

The Evolution of Today's Health Care Economy

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Abstract: The health care economy has fluctuated in the last 30 years. One of the contributing factors has been the reimbursement schemes used by hospitals and physicians, which has had a considerable impact on the behavior and performance of the health care market. Unlike health care markets in other countries, the U.S. has a multi-payer system. These third-party payers include the federal, state, and local governments, commercial health insurance companies (HMO's) and self-pay patients. In the 1980's, because of the confusion, some hospitals established internal agencies to regulate their cash flow and to review capital expenditure requests. State agencies were established to promote and embrace the facilities' changes as they evolved into more business-like organizations. There are four stages in the health care revolution: The first stage was characterized by having power in the hands of the provider with the greatest number of assets. The second stage saw the birth of "competing" for market share. In the third stage, everyone was reconstructing. The final stage questions the quality of care and if the patient is receiving good value for their dollar and has evolved into hospital consolidation into corporate chains, which was a major revolution and made it difficult for administrators, who lost their autonomy.

Key words: DRG, Cost Reimbursement, Quality of Care, Capitation, Fee for Service, HMO, PPO,

INTRODUCTION

The Health System as an Industry: The health care economy has fluctuated in the last 30 years. State agencies were established to promote and embrace the facilities' changes as they evolved into more business-like organizations.

The Four Stages of Health Care Revolution (From Code Blue [1]): There are four stages in the health care revolution. The first stage, which occurred in the 1950's, was characterized by having the power in the hands of the provider with the greatest number of assets. The care was determined by the availability of hospital beds. The government was providing aid for hospital construction programs.

In the 1970's, the second stage began, the need was met, but it exceeded the demand; therefore we saw the birth of "competing" for market share. Empty beds equaled failure. Marketing the hospital was the new tool.

In the third stage, everyone was reconstructing, consolidating and downsizing, eliminating unprofitable programs.

The final stage of these years is based on quality of care. Several factors are motivating the new emphasis on the quality of care, including:

Physicians and hospitals included by their insurance providers.

Continuous quality improvement ideas.

Internet is now available for health information.

Hospital Captive Health Plans: The idea of having hospitals consolidating into corporate chains was a major revolution. Many administrators lost their

autonomy and lacked accountability. In the 1980's, with the introduction of the prospective payment system, the cost reimbursement, in some instances, encouraged resource waste.

In the 1990's, the health management organizations started talking about providing revenues vital to the survival of the hospital.

First Health Insurance in USA: The Birth of Blue Cross: The first insurance company in the United States was Blue Cross. Justin Ford Kimbalo formed this organization in the 1930's. He was a university administrator serving at Baylor University. Kimbalo started Blue Cross because he was concerned about the number of patients who were not paying their hospital bills. In the 1930's, most hospitals were non-profit corporations. These were run by charitable organizations. When the time came to select the payment method, they chose cost reimbursement. This decision cost consumers billions of dollars over the next several decades. With the introduction of cost reimbursement, there were no incentives to be efficient [1].

Prospective Payment: prospective payment system is when the insurance company negotiates a fixed price for a set of medical goods and services prior to the onset of the patient's illness. There is more incentive to control costs in a fixed price contract than there is under the cost reimbursement contract. There is more risk involved for the hospital and physician in a fixed reimbursement system than in a cost reimbursement system. Institutions are more careful when spending their own money. Under cost reimbursement, the hospital accumulates costs per patient day.

Cost Reimbursement: Introduction of cost reimbursement occurred in the 1970's. The payment was made according to the length of stay. Therefore, longer hospital stays increased hospital reimbursement. Hospitals were not concerned with how long the patient stayed in the hospital. Most health insurance companies assumed the role of intermediate. Cost reimbursement provided few incentives for cost control.

The First Health Maintenance Organization (HMO): The Capitation System: Eric Keiser formed the first HMO in the 1940's. He had a contract to build ships for the war effort. In order to recruit employees without violating wage control, he began offering his employees health benefits. His program used a prospective payment system called capitation [1]. A capitation payment system is when the health care provider receives a fixed amount per patient per month to provide specific services. The physician received this payment regardless of whether the patient received the services or not. It provided an incentive to keep the patient well. Capitation payment does not provide an incentive for the physician to over utilize products or services [1].

With the capitation payment, it was beneficial to the hospital and physician to keep patients well.

The physician can lose money by keeping the patient in the hospital. Physicians and hospitals are further encouraged to cut costs to receive bonuses from HMO's. A downside to this could be fraud and poor quality of care.

Hospitals and the HMO

- * Review of how the hospital can lose money under the capitation system [1]
- * Unnecessary hospital admissions
- * Unnecessary length of stay in the hospital
- * Treatment of the patient in an inpatient setting instead of an outpatient setting
- * Failure to keep patient well
- * Preventative care
- * Failure to prevent or reduce nosocomial infections
- * Failure to detect disease early enough to prevent hospitalization
- * Establishing that the premium covers the actual cost of the treatment
- * Failure to be properly informed about each HMO program
- * Incomplete comprehensive medical records.

How the HMO Works for the Physician: When a physician is hired by the HMO, the organization gives the physician's salary and bonus [1]. The physician and hospital could lose their bonus if they are not efficient with their resources. This is a strong incentive for the physician not to keep patients in the hospital long-term. Physicians in the medical association have recognized the flaws in the HMO system and have been lobbying for changes in health care. In the early 1980's the federal government abolished all HMO restricting laws. With this legislation, there was a growth of HMOs around the country, offering outstanding insurance plans.

How Physicians are Getting Paid: The Diagnostics Reimbursement Group (DRG) is a form of prospective payment under capitation. Under DRG reimbursement, there are fixed payments related to the specific

diagnosis. Until the introduction of DRG reimbursement, the national average stay in the hospital was approximately 13 days. When DRG reimbursement took effect, the national average dropped to 7 days. The DRG reimbursement dictates the patient's length of stay. If the patient gets sicker while in the hospital and has to stay longer, the hospital loses money. Often, the hospital will not be reimbursed for multiple admissions within 30 days of each other and with the same diagnosis.

Hospital Crisis: The New Way of Thinking: Before the HMO-DRG form of healthcare was introduced, 30% of hospital administrators lost their jobs [1]. Many could not adjust to an entire new set of rules. One of the most dramatic changes under capitation payment is thinking of an empty bed as a profitable bed. The hospital had to change the way they did business since DRG reimbursement changed the equation. Since the reimbursement for admission was fixed, the financial incentive was only to provide the service necessary to cure the patients, discharging them as quickly as possible. Capitation payment changed the way we thought of patients. The hospital made money by keeping patients out of the hospital; therefore, the emphasis focused on prevention. How does the hospital make money? Good contacts with the HMOs, localization and an emphasis on prevention.

CONCLUSION

The ability of HMOs to provide pre-certifications effectively controls utilization. They are able to dictate to the physician how to take care of the patient. The HMO, therefore, is making an effort to control quality. How can we improve the physician's decision? We do not know the answer. We believe that the level of power that the HMO's exhibit is creating a state of panic in the health care industry. Instead of achieving a better quality of care, they are pushing physicians to see more patients to increase their revenue, since the payment for single patients is now "miserable". The hospitals have the same problem and are being forced to lay off employees. There are nurses who now take care of 12 patients instead of 6-8. If this system is not adjusted, a lower quality of care will result. The industry is functioning more from a cost containment perspective. In order to stay profitable, management is focusing on seeing more patients per hour, and at the same time, doing so with fewer nurses. Is this what we are looking for in health care? Is this what we are looking forward to when we retire and need health care? We are very worried!! There are fewer students enrolling in medical school. This is probably due to lack of passion because it is not worth it to make a salary comparable to a mid to lower level manager with only four years of college.

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