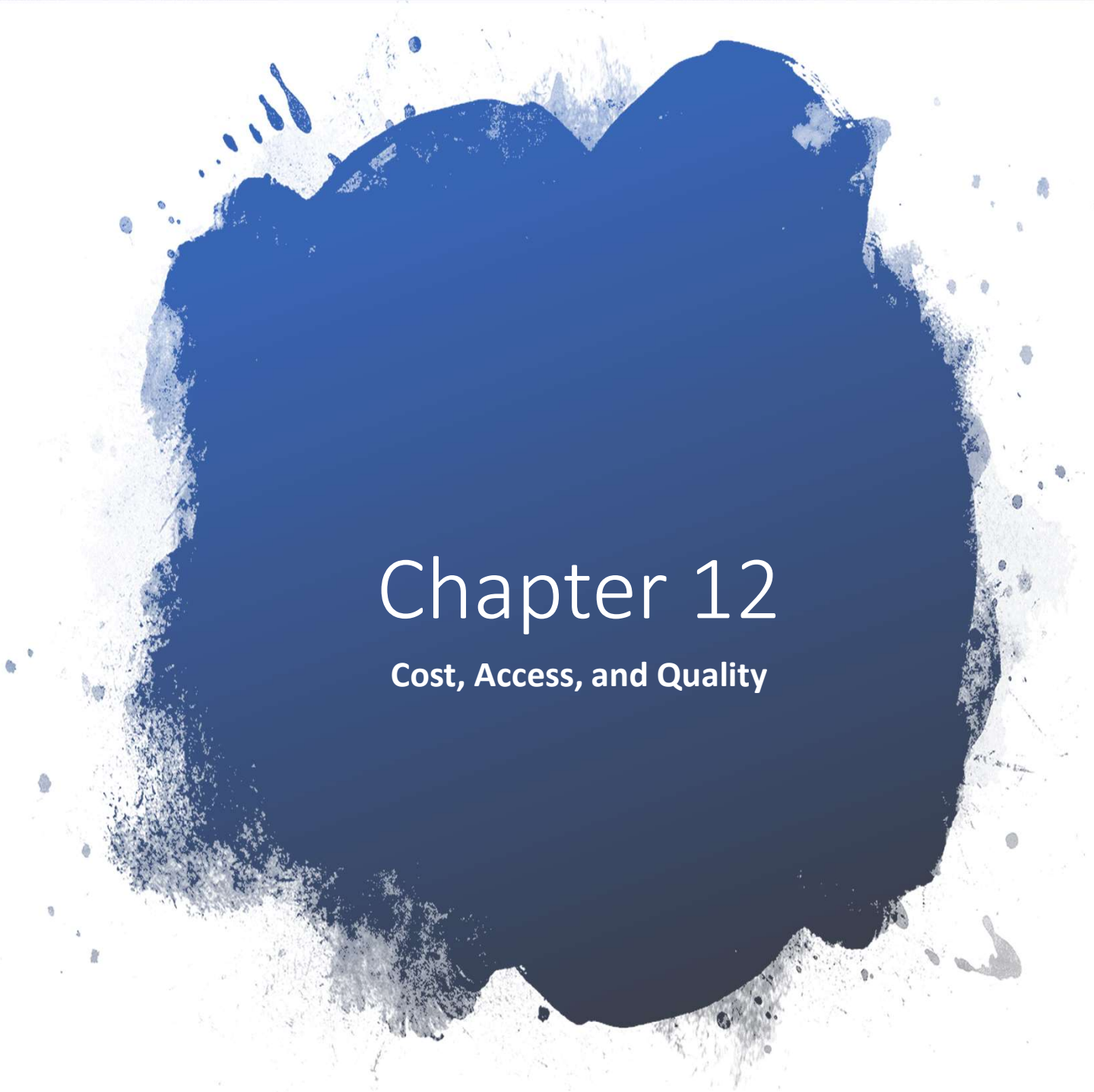


Chapter 12

Cost, Access, and Quality

What Are The Three Cornerstones of US Healthcare?

Introduction

Three cornerstones of healthcare delivery:

- Cost
- Access
- Quality

Uncontrolled expenditures reduce a nation's ability to provide access to quality healthcare (e.g. FAX)

Introduction

High quality care

- Most cost-effective care
- Cost is important in evaluating quality
- Achieved when:
  - accessible services are efficient
  - cost-effective
  - provided in an acceptable manner

Learning Objectives

- Understand:
  - Healthcare costs, their trends, and underlying factors
  - Why some regulatory cost-containment schemes were unsuccessful
  - Nature, scope and dimensions of quality
  - The difference between quality assurance and assessment
  - Regulatory and market-oriented ways to contain costs
- Appreciate the dimensions of access to care
  - Analyze access indicators and measurements
- Discuss the implications of the Affordable Care Act on cost, access, and quality

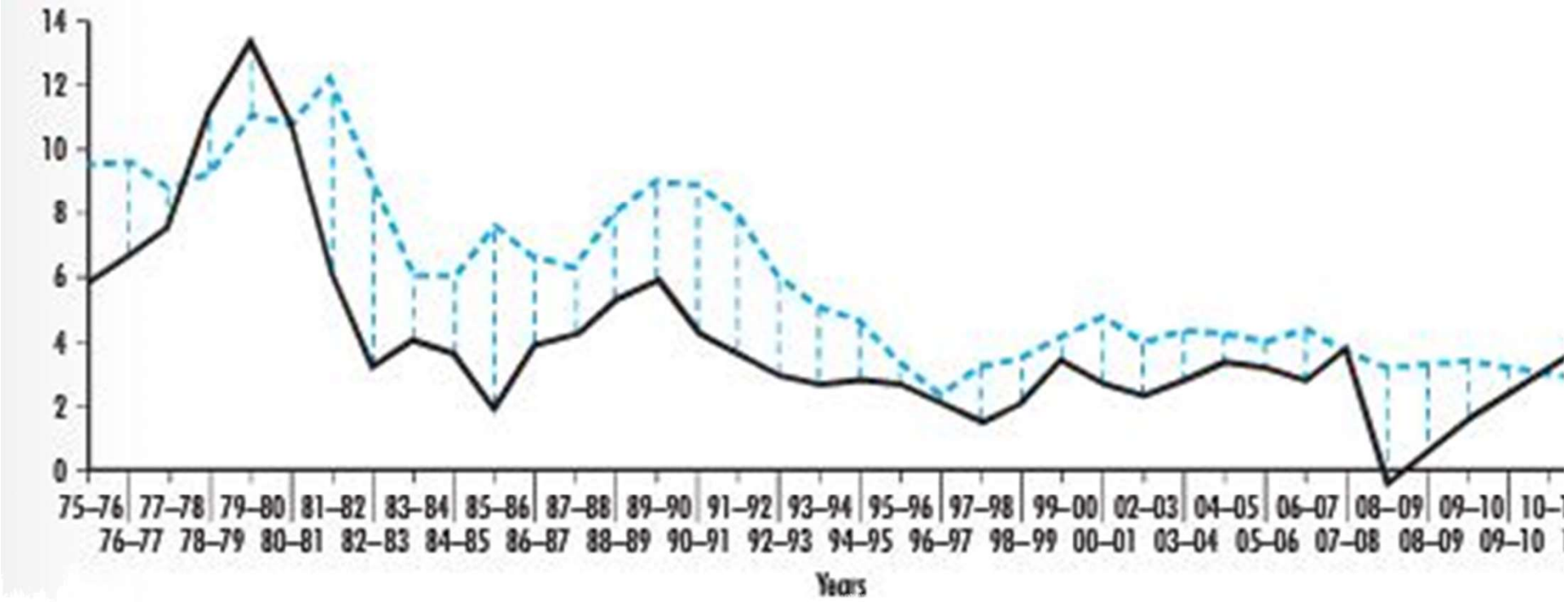
What Are Possible Meanings (or Perspectives) to: "Cost of Healthcare?"

Cost of Healthcare

Three possible meanings:

1) Price (Patient perspective): physician's bill, prescription bill, premiums
2) National perspective: how much a nation spends on healthcare (healthcare expenditures)
3) Provider perspective: cost of production (staff salaries, capital, supplies)

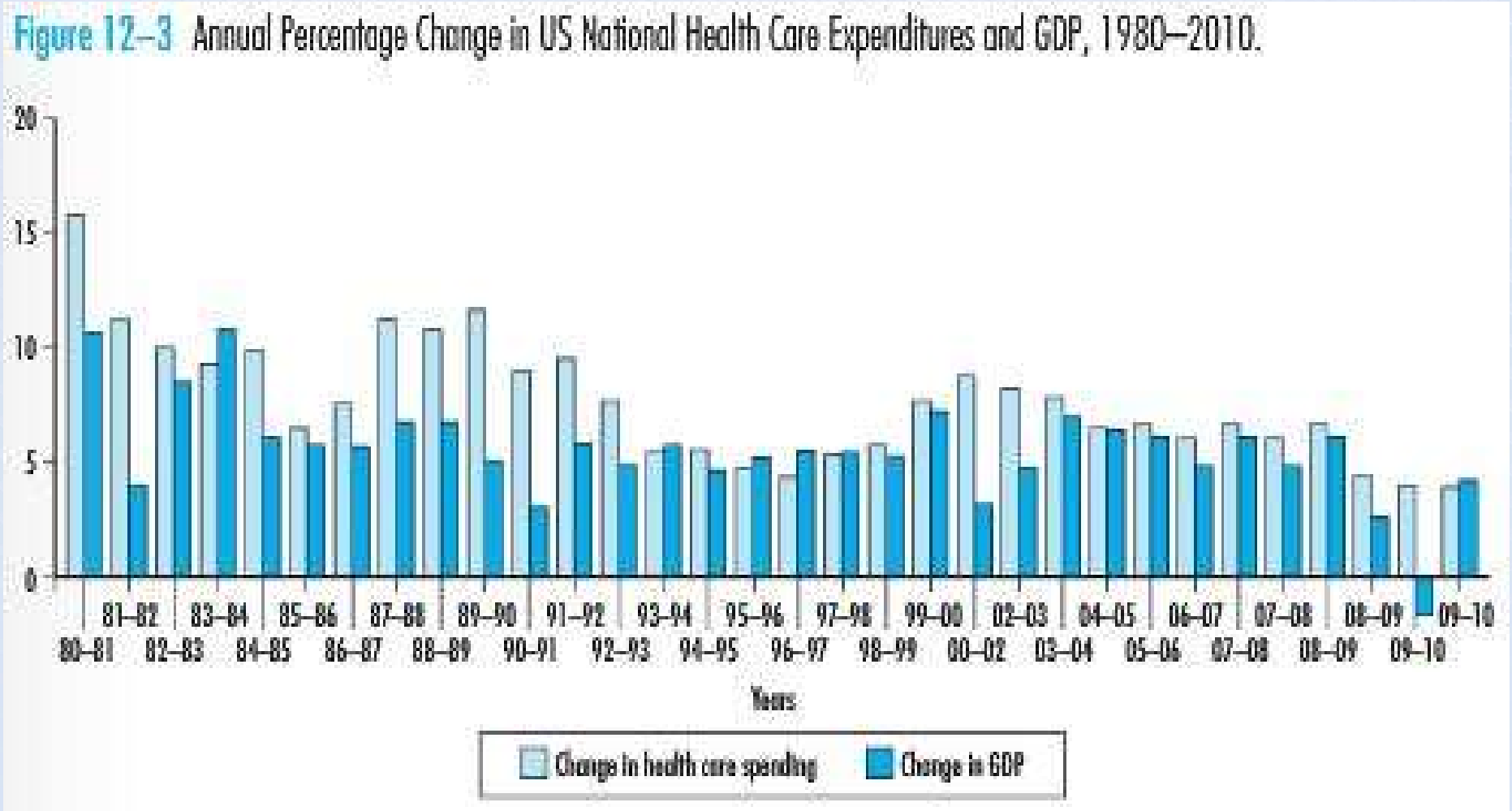
Figure 12–2 Annual Percentage Change in CPI and Medical Inflation, 1975–2011.



Trends in National Health Expenditures

https://fredblog.stlouisfed.org/2017/07/healthy-inflation

Trends in National Health Expenditures



Trends in National Health Expenditures

- In 2009, 17.4% of GDP was spent on healthcare
  - $7,960 per capita
- Slowed – 2016-2019, 17.8-18%
- CMS projecting 20% by 2025 now.

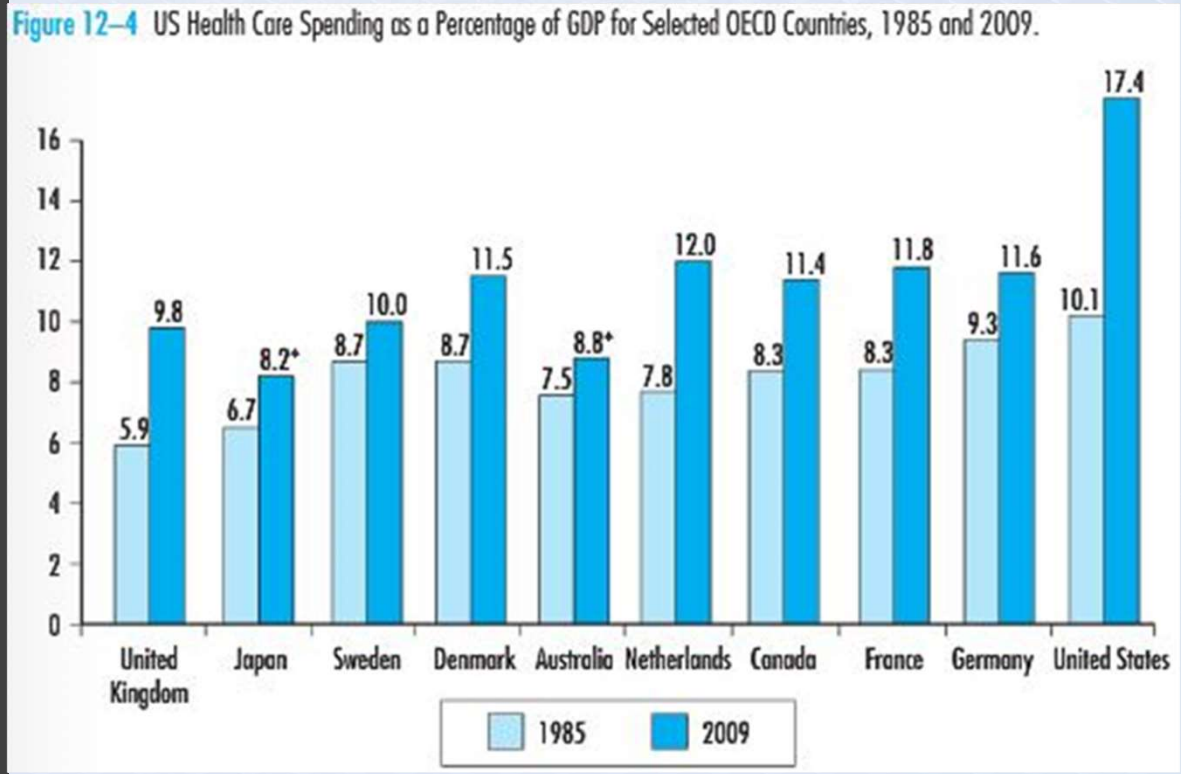


Figure 12–4 US Health Care Spending as a Percentage of GDP for Selected OECD Countries, 1985 and 2009.

Do We Need to Contain Costs?

Reasons to control costs:

1) Health care consumes a greater percent of the total economic output
   - Resources are limited
   - Other economic uses are curtailed
2) Limited resources should be directed to their highest value
3) Corporations bear the additional cost of doing business
4) Public spending for healthcare will become unsustainable

Reasons for Healthcare Cost Escalation (cost inflation)

- Third party payment
- Imperfect market
- Growth of technology
- Increase in elderly population
- Medical model of healthcare delivery
- Multi-payer system, administrative costs
- Defensive medicine
- Waste and abuse
- Practice variations

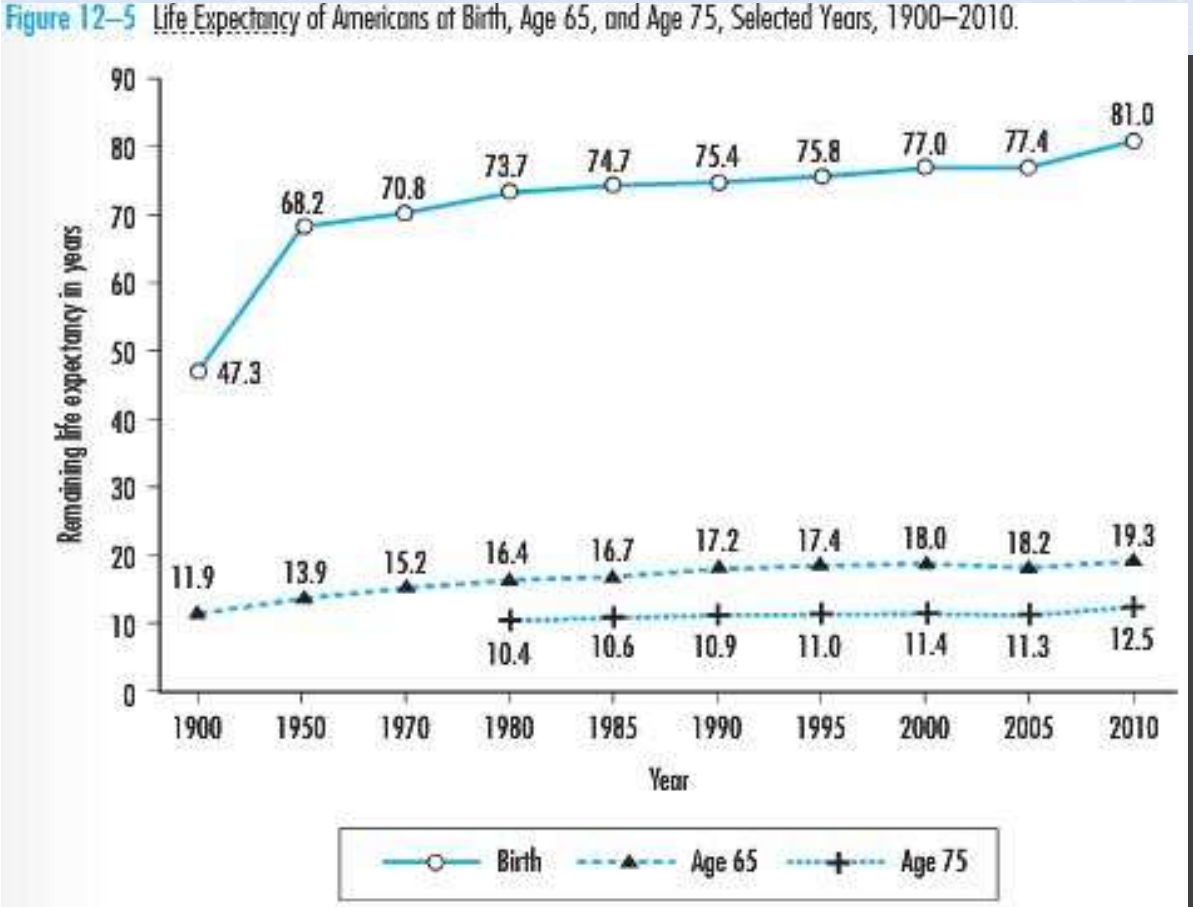
Reasons for Cost Escalation

Third party payment:

- Moral hazard
- Provider-induced demand

Imperfect market:

- Health care market in the U.S. is neither free nor highly regulated, and prices far exceed the cost of production
- E = Q x P [expenditures = quantity x price]
  - In national healthcare systems, both Q and P are controlled by a central agency
  - Both remain unchecked in an imperfect market



- Technology and specialization:
  - Beliefs and values
  - High R&D spending
  - Innovation that leads to utilization
  - Surplus of specialists
- Increase in elderly population:
  - Increased longevity
  - Baby boomers
  - The elderly use nearly three times as much healthcare as younger people

Reasons for Cost Escalation

https://www.ssa.gov/oact/STATS/table4c6.html

Reasons for Cost Escalation Multi-payer System and Administrative Costs

Inefficiencies related to:

- Financing
- Insurance
- Delivery
- Payment functions

- Enrollment process
- Contracts
- Claims processing
- Utilization
- Denials and appeals
- Marketing

Reasons for Cost Escalation

Defensive Medicine

- Medical tests and treatments that are not immediately justified, but done for self-protection (reduce litigation)

Waste and Abuse

- Inefficiencies and Fraud
  - Knowing disregard of the truth
  - A major problem in Medicare and Medicaid
    - Unnecessary services may be provided
    - Upcoding
    - Misallocation of costs to increase reimbursement (in cost-plus reimbursement systems)
  - Receiving kickback for referrals
  - Self-referral (Stark Laws – Medicare/Medicaid)

Reasons for Cost Escalation

- Practice variations (small area variations)
  - 2016 study documents differences
    - 40-50% demand for variation
    - 50-60% demographic supply
  - Signal gross inefficiencies in the system
  - Compromise both cost and quality

Cost Containment: Regulatory Approaches

- All-payer (single-payer) system
- ACA
- Health Planning
- Price Controls
- Peer Review

Cost Containment: Regulatory Approaches

All-payer (single-payer) system

- Top-down control (global budgets)
- The U.S. does not have an all-payer system
  - Bottom-up cost control
  - Cost shifting occurs

Health Planning

- Government's efforts to align and distribute healthcare resources to achieve health outcomes
  - e.g. one hospital for cancer; one hospital for heart disease
- No system-wide planning and controls in the U.S.
  - CON planning used by some states

Cost Containment: Regulatory Approaches

Price Controls

- Economic Stabilization Program used during the Nixon presidency
- Provider-induced demand (no control on Q) mitigated the effects of price controls
- DRG-based PPS (prospective payment system) shifted costs to the outpatient sector
- Arbitrary rate setting by Medicaid
- Pay for performance
- Drug price controls (new discussions in US policy)

Cost Containment: Regulatory Approaches

Peer Review

- Peer Review Organizations (PROs)
  - Statewide private organizations
  - Review by physicians and other health professionals
  - Paid by federal government
  - To review care provided to Medicare patients
    - Is care reasonable? Necessary? Appropriate?
    - Meets quality?

Cost Containment: Regulatory Approaches

Peer Review Organizations (PROs)

- Each state has a PRO
- Can deny payment if care not necessary or appropriate
- PROs are now called quality improvement organizations (QIOs)

Cost Containment: Competitive Approaches

- Demand-side Incentives
- Supply-Side Regulation
- Payer-Driven Price Competition
- Utilization Controls
- Competition
  - Rivalry among sellers for customers
    - Health care competition can be based on technology, quality, amenities, access

Cost Containment: Competitive Approaches

Demand-side incentives

- Cost-sharing by consumers
- A self-rationing mechanism (reduces moral hazard)
- RAND experiment (‘74-’81)

Supply-side regulation

- Antitrust laws
- Anticompetitive practices can be illegal

Cost Containment: Competitive Approaches

Payer-driven price competition

- Patients are not customers in the economic sense
  - They pay little out of pocket
  - They lack technical information
- Payer-driven competition occurs at two levels:
  - Employers shop for value in health insurance plans
  - Managed care shops for best value from providers

Utilization controls

- Employed by MCOs
- They overcome the information gap that patients face (case situations)

Access to Care

Access:

- Ability to obtain needed, affordable, convenient, acceptable, and effective personal health services timely
- Key implications:
  - Determinant of health
  - Benchmark in assessing effectiveness
  - Equity
  - Quality and efficient use of needed services

Access to Care

Access concepts:

- Does patient have a source of care?
  - Primary care physician
- Use of healthcare
  - Availability, convenience, referral
- Acceptability of services
  - A patient's preference and values

Access to Care

Dimensions of Access

- Accessibility: fit between the locations of providers and patients (transportation, convenience)
- Affordability: ability to pay
- Accommodation: how resources are organized to provide services and the patient's ability to use the services (timely appointments, quick service, walk-ins, etc)
- Acceptability: compatibility (waiting time; race, culture, gender, etc.)

Quality of Care

Institute of Medicine definition:

- Increased likelihood of desired health outcomes
- Use of current professional knowledge

Dimensions of quality

- Microview
  - Clinical (technical) aspects
  - Interpersonal aspects
  - Quality of life
- Macroview
  - Mortality
  - Incidence and prevalence

Quality Assurance

Based on total quality management (TQM)

- Similar to continuous quality improvement (CQI) and quality improvement (QI)

A step beyond quality assessment

- Cannot occur without quality assessment

A system-wide commitment to engage in the improvement of quality on an ongoing basis

Quality Assessment

- Measurement of quality against an established standard
- Use of data
- Subjective measures must be quantified
- Measurement scales must have
  - Validity (assesses what it says it measures)
  - Reliability (the same results should occur with repeated measurements)

Quality Assessment

The Donabedian Model (1985)

- Structure – the capacity to deliver quality
- Process – how healthcare is delivered
- Outcome – effects or results obtained

In 1980s, many industries realized good process = good outcome (e.g. CMM, ISO, etc.)

The Donabedian Model

Structure

- Facilities: license, accreditation
- Equipment
- Staffing levels
- Staff qualifications
- Staff training
- Distribution of hospital beds, physicians, etc. in a given population

The Donabedian Model

Process

- Clinical practice guidelines (medical practice guidelines)
  - Evidence-based protocols
  - Professional consensus when scientific evidence is lacking
- Critical pathways
  - Timeline
  - Identifies planned medical interventions
  - With expected patient outcomes for a diagnosis

The Donabedian Model Processes

Cost-efficiency

- Do benefits exceed the costs?
- Underutilization and overutilization are based on cost efficiency

Risk management

- Proactive
- Efforts to prevent adverse events related to clinical care and facility operations
  - Focused on avoiding medical malpractice

The Donabedian Model

Outcome

- Bottom-line measure of effectiveness
- Recovery, improved health
- Postoperative infections, nosocomial infections, iatrogenic illnesses, rehospitalizations
- Malpractice litigation
- Patient satisfaction
- Quality of Life measures

Quality Report Cards

- HEDIS
  - Health Plan Employer Data and Information Sets
    - Standard for reporting quality in managed care plans
    - Measures: effectiveness, access and availability, satisfaction, health plan stability, utilization, cost, informed choices
  - CMS Program on Quality
  - AHRQ Quality Indicators
  - State Public Reporting of Hospital Quality

ACA Takeaway

Cost control measures included:	• Competition among health plans to drive down insurance costs • Value-based purchasing • Reduction in Medicare payments to providers
Promised to increase access to affordable insurance coverage, and supports improvements in primary care and wellness	• Insurance premiums rose after the first few years due to insurers uncertainty about markets and their greed
Included provisions for improving quality of care, through programs that link payment to:	• Quality outcomes in Medicare • Strengthening of the quality infrastructure • Encouraging the development of new patient care models