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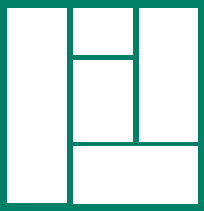

THE FUTURE OF THE PUBLIC SECTOR

A series on the long-term forces affecting U.S. social policy

Health Care Quality: At What Cost?

Len M. Nichols

After Congress rejected universal health insurance coverage in 1994, much of the nation's health policy attention has turned to quality assurance. The hundreds of specific clinical requirements for health plans introduced by state legislatures and Congress reflect widespread concern that too much access and service quality is being sacrificed for cost containment in the private sector. At the same time, some policymakers are demanding that our largest public programs, Medicare and Medicaid, emulate recent private sector cost savings, the very ones that have sparked the current concern over quality. Therefore two key health policy challenges for the future will be maintaining a high level of quality as we contain costs in public programs, and striking the right policy balance in monitoring and regulating the quality of health care in the private sector.

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After ten years of double-digit health insurance premium inflation in the 1980s, the current decade has seen a steady decline in the rate of private premium growth. A leading private consulting firm estimates that premiums for employer-sponsored insurance increased only about 0.5 percent in 1996, and total national health spending grew at only 4.4 percent, the smallest rate of growth since 1960. Slower national health care cost growth means that we have more resources available for other desirable uses. These cost containment successes are widely attributed to the spread of managed care.

Yet, some consumers and policymakers have come to fear the techniques that managed care health plans use to contain costs, such as limiting access to specific providers and services and creating incentives for providers to curtail access to care. These techniques can reduce costs but also risk reducing actual or perceived quality of care. The legislative proposals and the recent presidential commission on quality in health care are responses to this perceived risk.

Containing Government Costs

Governments directly purchase health care for almost 27 percent of Americans through Medicare (a federal program for the elderly and disabled) and Medicaid (a joint federal-state program for the poor). On behalf of these public program beneficiaries, the public sector directly pays for almost 40 percent of all health services delivered in this country—and the public share of health care finance is even higher if we count tax subsidies for private employment-related insurance. These coverage and cost percentages make clear that the elderly and the poor are indeed less healthy than the rest of us. No one disputes that cost growth must be curtailed in these large public programs. Combined, they now represent over $350 billion of government spending each year.

Table 1 shows these programs' historical growth in enrollment and expenditures (both programs began in 1965). In the 1980s

Medicare costs grew in real terms at more than 7 percent a year, and Medicaid costs at about 6 percent a year—historical growth rates that were clearly unsustainable. Spending growth has slowed somewhat, down to a real 6.3 percent for Medicare and 4.5 percent for Medicaid in 1995–1996, but is still faster than real GDP growth of 2.8 percent. Recent spending growth reductions in Medicare are largely due to fee-for-service payment reforms, while Medicaid's successes mostly reflect the end of enrollment expansions and the exhaustion of "Medicaid maximization" strategies, whereby many states substitute federal for state health care dollars.

The 1997 Balanced Budget Act achieved some Medicare savings and, to a much lesser extent, reduced Medicaid spending, but the budget agreement did little to address the long-run demographic problems that threaten the adequacy of Medicare funding: the decline in our worker/beneficiary ratio from the current 3:1 to 2:1 by the time the last baby boomers are retired. As a result, many inside and outside of Congress are proposing long-term structural changes to both programs that will institutionalize cost containment incentives. Managed care and the increased health plan competition that managed care makes possible are both central to these structural proposals.

A More Competitive Environment

The recent revolution in delivery patterns (less inpatient and more ambulatory care), spurred in part by 1980s Medicare payment reforms and lately by the demands of employers in the private sector, has created an excess supply of hospital beds and physicians. These developments have forced many health providers into price competition for the first time. Table 2 presents some indicators of these changing delivery patterns. With declines in hospital admission rates and average lengths of stay, average hospital occupancy rates are now below 63 percent, and recent estimates of the physician surplus suggest that we now need about 30 percent fewer physicians than we graduate each year. Price competition is inevitable in this environment, even in health care markets that have successfully resisted price competition in the past.

Provider price competition has many virtues, which managed health care plans, large self-insured employers, large and small employer coalitions, and some state governments have been quick to exploit. The provider price competition spawned by excess capacity is largely responsible for the slowdown in private sector premiums, and the lower premiums that managed care plans can offer are largely responsible for their increasing share of the health insurance market.

The downside of health care provider price competition is less obvious.

Table 1
Medicare and Medicaid Growth

	Enrollment		Expenditures	
	Medicare	Medicaid	Medicare	Medicaid
1965	0	0	$0	$0
1975	21.8 million	22 million	$42.9 billion	$35.4 billion
1985	27.1 million	21.8 million	$101.2 billion	$57.8 billion
1996	38.1 million	41.7 million	$203.1 billion	$147.6 billion

Source: Health Care Financing Administration, inflation-adjusted 1996 dollars.

Subsidizing Care for the Uninsured

Traditionally, acute hospital care for the uninsured has been financed through implicit cross-subsidies. That is, hospitals would charge paying (i.e., insured) patients more than the average cost of serving them, and the surplus thus extracted was used to finance care for the uninsured. This cross-subsidy was facilitated by the preponderance of nonprofit (and public) hospitals that could not, by law, distribute any surplus they might earn to stockholders, but instead were expected to "spend" any surplus in ways that benefited their communities at large.

A recent study reports that uncompensated hospital care has averaged about 6 percent of total hospital expenses each year since 1984. That figure masks the fact that a disproportionate share of uncompensated care is provided by hospitals (especially public teaching hospitals) that serve large percentages of Medicaid patients. Uncompensated care as a percentage of expenses approaches 20 percent for some major public teaching hospitals. This level of charity care requires direct subsidies or a significant markup on charges to insured patients. A more competitive market for insured patients will reduce hospitals' flexibility to charge more than true costs to any patients, private or public. This will be especially true as public programs move away from their rigid, formula-based payment methods and use competitive bidding with providers and managed care plans.

As public payors such as the Medicaid and Medicare programs adopt the cost control devices and techniques (managed care and competitive bidding) used by the private sector, the traditional, hidden sources of financing care for the uninsured will dry up. This scenario will force a policy choice between developing new and explicit funding sources to finance uncompensated care, expanding coverage to the uninsured through new government subsidy programs, and further restricting care for the uninsured. This choice will become more salient if the number of uninsured continues to grow as it has recently, from 34.7 million in 1990 to 41.7 million in 1996. The changing delivery patterns described in table 2 make this problem harder, not easier, because ambulatory care, especially physician care, for the uninsured has always been more difficult to finance with implicit cross-subsidies than has acute hospital care.

Clarifying Quality-Cost Tradeoffs

What happens to quality with all this emphasis on costs and competitive health markets? State governments have always played a major role in setting quality standards for health care through licensing and certification requirements for health professionals, insurers, and managed care plans. As evidenced by state and federal legislative interest in imposing specific clinical requirements on health plans (e.g., specific lengths of hospital stays after childbirth or certain surgeries), the boundaries of allowable private sector tradeoffs between cost and quality are now being redrawn.

A real danger, however, is that well-intentioned legislators may overreact to heightened concern about quality in managed care plans and dictate clinical rules that stifle managed care plans' ability to reduce costs while maintaining or even enhancing the quality of care. Fee-for-service medicine and indemnity health plans were never held to the standards now being discussed for managed care. For example, many health insurance purchasers have begun requiring health plans to report health outcome measures and the results of patient satisfaction surveys. A few buyers even make this information available to consumers so they can make informed choices about which plan to select. The general policy goal is to make quality-cost tradeoffs clear, not to force "one quality fits all" medicine, for that one quality level may be either more than some people can afford or less than what some people are willing to pay for.

The Limits of Quality Measures

The success of competitive market approaches to health policy ultimately rests on informed consumer choice. But consumers' use and understanding of quality measures may differ from those of employers who select most plans for their employees and from those of health professionals who actually know what our measures mean and don't mean. How consumers use quality measures will surely evolve as the use and dissemination of such measures by health plans and organized purchasers change over time.

A focus on quality and quality reporting is positive, but the pressure on managed care plans to "do well" on measurable outcomes may skew provider resources away from those dimensions of quality that are harder to measure but may be equally or more important to the average plan enrollee (e.g., discomfort during recovery). This "quality information" dimension of competitive health plan markets is still in its infancy. Consumers, legislators, employers, and public sector program managers need to remember this before demanding too much too soon, or believing they have received more predictive information than is actually possible to produce at the present time.

Another problem with relying too heavily on quality measures is that public health program beneficiaries such as the elderly and the low-income population may have criteria for quality care that differ from those of the employed nonelderly population, and may process and use available information in different ways. For example, the elderly may care more about comfort and may not want to sort through complicated comparison reports.

* * * * *

Although Medicare and Medicaid may benefit from the recent lessons learned in private health care markets, there are three reasons they cannot behave exactly like private employers or employer coalitions do when purchasing health insurance. First, public programs must serve all eligible beneficiaries, not just some. Medicare and Medicaid cannot segment themselves away from the sickest beneficiaries, as private insurance plans and employers often do. Thus, government programs do not have the same paths to cost reduction used by the private sector, some of which involve merely shifting costs to government. Second, public payors must be mindful of the effects that aggressive purchasing power can have. Urban public teaching hospitals provide vital services for economically disadvantaged populations. As competition forces these hospitals to reduce prices for paying patients, it also drains their traditional financing streams. When this happens, other public funding for these services must be found or the consequences of care rationing will become increasingly apparent, both in suburban emergency rooms and in the local media.

Finally, public program beneficiaries may need a more active ombudsperson as their purchasing agent than do the employed nonelderly who are making choices among managed care plans in an employer-sponsored setting. The principles of informed competition still apply to public health care programs, but policymakers who set the rules of that competition for public dollars should keep in mind the specific needs of these beneficiaries.

Table 2
Changing Delivery Patterns

	1975	1980	1985	1994
Hospital admissions per 1,000	156	—	141	118
Hospital occupancy rate	74.8%	—	64.8%	62.9%
Hospital outpatient visits per 1,000	911	—	936	1,478
Physician contacts per person	—	4.8	—	6.1
Population per physician	741	—	555	483

Sources: American Hospital Association, National Center for Health Statistics, and American Medical Association.

Related Reading

Levit, Katharine R., Helen C. Lazenby, Bradley R. Braden, and the National Health Accounts Team. 1998. "National Health Spending Trends in 1996." *Health Affairs*, vol. 17, no. 1 (Jan.-Feb.).

Mann, Joyce M., Glenn A. Melnick, Anil Bamezai, and Jack Zwanziger. 1997. "A Profile of Uncompensated Hospital Care, 1983–1995." *Health Affairs*, vol. 16, no. 4 (July-Aug.).

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