments to MA plans were reduced and economists and actuaries projected steep enrollment declines. Instead, MA enrollment doubled between 2010 and 2024 in large part due to expanded business opportunities for brokers and marketing organizations resulting from entry of the Baby Boomer generation and restructuring barriers to switching to MA from traditional Medicare, all of which have contributed to MA enrollment growth. While MA has broadened access to supplemental benefits, the program's rapid expansion raises questions about appropriate plan payments and the adequacy of beneficiary protections. Reforms are focusing on enhancing coverage information resources; improving plan oversight; assessment of "middleman" activities; realigning financial incentives; and monitoring plan quality to ensure access to timely, affordable care. M

Enrollment in traditional Medicare and Medicare Advantage, 2001-2024



NOTES: Data are for all Medicare beneficiaries, including those with Parts A and B, Part A only, and Part B only. During the period 2001-2003, the Medicare private-plan option was known as Medicare+Choice; Medicare Advantage rebranding occurred with the passage of Medicare Modernization Act in 2003.

Sources: For 2001-2004 data, Boards of Trustees. 2006 annual report of the Boards of Trustees of the Fed. Hosp. Insur. & Fed. Supplemental Medical Insur. Trust Funds. For 2005-2012 data, Boars of Trustees. 2013 annual report of the Boards of Trustees of the Fed. Hosp. Insur. & Fed. Supplemental Medical Insur. Trust Funds. For 2013-2024 data, CMS. Medicare monthly enrollment – Jan. '25.

Source: Adapted from Health Affairs "Medicare Adv. Enrollment Since the ACA: What the Projections do not See," Aug. '25

INSIDE THIS ISSUE:

The Business, Art & Science of Medicine

Medical Practice Landscape Changes

A recent study of hospital/physician acquisition and employment found that such acquisitions decreased competition and raised prices. A National Business Bureau Economic Research (NBER) working paper released in July 2025, analyzed the effects of mergers between complimentary firms on competition and pricing and found hospital prices increased by an average of 3.3%, while employed physician prices by an average of 15.1%.

As a result of the emergence of accountable care and value-based reimbursement environments which rely on achieving better outcomes and lower costs, hospitals have increasingly sought closer relationships with physicians, including via direct employment, contracting, co-management, and joint ventures. The American Medical Association (AMA) found that the proportion of physicians who are practicing in independent practice decreased significantly between 2012 and 2014 from 60% to 45.2% (a decrease of approximately 80,000 physicians).

The most influential factor for physicians in deciding to sell off private practices to either hospitals or private equity companies in 2024, was the ability to better negotiate higher payment rates with payors, according to the AMA's Physicians' Practice Benchmark Survey. . *(continued next page)*

'AMA found that the proportion of physicians who are practicing in independent practice **decreased significantly** between 2012 and 2014 from 60% to 45.2% (a decrease of approximately **80,000** physicians).'

Medical Practice Landscape Changes *(continued)*

The AMA recently surveyed 5,000 physicians who have completed Residency, provided patient care for at least 20 hours/week and are not employed by the federal government in practice in one of the 50 states or in the District of Columbia. According to the 2024 survey, the number of hospital-employed physicians rose by 33% between 2013 and 2022 from around 157,000 to more than 205,000. In contrast, private practices grew by 17%, indicating hospitals are hiring at roughly double the rate according to a report in the Journal of Society of Laparoscopic and Robotic Surgeons (May 2025). The following are key reasons that private practices were sold in 2024 based on the percentage of physicians who listed them as "important" or "very important:"

- Better negotiated higher payment rates with payors – 70.8%
- Improved access to costly resources – 64.9%
- Better management of payors regulation and administration requirements – 63.6%
- Ease of participation in risk-based payment models – 55.1%
- Better opportunities to compete for employees in the labor market – 48.9%
- Increased availability of additional services that patients need – 48%.

In conjunction with these statistics, it is noted that growing numbers of U.S. physicians are opting out of Medicare siting unsustainable reimbursement rates that no longer cover the costs of delivering care. According to the Centers for Medicare and Medicaid Services (CMS), nearly 50,000 physicians, approximately 5% of all U.S. doctors have officially withdrawn from Medicare participation. Additionally, physician Medicare reimbursement dropped 33% since 2000 when adjusted for inflation. As a result, many practices, particularly small, independent practices, can no longer afford to absorb losses or sustain a viable practice.

Of note, concierge and direct primary care practices are gaining traction among physicians, employers and patients increasingly frustrated by traditional payment mechanisms through Medicare. The growth of these practices where patients pay membership fees in exchange for increased access to physicians is symptomatic of some of the concerns about Medicare and Medicaid reimbursement that have not kept pace with inflation. Growing backlogs, coding and documentation tasks take doctors away from patients and increasing insurance premiums are also contributing to the pressures. Another problem remains the *prior authorization delays* and problematic claims processing which numerous physician practices encounter on a regular basis. Switching to a mostly cash pay platform for services can eliminate the many stressors involved with billing insurance such as claim denials, prior authorization, and quality reporting. Concierge doctors run their practice as they see fit without direction from a healthcare system or insurer-based employment model. The factors mentioned above fuel the development of concierge medicine and direct primary care growth. Even prominent organizations such as Boston's Mass General Brigham and Rochester Minnesota's Mayo Clinic have started their own concierge medical divisions. More hospital systems are adopting this strategy to attract more primary care doctors and garner referrals and admissions from primary care doctors who accommodate patients seeking more personalized care. M

More hospital systems are adopting this strategy (concierge medicine) to attract more primary care doctors and garner referrals and admissions from primary care doctors who accommodate patients seeking more ***personalized care****.*

Artificial Intelligence Here and Now

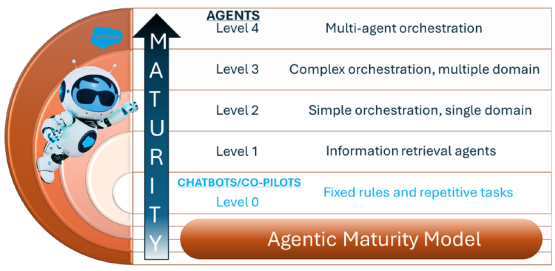
Artificial Intelligence (AI) was once viewed as something to experience in the future. It is now a standard feature across many of the major cardiovascular information systems (CVIS) and cardiac "picture archiving communication systems" (PACS). Most, if not all, health IT vendors currently have AI integrations in their products. This AI integration poses several problems, not the least of which is making sure that the AI in the vendor supplied product integrates with hospitals and health systems technology platforms. Echocardiography has seen the fastest uptake due to high volume of study. However, the newer technology continues to permeate virtually all aspects of cardiovascular testing evaluations. AI for cardiac CT angiography (CCTA) is still in an emerging process. It is newer technology and is gradually being taken up. It should be noted that CCTA may eventually replace some of the routine intracoronary angiography that is being performed in the cath lab. Ultimately, workflow processes are key to integrating AI and its capabilities to provide value. AI also allows the possibility of scanning images for unrelated CT or ECHO scans to look for incidental cardiac findings for more proactive preventive care. M

Sources: Adapted from source: "AI is now embedded in nearly every CV IT system"]

Agentic AI - The Evolving Journey

"Agentic AI" is a hot buzzword in the business field right now. There is quite a bit of ambiguity concerning terminology and what **agentic AI** provides. The graph below should be helpful for understanding the agentic maturity model.

- Level 1: **Information retrieval** – A Level 1 agent can retrieve information and make recommendations. This frequently takes the shape of an agent that helps customers on an external website or an internal agent that helps employees with tasks.
- Level 2: **Simple orchestration, single domain** – Building on the information retrieval and recommendation capabilities of Level 1, a Level 2 agent can act on the data it acquires and autonomously execute low complexity tasks such as summarizing and account records or cancelling a flight. As an example, a Level 1 agent could help an airline customer with a ticket cancellation policy by skimming through knowledge articles and access CRM records to provide details based on the customer loyalty programs, status, and remind them to use their credit within a specified amount of time. The use cases sound simple, but they deliver value. A Level 2 agent, for the same airline customer, can connect directly to the airline's reservation system and book a new ticket for a customer. Behind the scenes, companies at Level 2 maturity are focused on mapping their AI strategy against key business objectives and implementing companywide AI literacy efforts. It is at this level that guardrails and governance issues enter the equation and are essential.
- Level 3: **Complex orchestration, multiple domains** – Level 3 is where true complexity enters the picture and Level 3 agents can deliver concierge level service orchestrating end-to-end workflows with harmonized data across multiple domains. These agents can "reason" autonomously, determine the best course of action, and put their plan into motion without direct human intervention. In the airline example, a Level 2 agent was able to process ticket cancellation and even book a new flight, but the Level 2 workflow stops short of seat selection. A Level 3 agent already has access to the customer's CRM record, and it can see that typically a customer upgrades their seat to premium and proactively offers an aisle seat upgrade. A Level 2 agent, bound to a single domain (reservations), but the Level 3 agent can straddle multiple systems including billing to complete transaction. Currently, most agentic agents are at Level 3.
- Level 4: **Multi-agent orchestration** – Level 4 maturity envisions a bustling ecosystem of AI agents seamlessly connecting to other agents across disparate technological stacks. Currently, there appears to be no one that has started to use Level 4, but one can anticipate a future where Level 4 agents automatically connect an arriving airline customer to share a ride to meet travelers on arrival at a hotel agent to accommodate a speedy check-in. . *(continued next page)*



Sources: Adapted from SalesForce, 2025.

Agentic AI - The Evolving Journey *(continued)*

It should also be noted that as we follow AI and the developments of machine learning, the use of generative AI is changing. By analyzing thousands of posts on online forums like Reddit and Quora, researchers at filtered.com have discovered that people have begun turning to generative AI much more for personal and professional support. Therapy and personal organization are now the most common uses. Meanwhile, generative AI for technical assistance has become less prevalent.

Major Gen AI Use Case Themes That Emerged

Use cases have shifted from technical to emotive over the past year.

THEMES	2024	2025
CONTENT CREATION AND EDITING	23%	31%
TECHNICAL ASSISTANCE AND TROUBLESHOOTING	21%	18%
PERSONAL AND PROFESSIONAL SUPPORT	17%	16%
LEARNING AND EDUCATION	16%	15%
CREATIVITY AND RECREATION	13%	11%
RESEARCH, ANALYSIS, AND DECISION-MAKING	10%	9%

Source: Adapted from "The Use of Gen AI is Changing," Harvard Business Review, July-August 2025.

Top 10 Gen AI Use Cases

Use indicates a shift from technical to emotional applications, and in particular, growth in areas such as therapy, personal productivity, and personal development.

USE CASES	2024	2025	
GENERATING IDEAS	1	1	THERAPY/COMPANIONSHIP
THERAPY/COMPANIONSHIP	2	2	ORGANIZING MY LIFE (NEW USE)
SPECIFIC SEARCH *[FELL TO 13TH 2025]*	3	3	FINDING PURPOSE (NEW USE)
EDITING TEXT *[FELL TO 45TH 2025]*	4	4	ENHANCED LEARNING
EXPLORING TOPICS OF INTEREST*	5	5	GENERATING CODE (FOR PROS) *[UP FROM 47TH 2024]*
FUN AND NONSENSE	6	6	GENERATING IDEAS
TROUBLESHOOTING *[FELL TO 16TH 2025]*	7	7	FUN AND NONSENSE
ENHANCED LEARNING	8	8	IMPROVING CODE (FOR PROS) *[UP FROM 19TH 2024]*
PERSONALIZED LEARNING *[FELL TO 17TH 2025]*	9	9	CREATIVITY *[UP FROM 27TH 2024]*
GENERAL ADVICE*	10	10	HEALTHIER LIVING *[UP FROM 75TH 2024]*

*Did not make list of top 100 in 2025

Social Media as a Source of Health Information – For Better AND Worse

Social media is now a significant source of health information, especially for younger adults and minority groups, despite the presence of low trust levels. YouTube, TikTok, and Reddit are relatively more trusted for health information compared to other platforms like Facebook and Instagram.

According to a new Kaiser Family Foundation (KFF) health tracking poll of 1,283 U.S. adults, 55% say they use social media to find health information at least occasionally. Younger adults, Black, and Hispanic populations use social media more frequently. According to the report published August 7, 2025, 72% of adults say they have seen posts about weight loss, diet or nutrition on social media platforms in the past month, while 58% reported seeing content related to mental health. Even individuals who never use social media for health information or advice report frequent exposure to health information through other sources such as the television, including numerous commercials on weight loss, nutrition, and dietary information.

Despite all the information, fewer than 1 in 10 social media users say they trust most of the health information or advice they encounter on the platforms. YouTube, TikTok, and Reddit earned the highest marks, relatively speaking, as at least 30% of users on each of those platforms said they trusted some of the health information they saw. Takeaway - trust is tenuous, nevertheless, the information is present – user beware!

This introduces the issue of the presence of the "health influencer." About 1 in 6 social media users – 14% of the public overall – say they regularly turn to influencers for health advice. That share rises to 23% among 18–29-year-olds and 21% among Black adults. Among those who follow health influencers, 61% believe the content creators are motivated primarily by financial interest, still 36% seek health advice online from a particular influencer they "trust." Here are the most trustworthy people of a wide range of public-facing individuals: Joe Rogan, Dr. Phil, Oprah Winfrey, Dwain "The Rock" Johnson, and Tucker Carlson to physicians like Peter Attia, MD and Jennifer Lincoln, MD, IBCLC. *(continued next page)*

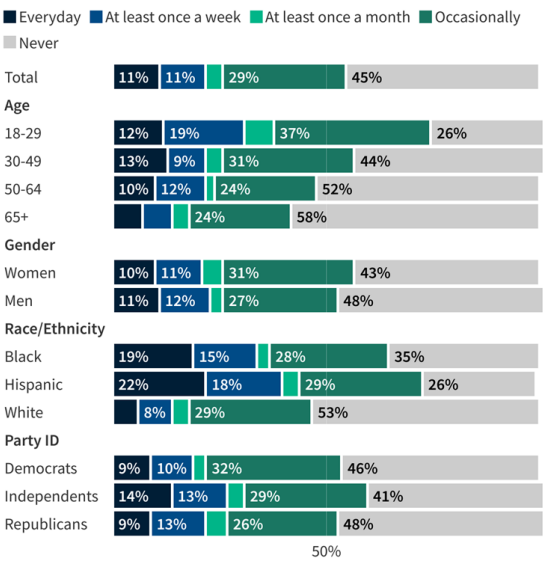
Social Media as a Source of Health Information – For Better AND Worse *(continued)*

Social media is paralleled by a tremendous amount of health information in television and radio ads as well. One can't possibly watch an evening TV show without numerous health-related ads appearing between content – user beware!! (see graphs below)

The down sides of adverse information on younger populations and different population groups have prompted investigation and calls for caution and proper guardrails. The adverse impact on some individuals from the use of social media should not be ignored – much more to come. M

About Three in Five Adults Say They Use Social Media To Find Health Information and Advice at Least Occasionally, Including Larger Shares of Younger Adults, and Black and Hispanic Adults

How often, if at all, do you use social media such as Facebook, X, Instagram, TikTok, YouTube, or similar sites or apps **to find health information and advice**?



Note: Question asked of those who say they use social media, reported among total adults. "Never" includes those who say they "never" use social media in general or for health information. See topline for full question wording.

Source: KFF Tracking Poll on Health Information and Trust (July 8-14, 2025) KFF

Source: KFF poll July 8-14, 2025 "Tracking Poll on Health Information and Trust"; Med. Economics on social media, TikTok, and so forth."

Weight Loss, Diet, Nutrition and Mental Health Top List of Health-Related Topics People See on Social Media

Percent who say they have seen information about the following on social media in the past 30 days:

	Weight loss, diet, nutrition	Mental health	Vaccines	Abortion	Birth control
Total	72%	58%	38%	30%	22%
Age					
18-29	76%	77%	37%	40%	39%
30-49	78%	67%	36%	30%	22%
50-64	70%	53%	38%	23%	15%
65+	62%	36%	42%	27%	13%
Gender					
Women	80%	64%	38%	32%	26%
Women ages 18-49	85%	74%	38%	37%	36%
Men	64%	52%	39%	27%	17%
Party ID					
Democrats	74%	61%	43%	35%	24%
Independents	74%	64%	41%	31%	24%
Republicans	69%	49%	31%	23%	15%

Note: See topline for full question wording.

Source: KFF Tracking Poll on Health Information and Trust (July 8-14, 2025) KFF

There is a Great Need

A recent study from 2022 indicated that at least 7.4% of emergency departments (ERs) across the United States did not have an attending physician onsite 24/7. More than 90% were in low volume and critical access hospitals – a federal designation for small rural hospitals. The results come from 82% of hospitals that responded to a survey sent to all emergency departments in the country, except those operated by the federal government. "The study is the first of its kind so there isn't proof that such staffing arrangements are increasing," said Dr. Camargo, the lead author and Professor of Emergency Medicine at Harvard Medical School. Other experts suspect the ERs are running without doctors and are doing so very commonly. Some of these hospitals staff their ERs with other healthcare providers such as advanced practice providers who have the right experience and support capable of overseeing an ER. The challenge is that mandating a physician to be onsite could drive some rural hospitals to close because they can't afford to recruit or pay doctors enough for care in a rural setting. *(continued next page)*

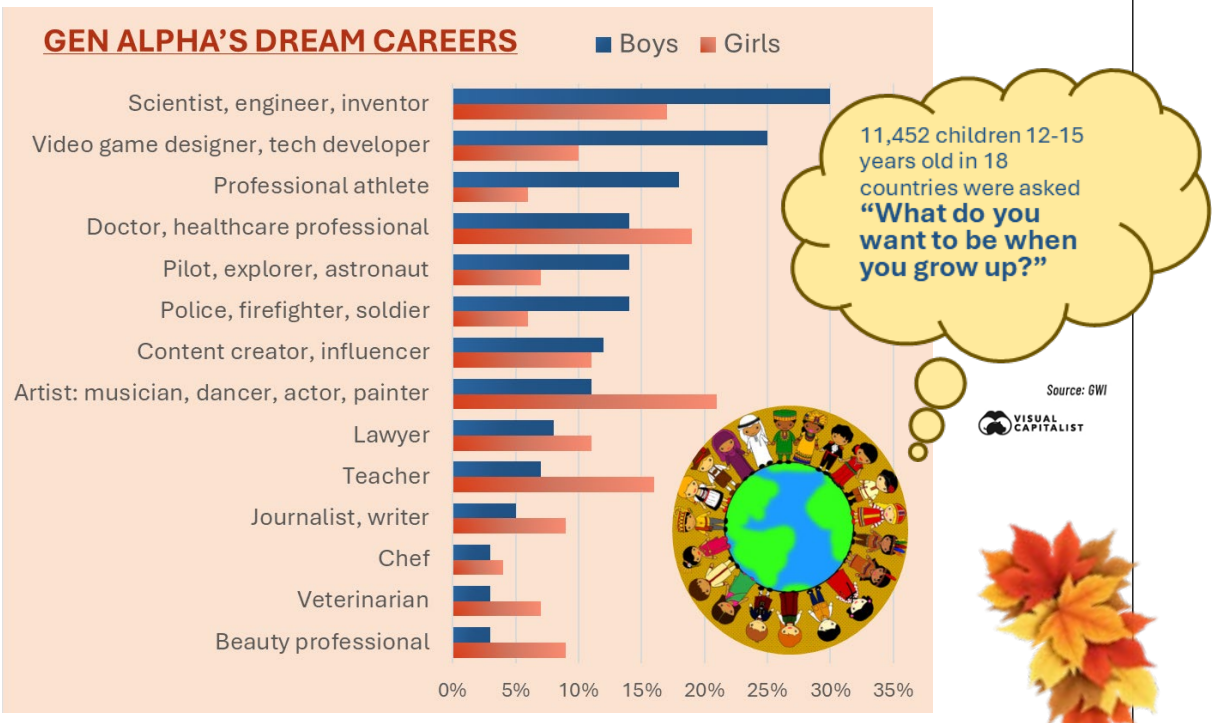
There is a Great Need *(continued)*

The proportion of ERs without an attending physician always onsite varies by state. The 2022 survey found that 15 states – including substantially rural ones such as New Mexico, Nevada, and West Virginia had no such emergency departments (EDs). Nonetheless, in the Dakotas, more than half of EDs were operating without 24/7 attending physician staff and in Montana it was 46% - the third highest state.

Sanford Health, which bills itself as "The Largest Rural Health System in the United States," is launching an emergency medicine Residency program in the region. The Sioux Falls, South Dakota-based program is intended to boost the ranks of rural emergency doctors in those states. The takeaway is that providing sophisticated care at varying levels in rural settings for varying levels of pathology is challenging and will, for the near future, remain so. M

The Future for the Next Generation: Dream Careers by Gender

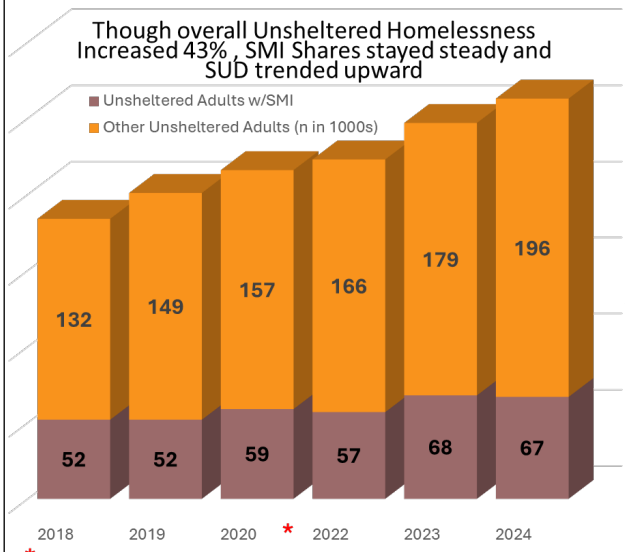
Most young people have thoughts about what they want to be when they grow up. The question is particularly interesting as it pertains to Generation Alpha which includes those born from 2010 onward**. They will be the first cohort to grow up entirely in the 21st century shaped by rapid technological change, global crisis, and evolving ideas of work.** The infographic to the right sheds light on Gen. Alpha's dream careers based on a GWI survey of 11,452 young people aged 12-15 across 18 countries. As one can see, there is a broad mix of career aspirations. You will note that the rise of content creators and influencers as a career goal underscores how social media is reshaping the idea of work. About 11-12% of both boys and girls expressed interest in this path, suggesting it is not just a transient trend, but a legitimate aspiration in the digital age - - - I think that for this author's age cohort, when we were teens, it was equivalent to "role model" or "leader." M



Homelessness and Mental Illness

In 2024, about one quarter (26%) of adults experiencing unsheltered homelessness, had a **serious mental illness (SMI)** and a similar share had chronic **substance use disorder (SUD)** – both statistics higher than in the general population. The U.S. Department of Housing and Urban Development's (HUD's) annual report defines SMI as a mental illness that substantially limits independent living and is expected to be of long-lasting or indefinite duration. A similar share – about 26% - were identified as having chronic substance use disorder (SUD) according to HUD's definition. Unsheltered adults account for about 40% of all adults experiencing homelessness, with remainder in sheltered settings (emergency shelters and transitional housing.) The shares with SMI or chronic SUD are higher among unsheltered adults than sheltered adults.

Note that data from HUD's annual Point in Time Homelessness Count and the figures attached include only unsheltered, homeless adults (ages 18+) excluding sheltered individuals and all children. (Data for 2021 are not shown due to quality issues and reliability concerns.)



Data are from HUD's annual point-in-time homelessness count. HUD defines SMI as a long-term or indefinite mental illness that substantially limits independent living; chronic SUD is defined similarly but focuses on substance use. SMI and SUD are not mutually exclusive, and available data do not show the degree of overlap. People in the "other" unsheltered category may still have mental illness or SUD, but at a level below the severity threshold for SMI or chronic SUD as defined in HUD's point-in-time count. Figure 1 includes only unsheltered homeless adults (ages 18+), excluding sheltered individuals and all children. Data for 2021 are not shown due to quality issues.

Source: KFF Analysis of CoC Homeless Populations and Subpopulations Reports

Historically, before institutionalization, people with serious mental illnesses were often housed in long term psychiatric institutions, but advances in treatment, growing public concern about poor institutional conditions, and civil rights litigation shifted care to community-based settings. Approval of the first anti-psychotic drug in the 1950s and growing public awareness of the poor conditions in mental institutions sparked the deinstitutionalization movement which shifted mental care away from long term institutional care towards community-based treatment. The 1963 Community Mental Health Act introduced federal funding to transition care to community mental health centers. (CMHCs) which were intended to provide 5 core services: inpatient, outpatient, emergency, partial hospitalization, and consultation/education. Medicaid was passed in 1965 which further reinforced the deinstitutionalization transition by reimbursing community-based mental health services while prohibiting payment for care institutions for mental diseases. CMHC development fell short of the original vision with fewer than half of planned centers built and many centers focused less than expected on people with severe mental illness than had previously been institutionalized in state facilities.

President Carter attempted to close some gaps with the passage of the Mental Health Systems Act (MHSA), which planned to expand services for those with chronic SMI and to tighten accountability through performance-based contracts and monitoring. However, President Reagan reversed course by repealing MHSA, converting federal funds into state block grants cutting funding by 25% and barring the use of grant funds for inpatient psychiatric care – a restriction that persists to this day. Philanthropic initiatives helped respond to gaps in healthcare through community-based health responses to homelessness. Meanwhile, federal civil rights laws and litigation from the 1990s and earlier affirmed the right of people with SMI to receive treatment in the least restrictive setting, reenforcing reductions in institutionalization. . *(continued next page)*

Homelessness and Mental Illness *(continued)*

As mental health services shifted toward outpatient care, the availability of psychiatric inpatient beds declined from 237/100,000 residents in beds in 1970 to 37/100,000 in 2020. Over time, psychiatric inpatient care has shifted in both populations served and facility characteristics. Facilities once housed people with developmental and intellectual delays as well as dementia, but after the 1970s they primarily served individuals with mental illness. Long-term stays, once common, are now less common and inpatient care has expanded to include psychiatric beds in general hospitals and non-state residential facilities, most of which focus on shorter term stays. It isn't clear to what extent this historical reduction in psychiatric beds directly explains current homelessness. In 2023, the demand for inpatient and residential psychiatric beds found the bed supply to be over 3,500 beds.

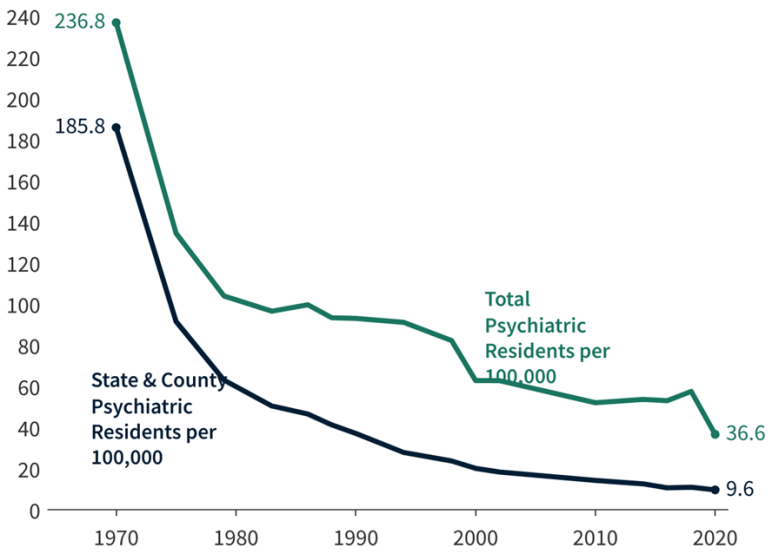
This count does not include instances where those experiencing psychiatric emergencies in the ED before being seen or gaining access to the bed. When psychiatric beds are unavailable, admitted patients may be "boarded" in emergency departments, a practice most common among patients with psychotic or bipolar disorders.

As mental health services shifted towards outpatient care during the deinstitutionalization, residents in psychiatric beds decreased immensely. Please see the graph below from 1979-2020.

There are some people who feel that we should reassess this issue and reestablish greater presence for inpatient and housing capabilities for people with behavioral health challenges. M

As Mental Health Services Shifted Toward Outpatient Care During Deinstitutionalization, Residents in Psychiatric Beds Declined Sharply

Time trends in residents in psychiatric inpatient and other 24- hour treatment beds per 100,000 population, 1970-2020



KFF

Note: The figure shows the number of residents (patients or clients) in hospital inpatient or residential beds specifically designated for mental health treatment services per 100,000 U.S. population. Data for 1970-2014 are from state mental health director reports; 2016, 2017, and 2020 data are from SAMHSA's National Mental Health Services Survey. The 2020 decline may partly reflect temporary COVID-19 effects.

Source: KFF analysis of data from National association of State Mental Health Program Directors report and 2016, 2018, and 2020 National Mental Health Services Survey (N-MHSS)

The Challenging Environment of Healthcare Delivery – Many Moving Parts

It isn't just times of pandemic that cause supply and demand challenges. We have a growing population in the United States without enough doctors, nurses, allied healthcare providers, and technicians to provide the types of care that people expect and need. We have approximately 340 million people in the U.S. and only about 840K direct patient care physicians and about 5.3M nurses. Shortages exist across other provider types and critical staff roles as well. In the U.S., we produce roughly 29K doctors a year and nearly 175K to 200K nurses per year. Currently, the number of physicians added is felt to at least match the number going part-time or retiring each year while the demand continues to grow.

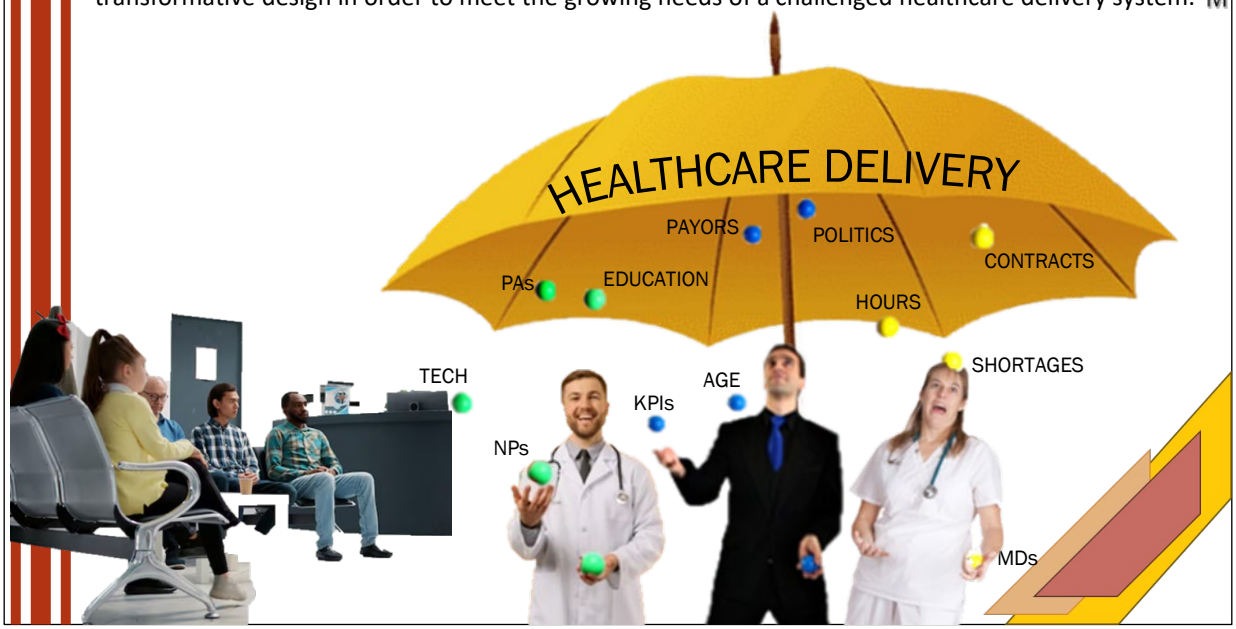
These challenging numbers are exacerbated in several ways.

- **Uneven distribution of physicians and other healthcare providers is significant**. As one may imagine, practice in certain geographic areas and settings as well as compensation expectations, etc. vary by geography. Significant numbers of rural and lower income regions are underserved in all capacities.
- **Some redesign of healthcare provision in certain settings is easier than others**. Primary care physicians can be associated with a Physician Assistant (PA) or Nurse Practitioner (NP) to extend the reach of that doctor. However, substituting specialists is far more difficult, particularly in high complexity care with multiple morbidities and pathologies. Despite efforts to expand medical education, the number of surgeons is expected to remain relatively flat over the next 15 years as demand continues.
- **The grapevine works.** Increasingly, people feel that they need to know someone to get care from the right physician or healthcare provider. Too often people feel that you have to "know someone" to get care as quickly as possible. (This dynamic rarely show up on a Key Performance Index [KPI], but in many sections of the country it is real – increasingly relied upon – and symptomatic of larger problems.) Ethically and professionally, one might argue that a system that privileges relationships over need is not functioning as well as it should be to meet the needs of the people it serves.
- **Alternative business models are growing.** This is happening in part due to limited number of physicians. Witness the growth of concierge medicine which is just one model in which patients pay a membership or retainer fee out-of-pocket in exchange for reliable access to a physician or practice. Additionally, many specialties are beginning to structure around self-pay models – prioritizing patients who can pay out of pocket – prioritizing them over the insured for the reasons outlined earlier in this newsletter.
- **It's more than the actual number of physicians** – it's the hours that physicians have in which to care for people. As one might imagine, projections for overall physician shortages too often do not take into account the number of hours that a physician may actually practice. Of the approximately 29,000 physicians who graduate annually in the United States, the estimate is that no more than 10,000 enter primary care. The estimated shortfall in primary care providers over the next decade ranges from 90,000 to nearly 200,000. This number is also complicated by primary care and specialty care physicians tending to go part-time in their 50s and 60s, thus reducing practice hours as they near retirement. This leads to an even larger shortage of actual doctor hours available to treat patients.
- **The education system producing doctors is a tedious and expensive process, due to the complexity of the issues and illnesses that they need to become competent to treat.** The average total cost for medical school in 2024 was approximately $238,420. A significant number of students graduate with a debt burden exceeding $200,000. A typical U.S. doctor often starts post-Residency practice at age 30 or older. The educational system needs to look at innovative ways of potentially reducing the age to initiate practice without compromising quality. Some countries allow it by age 26-28.
- **Politicians frequently control the strings and are unaware of the issues in depth**. Politicians are fixated on health insurance coverage, particularly during election years. However, coverage is a very different issue from access. Insurance coverage is definitely limited, especially if you cannot access a doctor in a timely manner and get continuity of care in many instances. (*continued next page)*

The Challenging Environment of Healthcare Delivery – Many Moving Parts *(continued)*

- **Physician retirement compounds the issue. As of 2021, nearly half of practicing physicians were over the age of 55, meaning more than 2 out of every 5 active physicians will hit retirement age within the next decade**. This highlights the critical need for health systems and medical practices to plan appropriately to maintain adequate care of the patients the practice sees on a regular basis. Elder care and geriatric care provide enhanced challenges as older patients need frequent, relationship-driven, and specialized care which is interrupted by retirements and the substitution of part-time care givers when they previously had continuity through one full time physician that saw them on a regular basis. This situation is more severe in communities already facing physician and other provider shortages.
- **Scarcity provides greater challenges. As stated above, the shortages across the healthcare sector in terms of access, continuity, and follow-up are significant and getting worse.** Again, those that can afford to buy access do so much easier than the underserved. When access is limited, travel becomes necessary while those that can afford to pay out-of-pocket have access to higher quality and more readily available care. Those with fewer resources have come to expect longer waits, fewer options, and sometimes inferior health outcomes. Note that a 2024 Commonwealth Fund analysis comparing 10 high-income countries ranked the United States last for access.
- **The future is not just technology – it's technology AND people.** The healthcare system needs to have physicians, nurses, and other healthcare professionals that are conversant with technology to help fill the gaps – we need both, not one or the other. Providers are needed to utilize technological tools appropriately for documentation, scheduling, and offering virtual/remote care options to address some of the challenges that can be overcome in lieu of in-person visits. At least in the near term, technology without more appropriately trained doctors and healthcare providers will not, in and of itself, solve the challenges in healthcare delivery.

The above items should not be looked upon as a complete list, but just a few of the complications that healthcare systems and healthcare providers face as we all look to the future. Ultimately, the strategic planning activities of these organizations and practices need to consider the trends that will significantly impact their business motifs as well as the care and quality of outcomes for the patients who seek healthcare provision. There is no shortage of work to be done – with utilization of transformative design in order to meet the growing needs of a challenged healthcare delivery system. M



MEDISCENE™

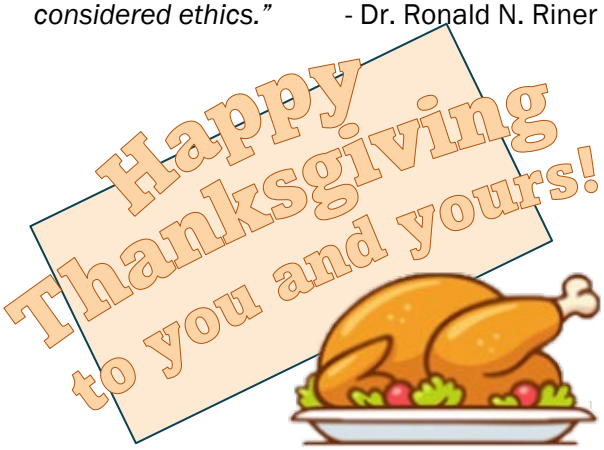
OUR FOCUS:
TRENDS IMPACTING HEALTH & HEALTHCARE DELIVERY

"Patient care and healthcare delivery of the future will require patient interaction with a delicate blend of trustworthy technology, true science, balanced economics, and well-considered ethics." - Dr. Ronald N. Riner

With over 40 years of practice and business in healthcare delivery, anchored by national, operational, and governance experience, we have successfully assisted our national client base with:

- STRATEGY,
- NEW BUSINESS ALLIANCES
- HEALTHCARE PROGRAM EVOLUTION
- LEADERSHIP COACHING
- EDUCATIONAL PROGRAMS

We specialize in understanding the unique business and clinical components of successful healthcare delivery, management, and governance.



VISIT OUR WEBSITE:
www.rinergroup.com

OUR PRIORITY

Excellence in the Business, Art, and Science of Medicine

OUR SPIRIT

Superb Patient Care

Recent Speaking Topics

Dr. Riner and his colleagues frequently speak at events across the country. Topics offer interesting perspectives on healthcare issues and trends pertaining to strategy and future opportunities for a variety of healthcare practices and healthcare businesses. Current topics of interest include, but are not limited to:

- Aging & the Anchors of Longevity
- A Dashboard for Wellness & Healthy Aging
- Medical Professionalism: Past, Present, & Future
- Strategic Healthcare Realities & Trends Impacting Healthcare Delivery
- Serviceline Development & Transfer of Place
- Doctor AI is Ready to See You Now: Really?
- Leadership & Peer-to-Peer Coaching for Success
- Ground Zero for Successful Healthcare Strategy: Not What You May be Thinking!
- The Evolving Healthcare System: Now & in the Future
- The Greatest Challenges Impacting Healthcare Delivery Today
- Critical Dialogues & Questions to Be Asked and Discussed in the Exam Room

The Helm Club—Executive and Medical Leadership Peer-to-Peer Coaching

The Helm Club

- PURPOSE
- DIRECTION
- INFLUENCE
- RESULTS

Leadership anchors all successful businesses. Leadership styles vary and the ability for organizations to develop future leaders is dependent on mentoring and coaching at all levels of the organization, including the Board. This is particularly true in healthcare.

The Helm Club features credible, knowledgeable coaching and mentoring programs provided by experts who have been in the shoes of those they instruct.

Our programs are customized to the needs of our organizational and individual clients.