PCH 358 – Structure of the health care "system"

Ellen Andrews, PhD
SCSU
Spring 2018

It's no use carrying an umbrella, if your shoes are leaking.

-- Irish saying

health care critical to CT's economy

- 14.4% of CT's economy goes to health care
  - One of every seven dollars
- $35.4 billion in 2014
  - $9,859 avg per resident
- One out of six CT workers is employed in health care services/social assistance

health care is expensive in CT

- Health care spending per person in CT is 23% higher than US
  - Gap is closing, CT rising slower than US avg
- From 2001 to 2011, total CT family premiums rose 85% while household incomes rose only 23%

Not getting what we pay for

- Only 48% of CT adults over age 50 receive recommended screenings and preventive care
- 17% of CT residents with asthma visit the ER annually
- 11% of CT hospitalizations, costing $1.2 billion each year, could be prevented with better access to adequate primary care

How health care is organized

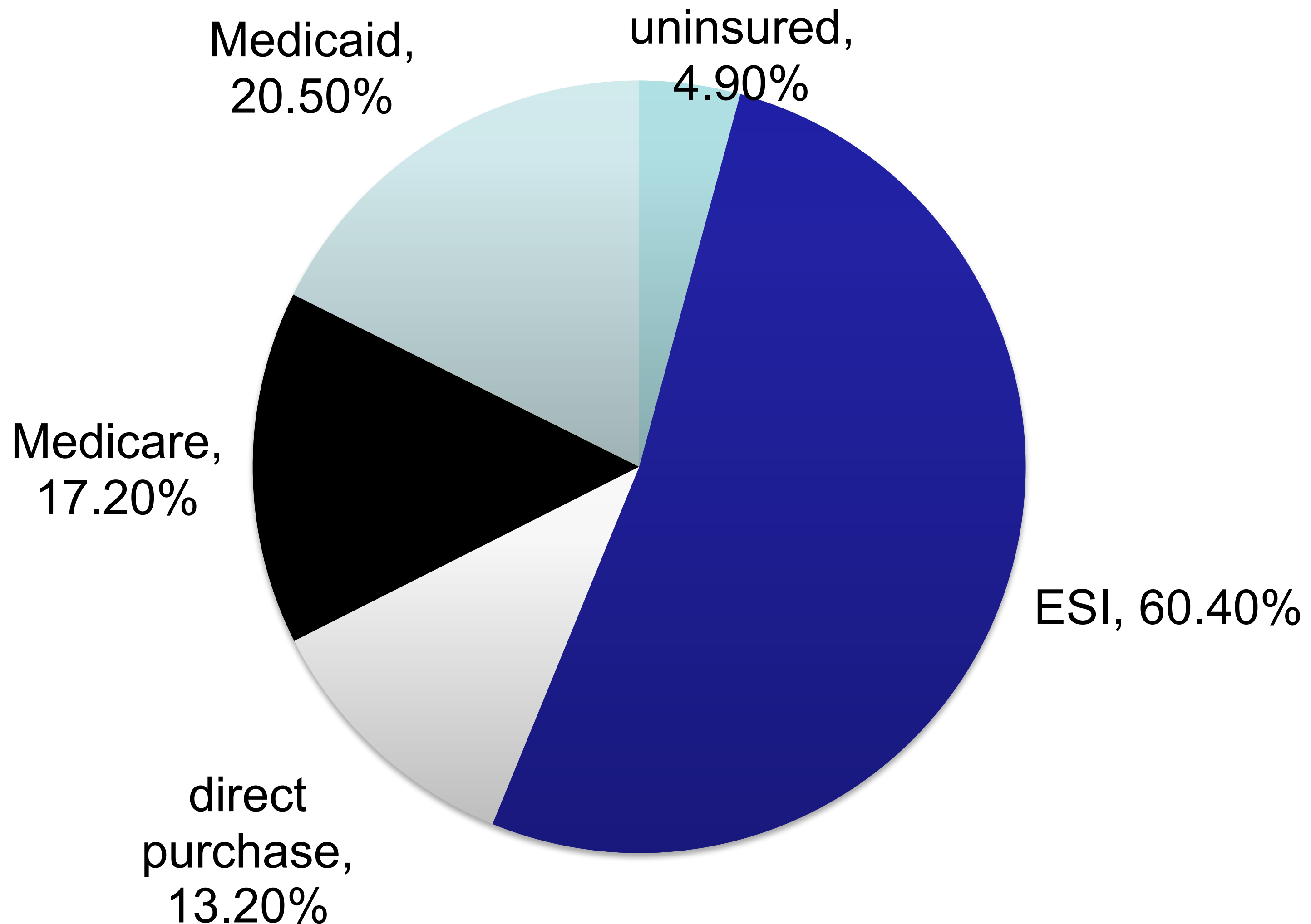
- Primary care - $
  - First stop for patients, 80 – 90% of health care visits
  - Common health problems, prevention
  - Should be permanent connection between patient & provider
- Secondary care -- $$$
  - Require more specialized clinical expertise
  - E.g. Hospital stay for renal failure
- Tertiary care -- $$$$$$$
  - Management of rare and complex disorders
  - E.g. pituitary tumors, congenital malformations
- No formal structure of movement through the levels in US
  - Patients can self-refer to specialists, skipping primary care
  - Leads to fragmentation, costly overtreatment

How patients move through the system

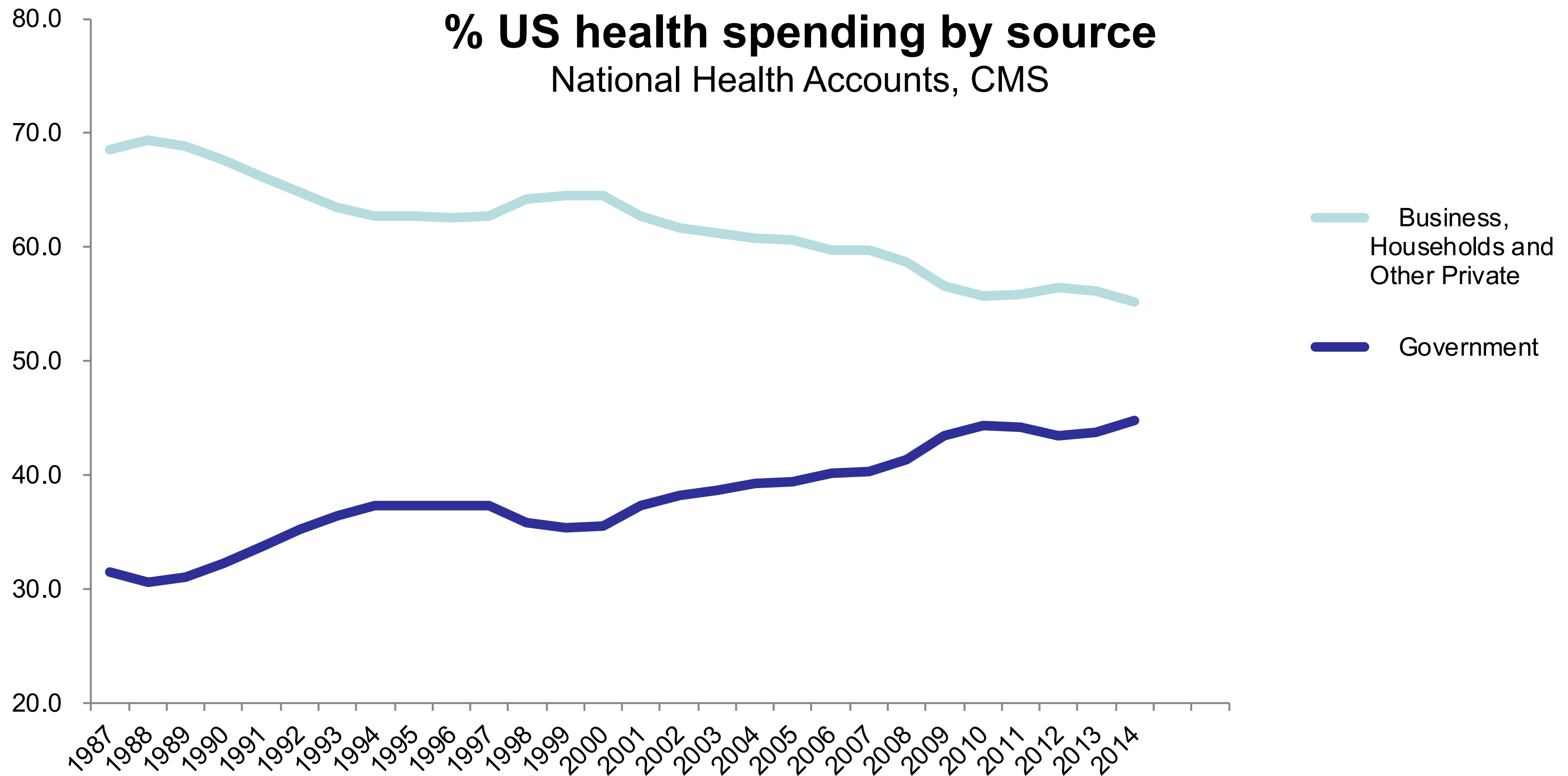
- Depends where you start
- Great variations in access, quality
- Varies by income, educational level, payer, geography, race/ethnicity
- Family support critical
- Self-advocacy skills
- Patient characteristics
  - Difficult patients – 15% -- often undiagnosed mental health issues
- LUCK

Insurance status

% CT residents, 2016 (US Census)



Shift to public programs



Providers

- Great variations in income, prestige, autonomy
- Great variation in educational requirements
  - Debt loads driving practice decisions
  - Can’t work your way up, have to go back to school
  - Concerns about supports to move up the ladder
- Quality of life, workplace issues
- Trend toward team-based care
- Trend toward data and evidence-based medicine
  - Less art, more science
- Accountability -- must justify value of care at their level
- Mid-level providers, community health workers

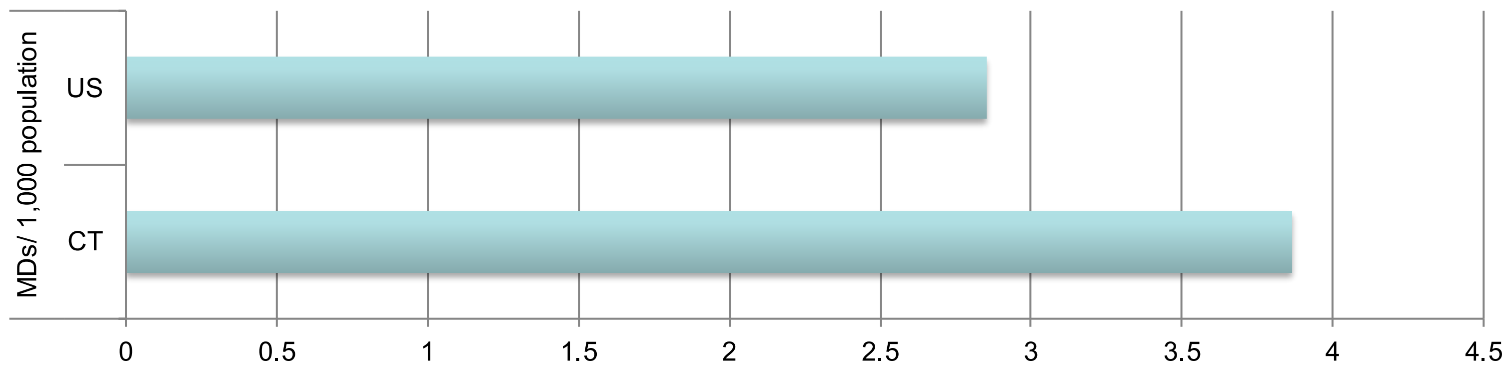
CT providers of care

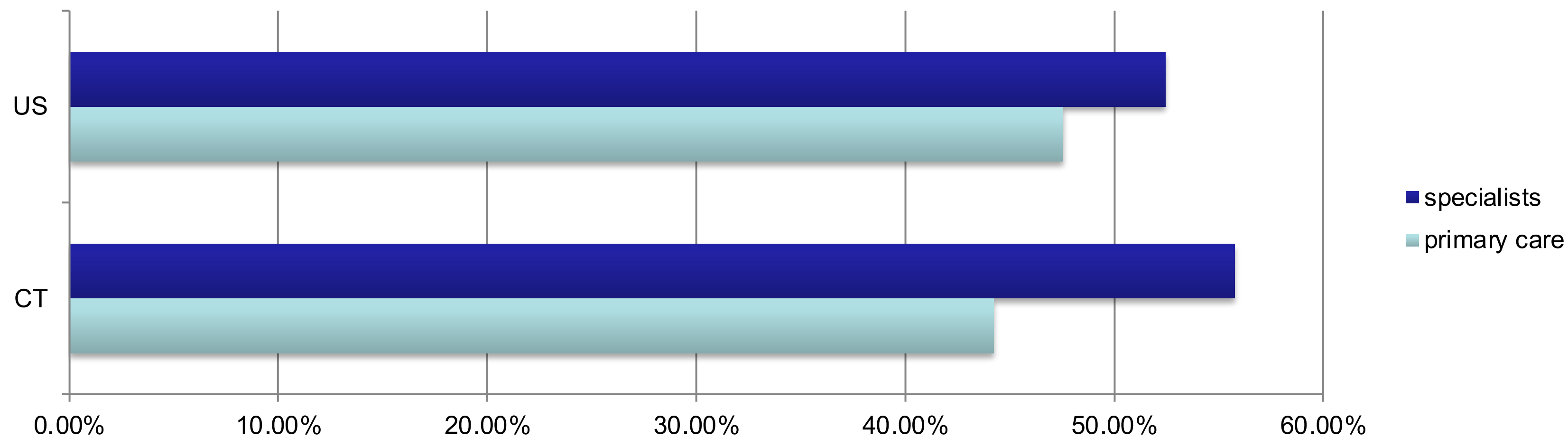
- 36,320 nurses
- 13,703 MDs actively practicing
- 1,692 physician assistants
- 3,424 nurse practitioners
- 28 acute care hospitals
- 237 certified nursing facilities
- 13 FQHCs with 152 sites
- 7 licensed free clinic sites
  - One mobile van
  - Four run by AmeriCares

CT provider dynamics

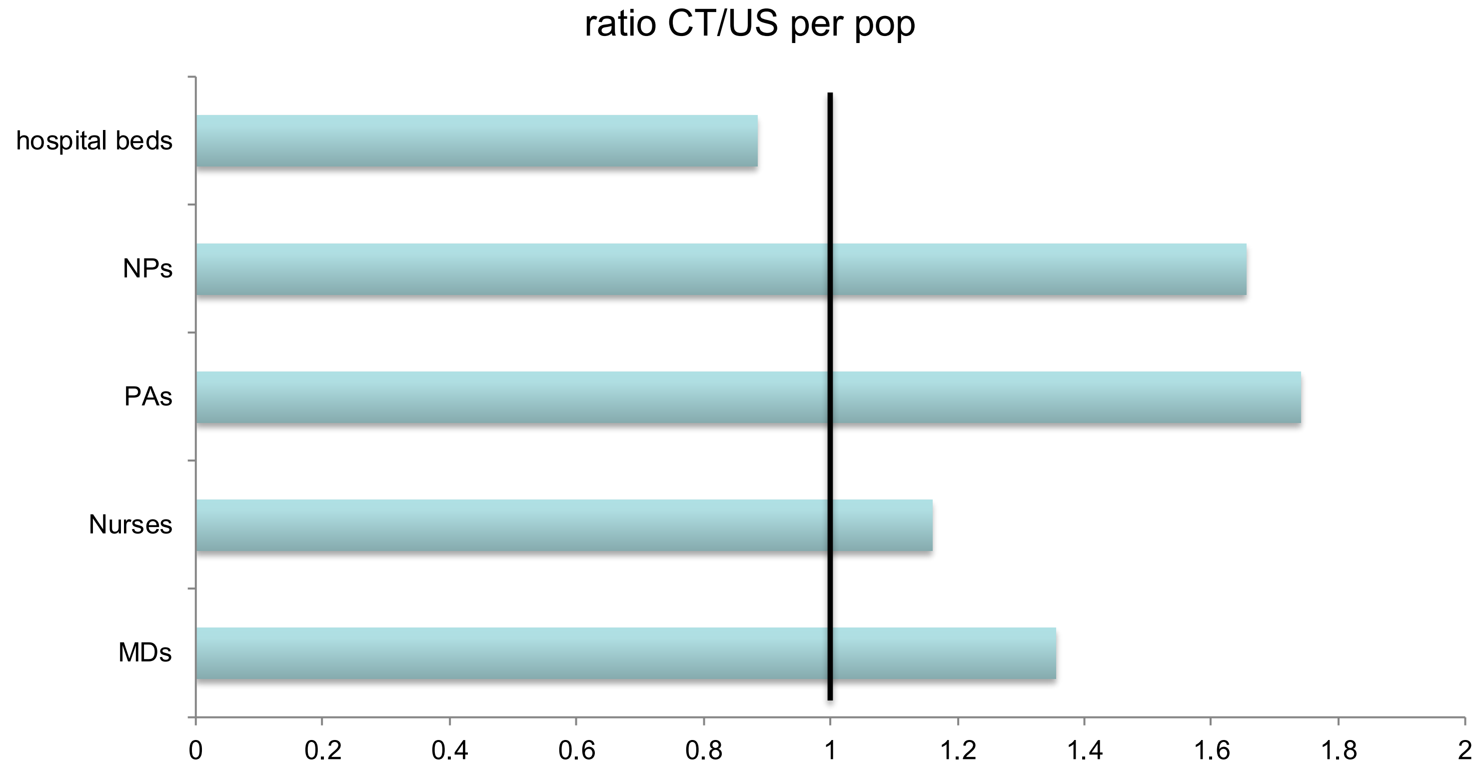
- Serious, ongoing scope of practice tensions
  - Optometrists, ophthalmologists, opticians
  - Dentists, hygienists, new Advanced Dental Hygiene Practitioner
  - MDs, nurses, nurse practitioners, physician assistants
- Groups work hard for recognition, to certification, licensure, billing, independent practice
  - Argue for inclusiveness early, switches to exclusion as they move up the ladder
- Payment levels vary widely for same service
  - By timing, by payer, by geography, visibility in market, safety net vs. commercial, state facility vs. private, advantages set in law/regulation
- Hospitals, doctors
- Large, small, hospital-based practice shifts

CT MDs





Does CT have enough/too many providers?



Do providers drive costs?

- “most expensive piece of equipment in health care is the doctor’s pen”
- Supply-sensitive care
  - Discretionary treatments – more common in areas with more providers
- Not a typical market
  - Providers can drive demand for their services
  - Rare that patients argue with a doctor’s recommendation
- Areas with more providers/population have higher total costs of care per person
  - No evidence of better quality or outcomes
  - No better patient satisfaction levels
  - Less care coordination

Table 1. Supply of Physicians in U.S. Hospital-Referral Regions and Associated Quality of and Access to Care, 2005.*

Variable	Regions in Lowest Quintile of Supply	Regions in Middle Quintile of Supply	Regions in Highest Quintile of Supply	Ratio of Lowest to Highest
Total number of physicians per capita (per 100,000 population, adjusted for age and sex)	169.4	204.8	271.8	1.60
Primary care	61.5	72.7	95.7	1.56
Medical specialists	34.1	44.3	64.3	1.89
Surgical specialists	37.4	43.2	53.4	1.43
Hospital-based specialists	23.8	26.1	28.7	1.21
Medicare composite quality scores				
Acute myocardial infarction	91.0	91.7	93.1	1.02
Congestive heart failure	84.1	85.9	88.6	1.05
Pneumonia	79.5	78.8	79.2	1.00
Medicare access and satisfaction				
Ever had a problem and didn't see a doctor? (% responding no)	91.7	92.8	93.2	1.02
Do you have a particular place for medical care? (% responding yes)	95.0	94.8	95.5	1.01
Satisfied with ease of getting to the doctor? (% responding yes)	94.9	93.5	94.7	1.00
Satisfied with doctor's concern for overall health? (% responding yes)	95.5	94.2	95.7	1.00
Satisfied with quality of medical care? (% responding yes)	96.7	96.3	97.0	1.00

* Data are for hospital-referral regions according to quintile of beneficiary-weighted total number of physicians per capita for 2005. Total numbers of physicians include the number of full-time clinical postgraduate physicians and 0.35 times the number

Primary care

- Areas with more primary care had lower total per person costs, better outcomes
  - Lower hospital admissions, more preventive care
- Several mechanisms
  - Better access to needed services
  - Coordination, continuity of care
  - Greater focus on prevention
  - Focus on whole person, family, community
  - Early management of health problems
  - Less costly, less incentive to overtreat/refer
  - Closer, continuous connection to patients

Primary care shortage

- Paid less than specialists
- Fewer new MDs in primary care
  - Debt levels, income, prestige, lifestyle issues
- More accountability, paperwork, reporting
- New technology demands
- Patient empowerment
- ACA adding to demand with new enrollment, no copays on prevention
- Aging population, increasing prevalence of chronic illnesses that need management

Primary care shortage

- CT – 28% internists, 26% family practitioners not taking new patients – before ACA implementation
  - 22%, 25% are considering a career change
- Solutions
  - More training slots
  - Primary care rate increases
  - Team-based care
  - Larger groups, hospital-based practices to relieve admin burden
  - Specialists providing more primary care
  - APRNs, PAs

Nursing shortage

- Nurses on longer shifts, reduced staffing levels
- Reduces quality
- Reasons:
  - Hard job, getting harder, more complex, difficult
  - Aging nurses
  - Aging population, with more complex care needs
  - Not enough slots for qualified students, faculty shortage – can make more in practice
  - Not enough training slots – chicken & egg
  - Nurses leaving bedside
- Eased recently with recession, but returning

Hospitals

- Mergers, for-profit conversions
  - CT has two for-profit systems now
  - Lots of mergers, concerns about market concentration, driving prices even higher
- Serious quality issues, across the state
- For-profit quality concerns, benefits
  - Mortality higher, staff cuts, less uncompensated care, less investment of profits, less community involvement, less transparency
  - Access to capital
- Financial pressures similar to other providers
  - Reduced admissions, length of stay
  - Quality penalties and rewards
  - Responsible for patient satisfaction, readmissions, population health
  - Lower subsidies for uninsured

Safety net

- Providers who accept patients regardless of ability to pay
  - Not necessarily free care
- Hospitals, community health centers, free clinics, school-based health centers
- More mid-level providers
- Many grant funded, shifting to billing
- Technology, coordinating with the rest of the system
- Some not as well funded, some better
- Not seeing reduction in need with reform
  - MA clinics and free clinic saw no decrease, some increases
- Future?

Trends, concerns for CT providers

- Accept more financial risk, accountability for quality
- Hospitals – massive changes
  - Serious state budget cuts
  - More pressure for health of patients outside the hospital, patient satisfaction
  - Mergers, affiliations, for-profit environment, labor issues
  - Joining, creating larger health systems, state regulation
- Practices – changes coming slightly more slowly
  - More Medicaid patients, but has leveled off
  - Pressure to join large groups, ACOs – hospitals vs. physician invested
  - Competition from other settings
  - Medicare "fix" should lower the ongoing crises, lends some stability to future
  - Shift from specialist to primary care-centered system, PCMH pressure
  - Shift to employee model from independent practice

Trends in health care organization

- Will take on financial risk away from insurers
- More primary care
  - Less intensive, inpatient care
- Team-based care
- Align incentives to reward value
- Big data, HIT – to direct resources, identify hotspots, evaluate programs, coordinate care, improve patient safety
- Population health focus
- Shift enrollment from private to public payers
  - Less uninsured
- Patient-centered care