CUSTOMER NEEDS

APPENDICES

APPENDIX 1
Summary of Key Literature Reviewed

LITERATURE

ARTICLES REVIEWED

- ***"How Consumers Choose Health Insurance: Analyzing Employees' Selection Process in a Multiplan Environment Identifies the Trade-offs Consumers Make and the Benefits that Affect Their Decision Makaing", G. Chakraborty, R. Ettenson, and G. Gaeth***
- ***"The Process of Choice of Health Care Plan and Provider: Development of an Integrated Analytic Framework", M. Klinkman***
- ***"Walk-in-Clinics versus Private Practitioners: Determinant Attributes of Health Care Provider Choice Among the Elderly", J. Lumpkin and R. Tudor***
- ***"Issues in the Consumer Choice of Health Care Coverage Plans", A. Thompson and P. Kaminski***
- ***"The Role of Health Care Attributes and Demographic Characteristics in the Determination of Health Care Satisfaction", A. Dolinsky and R. Caputo***
- ***"Eleven Behavioral Elements in the Successful Medical Encounter", M. Stuart and E. Oshiro***
- ***"The Use and Development of a Member Satisfaction Model in a HMO", S. Hiramatsu***
- ***"Choosing a Hospital", J. Jensen***

8 KEY ARTICLES

How Consumers Choose Health Insurance

G. Chakraborty, R. Ettenson, and G. Gaeth

- ABSTRACT:

  - The authors used choice-based conjoint analysis to model consumers' decision processes when evaluating and selecting health insurance in a multi-plan envrironment. Results indicate that consumer choice is affected by as many as 19 attributes, some of which have received little attention in previous studies. Moreover, the importance of the attributes varies accross different demographic segments.

- KEY OBSERVATIONS:

  - Previous consumer choice studies often asked consumers to evaluate the importance of an individual health plan attribute in isolation from the multitude of attributes that necessarily comprise a health insurance plan. Evidence indicates that conusmer's health insurance decisions are made on the basis of evaluating and combining multiple attributes or "elements"

  - Method used for this research
    - First used focus groups to identify an extensve set of attributes that might affect consumers' health insurance decisions. The attributes were incorporated into the conceptual framework for health care decision-making proposed by Berki and Ashcraft
      - This framework incorporates delivery system characteristics, treatment oriented characteristics, policy premium information, and cost sharing provisions
      - Then used choice modeling survey technique to answer the following three questions:
        - How important is each of the attributes in consumer decision-making?
        - How do consumers evaluate the levels of each attribute when choosing among health care plans?
        - Do the importance values for the attributes vary across different consumer segments in a systematic fashion?

  - The most imporant attribute in consumers' choice of plan was hospitalization coverage followed by choice of doctors, policy premium, dental coverage, and choice of hospital
    - Hospitalization coverage and hospital choice have received little if any attention in previous health care decision making research

  - Four attributes were found to be non-significant in consumers' choice of plan
    - Travel time to hospital
    - Wellness and educational programs
    - Communications with plan participants
    - Prescription coverage

How Consumers Choose Health Insurance

Continued

- Differences in decision-making by segment:

  - Gender
    - Females placed more importance on 24-hour phone consultation, vision/hearing care, emergency care, and alcohol/substance abuse coverage
    - Males were more concerned with out of town coverage, office visit coverage, office hours
    - Both groups agree about the importance of the top five factors. Also five attributes were statistically nonsignificant for both males and females

  - Age
    - Policy premium, preventative care, and travel time to the hospital were of considerably greater importance to younger enrollees
    - Hospital choice, out of town coverage, and alcohol/substance abuse coverage were greater concern to enrollees over 40
    - Agreement between the age segments were found for the two most important attributes (hospitalization and choice of doctor) and for four of the five attributes that were identified as least important

  - Current Plan Type (Traditional vs. Prepaid)
    - Choice of doctor, choice of hospital, and out-of-town coverage were more important for Traditional enrollees than pre-paid plan enrollees
    - Prepaid plan enrollees emphasized policy premium, preventative care, and amount of paperwork to a greater extent in their health insurance decisions
    - Emergency care, alcohol/substance abuse coverage, office visit coverage, and prescription coverage were significant only to Traditional enrollees while office hours and eaiting time in office affected the health insurance selection of prepaid plan enrollees only

The Process of Choice of Health Care Plan and Provider: Development of an Integrated Analytic Framework

M. KLINKMAN

- **ABSTRACT:**

  - *Reviews current state of research in the choice of health care plans and providers*
  - *Presents an expanded analytical framework for the process of both plan and provider*

- **KEY OBSERVATIONS:**

  - Early work in the field of choice of health care plan reflected assumptions that individuals chose their source of care in a rational way and that it was an informed choice that accurately reflected their preferences regarding health care.

  - More sophisticated research evolved in early 1980's with Berki and Ashcraft.
    - Choice process defined as primarily one of plan with the choice of provider second based upon and limited by the plan chosen. Choice of an HMO incorporated choice of delivery characteristics not specific provider attributes or choice of individual provider
    - Two explanatory hypotheses: financial vulnerability and health risk perception -- consumer attributes and economic factors filtered through these hypotheses to determine needs and expectations and matched to plan attributes in choice process

  - Only a handful of studies have been published since Berki and Ashcraft
    - Most used some aspects of Berki and Ashcraft's conceptual framework and applied to expanded choices (PPOs, closed panel HMOs, etc.)
    - Several examined influence on choice process of prior relationships with health care providers or plan or "integration"

  - Research offers inconsistent, sometime contradictory results
    - For example, some studies support health risk hypothesis while others do not
    - Inconsistency most likely due to oversimplification of models of choice and use of variable methods (retrospective, independent variables differentially operationalized, no independent variables representing provider attributes or cost as factors in determining choice)

The Process of Choice of Health Care Plan and Provider: Development of an Integrated Analytic Framework

Continued

- **KEY OBSERVATIONS (Continued):**
  - Klinkman suggests an alternative integrated framework
  - Because of the potential influences of the employer on an employee's choice of health care, a full conceptual framework must include choices made by employer (which plans to offer) and employee (which plan and which provider to select)
  - Stage One - The Contract between Employer and Guarantor (insurance company)
    - Criteria used by employers include:
      - Cost
      - Stability
      - Acceptability
      - Quality
    - Choice of plans is further constrained by the availability of plans and/or providers in the geographic area
  - Stage Two - The Contract between Employer and Employee
    - Three steps:
      - What is our ideal plan?
        - What we can afford
        - What we need
        - What we would like
      - What are our choices?
        - The output of Stage One becomes the menu from which employees may choose
        - A choice of health care plan and provider is made
      - How satisfied are we with our choice?
  - Klinkman suggests the choice process is further affected by limitations in information supply and information seeking behavior

Walk-in-Clinics versus Private Practitioners: Determinant Attributes of Health Care Provider Choice Among the Elderly

J. Lumpkin and R. Tudor

- ABSTRACT:

  - *This study investigated the perceptions of elderly individuals concerning their choice between two types of health care facilities: walk in clinics and private practitioners. A determinant attribute approach was employed using the perceptions of the elderly on twenty-six attributes and the importance of each of these attributes in choosing a health care facility. It was found that quality, sociopsychological, and economic attributes were determinant while convenience attributes were not determinant.*

- *KEY OBSERVATIONS:*

  - Literature review regarding consumer choice behavior
    - Stratmann identified five categories of factors which the consumer uses to make a health care provider decision:
      - Economic factors (cost of service, acceptance of insurance)
      - Temporal factors (waiting time, length of time with doctor)
      - Convenience factors (Ease of parking, hours of operation, location)
      - Sociopsychological (doctor's manner, staff's manner)
      - Quality of care (doctor's competence/qualifications, thoroughness of exam)
    - Berger and Guiltinan
      - Consumers were able to perceive differences between providers across a variety of attributes including cost of care, ability to see same physician each visit, ease of obtaining an appointment
      - Potentially determinant attributes related to actual physician-client interaction
    - Sloan
      - Found demographic determinants of health care provider choice to be wage and total family income
    - Hisrich and Peters
      - Attributes that influenced hospital choice included whether their doctor was on staff, location, prior family experience with the facility, recommendation of their doctor, and reputation of the facility
    - Newman
      - Investigated patient's preferences concerning outpatient clinics and found the attributes considered when choosing an outpatient clinic were price, waiting time, followed by location of the facility

Walk-in-Clinics versus Private Practitioners: Determinant Attributes of Health Care Provider Choice Among the Elderly

Continued

- KEY OBSERVATIONS (Continued):
  - Purpose of current study is to determine what are the perceptions of the elderly regarding walk-in-clinics as health care providers and what are the factors that are determinant in the elderly's choice of health care provider
  - Attributes that directly influence consumer choices are determinant. An attribute is determinant if :
    - it is important in making a patronage decision and
    - if the delivery modes available to the consumer differ on the attribute
  - Respondents rated importance and the extent to which they perceived walk-in-clinics and private practitioners as having twenty six health care provider attributes (generally quality, economic, sociopsychological, and convenience)
  - Results
    - All of the determinant attributes were perceived to exhibited more by the private practitioners than walk-in-clinics
    - None of the convenience attributes were determinant
    - Ability to see same doctor each visit, doctor's competence, evidence of modern equipment - all quality attributes - were determinant.
    - Doctor's reputation, manner, the ability of the doctor to provide thorough exam, facility's reputation, staff's manner, and privacy of exam - sociopsychological attributes - were determinant
    - Two economic factors found determinant were acceptance of insurance and acceptance of Medicare

Issues in the Consumer Choice of Health Care Coverage Plans

A. Thompson and P. Kaminski

- ABSTRACT:

  - *Developing and implementing successful marketing strategies for prepaid health care coverage plans is becoming an important issue as managers of these plans struggle to remain competitive in the market place. This paper provides insight into the reasons why consumers make choices among varying types of health care coverage plans. Some suggestions are made to plan managers for incorporating these results into the development of marketing strategies for prepaid health care coverage plans*

- KEY OBSERVATIONS:

  - Previous research of health care consumers primarily has been of an economic or demographic nature. The objective of most of this research has been descriptive, primarily aimed at answering questions about who chooses HMOs rather than focusing on the reasons for the choice.
  - The research question of why consumers choose or do not choose alternative health care coverage plans has been little explored.
  - Consumer Behavioral Model based upon the Innovation Decision Process Paradigm was used in this study with particular emphasis on the Awareness phase
  - Respondents were asked:
    - Activity, Interest, Opinion questions
    - The level of compatibility, complexity, relative advantage, and trialability of a conventional plan, open prepaid plan, and closed prepaid plan
    - The importance of channel of information relevant to a health care decision
    - Awareness and intention to use a particular plan

Issues in the Consumer Choice of Health Care Coverage Plans

Continued

- KEY OBSERVATIONS (Continued):
  - Results:
    - Consumers intending to use conventional health care plans think it is difficult to receive health services with an HMO plan, have established physician relationships with doctors not in HMOs, and receive most of their information about health care plans from advertising.
    - Consumers intending to use a closed panel prepaid plan thought the plan provided for all their health care needs, offered better coverage than their current plan, and offered a degree of trialability. However existing physician relationships are a big obstacle to use this plan.
    - Consumers intending to use an open panel prepaid plan had similar concerns to those opting for the closed plan however were also concerned with the cost of the plan as well.

The Role of Health Care Attributes and Demographic Characteristics in the Determination of Health Care Satisfaction

A. Dolinsky and R. Caputo

- ABSTRACT:

  - *The authors investigate the influence of demographic characteristics and health care attributes on overall health care satisfaction. They use a national crosssection sample of HMO members and another of non-HMO members. Demographic characteristics are treated as antecedent to satisfaction with the health care attributes in the determination of overall health care satisfaction. The health care attributes are very similar in impact for both samples, suggesting HMOs should emphasize those attributes both to ensure reenrollment and to encourage new enrollment. Findings also show that satisfaction with several health care attributes varies along a few demographic dimensions, suggesting demographic bases along which the health care market can be segmented.*

- KEY OBSERVATIONS:

  - Literature review:
    - Absent from consumer health care satisfaction research is a conceptual framework for explaining satisfaction, particularly one that integrates the roles of health care attributes and demographic characteristics
    - Limitation of external validity or generalizability characterize virtually all of the consumer health care performance/ satisfaction studies
    - Berki and Ashcraft noted that satisfaction on both delivery characteristics (e.g. quality, continuity, comprehensiveness, accessibility) and insurance characteristics (eg., price, benefit package) contribute most to HMO enrollment decisions
    - Scotti, Bonner, and Wiman found satisfaction with quality of care factors were more important cost/benefit factors in explaining HMO reenrollment decisions.
    - Several studies found physician continuity, self-assessed health, preventive health practices, and communication appropriateness from physician explained much of the variance in HMO member satisfaction.
  - Purpose of current study is to understand the effects of demographic characteristics on overall health care satisfaction. The hypothesized framework treats demographic characteristics as affecting overall health care satisfaction indirectly through various health care attributes. Also, the extent to which these characteristics have direct affects on overall health care satisfaction was explored.

The Role of Health Care Attributes and Demographic Characteristics in the Determination of Health Care Satisfaction
Continued

- KEY OBSERVATIONS (Continued):
  - Results:
    - The two most important health care attributes in determining satisfaction are cost and ability to see a specialist. The importance of the attributes are very similar in both the HMO and non-HMO population.
    - Quality of doctors and the availability of 24 hour medical services are next in importance in determining satisfaction.
    - The availability of doctors when needed is considerably more important in determining satisfaction for the HMO than for the non-HMO sample. The opposite is found for waiting time to see a doctor after scheduling an appointment.
    - The demographic characteristics have limited direct effects on overall health care satisfaction. The characteristics are working indirectly through the health care attributes in determining satisfaction.
    - In the HMO sample, the demographic variables age, marital status, and race are the most important determinants of the health care attributes.
    - In the non-HMO sample, the demographic factors have a considerably weaker role, with the exception of age.

Eleven Behavioral Elements in the Successful Medical Encounter

M. Stuart and E. Oshiro

- ABSTRACT:
  - *This paper discusses the quality of the medical encounter (patient-physician interaction) on customer satisfaction. A review of the literature and the results of work completed at Group Health of Puget Sound regarding doctor-patient communication and behavioral elements are included.*

- KEY OBSERVATIONS:
  - Group Health of Puget Sound consumer satisfaction and intention to enroll or disenroll surveys indicated that quality of services to the most powerful predictor of disenrollment.
  - Dissatisfaction with aspects of physician-patient encounter was found to be of major importance, specifically a perceived lack of concern by the physician for the patient's presenting problem and a lack of staff courtesy.
  - Review of literature found that human aspects of medical care are especially important to patients and frequently overlooked by physicians.
  - Patients who liked their doctors' communication skills were satisfied with treatment.
  - Physician conduct has been found to be an important factor in satisfaction with health care. Completeness of facilities, continuity of care, accessibility, and availability were also rated as important but physician conduct was selected four times as often as other considerations.
  - In a study of three hospitals, 25 % of patient complaints stemmed from the quality of their interactions with physicians and nurses.
  - The medical literature supports the concept that the successful physician-patient relationship is based not so much on the biomedical model but on physician awareness of and attention to patient's individualized needs (eg. care attitude of the physician).
  - Research shows a strong association between physician's good interpersonal skills and patients' ability to recall the name or effect of the medicine, dosage, and schedule as well as patient satisfaction.

Eleven Behavioral Elements in the Successful Medical Encounter

Continued

- KEY OBSERVATIONS (Continued):
  - Major ideas regarding physician communication and interpersonal skills from literature and Group Health of Puget Sound experience:
    - Clear your slate before each patient encounter -- preoccupation and distractions decrease your ability to gather new information.
    - Validate your patient's need to be there -- strive to be aware of and maintain patient self-esteem, dignity and appropriate level of autonomy.
    - Devote your undivided attention to the care of the patient.
    - Convey a caring attitude by verbal and non-verbal behavior.
    - Listen actively (pay attention, give feedback, summarize, paraphrase)
      - In only 23% of visits was the patient provided the opportunity to complete his/her opening statement of concerns
    - Elicit the patient's opinion
      - Patient satisfaction and compliance are correlated with physician's facilitating patients' expressing themselves and physicians' asking for patients' opinions.
    - Acknowledge the emotional content of the patient's problems and respond caringly
      - In a study of resident physicians, two thirds of physicians asked closed questions and minimal encouragement, acknowledgement of information, empathy, or concern were demonstrated.
    - Assume responsibility for follow-up and/or continuity of care.
    - Support the efforts of other care providers.
    - Provide reassurance only after you have understood the content of the patient's problems.
    - Strive for understanding with your patient of the origin, significance, and the effects of the condition. Develop a plan for dealing with the problem.

The Use and Development of a Member Satisfaction Model in a HMO

S. Hiramatsu

- ABSTRACT:

  - *Group Health Cooperative completed a member satisfaction survey to understand how to increase enrollee satisfaction. The study was designed to investigate GHC's product in its entirety - insurance aspects as well as provider aspects. Specific goals for the study were to understand 1) what are the best predictors of satisfaction with GHC, 2) What are the best predictors of satisfaction with providers?, 3) To what degree does satisfaction with providers influence overall satisfaction?*

- KEY OBSERVATIONS:

  - Research suggests that consumers recognize quality in health care differently than do health care professionals or employers.
    - Health care professionals tend to approach quality from a technical standpoint, focusing on outcome data, level of staff training, or number of procedures performed.
    - Consumers tend to focus on the process and style in which the care is delivered. Since most outpatient medical encounters do not result in measurable changes in health status, consumers tend to focus on affective outcomes of care rather than physical outcomes.
  - Retrospective studies of disenrollment from HMOs found that disenrollment was related to lack of physician thoroughness and interpersonal skills, insufficient time with the physician, and physician access.
  - A study of the determinant of reenrollment in a closed panel HMO found that quality of care received from physicians explained most of the variation in the intent to re-enroll, followed by cost, coverage, and access to care.

The Use and Development of a Member Satisfaction Model in a HMO

S. Hiramatsu

- KEY OBSERVATIONS (Continued):
  - Results of current study
    - Quality of physicians available through GHC was the primary determinant of member satisfaction, followed by satisfaction with gatekeeper access to specialist, comprehensiveness of current coverage, and the rating of care for critical health problems.
      - Quality of physicians was correlated with number of physicians, number of specialists, and ability to see a preferred physician. Even consumers who decides on a staff model system associate physician quality with a degree of physician choice. Having a number of physicians available may be an indication to consumers that quality is obtainable though the selective choice of a physician.
    - The attributes that contributed most to satisfaction with providers were the doctor's technical skills, availability of physicians after hours, equipment and facilities, communication of normal test results, rating of care for routine health problems, and the technical skills of other office staff
      - Technical skills of physician were highly correlated with other physician attributes, listening skills, willingness to explain, friendliness, courtesy, concern or caring, and thoroughness of care. Consumers associated the technical skills of a physician with their interpersonal skills.

CHOOSING A HOSPITAL

J. Jensen

- ABSTRACT:
  - *Results from National Research Corporation research on consumer health care decision-making, specifically regarding selection of hospitals.*
- KEY OBSERVATIONS:
  - One-third of consumers hospitalized in the past three years selected the hospitals themselves, one-third decided jointly with the doctor, with the final one third hose doctor chose a hospital for them.
  - Only 22% of consumers selected a hospital completely on their own. Fifty two percent let their doctors chose the hospital, 18% choice among hospitals selected by their doctor or asked their doctor to choose among hospitals, and 12 percent went to a particular hospital because of health insurance requirements, an ambulance selected it, or because there was only one hospital in an area.
  - In cases of an accident or injury, consumers pick the hospital 33% of the time. Twenty-nine percent chose a hospital themselves for general tests and treatment. With illness or maternity, 27% choose the hospital on their own. When surgery is necessary, only 17% choose a hospital themselves.
  - Ranking of the most important factors when choosing a hospital:
    - Medical staff quality
    - Quality emergency care
    - Nursing care
    - Complete services
    - Newest equipment
    - Doctor's recommendation
    - Courteous employees
    - Pleasant surroundings
    - Cost of care
    - Treated there before
    - Convenience to home
    - Family's recommendation
    - Private rooms
    - Friend's recommendation

APPENDIX 2
Detailed Back-up from Benchmarking

GROUP HEALTH OF PUGET SOUND

- "Group Health Cooperative Launches Pilot Project to Improve Consumer Satisfaction and Primary Care Access" (1994)
  - Internal customer satisfaction surveys revealed many patients were dissatisfied with the HMO due to difficulty in obtaining appointments, difficulty seeing the provider they request, and transferred or put on hold when calling in
  - After reviewing survey data, GHC set target goals in customer service areas as well as establsihed teams of providers and support staffs to identify strategies in order to meet these goals
  - Strategies varied from expaning appointment line hours, increasing the number of appointment times left open for same-day appointments, etc.
  - Lessons and solutions from six pilot sites are being compiled into a "tool kit" to share with all 20 GHC centers

- "The Use and Development of a Member Satisfaction Model in a HMO" (1988)
  - Developed survey to provide managers with a rational model of predictors of enrollee satisfaction that would assist in making operational decisions
  - Satisfaction found to be highly dependent on quality of physicians associated with number of physicians. GHC decided to staff each medical center so that 80% of physician panels had openings for new enrollees or current enrollees who wanted to change their physician.
  - It was found that consumers used interpersonal criteria as muct as technical criteria in judging quality of care. Emphasis was placed on interpersonal skills in physician recrutiment and new physician orientation. Focus group videptapes were even used in orientation sessions.
  - Using survey results to formulate criteria for quality of service on an organization wide basis

- "Eleven Behavioral Elements in the Successful Medical Encounter" (1987)

  - Disenrollment studies conducted found dissatisfaction with aspects of the physician-patient encounter to be of major importance.
  - A continuing medical education program was developed, which emphasized the physician behaviors which would be likely to improve both physician and patient satisfaction with medical encounters, in order to promote better relationships and communication between patients and physicians and to increase physician awareness of recent literature on doctor-patient communication
  - A seminar format, which would included a set of case studies based on actual physician-patient encounters and literature review, was developed and presented to all GHC physicians

HARVARD COMMUNITY HEALTH PLAN

- "Rating Health Plans: Consumers Throw Experts a Curve"
  - A recent survey found that most consumers thing they are already have the necessary information to make decisions about their health care plans, and quality and satisfaction performance data are not yet key factors in those decisions
  - Information on choice of physicians is considered the most imporant factor in choosing a health plan, followed be detailed concerning the benefits package, patient satisfaction surveys, premium costs, and standardized measures of quality
  - Opinions of friends, neighbors, and co-workers figure mosre heavily in their choice of health plan that the results of satisfaction surveys of standardized quality ratings.

- "If You Only Knew: Assessing Quality of Care through Patient Satisfaction Surveys"

  - HCHP conducts two different surveys of stasigaction with health care service delivery - one from the Market Research Department and one from the Quality of Care Measurement Department
  - The Member Satisfaction survey has been primarily used for marketing and planning functions while the QCM visit survey data are used primarily as a means of monitoring the actual delivery of services
  - The two surveys have different time frames, response rates, levels of generalizability, scope of questions, response format, database
  - The differences in the two surveys become complementary when they are used together and the strengths and weaknesses of the sampling procedures and data collection methodologies balance out.

PRUDENTIAL

- "Outcomes Research in HMOs: Studies in Quality" (Sept/Oct 1994)
  - Prudential Center for Health Care Research and Harvard Medical School have announced collaboration in the field of HMO research.
  - Prudential's initial areas of inquiry include consumer information and decision-making, interventions and cost-effectiveness, and performance measurement.
  - Harvard received a $100,000 three-year retainer from Prudential.
  - Prudential's research center plans to complete two projects by end of year 1994.

Blue Care Network of East MI

- "A Michigan HMO Finds Innovative Ways to Show it Members that it Cares" (1992)

  - After an evaluation of member education efforts, it was found that despite effective traditional communication, the members, particularly new ones, have difficulty undertstanding the system to which they belong.

  - A program was developed to better explain the HMO system to individuals who had no experience in managed health care. It was hypothesized that this enhanced member education program would develop knowledgable members resulting in fewer claims translating into happier members and employers

  - The program consisted of personal phone calls to new members welcoming them to the plan and using the opportunity to explain the HMO system and the development of a new member video, which is mailed to each new subscriber, along with a handbook to individually educate families in a home setting.

So CA Permanente Medical Group

- "Achieving Appointment Access According to the Customer" (1994)
  - In 1976, research suggested that a majority of members and medical staff were experiencing dissatisfaction in the delivery of ambulatory adult primary care, specifically with regard to appointment access to primary care specialties.
  - Growth in membership demanded restructuring of delivery of primary care services in order to meet access needs of customers
  - Activities over a 15 year period included redefining roles and responsibilities, development of standards of quality, development of monitoring mechanism to assess patient and provider satisfaction, cost effectiveness, and accessibility, evaluated of the ratio of primary care to sepcialists, implemented extended/flex hours for primary care appointments, evaluated access member satisfaction and scheduling practices of nurse practitioners and physician's assistants within the primary care model.

TAKECARE

- "Reaching Out to Your Members: The TakeCare Member Health Partnership Council"

  - Why was the Member Health Council formed?
    - To get direct customer input and feedback
    - To provide forum to address tough issues
    - To build relationships between Plan and customers
    - To use successful method of focus groups
    - To design customer-inspired health plan of the future

  - Goals of Council
    - Help Plan management listent to members
    - Help Plan management make better decisions
    - Educate members about State and Federal reform
    - Learn how Plan can improve user friendliness
    - Learn how Plan can help members be better users of the system
    - Teach members how to live healthier lives

  - First meeting - Five questions
    - What are your bigest concerns about health care?
    - What comes to mind when you think of TakeCare Health Plan?
    - What do you like best about TakeCare?
    - What do you like least about TakeCare?
    - If you were president of TakeCare, what would you do to improve the Plan?

  - Second meeting - Three issues
    - How should TakeCare improve the "user friendliness" of our delivery system, administrative services, and how benefits are delivered?
    - How can TakeCare help members become better users of the health care delivery system?
    - How can TakeCare provide information in a format that allows members to take care of their own health and not use health care resources unnecessarily?

  - Council allowed TakeCare to:
    - Establish customer relationships
    - Receive meaningful and straightforward customer feedback
    - Knowledge of specific issues to address
    - Collaborative resolution of "hot" issues

EMPLOYERS

- "Three Big Firms Survey Workers to Evaluate, Improve Health Care" - Xerox, GTE, Digital (1993)
  - About 35,000 employees of Xerox, GTE, and Digital were asked to complete comprehensive surveys, Employer Health Care Value Survey, yielding information on their satisfaction with health services as well as their health status.
  - Collaboration between the three employers and the Health Institute at the New England Medical Center in Boston.
  - Xerox plans to use the results of the survey to set performance improvement targets.
  - Digital hopes to use the survey in negotiating prices and to help determine whether its health plans are providing an appopriate level of services based upon the health of their members.
  - The results will be published in a report card that employees can use to help choose their health plans.
- "Employers Making Use of Price, Quality Data" - Quaker Oats, State of Minnesota, Hershey (1991)
  - The state of Minnesota sent the results of a health care satisfaction survey to its employees and urged workers to use it to help them decide which of the five plans they should join for 1992.
  - Quaker Oats published regional hospital price guides based on state-wide patient discharge data to help its employeees find low-cost providers.
  - Hersehy and Navistar are developing networks of preferred providers based on local hospital quality and price data.
  - Trend toward employers forming partnerships with employees in making health care purchasing decisions.

APPENDIX 3

Current BCBSF Market Segments with BCBSF Share and Customer Needs Analysis for Each

CURRENT MARKET SEGMENTATION

Segment	Sales focus (group/ subscriber)	Total number of consumers	BCBSF customers	BCBSF penetration	BCBSF revenue ($M)	1993 reported		
						Gross margin	Contribution margin	Contribution ($M)
Local group	Group	2,648,671	325,001	12.3%	835	27.4 %	13.9%	116
National/ corporate	Group	2,800,000	376,785	13.5	1,137	8.4	2.1	24
FEP	Both	258,158	124,140	48.1	112	n/a	(3.6)	(4)
State	Group	360,000	251,280	69.8				
Direct over 65	Subscriber	2,600,141	285,521	11.0	572	27.1	18.7	92
Direct under 65	Subscriber	3,680,255	122,216	3.3			9.7	
Medicaid	Group	1,600,000	0	0	0	n/a	n/a	0
Total		13,947,225	1,484,943	10.7%	2,655	22.3 %	8.6%	228

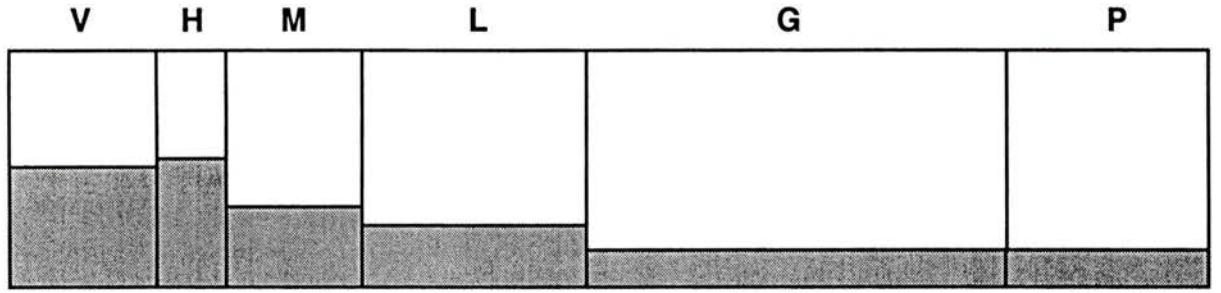
Need to understand behavioral groups within and among these market segments

Source: Corporate Strategic Planning - Marketing Strategy Development

UNDERSTANDING OF CUSTOMER NEEDS VARIES BY SEGMENT

Segment	Population	Sub-segments	Perceived depth of understanding	Comment
Local Group	Employees of Florida companies with less than 500 people	V, H, M, L, G, P Account size	Moderate	Current VHML segmentation may not be appropriate for needs analysis
National/ Corporate	Companies with more than 500 employees	Control, par/serviced, out of area, corporate (based on size, HQ location)	Moderate (but no understanding of needs hierarchy)	Why do customer needs vary by employer HQ location? Is this segment the same as local group, from a needs perspective?
FEP	Federal workers/ retirees in Florida	Active, annuitant	Low	High BCBSF share suggests needs are being met
State	Florida state workers/ retirees	PPO, HMO, no coverage	Low	Least customer needs information available of any segment
Over 65	Senior citizens	Direct, group, non-supplement	High	Understanding of differences in needs between Medicare HMO and supplement markets needs to be improved
Individual under 65	People under 65 not eligible for any group coverage	Insured, uninsured group, dependents, adults not in labor force, self-employed, temporarily unemployed, early retirees	Moderate-high	Insured vs. uninsured groups appear to have greatly different needs
Medicaid	People eligible for Medicaid program under federal guidelines	Medicaid, HMO AFDC, SSI	Low	Segment has very different needs (especially in customer service) than other segments

DETAIL OF LOCAL GROUP SUB-SEGMENTS
And BCBSF Share by Segment



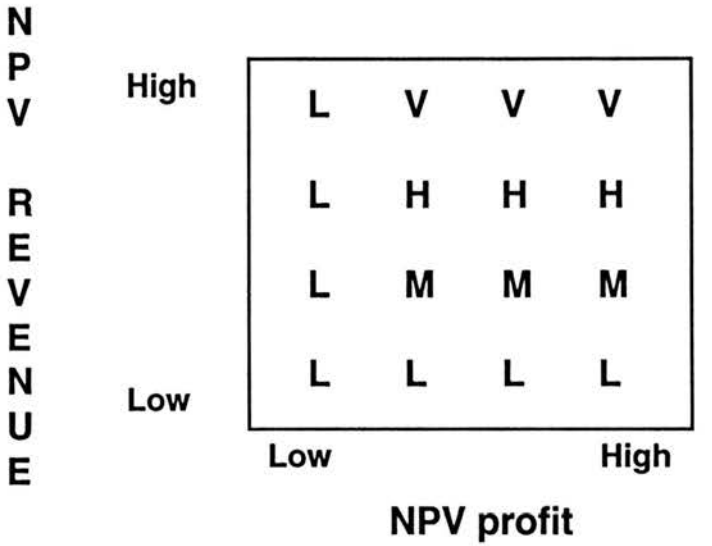
	V	H	M	L	G	P	Total
Large (300+ employees)							
Market size	98,519	49,869	96,380	160,435	297,522	146,085	848,810
BCBSF share (%)	50.5	52.9	35.8	30.9	16.6	16.6	27.6
Contribution margin							
Medium (50-299 employees)							
Market size	161,893	97,790	140,216	207,721	82,535	57,239	747,394
BCBSF share (%)	25.5	22.2	19.0	14.5	6.0	19.8	18.2
Contribution margin							
Small (2-50 employees)							
Market size	227,339	186,606	208,422	324,497	25,509	49,431	1,021,804
BCBSF share (%)	10.6	7.8	6.6	4.6	1.8	11.7	7.2
Contribution margin							

BCBSF penetration
Market potential

Source: Marketing: Current Assessments of Major Markets and Subsegments, 4/18/94

MARKETING SEGMENTS LOCAL GROUP BASED ON SIZE OF REVENUE AND PROFIT

V, H, M, L Scale



V = Very high benefit
H = High benefit
M = Medium benefit
L = Low benefit

1. Based on company's SIC code, estimate average employee wage and health benefits as a % of wages

2. Average employee wage x health benefits as % of wages = Health benefits per employee

3. Health benefits per employee x size of company = Health benefits per company

4. Health benefits per company x industry growth x retention rate = **NPV of revenue**

5. NPV of revenue x loss ratio = **NPV of profit**

Source: Local group market management - Marketing discussion, 4/12/94

LOCAL GROUP SEGMENTATION DOESN'T REFLECT TRUE NEEDS OF CONSUMER

Size of Firm Can Distort Rankings

Example:

Firm A	Firm B
• Small (20 person) law firm • High wages • Spend $4,000 per employee for health benefits • Slow growth industry	• Medium (80 person) manufacturing firm • Low wages • Spend $1,000 per employee for benefits • Rapid growth industry

- Both firms would be classified as "medium" or "high" potential accounts, yet have very different benefits needs
- Health benefits per employee may better reflect needs than V, H, M, L

LOCAL GROUP CUSTOMER NEEDS
Cost Most Important Issue across all Benefit Levels

Sub-segment		Very high	High	Medium	Low	Government	Provider
Dimension	Attribute						
Access	Broad coverage	2	3	3	3	2	2
	Portability	2	2	2	4	4	4
Benefit design	Reliability	2	2	4	4	2	2
	Education	3	3	3	3	3	3
Cost	Out of pocket expense	1	1	1	1	1	1
	Catastrophic coverage	1	1	1	1	1	1
Quality	Performance	2	2	3	3	2	2
	Accuracy-clinical	2	2	2	2	2	2
Service	Accuracy-billing	3	3	3	3	3	3
	Customer service	3	3	3	3	3	3

1 - Most important
2 - Very important
3 - Important
4 - Not important

Source: Local Group Market Management - Marketing Group Discussion, 4/12/94

PRODUCT PREFERENCE DOESN'T VARY SIGNIFICANTLY BY SEGMENT

All Prefer POS PPOs except Government

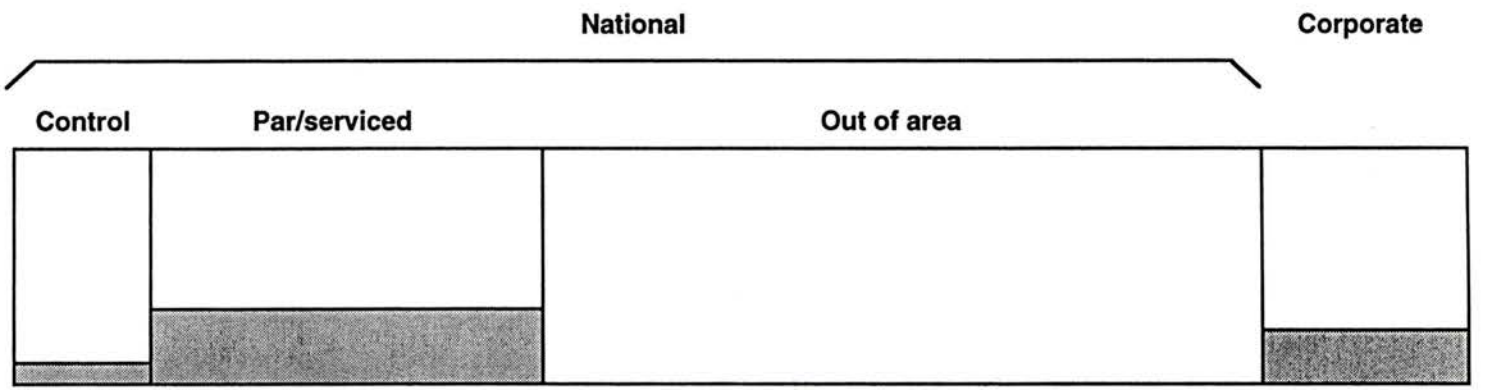
Product preference:

Segment	V	H	M	L	G	P
1st choice	POS PPO	POS PPO	POS PPO	POS PPO	Elect care	POS PPO
2nd choice	Traditional	Elect care	Elect care			Elect care
Other	• Know and like HMOs • Highly aware of elect care	• HMOs rated OK • Less aware of elect care			• Less aware than other segment	

Source: Local Group Market Management, 4/12/94

SIZE OF NATIONAL/CORPORATE SEGMENTS

Profit Margin much Lower than Local Group Segment - Does Difference in Needs Drive this or Does Cost Allocation Method?



	Control	Par/serviced	Out of area	Corporate	Total
Market size	250,000	750,000	1,400,000	400,000	2,800,000
BCBSF share (%)	10	35	0 ($150 million in claims processed)	23	13
Contribution margin					2.1%
Companies in segment:	More than 500 employees				
	FL, HQ, employees out of state	HQ out of state, employees in FL	HQ and operations out of state, another BCBS provides company insurance, BCBSF processes claims filed in FL (e.g., retired auto worker covered by BCBSM lives in Tampa)	HQ and employees in FL	

BCBSF penetration
Market potential

Source: BCBSF interviews; Corporate Strategic Planning - Marketing Strategy Development, 5/94

NATIONAL/CORPORATE CUSTOMER NEEDS
Appears to be Similar to Local Group

Access
- Convenience of location/office hours
- Medical care/specialty care/hospital care if and when needed
- Phone: availability of information/ability to make appointments
- Prescription services/mental health/substance abuse
- Choice of doctors/treatments

Benefit design
- Managed coordination/communication of benefits
- Support services (information/clarity regarding covered services)
- Paperwork required

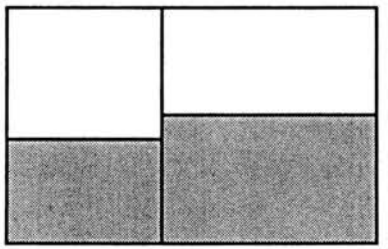
Cost
- Premiums
- Out of pocket costs
- Protection against financial hardships (getting care without financial problems)

Quality
- Technical skill of doctors
- Communication skill of doctors
  - explanation of procedures
  - attention to patient
  - advice to avoid illness
- Accuracy/thoroughness of treatment
- Quality/appropriateness/benefits of care

Service
- Interpersonal skills
  - courtesy of doctors/staff
  - personal interest
  - respect shown
  - reassurance, friendliness and support
- Time
  - from appointment to visit
  - waiting in office

Source: Employee Health Care Value Survey: Round One (GTE study), 6/15/94; AT&T Site Visit Preparation Materials, 3/20/94

SIZE OF FEP SEGMENTS
BCBSF Dominant Player in Market

	Active	Annuitant	Total
			
Market size	105,855	152,663	258,158
BCBSF share (%)	42	52	48
Contribution margin (%)			

Source: Corporate Strategic Planning - Marketing Strategy Development, 5/94

BCBSF penetration
Market potential

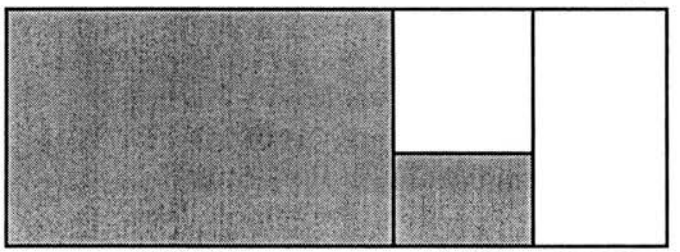
FEP CUSTOMER NEEDS

Lack of Information on Cost Attributes Highlights Gaps in Knowledge

Access	**Choice of doctor** **Choice of hospital**
Benefit design	**Benefits provided (dental)** **Written explanation for pay/nonpayment** **Timeliness of claims processing** **Timely ID cards** **EOB**
Cost	
Quality	**Quality of doctor**
Service	**Service efficiency and quality** **Courtesy/professionalism** **Waiting time**

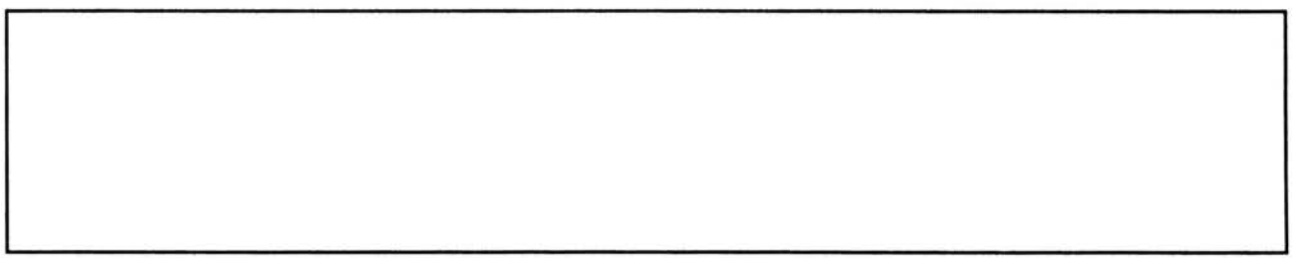
Source: FEP Customer Satisfaction Survey - Additional Analysis Report, 8/24/93, Corporate Strategic Planning - Marketing Strategy Development, 5/94

SIZE OF STATE SEGMENTS
Segmentation Based on Managed Care Choice

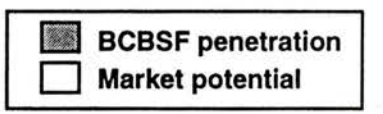


	PPO	HMO	No coverage	Total		
Market size	107,000	40,000	37,000	185,000	Accounts (employed and retired)	165,000 State employees 20,000 Retired
BCBSF share (%)	100	38	0			

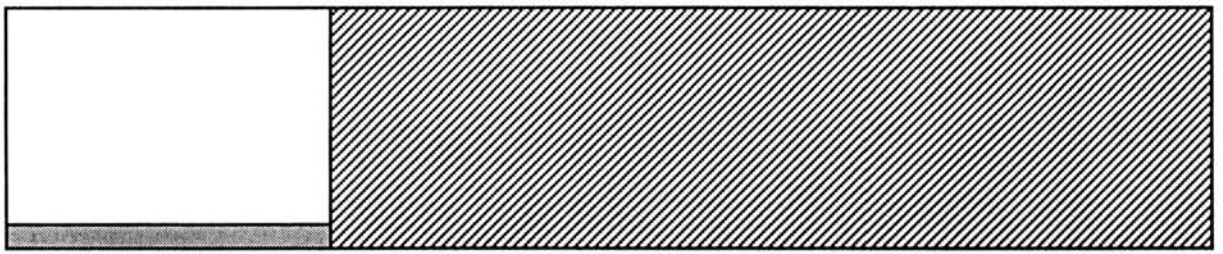
Contribution margin (%)



360,000 people covered (accts and dep.)

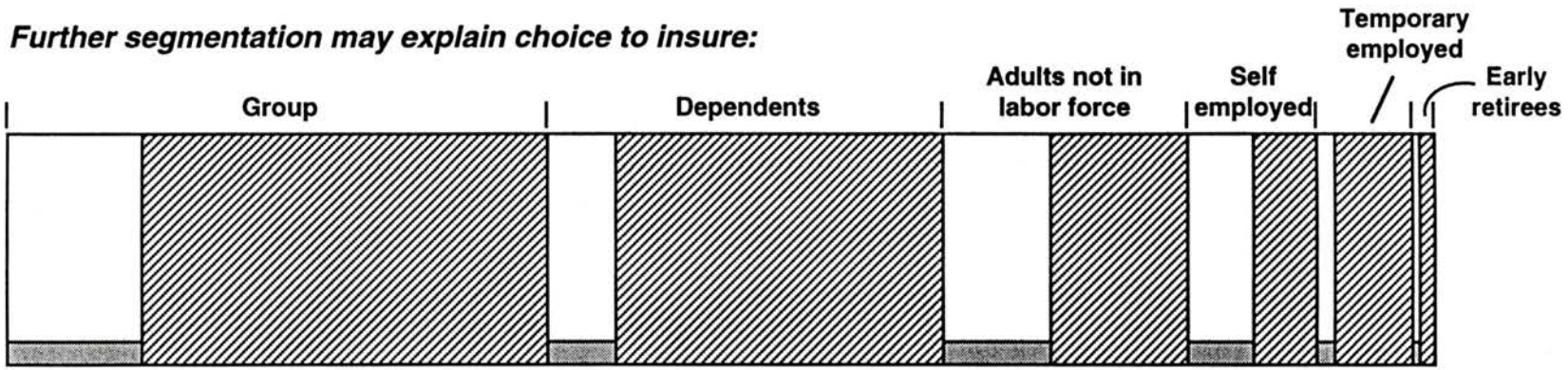


SIZE OF INDIVIDUAL UNDER 65 SEGMENTS
Most People in Market are Uninsured

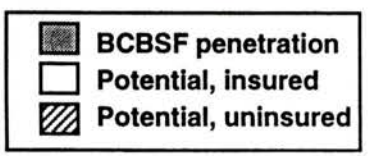


Market size	969,968	2,710,287	3,680,255
BCBSF share (%)	12.6	0	3.3
Contribution margin (%)	9.7	–	9.7

Further segmentation may explain choice to insure:



Share of individual <65 market (%)	37	28	17	9	7	2
% insured	24	16	38	47	13	71
BCBSF share %						
Contribution margin						



Source: Under 65 Market Study - Research Report, 8/92; Corporate Strategic Planning, 5/94

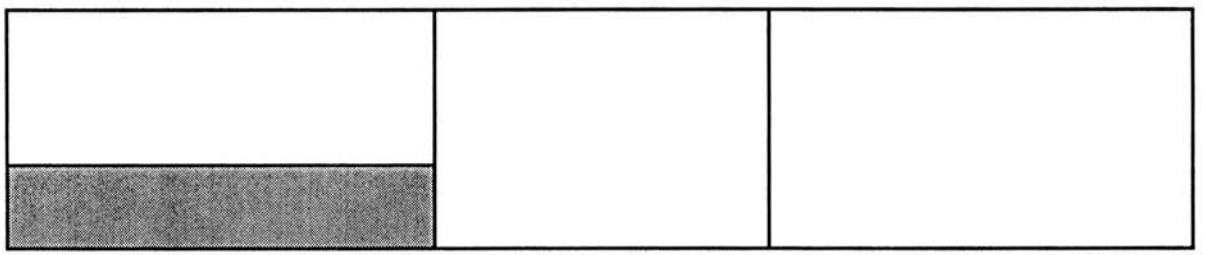
UNDER 65 NEEDS

Needs of Insured are Very Different than Uninsured

	Insured	Uninsured
Access	2. Unlimited choice doctors 3. Unlimited choice hospitals 6. Office visits	4. Office visits 5. Unlimited choice doctors 6. Unlimited choice hospitals
Benefit design	5. Prescription drugs 8. Maternity 9. Annual check-ups 10. Dental coverage 11. Vision coverage	3. Prescription drugs 8. Dental coverage 9. Maternity 10. Annual check-ups 11. Vision coverage
Cost	1. 100% hospital coverage 4. Low co-payment 7. Low deductible	1. Low co-payment 2. Low deductible 7. 100% hospital coverage
Quality		
Service		

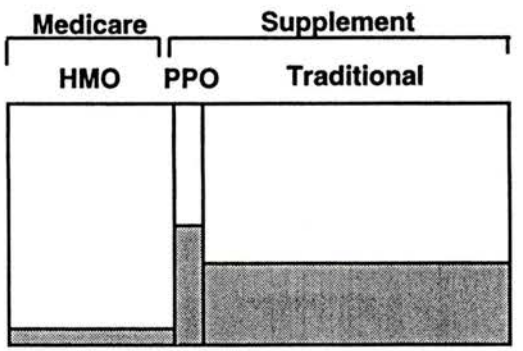
Note: Attributes ranked in order of preference
Source: Under 65 Market Study - Research Report, 8/92

OVER 65 NEEDS

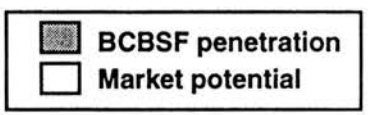


	Direct	Group	Non-supplement	Total lives
Market size	900,000	709,000	911,000	2,520,000
BCBSF share (%)	27.1	0.0[1]	0.0	9.7
Contribution margin (%)	18.7			18.7

Direct segment can be subdivided:



	Medicare		Supplement	Total policies[2]
	HMO	PPO	Traditional	
Market size	343,000	51,000	656,000	1,050,000
BCBSF share (%)	7.0	54.9	35.5	27.1
Contribution margin (%)	16.5	23.4	19.1	18.7



(1) Seniors that receive benefits from former employers are included in BCBSF group segments (local group and national/corporate).
(2) 900,000 seniors have purchased 1,050,000 policies, as some carry multiple policies
Source: The Florida Senior Market - Market Segment and Product Scenarios, 8/12/94

RECENT CONJOINT STUDY HIGHLIGHTS OVER 65 CUSTOMER NEEDS

Study done for Medicare HMO product launch in 3 markets: Jacksonville, Orlando, and Tampa

Plan attributes were focal point of study; did not address other dimensions such as access or quality

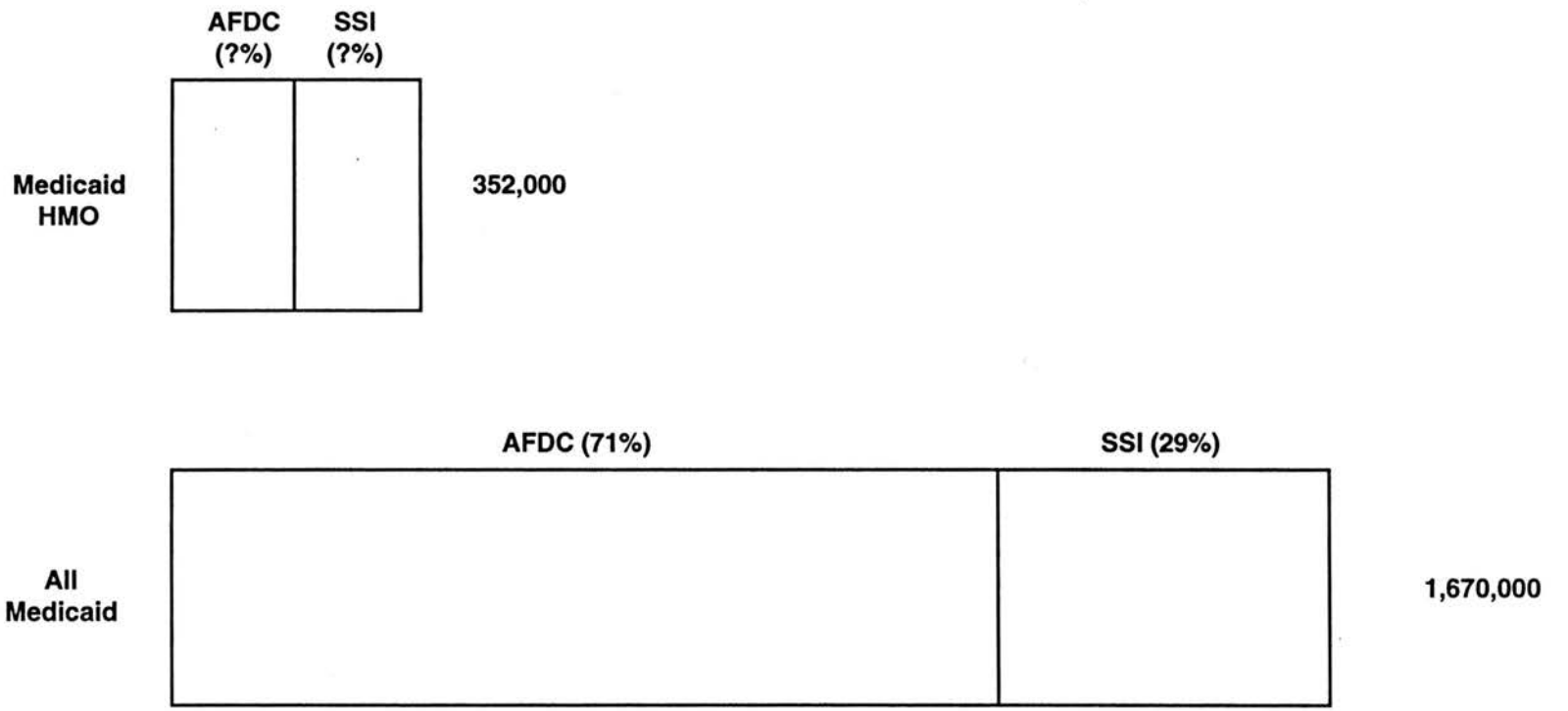
Most important plan attributes were (rank ordered):

1. **Monthly premium levels**
2. **Ambulance service**
3. **ER - Network Hospital**
4. **Visit to primary care physician**
5. **ER - non-network hospital**
6. **Visit to specialist**
7. **Vision care program**
8. **Urgent out of area care**
9. **Prescription drug plan**

Source: Medicare Risk - HMO Development Project, 7/23/93

MEDICAID SEGMENT SIZE
BCBSF Not in Market

Medicaid



Source: Medicaid Business Venture Workgroup, 8/24/94

MEDICAID CUSTOMER NEEDS
Much Greater Service Need than Other Segments

Access

- Transport
- Child care

Benefit design

- Extensive mandatory services (mandatory are similar to HOI benefits, but also include EPSDT, oral contraceptives and OTC drugs)
  - In-patient
  - Out-patient
  - Physician services
  - Prescription drugs
  - Lab
  - Radiology
  - EPSDT
  - Home health care
  - Durable medical equipment
  - Family planning
  - Hearing services
  - Vision services
  - Dental services
  - Transport
  - Nursing homes
- Disproportionate use of "high cost" services (ER, in-patient)
- SSI population (30% of members) will account for bulk (70%) of expenditures
- AFDC segment will use primarily maternity and birth related care

Cost

- Have virtually no discretionary income to pay for additional medical expenses

Quality

Service

- Program materials need to be targeted at 4th grade reading level
- Must have orientation meetings, continuing education and dedicated customer service representatives at convenient locations (e.g., public assistance offices) to explain program
- Must be able to enter/exit program easily as Medicaid population turns over frequently
- Has lower service expectations than other segments

Source: Medicaid Business Venture Workgroup, 8/24/94

APPENDIX 4

Fortune Magazine Article; September 5, 1994, "*Seeing The Future First*"

SEEING THE FUTURE FIRST

Could you and your team debate a trend for eight hours? Most managers spend far too little energy forging a long-term view of their industry. ■ *by Gary Hamel and C.K. Prahalad*

ARE YOU competing to dominate your industry's future? To find out, ask yourself three questions we often ask senior managers: First, what percentage of your time is spent on external rather than internal issues—understanding, for example, the implications of a particular new technology vs. debating corporate overhead allocations?

Second, of this time spent looking outward, how much is spent considering how the world could be different in five or ten years, as opposed to worrying about winning the next big contract or how to respond to a competitor's pricing move?

Third, of the time devoted to looking outward and forward, how much is spent in consultation with colleagues, where the objective is to build a deeply shared, well-tested view of the future, as opposed to a personal and idiosyncratic view?

The answers typically conform to what we call the 40-30-20 rule. In our experience about 40% of senior executive time is spent looking outward, and of this time about 30% is spent peering three or more years into the future. And of the time spent looking forward, no more than 20% is spent attempting to build a collective view of the future (the other 80% is spent looking at the future of the manager's particular business). Thus, on average, senior management is devoting less than 3% (40% x 30% x 20% = 2.4%) of its energy building a corporate perspective on the future. In some companies the figure is less than 1%.

Our experience suggests that to develop a prescient and distinctive point of view about the future, a senior management team must be willing to spend 20% to 50% of its time over a period of months. It must then be willing to continually revisit that point of view, elaborating and adjusting it as the future unfolds.

The vital first step in competing for the future is the quest for industry foresight. This is the race to gain an understanding deeper than competitors, of the trends and discontinuities —technological, demographic, regulatory, or lifestyle—that could be used to transform industry boundaries and create new competitive space.

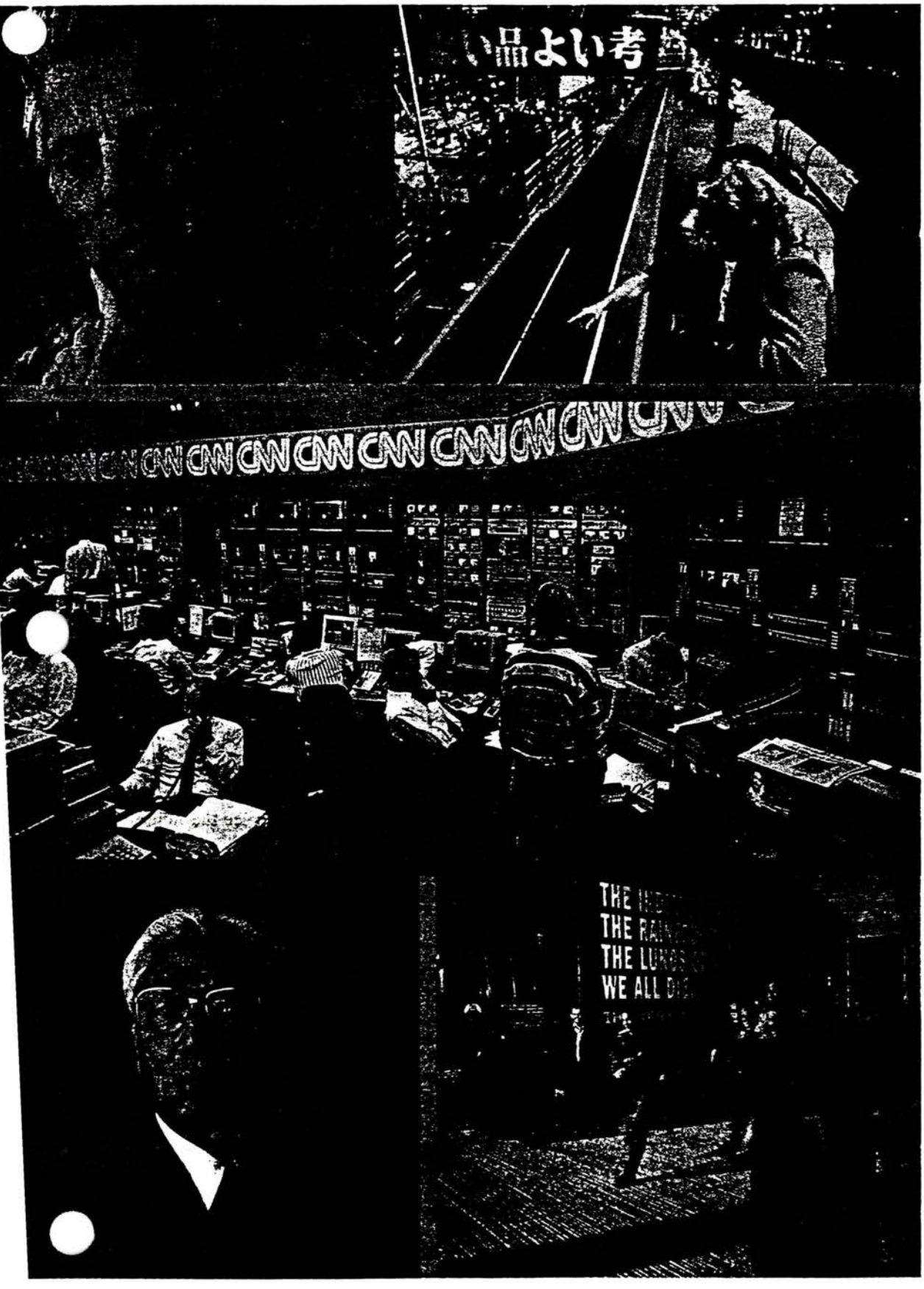
Industry foresight gives a company the potential to get to the future first and stake out a leadership position. It informs corporate direction and lets a company control the evolution of its industry and, thereby, its own destiny. The trick is to see the future before it arrives.

We don't believe any company can get along without a well-articulated point of view about tomorrow's opportunities and challenges. Today many companies seem convinced that foresight is the easy part; it's implementation that's the killer. We believe that creating industry foresight and achieving operational excellence are equally challenging. Many times what are described as today's implementation failures are really yesterday's failures of foresight in disguise. The quality deficit, which cost U.S. automakers so much market share in the 1970s and 1980s, was more than just "poor execution." Detroit didn't suddenly get sloppy, and Japanese carmakers didn't start out with a quality advantage. Japanese auto companies realized decades ago that new and formidable competitive weapons would be needed to beat U.S. car companies in their home market. The new weapons they set about developing were quality, cycle time, and flexibility.

ABOUT THE AUTHORS

Gary Hamel is a professor at the London Business School. C.K. Prahalad is a professor at the University of Michigan business school. Both consult extensively with companies, and they are co-authors of influential articles, including "Strategic Intent" and "The Core Competence of the Corporation."

From *Competing for the Future* by Gary Hamel and C.K. Prahalad, to be published in September 1994 by the Harvard



We didn't know we wanted minivans, midsize Japanese cars of unrivaled quality, 24-hour TV news, Walkmen, or sensibly priced cosmetics sold without hype until innovative contrarians put them in our hands. Shown here (clockwise from top left), minivan inventor Harold Sperlich; an assembly line at Toyota City, Japan; CNN's newsroom in Atlanta; Body Shop founder Anita Roddick; and Sony Chairman Akio Morita.

Foresight often comes not from being a better forecaster, but from being less hidebound.

Twenty years later, Toyota's foresight had become GM's implementation nightmare.

For a variety of reasons we prefer the word *foresight* to *vision*. Vision connotes a dream or an apparition, but there is more to industry foresight than a single blinding flash of insight. Industry foresight is based on deep insights into the trends in technology, demographics, regulation, and lifestyles that can be harnessed to rewrite industry rules and create new competitive space. While understanding the potential *implications* of such trends requires creativity and imagination, any "vision" that is not based on a solid factual foundation is likely to be fantastical.

To get to the future first, top management must either see opportunities not seen by other top teams or be able to exploit opportunities, by virtue of preemptive and consistent capability-building, that other companies can't. We find few senior management teams that can paint an enticing picture of the new industry space their company hopes to stake out over the next decade, few that spend as much time on opportunity management as they do on operations management.

Industry foresight requires a curiosity as deep as it is boundless. Gaining enough insight into potential discontinuities to actually draw conclusions about what to do—which alliances to form, how much to invest, what kind of people to hire—demands a significant expenditure of intellectual energy by senior management. The half-day or day-long planning review meetings that typically serve as forums to debate the future are utterly inadequate if the goal is to build an assumption base about the future that is more prescient and better-founded than the competitors'.

Recently one of us spent a day with the top officers of a well-known U.S. company. The question put to these managers was simple: What are the forces already at work in this industry that have the potential to profoundly transform industry structure? A heated discussion followed, and a dozen discontinuities were identified. One of the potential drivers was picked at random, and the top team was asked, "Could you sustain a debate for a full day, among yourselves, about the implications of this trend to your company and the industry? Do you understand how fast this trend is emerging in different markets around the world, the technologies that are propelling it, the technology choices competitors are making, which companies are in the lead, who has the most to gain and to lose, the investment strategies of your competitors vis-à-vis this trend, and the variety of ways in which this trend may influence customer demands and needs?"

The top team agreed that it simply didn't know enough about this critical driving force to answer these questions, and certainly couldn't keep a detailed, intelligent debate going for a full day. A few people suggested that these questions weren't really fair.

They were then asked, "Could you sustain a debate for eight hours on the issue of how you allocate corporate overheads, set sales targets, and manage transfer prices?" Now this was a fair question. "On this we could keep going for eight days, no sweat," replied a senior executive.

Suddenly the point hit them: This group of managers was not in control of their company's destiny. They had surrendered control of that destiny to competitors who were willing to devote the time and intellectual energy necessary to understand and influence the forces shaping the future of the industry.

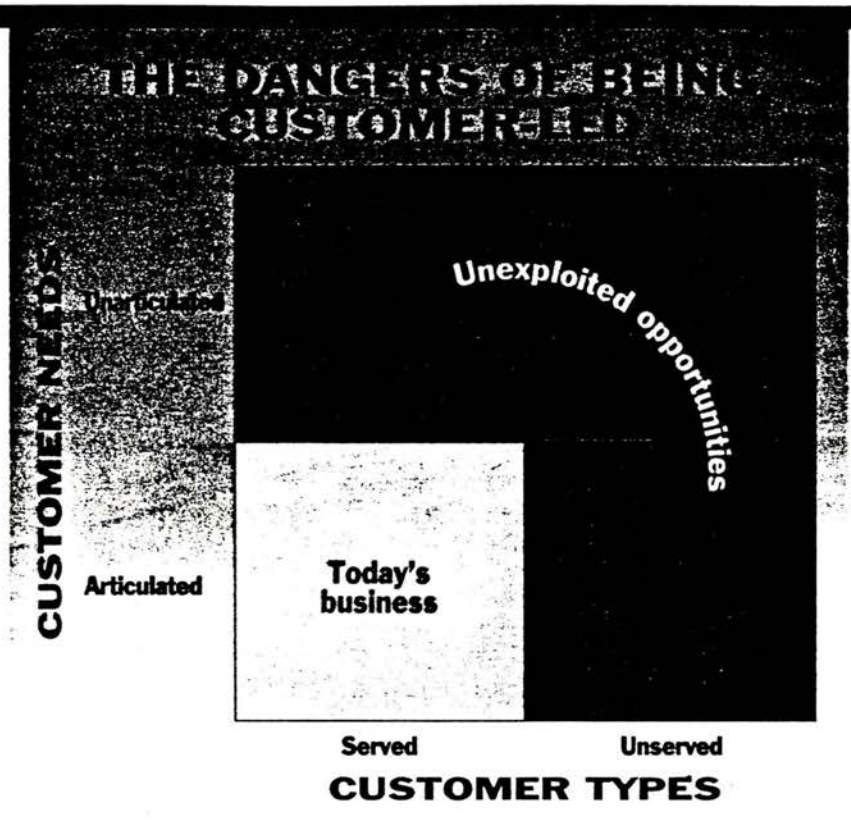
THE FIRST response to this painful realization was typical: "I'll set up a couple of days when each of my divisional vice presidents can come in and pitch their view of the future." Back came our argument: It takes more than two days to develop industry foresight; building foresight is not about "pitching" and "reviewing," but about exploring and learning. To really understand the future, to have the courage to commit, top management must get more than just a fleeting glimpse of the future. The required effort is measured in weeks and months, not in hours and days.

The outcome of this second painful realization was the establishment of a dozen or so "headlights" teams that worked for several months to refine and extend top management's initial list of industry drivers. The teams then proceeded to investigate each discontinuity in great depth. They sought answers to a variety of questions: How might this trend influence our current customers? How might it influence our current "economic engine"? What are the dynamics of this trend—how fast is it developing, and what are the factors that may accelerate or decelerate the trend? Who is moving to exploit this trend, or indeed, who is causing it—essentially, who is in the driver's seat, who is a passenger, and who is a bystander? Who has the most to lose and the most to gain from this discontinuity? What new opportunities—products or services—might be created by this discontinuity? What are our options for gaining further insight into this trend, influencing its direction and speed, or actually intercepting it?

As tentative answers emerged, they were debated in marathon sessions involving business unit and corporate managers. At the conclusion of the exercise, top management felt confident that it had developed the most penetrating set of headlights in its industry. To see the future first, top management must have a curiosity that is as deep as it is broad.

Building industry foresight demands that senior management be willing to move far beyond the issues on which it can claim expert status. It must admit that what it knows most about is the past and participate in debates about the future as equals, not as omnipotent judges. Impatient, results-oriented senior executives must be willing to come back again and again to issues that are complex and seemingly indeterminable. They must recognize that building industry foresight is, at least initially, as much about discovering as deciding.

Take an issue that begs for thoughtful speculation: the impact of virtual reality (VR). Virtual reality is a technology with profound implications for



Customers are notoriously lacking in foresight. Meeting only the articulated needs of customers you already serve cedes vast opportunities to more farsighted competitors.

lmost every industry. VR is not about ide[illegible]es or cybersex, but about a apacity to model and simulate just bout anything. As far-reaching as virual reality's impact may be, how many enior teams have given any thought to ow VR might influence their busiess? We were particularly pleased vhen the executive committee of a ompany we work with allowed itself o be led, by a 20-something savant, hrough an intellectually challenging eries of meetings where the implicaions of VR were debated in depth. Concluding that it needed to better nderstand virtual reality, the top eam set up an internal monitoring unction to keep it informed of VR's levelopment and suggest novel ways f exploiting the emerging technology.

THE FUTURE is to be found in the intersection of changes in technology, lifestyles, regulation, demographics, and geopoltics. For example, the opportunity hat CNN found for global, 24-hour elev[illegible] news grew out of changes n lifestyle (ever longer and more unpredictable work hours), changes in echnology (handicams and suitcaseize satellite linkups), and changes in he regulatory environment (the liensing and growth of cable televiion companies).

Companies that create the future re rebels. They're subversives. They reak the rules. They're filled with eople who take the other side of an ssue just to spark a debate. In fact, hey're probably filled with folks who lidn't mind being sent to the princial's office once in a while. Foresight ften comes not from being a better precaster, but from being less hideound. Ted Turner was a contrarian –you don't need superstar news eaders with their superstar salaries. Anita Roddick, founder of the Body Shop, was a contrarian. She believed, ontrary to much of the cosmetics inlustry, that trying to seduce women nto buying overpackaged, overhyped, nd overpriced cosmetics was an inult t[illegible]eir intelligence.

It [illegible]ch in vogue to be customered. From their bully pulpits, which toay are likely to be worldwide satellite hookups, CEOs tell the troops that "everything begins with the customer." Companies claim to be reengineering their processes from the customer backward. Rewards and incentives are tied to measures of customer satisfaction. And it is almost impossible to check out of a hotel, pay for a restaurant meal, or hire a car without being asked to rate the vendor's customer service. While we are somewhat taken aback by the fact that some corporate leaders seem to find the idea of putting the customer first *novel*, we nonetheless applaud the sentiment and commend the ensuing effort. On the other hand, if the goal is getting to the future first, rather than merely preserving market share in existing businesses, a company must be much more than customer-led.

Customers are notoriously lacking in foresight. Ten or 15 years ago, how many of us were asking for cellular telephones, fax machines, and copiers at home, 24-hour discount brokerage accounts, multivalve automobile engines, compact disk players, cars with on-board navigation systems, handheld global satellite positioning receivers, automated teller machines, MTV, or the Home Shopping Network? As Akio Morita, Sony's visionary leader puts it: "Our plan is to lead the public with new products rather than ask them what kind of products they want. The public does not know what is possible, but we do. So instead of doing a lot of market research, we refine our thinking on a product and its use and try to create a market for it by educating and communicating with the public." The company's founder and honorary chairman, Masaru Ibuka, concurs: "Our emphasis has always been to make something out of nothing."

A DETROIT automaker introduced in 1991 a new compact that had been five years in development. The car's design and specifications grew out of the most intensive customer research ever carried out by the company. Yet when the car was launched, it turned out to be the perfect car to compete with the three-year-old models of Japanese competitors. The U.S. company was following its customers all right, but its customers were following more imaginative competitors. By way of contrast, Honda introduced in the early 1990s its mid-engine NSX sports car, which

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nearly matched the performance of a Ferrari but at a fraction of the price. In the print ad for the car, Honda claimed that the NSX was "not a car buyer's dream—no car buyer could have dreamt of this car." Instead, crowed Honda, the NSX is a "carmaker's dream," which fulfilled the company's long-term ambition of producing a car that was both exotic and housebroken. Having achieved this goal, it is interesting to ask, who is Honda going to benchmark now? One gets the feeling that Honda is more interested in outpacing competitors than benchmarking them.

There are three kinds of companies: Companies that try to lead customers where they don't want to go (these find the idea of being customer-led an insight); companies that listen to customers and then respond to their articulated needs (needs that are probably already being satisfied by more foresightful competitors); and companies that lead customers where they want to go but don't know it yet. Companies that create the future do more than satisfy customers, they constantly amaze them.

NONE OF THIS is to argue that existing or potential customers can't play an important role in helping the firm stretch the boundaries of its opportunity horizon. But too often the questions asked of customers by market researchers—"Do you prefer a widget with a green strip or one with a red strip?"—provide little scope for fundamentally challenging traditional product concepts or creating real competitive differentiation. Although market research can be helpful in fine-tuning well-known product concepts to meet the demands of a particular class of customers (such as trying to discover just what diet cola formulation will appeal to European customers, which was the goal of researchers testing PepsiCo's new Europe-targeted soft drink, Pepsi Max), it is seldom the spur for fundamentally new product concepts (such as IDV's Aqua-Libra, which created an entirely new category of sophisticated adult "health" drinks in Britain).

Listen to Hal Sperlich, father of the minivan, who took the concept from Ford to Chrysler when Ford balked at turning it into reality: "[Ford] lacked confidence that a market existed, because the product didn't exist. The auto industry places great value on historical studies of market segments. Well, we couldn't prove there was a market for the minivan because there was no historical segment to cite. In Detroit most product-development dollars are spent on modest improvements to existing products, and most market research money is spent on studying what customers like among available products. In ten years of developing the minivan we never once got a letter from a housewife asking us to invent one. To the skeptics, that proved there wasn't a market out there."

Insights into new product possibilities may be garnered in many ways, all of which go beyond traditional modes of market research. Toshiba has a Lifestyle Research Institute; Sony explores "human science" with the same passion it pursues the leading edge of audiovisual technology. The insights gained allow these firms to answer two crucial questions: What range of benefits will customers value in tomorrow's products, and how might we, through innovation, preempt competitors in delivering those benefits to the marketplace? Yamaha gained insights into the unarticulated needs of musicians when it established a "listening post" in London, chockfull of the latest gee-whiz music technology. The facility offered some of Europe's most talented musicians a chance to experiment with the future of music making. The feedback helped Yamaha continually push out the boundaries of the competitive space it had staked out in the music business. Yamaha's experience illustrates an important point: To push out the boundaries of current product concepts, it is necessary to put the most advanced technology possible directly into the hands of the world's most sophisticated and demandin customers. Thus arose Yamaha' London market laboratory: Japan i still not the center of the world's po music industry.

Being a perpetual follower is not th only risk from being customer-led. Be ing customer-led begs the whole ques tion of who *are* my customers? A IBM, DEC, Xerox, and many othe companies have learned, today's cus tomers may not be tomorrow's. Folk buying Buick Roadmasters and Olds mobile Ninety-Eights may be happ enough with GM service and quality but if GM can't make a car that ap peals to 30-something Benz and Bim mer owners, it will surrender its future Recognizing this, GM has launchec many self-proclaimed import beaters and its latest, the Oldsmobile Aurora may finally prove a worthy contender Although it is important to ask hov satisfied my customers are, it is equall important to ask which customers are we not even serving.

Think of a simple two-by-two ma trix (see diagram). On one axis are needs—those that customers are ca pable of articulating and those that they can't yet articulate. On the othe axis are classes of customer—those classes the company currently serves and those it doesn't. However well a company meets the articulated needs of current customers, it runs a great risk if it doesn't have a view of the needs customers can't yet articulate but would love to have satisfied. And however content a company's existing customers may be, it may find its growth stymied if it can't reach out and appeal to fundamentally new customer groups. Any company that can do no more than respond to the articulated needs of existing customers will quickly become a laggard.

Many companies use an array of tools that make them think they're looking into the future: technology forecasting, market research, scenario planning, competitor analysis. Although potentially useful, none of these will necessarily yield industry foresight. The reason: None compels senior management to reconceive the corporation and the industries in which it competes. Until managers do that, they haven't begun competing for the future. F