

**“DIVERSELINE”**

Paul Seeman  
David Bentzel  
Su Kim  
Nathalie Morin  
Larry Shelton  
Sharon White

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Major changes have occurred in American health care delivery over the past two decades. Factors such as cost, access, and quality have contributed to the changes that have occurred. Of these factors, cost has been very influential in generating major changes across several sectors of American health care delivery including ambulatory care, hospitals, long-term care, and mental health care.

Health care is the largest service industry in the United States. The U.S. spends over 1 trillion dollars on health care annually and health care represents over 13% of U.S. gross domestic product (GDP). The financial magnitude of the health care industry in the U.S. makes cost a central factor in any discussion of health care delivery.

Discussion of the impact of cost, quality, and access on health care delivery in the U.S. has revealed the intertwined nature of these factors. A discussion of one cannot take place without noting its effect on the others. For example, discussion participants noted that access to health care and the quality of the care received is heavily dependent on the ability to pay for care. Participants further noted that cost was a critical determinant in the type of care one received and where one received it. Additionally, discussion participants noted the impact of technology and modern medical science as contributing to the rise in the cost of health care. Lastly, the experience of population subgroups, socioeconomic status, and knowledge of the American health care “system” were noted to be important elements related to issues of cost, quality, and access.

The consensus reached by this discussion group was that cost was the most overriding of the three factors contributing to the changing face of health care delivery in the U.S. Access and quality depend on the ability to pay one way or another. Following will be a description of major changes that have occurred in several sectors of health care delivery due to cost.

Cost has been the driving force behind major changes that have occurred in the organization of the ambulatory care sector and the services that it provides. The organization of physicians is an example of a major change that has occurred due to the influence of cost. Physicians are a major source of health care delivery in the ambulatory care sector. Traditionally, in American ambulatory care, physicians delivered health care as solo practitioners. Recently, there has been a migration of physicians from solo practices into group practices made up of several physicians. Furthermore, many group practices have formed larger networks of group practices to deliver health care in the ambulatory setting. Cost has been a major contributing factor to this change. Faced with an increasing cost of health care, the major payers of the cost of health care (e.g. insurance companies, health maintenance organizations (HMO), and managed care organizations) have taken actions to control it. These actions resulted in the changes in physician organization noted above. For example, the payers have reduced the amount of reimbursement to physicians for the health care that they provided to the payer’s beneficiaries. They have also shifted the risk for the cost of care to physicians through capitation. Physicians, under pressure from the cost of the care that they provide and reduced reimbursement, needed to change their organization to meet their cost obligations and still earn a living. To control their costs, physicians migrated from solo practices to group practices to achieve greater efficiency and economies of scale. In addition, in the capitation environment, organizing into groups has allowed physicians to spread the risk of the cost of care for a group of patients over several physicians. Lastly,

physicians, who have organized into groups and networks of groups that can offer comprehensive services, are more competitive in obtaining contracts for the care of groups of patients from HMOs and managed care organizations. They have been able to achieve greater strength in negotiating those contracts as well.

The services offered in the ambulatory care setting have changed due to the effects of cost as well. In an effort to control the cost of health care, HMOs, managed care organizations, and other large payers have sought to place the primary care physician in the role of a “gatekeeper” to reduce referrals to more expensive specialty care and laboratory services. In addition, the major payers have also used financial incentives to physicians to control utilization rates and in effect, ration health care. The ambulatory care sector has also seen the shift of services traditionally offered in other sectors to it in an attempt to reduce the cost of health care. An example of this is the recent development of the ambulatory surgery center. Patients who require a surgical procedure, but do not require hospitalization, can have the procedure done on an ambulatory basis at a lower cost than that of a hospital setting.

Cost pressures in the ambulatory care setting have also affected factors such as access and quality of care. For example, patients enrolled in HMO and managed care plans are required to see physicians in the network contracted by the plan or the plan will not pay the bill. This requirement has greatly reduced the patient’s freedom to choose which physician in the community that they see for health care. In addition, many plans require pre-authorization for care or refuse to cover certain types of care. This diminishes the range of services available to patients and may affect the quality of care that the patient receives. This phenomenon has also affected public or “free” clinics. Many of these clinics are now required to meet their operating expenses with revenues generated by third party payers or government program payers. As these revenues decrease, so do the range of services provided.

The hospital setting has also undergone major changes due to the influence of cost as well. The evolution of care in the hospital setting and recent changes in this setting are a direct result of financial policies of the U.S. government and policies of the payers of the cost of care in the hospital setting such as insurance companies, HMOs, and managed care organizations.

As medical science and technology increased during the twentieth century, care moved out of individuals’ homes and into hospitals. The U.S. government paid much of the cost of hospital construction during this period through the Hill-Burton Act. Additionally, the growth in health insurance coverage and the scope of that coverage funded the expansion of hospital facilities, the services provided, and the implementation of modern medical science and technology. Hospitals historically have been able to finance the implementation of the most current technology through cost based reimbursement.

Hospitals presented increasing bills to the major payers of health care of the last few decades. Consequently, the payers took action to control those costs. For example, the U.S. government profoundly altered the delivery of care when it switched from cost based reimbursement to prospective cost reimbursement in an effort to control the cost of health care in the hospital setting. The U.S. government is a major payer for health care through the Medicare and Medicaid programs and is able to exert a large amount of influence on the health care industry. The government accomplished the switch to

prospective cost reimbursement in part with the use of diagnostically related groups (DRG). What this meant was that government programs would no longer reimburse hospitals for what it cost them to care for a patient. The hospital would receive a prospectively determined amount based upon the patient's diagnosis or DRG. If the hospital's cost for the care of a particular patient was greater than the amount of reimbursement based on the patient's DRG, then the hospital would suffer a financial loss for the care of that patient. Insurance companies, HMOs, and managed care organizations followed suit with prospective payment plans to hospitals for the individuals for whom they provided coverage.

This change to prospective reimbursement has caused hospitals to change the ways in which they operate. A hospital is in essence a business that must remain financially sound to remain a viable entity. If a hospital is to stay in business, it must be able to meet its costs with the revenue that it receives. Prospective payment plans have forced hospitals to closely examine their utilization rates and how well they manage the services that they provide. For example, hospitals are now very involved in discharge planning and the industry has seen much shorter hospital stays than under cost based reimbursement in an effort to control the cost of hospital admissions.

Cost has also changed the way the hospital industry is organized. Hospitals have organized into horizontal networks to achieve economies of scale and to increase their negotiating and contracting power with HMOs and managed care organizations. This has also allowed hospitals to achieve efficiencies in areas such as group purchasing and the elimination of redundancy to control costs. Hospitals have also sought to integrate into vertically organized structures providing everything from primary care in the ambulatory setting to tertiary care in the hospital setting so that they can remain competitive in the HMO and managed care environment.

There has also been a change in the services that many hospitals offer due to cost. Many hospitals have begun offering primary care services to make up for lost revenues from their traditional in-patient business. In addition, hospital emergency rooms have made changes in the services that they provide. Emergency room care is very expensive. However, many people visiting a hospital emergency room do not require the expensive services that an emergency room provides and insurance companies and other payers frequently refuse to pay for it. In response to this, hospitals have begun triaging emergency room visitors and have begun to offer ambulatory care services to those that do not require traditional emergency room care in an effort to reduce the hospital's cost.

Cost greatly influences the long-term care and mental health care settings as well. A variety of types of services characterizes both of these settings. Both long-term care and mental health care involve treating conditions that are often chronic and require lengthy treatment that is also very costly. A patient's access to care in these settings and the services available depend heavily upon who is paying and how much will be paid. For example, many elderly patients who do not have the personal wealth or insurance coverage to pay for nursing home care when needed often rely on family and friends. In effect, the cost of the patient's care has shifted to the family member or friend. This can be in the form of lost pay and productivity from taking time off from work to care for an elderly relative. It may also involve direct costs such as transporting an elderly relative to a doctor's appointment.

The delivery of health care in the U.S. has undergone major changes recently. Cost, access, and quality are key factors that have influenced these changes. The consensus of this discussion group is that cost is the most influential factor contributing to change in health care delivery in the U.S. However, leaders in the health care industry cannot focus on cost alone without careful attention to its interrelationship to access and quality. The challenge for future leaders will be to control costs while striking a balance with access and quality.