

HS 100: Lab 2

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Sonya Gabrielian

Agenda

- ◆ Historical Perspective
- ◆ Healthcare Finance
- ◆ The Uninsured in California
- ◆ Andersen's Behavioral Model
- ◆ Group Exercises

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- ◆ Historical Perspective

Historical Perspective: 1960s

- ◆ Increased Access to Care
 - ◆ Medicare enacted to cover the elderly
 - ◆ Medicaid enacted to cover underserved
- ◆ Increased Capacity
 - ◆ For-profit companies used capital to facilitate growth of facilities

Historical Perspective: 1970s

- ◆ Continued increase in capacity
 - ◆ Medicare and Medicaid FFS reimbursement fuels growth
- ◆ Costs increase beyond average cost of inflation
- ◆ Growing sentiment about the staggering amount of GDP that goes to healthcare

Historical Perspective: 1980s

- ◆ Continued skyrocketing cost of healthcare
- ◆ Managed care introduced
- ◆ Capitated reimbursement arrives

Historical Perspective: 1990s

- ◆ Power falls into the hands of insurers/payors
 - ◆ Control patient referrals
 - ◆ Demand fees below costs
- ◆ Financial risk transference
 - ◆ Capitation
- ◆ Physician income drops
- ◆ Empowered consumer
- ◆ Hospital Closures

Now and in the Future...

- ◆ Retribution against HMOs and managed care
 - ◆ Patient Bill of Rights
- ◆ Hospital providers fighting back by canceling contracts
- ◆ Medical information continues to be disseminated quickly over the Internet

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Health Care Costs

- ◆ Expenditures vs. Costs
 - ◆ Expenditures: How much is spent
 - ◆ Costs: Apply to the production process
 - ◆ Accounting definition: value of resources used in production
 - ◆ Labor
 - ◆ Materials
 - ◆ Capital
 - ◆ Economic definition: value of resources expended + normal return on investment
- ◆ So what do we use in analysis?
 - ◆ Difficult to obtain cost data

Sources of Data

- ◆ CMMS (formerly HCFA)
- ◆ Medicaid: by states
- ◆ Hospital: AHA
- ◆ Out of pocket
 - ◆ Consumer expenditure surveys
 - ◆ Nursing home surveys
 - ◆ Home health care
 - ◆ AMA, ADA

Measuring Health Care Prices

Consumer Price Index (CPI)

- ◆ Bureau of Labor Statistics
 - ◆ Weighted market basket of goods and services
 - ◆ % spent on food, apparel, housing, energy, medical care
 - ◆ Weighted based on relative importance in spending patterns
 - ◆ Measures changes in prices
 - ◆ Monthly price data: 80% of US localities
 - ◆ Changes in price compared to base period ('82-4)

CPI: Medical Care Component

◆ Services

◆ Professional Medical

- ◆ Physicians
- ◆ Dental
- ◆ Eye care
- ◆ Other med profs.

◆ Hospital

- ◆ Inpatient hospital
- ◆ Outpatient hospital
- ◆ Nursing home

◆ Commodities

- ◆ Prescription drugs
- ◆ Nonprescription drugs & medical supplies
- ◆ Internal and respiratory OTC drugs
- ◆ Nonprescription medical equipment & supplies

- ◆ NOTE: CPI does NOT include premiums or government paid health care

CPI: Important Limitations

- ◆ Measures changes in price, NOT expenditures
- ◆ Measures change in prices, NOT prices actually paid
- ◆ Measures changes in prices for FIXED market basket
 - ◆ Does not account for quality improvements and changes in consumption patterns
- ◆ Measures changes on the consumer side, not employer and government payments

U.S. Health Spending: Why is it so high?

- ◆ Physicians paid more
 - ◆ Average of 2-3X higher than other developed countries
- ◆ Hospital day is more expensive
 - ◆ ALOS much less than other countries
 - ◆ Higher intensity of care, thus higher costs
- ◆ Rapid diffusion of technology
- ◆ Fewer cost control mechanisms

U.S. Health Spending Summary

- ◆ 1999: \$1.2 trillion spent
 - ◆ Private share grew, offsetting slower Medicare growth
- ◆ Slow expenditure growth in early 1990s
 - ◆ Managed care: a "one-time" benefit?
 - ◆ Medicare anti-fraud/abuse efforts
 - ◆ BBA provisions
- ◆ Now, expenditures are rising

Causes of Expenditure Growth

- ◆ Function of both "price" and "non-price" factors
 - ◆ Price: medical inflation > general inflation
 - ◆ Non-price:
 - ◆ Utilization
 - ◆ Aging population
 - ◆ Technology
 - ◆ Service mix = (severe cases) / (non-severe cases)

Recent Expenditure Growth

- ◆ As nations become wealthier, consumers demand that they spend more on healthcare
- ◆ Healthcare consumers know more and expect more
- ◆ Managed care backlash
 - ◆ Fewer restrictions
- ◆ Tight labor market
- ◆ Future projections??

Where the \$\$ Comes From

- ◆ Private funds
 - ◆ Private health insurance
 - ◆ Out-of-pocket payments
- ◆ Government
 - ◆ Medicaid
 - ◆ Medicare

Where the \$\$ Goes (1999 figures)

- ◆ Hospitals
 - ◆ \$391 billion
- ◆ Nursing Homes
 - ◆ \$90 billion
- ◆ Physicians
 - ◆ \$270 billion
- ◆ Prescription Drugs
 - ◆ \$100 billion
- ◆ Home Health
 - ◆ \$33 billion

The Future...

- ◆ Factors within health care
 - ◆ Genomics
 - ◆ Technology
 - ◆ Systemic change
- ◆ Factors outside health care
 - ◆ Federal budget
 - ◆ Competing priorities (Defense, bioterrorism, etc.)
- ◆ Facilities must:
 - ◆ Balance social mission and business operations
 - ◆ Maximize efficiency and equality

Survival of the Fittest

- ◆ Winners and Losers
- ◆ Consolidations/Mergers
- ◆ Excess Capacity will be Eliminated
- ◆ Some Markets will be Abandoned
- ◆ Closures/Reduced Services often bring community outrage, organized labor challenges
- ◆ Price and quality considerations BOTH become important
- ◆ Freestanding organizations are "at risk"

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The Uninsured in California

- ◆ 6.8 million uninsured in CA in 1999
 - ◆ 5 million are adults
 - ◆ 685,000 eligible for Medi-Cal, but not enrolled
 - ◆ 1.1 million undocumented immigrant adults not eligible for Medi-Cal or Healthy Families

Who are the uninsured?

- ◆ In 1999:
 - ◆ 8 in 10 uninsured persons came from working families
 - ◆ 71% from families with one or more full-time worker(s)
 - ◆ 12% from families with part-time workers

Without insurance...

- ◆ Patients:
 - ◆ Postpone or forgo healthcare
 - ◆ Are unable to afford prescriptions or recommended additional treatments
 - ◆ Anticipate high bills
 - ◆ Do not receive appropriate preventive screenings

Finding the Solution

- ◆ How does lack of insurance affect access to healthcare?
- ◆ Ideas for system-wide improvement or change?
- ◆ What is the ideal healthcare system?

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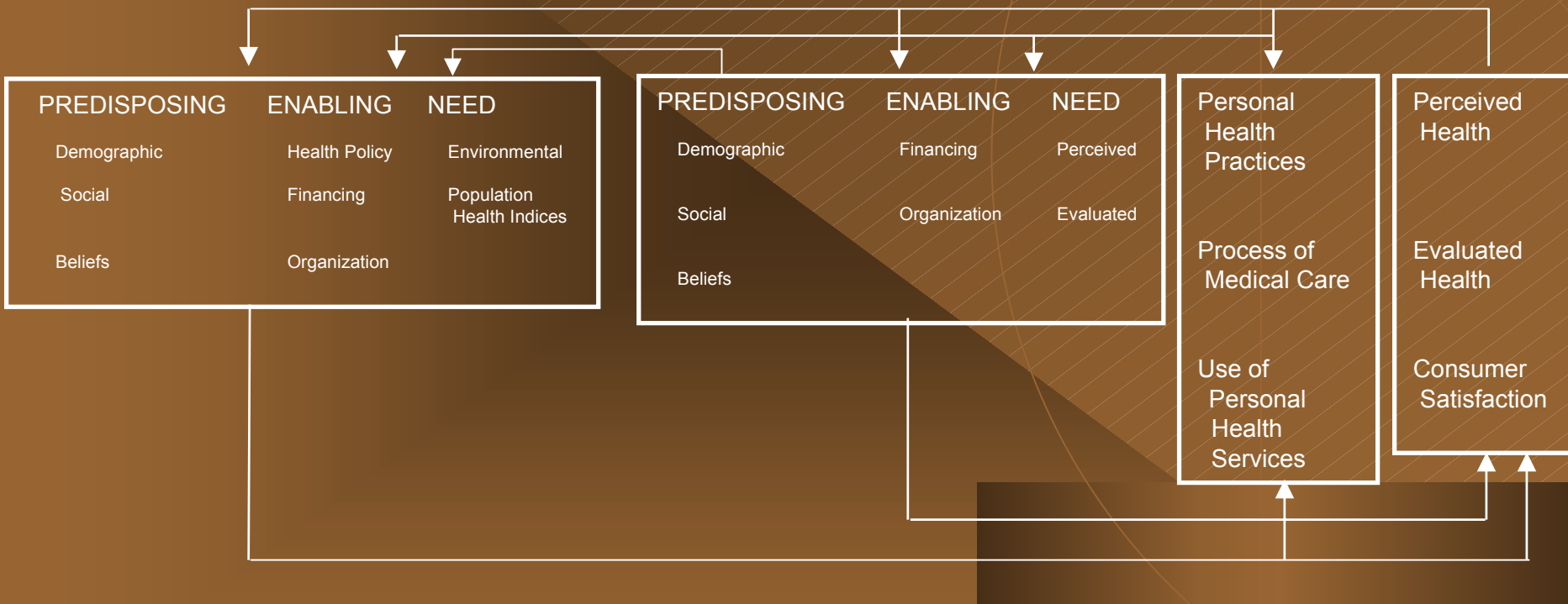
A Behavioral Model of Health Services Use Stressing Contextual as well as Individual Characteristics

Contextual Characteristics

Individual Characteristics

Behaviors

Outcomes



Andersen's Behavioral Model

- ◆ A tool to assess and study healthcare access
- ◆ Access:
 - ◆ Realized use of health services
 - ◆ Includes inhibitors and facilitators of health service utilization
 - ◆ Bridge between healthcare systems and their target populations
 - ◆ Promotes social justice and health outcomes

Andersen's Behavioral Model

- ◆ Contextual characteristics:
 - ◆ The circumstances and environment of healthcare access
- ◆ Individual characteristics:
 - ◆ The individual circumstances affecting healthcare access
- ◆ Health behaviors and outcomes:
 - ◆ Affected by and contribute feedback to Contextual and Individual characteristics

Types of Access

- ◆ Potential: enabling factor
 - ◆ Insurance
- ◆ Realized: use of services
 - ◆ Physician visits
- ◆ Equitable: what is fair
 - ◆ Traditionally defined by demographic and need variables

Types of Access

- ◆ Inequitable
 - ◆ Occurs when social characteristics and enabling resources determine who gets medical care
- ◆ Effective
 - ◆ Timely use of personal health services to achieve the best possible health outcome
- ◆ Efficient
 - ◆ Most value for money spent

How models are used

- ◆ Pick a “variable of interest”
 - ◆ race/ethnicity
 - ◆ insurance status
- ◆ Compare use of health care, health status, outcomes or cost
- ◆ Identify problem, recommend solutions

Models in Policy & Management

- ◆ Policy—Determine Equity of Health Care
 - ◆ By race, ethnicity, disability, state or county, enabling factors
- ◆ Management—Define market population for underwriting/rating purposes
 - ◆ Relative use of health care given by demographics, enabling characteristics, health organizations in area

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Group Activity: Scenario 1

- ◆ Take two "average" individuals, a physician from the Westside and garment worker in Pacoima. Use the Andersen Model to show how contextual and individual characteristics impact health behaviors and outcomes.
 - ◆ List three indicators and explain why they would be good measures of equitable access

Group Activity: Scenario 2

- ◆ Take a Medicaid-enrolled infant living in Venice.
- ◆ Use the Andersen Model to identify one individual characteristic in each of the following categories:
 - ◆ Predisposing
 - ◆ Enabling
 - ◆ Need.
 - ◆ Describe how each affects health care use.

Group Activity: Scenario 3

- ◆ Identify a community with which you are familiar.
- ◆ Using the Andersen Model, describe typical health care access and use in this community in terms of:
 - ◆ 2 contextual characteristics
 - ◆ 1 health behavior