CHAPTER II

LITERATURE REVIEW

The goal of health care cost management is to restrain costs without reducing the quality of care. Health care costs have risen as a result of the changing demographics of workers (for example, the ageing population and increasing number of women workers), the labour intensive nature of health care services and the introduction of new technology. Available data suggest that there are at least three areas of inefficiency in the present health care system. These are the use of procedures and treatments for unprove or marginal indicators, treatment at a level greater than medically indicated and redundancy in the process of health care itself.

Chang (1997) looked at the issue of costs from the point of view of supply and demand.

<u>Supply</u>

These include the doctors, hospitals, pharmacies, laboratories and others. They have incentives to increase services and do more than necessary. For example doctors may practice defensive medicine, thus performing more procedures and tests than is clinically required. Doctors may make more referrals, for example to hospitals and laboratories, especially if they have financial interests in these businesses.

Another factor is the rapid development of new technology. Unlike other commercial products, however, its application is not always clear and controversy over its appropriate use is common. Thus far, technology is seen as the culprit that drives up costs. In business, innovation is the driver to continuous

quality improvement and cost reduction. But in medical practice, prices remain high even when they are widely used and in the face of excess capacity.

Free market rules do not work in health care. In a competitive market, the producers' desire to create more demand are counter-balanced by buyers who purchase only what they need. Demand should fall when price increases or quality at a given price decreases. Because of the lack of information, consumers are uncertain about the need for treatment, the quality of desired service and the outcome of such service. Hence doctors are able to increase the volume of services simply by recommending them, even if the additional services do not lower price or improve quality. This tendency for supply to create demand is demonstrated by the fact that demand for doctors' services increased in areas where there are more doctors (Belk, Harris and Wood, 1991).

Demand

This includes patients and companies buying medical insurance. Consumers lack information and so cannot pressurise providers to improve quality and reduce cost. They actually continue to use the services of providers that have poor outcomes and elevated costs. In many cases, it is the consumer's one-time purchase and therefore he or she cannot make any comparison. The consumer thus has to listen to the expert opinion of the doctors. In this country, advertisement by doctors is not permitted. Hence information is even less available.

In his paper, Tanner (1997) stated that patients are not price sensitive. This is compounded by third party payments. Such consumers have little incentive to control costs and every incentive to demand more services. In addition, health insurance benefits have been based on the expenditures for health care services rather than on the actual loss due to a particular illness.

As a result, health insurance lowers the retail price of medical services for the patients and thus increase their demand for health care services. This is known as "moral hazard". Custer (1990) suggested that the increased demand for health services due to moral hazard is one of the sources of health care cost inflation.

The key word in the mind of management is value. Did the company get value for the cost spent on health care? Chassin (1987) showed that 20% - 40% of medical procedures were either inappropriate or of questionable value on clinical effectiveness.

Most consumers are not aware that their inefficient use of medical services has impact on a larger segment of the population. Burton, Hoy and Stephens (1991) used the Parieto Principle to model the utilisation of health care. This means that resources are not consumed in an evenly manner but where a small proportion of high utilisers are responsible for disproportionate consumption.

Cost Management Strategies

There are three broad strategies that could retard the growth of health care costs (Custer, 1990). They are:

1. Cost Sharing

This provides patients with incentives to weigh the costs and benefits of a procedure. It reduces the incentive for moral hazard and forces the patients to assume some of the risks of the efficacy of treatment. It gives incentives to the patients to shop for the most cost-effective provider.

Patients are urged to be involved in the decision-making process with regard to their own health. To achieve this, patients must be kept fully informed through health promotion. Greenfield, Kaplan, Ware (1988) showed that consumers perceived involvement in decision-making as significantly correlated with the level of satisfaction and functional outcome.

Providers, whether they are insurers, HMOs or the company itself, generally adopt the following means to reduce health care costs (Greenfield et. al., 1988):

Contribution rates: These are paid by employees to the health insurance schemes for themselves and their dependants. This shifts some of the costs of health care from employers to employees.

Deductibles: These are fixed amounts paid by employees before the insurance company incurs expenses. This serves to reduce the amount of small claims.

Co-insurance: This is the proportion of reimbursement that is required to be paid by the employee.

Stop Losses: Most insurance policies have limits called "stop losses", after which co-payments no longer apply. This is designed to protect patients from catastrophic losses.

2. Utilisation Review

Medical care utilisation varies widely even among populations that appear to be similar to each other. This degree of variability depends on the clinical procedure being performed. For example, the variability in the treatment of a bone fracture is minimal. But for the treatment of back pain and prostate cancer, the variability is great. Using utilisation management, costs can be controlled by tracking where medical services are used inappropriately and inefficiently.

3. Packaging Provider Services

Insurance companies offer packages that cover surgical and hospitalisation costs. Other providers in the form of Health Maintenance Organisations (HMO) and Preferred Provider Organisation (PPO) are now available.

Health Maintenance Organisations (HMO)

This is another health benefit option. Individuals are enrolled in the plan, and in return, the plan is responsible for providing the needed services through an organised system of providers affiliated with the plan. These services are financed by a prepaid periodic payment per member that is fixed in advanced. The service providers may be compensated by capitation rather than fee-for-service. The latter is the standard mode of payment in this country. Capitation is new here. In this form of payment, doctors are given a lump sum based on the number of patients who had enrolled with them.

Unlike insurance coverage where the responsibility is restricted to paying contracted amounts for any covered care received, HMOs are also responsible for providing or arranging for all medically necessary care included in the benefit package. Another difference is the provision of preventive services. Early identification of treatable illnesses and reduction of risk factors can help reduce the costs of preventable conditions. Besides well-known medical problems like diabetes, hypertension and heart diseases, three other classes of preventable health problems, namely, mental health, substance abuse and dental health, are often ignored.

The controversy is deciding what preventive services should be incorporated into the benefit plan. Except for immunisations and prenatal care, there are no definitive cost/benefit studies.

Preferred Provider Organisation (PPO)

These are similar to the panel of doctors system used in this country. The difference is that the providers are selected on the basis of their cost-effective practice and they agree to discount their fees within the PPO.

Clinical Practice Guidelines

Economist, Kenneth Arrow (1963), suggested that the economic problem of medical care is due to uncertainty. The uncertainty in treatment effectiveness means that it is difficult to make a correct diagnosis given a set of symptoms, that once the correct diagnosis is made a given procedure may produce different outcomes for people with the same diagnosis.

Because medical practices for similar conditions vary widely, professionally derived recommendations for practices and patterns of prevention, diagnosis and treatment are drawn up. It was the opinion of Harris (1997) that this would serve to optimize the quality of patient care, to improve the efficiency, effectiveness and appropriateness of medical care and also to aid defense against malpractice.

Practice guidelines are specific, standardized and structured approaches to medical care, which can improve both quality and value of the medical care provided. To formulate the guidelines, clinical research literature is first reviewed. Then expert clinical opinion is added to whatever research data are available to produce the useful guidelines.

Practice guidelines are specific recommendations that should or should not be undertaken in specific clinical circumstances. It indicates whether it is appropriate to perform a surgical procedure or a diagnostic test or to make a particular prescription.