King Saud University
College of Business Administration
Department of Health Administration - Masters` Program

HHA 524 Health Economics
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PHYSICIAN BEHAVIOR

Learning Objectives

- ***Explain the benefits of physician group practices** for consumers and providers.*
- ***Describe the various ways market power** manifests in healthcare markets.*
- ***Discuss monopolistic competition** in the context of physician markets.*
- ***Summarize the various physician payment mechanisms** and the incentives they create.*
- ***Describe the factors that influence small area variation**.*
- ***Explain the theory of supplier-induced demand** and how the target income hypothesis is related to the demand for physician services.*

PHYSICIAN BEHAVIOR

Core Concepts

Long ago, a patient could just pick up the phone and make an appointment with any provider he wanted to see, and a physician could offer treatment and other services on the basis of professional medical judgment alone, charge whatever he or she deemed appropriate for the services rendered, and receive full payment from the patient or another payer.

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Core Concepts

- ***Those days are gone**. In its current incarnation, healthcare is complex and so are the relationships providers have with patients and third-party payers (e.g., insurance carriers).*
- ***Several factors now influence these relationships**.*
- ***First, healthcare consumers have a lot more resources (other than their doctors) to turn to for medical information and advice**, and the Internet has become a primary outlet—although most people know to be cautious of what they read or watch online.*

PHYSICIAN BEHAVIOR

Core Concepts

- ***Third, many providers have transitioned from solo to group practice.***
- ***When scheduling an appointment with a physician in a group, a patient may have to settle for whichever physician is available to see him and not see his provider of choice.***
- ***The one-on-one relationship between the provider and the patient is not yet rare, but it is becoming less common.***

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Transition from Solo to Group Practice

- ***Physicians' mode of practice has steadily changed over the years from solo practice to group practice.***
- ***In theory, physicians in a group practice share certain traits such as training and medical philosophy. Working in a group may result in a loss of autonomy for the provider, but it also offers many benefits (see Exhibit 7.1).***

Exhibit 7.1 Benefits of Working in a Group Practice

Physicians in a group
• ***share*** ***the responsibility of running the business,***
• ***gain*** ***a greater knowledge base,***
• ***increase*** ***their market power, and***
• ***experience*** ***easier patient referrals within the practice.***

PHYSICIAN BEHAVIOR

Economies of Scope and Scale

- ***A multispecialty group has an economies-of-scope advantage*.**
- ***Often, patients find that using the services of different specialists in the same practice* is more practical and convenient than shopping around for specialists in different practices.**
- ***Providers, in turn, benefit financially by referring their patient* to providers in their own practice.**

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Economies of Scope and Scale

- ***Group practices also have an economies-of-scale advantage.***
- ***Costs such as the building lease and the salaries of the front-office staff are spread among the providers in the group instead of being the responsibility of just one practitioner.***
- ***Such savings could mean that the group has the capacity to offer different and higher-quality services by purchasing up-to-date technology or extending patient hours.***

PHYSICIAN BEHAVIOR

Market Power

- ***Another advantage a group practice has over a solo practice is that it has greater market power.***
- ***With market power, a physician group (or any other entity) can influence the terms of the exchange—price, quantity, or quality of services—in a way that serves its interests.***

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What Constitutes Physicians' Market Power?

- ***Market power takes on several different forms, all of which give certain types of businesses an advantage.***
- ***Market power The ability of one group or firm to influence the terms of the exchange (price, quality, or quantity) in a market***

Exhibit 7.2 Market Power in Healthcare

Healthcare entities with market power can do the following:

- ***Negotiate higher reimbursement rates for services rendered***
- ***Set a price lower than the competitors' price***
- ***Benefit from government, or association regulations***
- ***Set higher prices than would be set in a competitive market***

PHYSICIAN BEHAVIOR

Higher Reimbursement Rates

- ***Every year, physicians and insurance companies negotiate reimbursement rates for each health-related good or service.***
- ***Thus, physicians know at the beginning of the year how much each insurance company will pay for a particular service.***

PHYSICIAN BEHAVIOR

Higher Reimbursement Rates

- ***For example, Bupa Insurance may pay SR500 for a physical exam, while Tawuniya Health Plan may offer SR300 for the same service.***
- ***When a patient with Tawuniya insurance shows up at the doctor's office for a physical, the office already knows how much it will be reimbursed for services rendered.***

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Higher Reimbursement Rates

- ***Group practices (particularly large ones)** have greater influence than do solo practitioners in these price negotiations.*
- ***Both the insurance company and the group practice** have an incentive to find a reimbursement level that both parties can live with.*
- ***If they cannot come to an agreement**, then the provider will not accept the insurance plan and the insurance will not list the practice as a participant.*

PHYSICIAN BEHAVIOR

Higher Reimbursement Rates

- ***As a result, patients who are shopping for a new plan may not select the insurance carrier if it does not cover the provider(s) they prefer.***
- ***The physician practice, in turn, misses out on the prospective patients that insurance companies bring.***
- ***When physicians form groups (instead of working independently), a potential result is that there will be fewer physician choices in the market for patients.***

PHYSICIAN BEHAVIOR

Higher Reimbursement Rates

- ***This is especially true in a small geographic market.***
- ***For example, if a patient's provider, with whom she has developed a relationship, joins a group practice that does not participate in her insurance plan, she will lose that provider and will have to find another one, which may not be easy in a market with a limited number of providers.***

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Lower Price

- ***Setting a price lower than a competitor's price can attract customers*.**
- ***However*, not all firms can lower their price, as it means less money coming in to cover the cost of production, such as wages and salaries, office and equipment leases, and other expenses related to providing services.**

PHYSICIAN BEHAVIOR

Lower Price

- ***A firm might be able to set a price lower than its competitor's if it has enough capital on hand to offset potential monetary losses or if it has a diversified product base.***
- ***This diversification allows the firm to use one product's revenue stream to pay for parts of the business that have a low-pricing strategy.***
- ***Small firms, especially those with limited sources of revenue, are less likely to engage in a low-pricing strategy.***

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Regulations

- ***Government, and professional association regulations** are a fact of life in healthcare. These regulations dictate everything from physicians and nurses licensing to the capital infrastructure process.*
- *One Government regulation is the **certificate of need (CON)**.*
- ***CON** is an approval of a planned acquisition, building, or expansion of a medical facility or the purchase of major equipment (**e.g., a magnetic resonance imaging [MRI] machine**).*

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Regulations

- ***In theory, CON is in place to prevent the market from supply oversaturation*.**
- ***Oversaturation can create an opportunity* and *incentive for providers in the market (e.g., hospitals, group practices) to use their knowledge to recommend to patients' medical service that are not entirely necessary.***

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Regulations

- ***In an extreme scenario, communities without CON regulations may be left with unused medical infrastructure. CON is intended to protect the consumer.***
- ***However, for providers that already operate in the market, CON may reduce the kind of competition that spurs improvement in quality of care.***

PHYSICIAN BEHAVIOR

Market Concentration

- ***Market concentration is the extent to which a small number of firms make up a large percentage of the market.***
- ***Extreme market concentration occurs when only one firm operates in the market.***
- ***This is a monopoly, where no close substitutes exist and the monopolist (which has all the market power) can set a price much higher than the price set in a competitive market.***
- ***In general, as the number of sellers (or providers) increases, the influence any one firm can have over price, quantity, and quality decreases.***

PHYSICIAN BEHAVIOR

Physicians as Monopolistically Competitive

- ***Most health economists believe that physicians do not operate in a perfectly competitive environment*.**
- ***One assumption of a perfectly competitive market is that all products are alike*, and it is reasonable to believe that a visit to one doctor is not exactly the same as a visit to another doctor.**

PHYSICIAN BEHAVIOR

Physicians as Monopolistically Competitive

- ***Even if they have the same training**, each physician has his own style.*
- ***Some take time during an appointment** to talk with patients and ask and answer questions, developing a relationship in the process.*
- ***Others rush through every patient visit**, barely making conversation. Aside from personal style, the approach to treating a condition also varies from one physician to the next.*

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Physicians as Monopolistically Competitive

- ***Even aspects of a physician's service—such as wait time, interaction with staff, and follow-up—can range so widely that the experience cannot be viewed as uniform.***
- ***Given the differentiated products, many economists believe each physician (or physician group) has her own individual market.***
- ***In economic terms, this means every physician faces her own demand curve.***

PHYSICIAN BEHAVIOR

Physicians as Monopolistically Competitive

- ***A market characterized by many firms with their own demand curve is monopolistically competitive.***
- ***Thus, it is fairly common for economists to classify a market with many physicians as monopolistically competitive.***
- ***One major implication of the monopolistically competitive market structure is that each firm can set its own price higher than it would be in a competitive market (in which firms do not set their own price).***

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Physicians as Monopolistically Competitive

- ***In this market, patients are willing to pay a high price—for various reasons, such as they do not want to find a new provider, they value their long history with their doctor, they find the location convenient, they deem the service high quality, or they like the short wait times.***
- ***This low-price sensitivity means that sellers have the ability to raise prices without fear of losing buyers.***

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Physicians Payment Methods

- ***Monopolistically competitive providers' ability to set prices is influenced by the methods by which they get reimbursed for their services.***
- ***These methods include the three most common: fee-for-service, capitation, and salary.***

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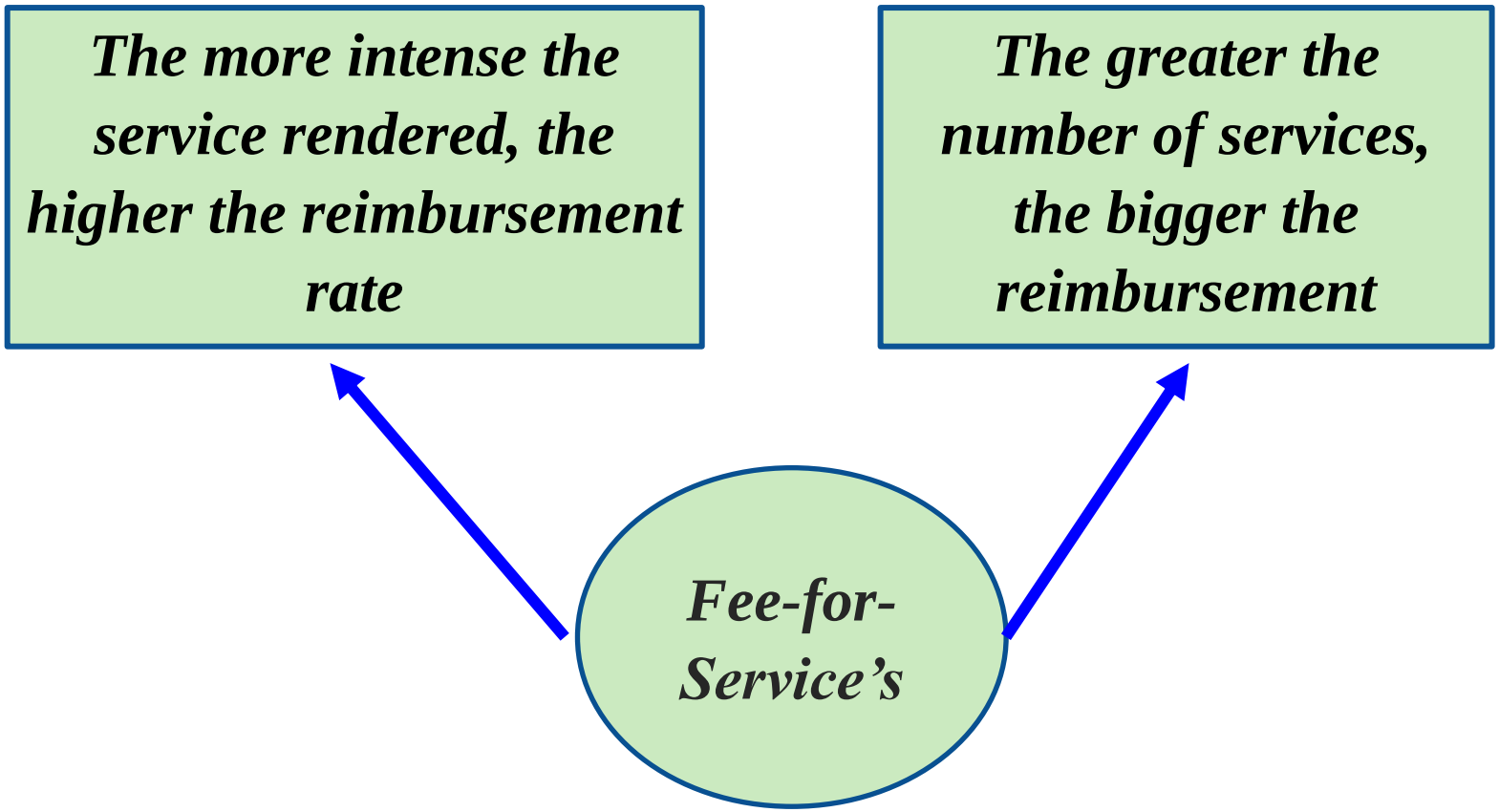
Physicians Payment Methods

- ***Fee-for-service** functions exactly how it sounds: payment for each service rendered to a patient.*
- ***As mentioned earlier**, providers typically negotiate reimbursement rates with insurance companies on a yearly basis.*
- ***The fee schedule does not change for the duration of the annual contract.***
- ***Hence, under fee-for-service,** how much a physician will be paid for each service is known in advance.*

Exhibit 7.3. With the fee-for-service payment method, the physician has a financial incentive to provide more services (because additional services mean more income) and more intense services (because these are typically reimbursed at a higher rate)



PHYSICIAN BEHAVIOR

Capitation

- ***Under capitation** (or per capita payment), the insurance company pays a provider a fixed amount each month to care for a defined population.*
- ***The provider gets paid whether or not patients go to the doctor.***
- ***This arrangement gives the provider an incentive to keep her patients healthy and thus use fewer (or less expensive) services.***
- ***The fewer the services rendered, the greater the profit level for the provider.***

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CONSIDER THIS

- ***Suppose a provider receives $100 per month per patient from an insurance carrier.***
- ***The provider is responsible for 20 patients. If these 20 patients do not seek services, then the provider has no patient costs and earns $24,000 at the end of the year.***
- ***On the other hand, if some of the patients are sick (perhaps with multiple comorbidities), then the provider may have to provide multiple services and end up spending some (or all) of the $24,000***

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Salary

- ***Sometimes hospitals, outpatient clinics, and managed care organizations hire physicians and pay them a salary.***
- ***A provider who is a salaried employee does not have the same economic incentives as a provider getting paid on a fee-for-service or capitated basis.***
- ***In addition to salary, a provider may receive an end-of-the-year bonus from the organization if the organization earns a large profit.***
- ***This gives the provider an incentive to perform at the highest level and to align himself with the organization's economic strategy.***

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Payment Cross-subsidization

- ***To assume that most physicians work with patients** who have different types of insurance is reasonable.*
- ***Some patients have public health insurance**, others have private health insurance, and still others have no insurance at all.*
- ***Each insurance carrier has its own relationship with the physician.***
- ***Private insurance companies typically pay a higher rate than public insurance do.***
- ***Effectively, insurance carriers** (or patients) that pay the greatest amount for a service subsidize the care of the patients who pay the least.*

PHYSICIAN BEHAVIOR

Knowledge about variation

- ***« Life is variation. Variation there will always be, between people, in output, in service, in product… No two people are alike. Arrival of a train or of an airplane varies from day to day. Time in route to work varies day to day, no matter what be the mode of transport…»***

(Deming, 1993)

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Why Is Understanding Variation Important?

- ***Deming** believed that excessive **variations** were most of the time, sources of problems and, therefore, it is preferable, all things being equal, reduce variation, or at least understand them.*
- ***Reducing **variation** is to avoid irregularity when possible. « Most people prefer certainty to uncertainty, prefer predictability to unpredictability, and prefer to receive services or information when expected rather than too early or too late, and prefer not to be surprised or hassled.***

PHYSICIAN BEHAVIOR

Process Variation

- ***Process variation** is one category of **variation** in medical practice. It refers to different usage of a therapeutic or diagnostic procedure in an organization, geographic area, or other grouping of healthcare providers.*
- ***In addition to variation** in use versus nonuse of a particular procedure, **variation** may arise when multiple procedures can be used to achieve approximately the same ends.*

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Process Variation

- ***For example**, in the case of screening for colorectal cancer, the same purpose (**screening**) may be served by fecal occult blood testing, sigmoidoscopy, colonoscopy, or some combination of these options.*
- ***Process variation** should not be confused with **technique**, which refers to the multitude of ways in which a particular procedure can be performed within the realm of acceptable medical practice .*

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Outcome Variation

- ***Another category is outcome variation, which occurs when different results follow from a single process. Healthcare quality researchers and medical practitioners often focus on this measure and seek to identify the process that yields optimal results.***

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Performance Variation

- ***Performance variation*—*the difference between any given result and the optimal result is arguably the most important category of variation applicable to healthcare quality improvement.***
- ***Logically, it may relate to both choice of process and application of that process to achieve the optimal result.***

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Performance Variation

- ***With respect to quality of care, "the variation that is the greatest cause for concern is that between actual practice and evidence-based 'best practice.'"***
- ***The measurement of performance variation and its application to quality improvement work assume, however, that a best practice has been identified.***

PHYSICIAN BEHAVIOR

Variation in Medical Practice

- ***Variation in medical practice** has excited interest since 1938, when **Dr. J. Allison Glover (1938)** published his classic study on the incidence of tonsillectomy in school children in England and Wales, uncovering geographic variation that defied any explanation other than variation in medical opinion on the indications for surgery.*

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Variation in Medical Practice

- ***Subsequent studies have revealed similar variation internationally and across a variety of medical conditions and procedures, including prostatectomy, knee replacement, arteriovenous fistula dialysis, and invasive cardiac procedures.***

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Variation in Medical Practice

- ***The first important distinction to make when considering variation in medical practice is the difference between warranted variation, which is based on differences in patient preferences, disease prevalence, or other patient-related factors, and unwarranted variation, which cannot be explained by patient preference or condition or evidence-based medicine.***

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Variation in Medical Practice

- ***While the former (warranted variation) is a necessary part of providing appropriate and personalized evidence-based patient care, the latter (unwarranted variation) is typically regarded as a quality-of-care concern by hospitals and healthcare systems.***

PHYSICIAN BEHAVIOR

Variation in Medical Practice

- ***The effects of unwarranted variation include inefficient care (i.e., underutilization of effective procedures and/or overutilization of procedures with limited or no benefit) and related cost implications as well as disparities in care between geographic regions or healthcare providers.***

PHYSICIAN BEHAVIOR

Variation in Medical Practice

***John Wennberg*, defines *three categories* of care in which *unwarranted variation* indicates different possible problems:**

1. ***Effective care* (*15 percent of healthcare*) is care for which the evidence has established that its benefits outweigh its risks and the "right rate" of use is 100 percent of the patients defined by evidence-based guidelines as needing such care. In this category, variation in the rate of use within a defined patient population indicates areas of underuse.**

PHYSICIAN BEHAVIOR

Variation in Medical Practice

John Wennberg*, defines *three categories

2. ***Preference-sensitive care* (*25 percent of healthcare*) *includes areas of care in which there is more than one generally accepted treatment available for the condition being addressed, so the "right rate" should depend on patient preference. A challenge posed by this type of care is the uncertainty of whether patient preferences can be accurately measured using current methods—and if they can, whether measurement methods are so resource intensive that inclusion of patient preference is impracticable in large population-based studies.***

PHYSICIAN BEHAVIOR

Variation in Medical Practice

***John Wennberg*, defines *three categories*:**

3. ***Supply-sensitive care* (*60 percent of healthcare*) is care whose frequency of use relates to the capacity of the local healthcare system. Studies have repeatedly shown that regions with high use of *supply-sensitive* care do not perform better on mortality or quality-of-life indicators than do regions with low use, so variation in this area of healthcare services can provide *evidence of overuse*.**

PHYSICIAN BEHAVIOR

Variation in Medical Practice

- ***"Supply sensitive care" is health care delivered at a volume that responds to availability of provider supply and in ways that cannot be explained by other factors like the health of the patient population.***
- ***Of course, all care is supply sensitive to some extent, but some things are more so than others, particularly when there is a lack of evidence or guidelines to inform best practice.***

PHYSICIAN BEHAVIOR

Variation in Medical Practice

- ***In areas with more hospital beds and more physicians, patients are admitted more frequently and see their physicians more often for reasons not necessarily justified by clinical condition.***
- ***Unfortunately, the supply of resources appears to be more powerful than patient preferences in guiding health care delivery.***

PHYSICIAN BEHAVIOR

Small Area Variation

- ***Small area variation (SAV) The difference in service usage and practice patterns among geographic areas.***
- ***Every community, region, or country has unique cultural norms surrounding physician payment, medical recommendation and intervention, treatment preferences, service usage, and so on that differ from the norms and patterns in other communities.***
- ***These differences are called small area variation.***
- ***Variation in treatment is not always a given, however.***

PHYSICIAN BEHAVIOR

Small Area Variation

- ***For example**, when an individual breaks or fractures a hip, the standard, consistent course of action is surgery (though taking into account the person's age, sex, and other comorbidities).*
- ***The same can be said for the treatment of colon cancer.***
- ***For many medical conditions, however**, providers follow their own or the community's preferred treatment protocol.*

PHYSICIAN BEHAVIOR

Small Area Variation

- ***There are some situations in which a variety of treatment options may be available, and providers in certain areas have a fondness for a particular treatment protocol.***
- ***Alternative treatments might be anything from "wait and see" to medical management via pharmaceuticals to surgical intervention.***
- ***SAV studies have focused on many aspects of care delivery, including cesarean section rates, ordering of lab services, use of diagnostic tests (e.g., MRI, computed tomography [CT] scans), and hospitalization.***

PHYSICIAN BEHAVIOR

Small Area Variation

- ***Care at the end of life, especially hospitalization and life-extending intervention, has also been the subject of SAV debate.***
- ***Overuse of end-of-life care is of particular interest to policymakers interested in isolating situations where the benefits of treatment are low and the costs are high.***
- ***Of course, if more services or more intense services result in improved patient outcomes, then the treatments are seen as a benefit.***

PHYSICIAN BEHAVIOR

Small Area Variation

- ***The big question** that researchers and policymakers ponder about SAV is why similar conditions are treated differently in different parts of the country.*
- ***Is it because patients in some areas have more comorbidities than in others?***
- ***Is it because of the lack of access to care in certain communities?***
- ***Are physician styles and treatment preferences the reason one service is chosen over another?***
- ***Researchers and policymakers grapple with these questions to determine the most cost-effective means of providing care.***

PHYSICIAN BEHAVIOR

Supplier-induced Demand

- ***Under the fee-for-service payment mechanism*, providers can increase their income by recommending more (or more intense) services for their patients.**
- ***This economic incentive, along with the medical knowledge advantage physicians have, sets the stage for patients using services they might not need*.**
- ***Supplier-induced demand The demand created when suppliers (e.g., physicians) encourage their buyers (e.g., patients) to consume unnecessary goods or services.***

PHYSICIAN BEHAVIOR

Supplier-induced Demand

- ***A fundamental assumption of the supplier-induced demand (also called physician-induced demand) theory is that sellers (physicians, in this case) are motivated to offer buyers (patients and other consumers) unnecessary goods and services to increase their income.***
- ***In healthcare, unnecessary services are medical interventions that would not have been offered if there was not a financial incentive to do so.***

PHYSICIAN BEHAVIOR

Supplier-induced Demand

- ***Examples** of such services are frequent follow-up visits, redundant tests, and expensive surgical procedures instead of less expensive therapies and noninvasive alternatives.*
- ***As discussed before, healthcare demand is influenced by factors such as price, income, health status, and taste and preference.***
- ***According to the supplier-induced demand theory, providers also can influence patients' demand—specifically for unnecessary services.***

PHYSICIAN BEHAVIOR

Supplier-induced Demand

- ***Providers who do this are exploiting what economists call the principal–agent relationship*.**
- ***Principal–agent relationship* The arrangement between two entities in which the agent (e.g., physician), as a result of her knowledge and expertise, represents or acts in the best interest of the principal (e.g., patient)**

PHYSICIAN BEHAVIOR

Physician Agent

- ***Because the physician has more healthcare knowledge (presumably) and can evaluate the patient's medical needs, he or she serves as the patient's agent.***
- ***In theory, the physician should act in the best interest of the patient.***
- ***However, the imbalance of information between the provider and patient leaves a window of opportunity for the provider to exploit the relationship for his own financial gain.***

PHYSICIAN BEHAVIOR

Physician Agent

- ***The basis for this exploitation lies with the structure of health insurance.***
- ***Healthcare consumers, with public or private insurance, are somewhat removed from the physician payment process.***
- ***That is, patients are not involved in the provider–insurer negotiations on reimbursement rates.***

PHYSICIAN BEHAVIOR

Physician Agent

- ***Furthermore, they are not wholly financially responsible for the services they consume.***
- ***Although exploitation of the principal–agent relationship may be distasteful from an ethical standpoint, it is reasonable to believe that individuals act in their own best economic interest.***

PHYSICIAN BEHAVIOR

Target Income

- ***When analyzing supplier-induced demand, health economists often look at increases in the supply of physicians in an area.***
- ***The expectation is that when the supply increases, price reduction occurs (as the physicians attempt to persuade consumers).***

PHYSICIAN BEHAVIOR

Target Income

- ***When the price drops, supplier income also falls*.**
- ***The decrease in price, coupled with reduced income (because some patients might have switched providers), can entice physicians to find ways to increase the demand for their services to maintain a target income.***

PHYSICIAN BEHAVIOR

Target Income

- ***The target income hypothesis states that suppliers (e.g., physicians and other providers) alter their work to maintain a specific income level.***
- ***In the context of supplier-induced demand, when physicians see their income dropping, they may order unnecessary tests and follow-up visits or recommend unnecessary services just so they can reach their target income level.***

PHYSICIAN BEHAVIOR

Supplier-Induced Demand Theory

- ***What complicates the relationship between the patient and the provider is that the patient is greatly influenced by what a physician tells him.***
- ***For example, if a doctor recommends an MRI scan to a patient who suffers from regular migraine headaches, there is a good chance that the patient will agree—regardless of whether the scan is really necessary.***
- ***Economic incentives are full of ethical implications.***

PHYSICIAN BEHAVIOR

Physician-to-Population Ratio

- ***To fully understand supplier-or physician-induced demand, economists examine whether changes in the supply of physicians are associated with changes in the utilization of health-related goods and services.***
- ***Under the supplier-induced demand theory, healthcare demand is influenced by the number of physicians in the market.***

PHYSICIAN BEHAVIOR

Physician-to-Population Ratio

- ***When new physicians enter the market and the patient population does not change, the physician-to-population ratio increases.***
- ***This growth in supply means that the patient base is spread over a larger number of physicians and that physician income is at risk of falling.***
- ***Hence, the competition for patients is greater.***

PHYSICIAN BEHAVIOR

Price Discrimination

- ***Physicians have the ability to charge different populations different prices for the same service.***
- ***This practice is unique to the healthcare delivery setting.***
- ***In retail, one shopper does not get charged $100 for a pair of pants while her friend is charged $50 for the same pair. But physicians can do exactly that.***
- ***The price providers charge depends largely on their patients' insurance coverage and the patients' price sensitivity.***

PHYSICIAN BEHAVIOR

Utilization Management

- ***Utilization management is the evaluation of the appropriateness, medical need and efficiency of health care services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan.***
- ***Typically, it includes new activities or decisions based upon the analysis of a case.***

PHYSICIAN BEHAVIOR

Utilization Management

- ***The principal objective of utilization management is the reduction of practice variations by establishing parameters for cost-effective use of health care resources.***
- ***There are four main techniques or tools used in utilization management: demand management, utilization review, case management, and disease management. Utilization management helps HCOs control costs and improve quality.***

PHYSICIAN BEHAVIOR

Utilization Management

- ***Fundamentally, the purpose of UM is to ensure that patients receive necessary medical services at the least cost.***
- ***In any business transaction, buyers do not want to pay for something they do not need, and they do not want to pay for top-shelf products when a less expensive product will work just as well.***

PHYSICIAN BEHAVIOR

Utilization Management

- ***For instance**, when your car needs an oil change, you don't want to buy extra parts or high-performance oil blends you do not need. You pay the entire bill in this transaction, so you decide what is necessary.*
- ***You may consider the mechanic's recommendations**, but you also know that the mechanic's desire for profit could motivate him to suggest unnecessary products or services.*

PHYSICIAN BEHAVIOR

Utilization Management

- ***In healthcare, the buyer–seller relationship is different.***
- ***First, an insurance company often pays the majority of the bill, whereas the patient pays nothing or only a small portion of expenses.***
- ***Health insurers are the primary buyers of healthcare services, and like all buyers, insurers do not want to pay for unnecessary care.***
- ***Healthcare customers—patients—rely almost solely on physicians and other providers to decide which services are necessary.***

PHYSICIAN BEHAVIOR

Utilization Management

- ***Profit considerations could influence** healthcare recommendations, as in other industries; however, the average patient cannot distinguish between necessary and unnecessary services, putting her at a disadvantage.*
- ***Likewise**, the average patient cannot recognize underuse of services—situations in which beneficial services are not provided.*
- ***Fortunately**, those in the best position to judge medical necessity—practitioners and healthcare organizations—actively evaluate services to prevent **overuse** and **underuse**.*

PHYSICIAN BEHAVIOR

Utilization Management

- ***Medically necessary*** ***Appropriate and consistent with diagnosis and, according to accepted standards of practice in the medical community, imperative to treatment to prevent the patient's condition or the quality of the patient's care from being adversely affected.***
- ***Underuse*****, *Failure to provide appropriate or necessary services, or provision of an inadequate quantity or lower level of service than that required.***

PHYSICIAN BEHAVIOR

Utilization Management

- ***Utilization**, Use of medical services and supplies, commonly examined in terms of patterns or rates of use of a single service or type of service, such as hospital care, physician visits, and prescription drugs.*
- ***Overuse**, Provision of healthcare services that do not benefit the patient and are not clearly indicated or are provided in excessive amounts or in an unnecessary setting.*

PHYSICIAN BEHAVIOR

Defining Appropriate Services

- ***Many healthcare decisions are easily made**. For instance, a patient with a broken arm needs bone realignment and a cast. Some medical decisions are not so obvious, however.*
- ***To practice UM**, purchasers and providers must have a way to judge the **appropriateness** of services.*
- ***Until relatively recently, only physicians decided** whether services would benefit their patients.*

PHYSICIAN BEHAVIOR

Defining Appropriate Services

- ***Researchers found** that in areas of treatment that enjoy strong professional consensus on the appropriate use of particular services (e.g., hospitalization for hip fracture), **utilization varies relatively little**, whereas in areas that enjoy low consensus (e.g., the need for hysterectomy and prostatectomy), **utilization varies more**.*
- ***Health insurers encouraged** the development of **clinical practice guidelines and standardization of care** for UM purposes, specifically to reduce the provision of unnecessary services.*

PHYSICIAN BEHAVIOR

Defining Appropriate Services

- ***Although hundreds of clinical practice guidelines are in place, for many conditions evidence is insufficient to use as a basis for judging treatment appropriateness. In these situations, physicians have considerable latitude in making treatment decisions.***
- ***For this reason, variation in the services provided to patients with similar conditions is still evident.***

PHYSICIAN BEHAVIOR

Defining Appropriate Services

- ***However, the development and availability of clinical guidelines are often insufficient to align practice with scientific standards due to numerous factors, including physician inertia, uncertainty regarding the knowledge base for the guidelines, the perception that guidelines "deskill" physicians through the introduction of "cookbook medicine," and physicians' common perception that their practice is already consistent with best practices.***

PHYSICIAN BEHAVIOR

The Role of Health Insurance in UM

- ***There are many who believe that unrestrained fee-for-services medicine has led to inappropriately high utilization and is therefore the root cause of the health care cost crisis.***
- ***While there is merit in the argument, it is simplistic.***
- ***Health care costs are escalating at an alarming rate for many reasons, not just fee-for-service medicine. UR has emerged as a key feature of cost management.***

PHYSICIAN BEHAVIOR

The Role of Health Insurance in UM

- ***Essentially, with the fee-for-service model, providers are financially rewarded for quantity over quality.***
- ***With this payment model, it's easy to see how patients can sometimes undergo unnecessary tests or treatments when perhaps less invasive, lower cost, and just-as-effective options are available.***

PHYSICIAN BEHAVIOR

The Role of Health Insurance in UM

- ***Volume** has become an important indicator of healthcare quality. **The basic premise**, which on the surface may seem intuitive, is that the higher the volume, the better the quality.*
- ***However**, this simplistic view may significantly underestimate the complexity of the issues.*
- ***Historically**, payers have concentrated their cost-containment energies on the unit price of medical services and have directed less attention to the **volume** of those services provided by institutions and practitioners.*

PHYSICIAN BEHAVIOR

The Role of Health Insurance in UM

- ***To the dismay over rising health care costs has been added a growing perception that much medical care is unnecessary and sometimes harmful.***
- ***The studies that have contributed to this perception have also produced some optimism that external review of physician practice decisions could detect unnecessary care, influence physician behavior, and reduce costs without jeopardizing access to needed services.***

PHYSICIAN BEHAVIOR

The Role of Health Insurance in UM

- ***Utilization management (UM) (from the health insurance organizations perspective) refers to any clinical restriction on utilization designed to approve or disapprove care based on clinical necessity.***
- ***UM techniques do not preclude patients from obtaining the service; they simply say that the insurer is not liable for the cost of the service if UM procedures are not followed.***

PHYSICIAN BEHAVIOR

The Role of Health Insurance in UM

- ***Several types of UM techniques** have been used over the years, including:*
- ***Preadmission certification**. The insurer requires that nonemergency hospital admissions be approved by the insurer before the patient is admitted to the hospital.*
- ***Concurrent review**. This is typically used in conjunction with preadmission certification. It specifies the number of hospital days a patient is authorized to stay. If a physician wants a patient to stay longer, additional days have to be requested.*

PHYSICIAN BEHAVIOR

Several types of UM techniques

- ***Retrospective review*. *This inpatient review is undertaken after the patient has been discharged. If the insurer determines that the patient should not have been admitted or should not have stayed so long, it will advise the provider to follow the insurer's admission protocols.***
- ***Denial of payment*. *This inpatient review is used in conjunction with retrospective review. If the patient should not have been admitted or stays too long, the insurer will not pay for the inappropriate admission or days.***

PHYSICIAN BEHAVIOR

Several types of UM techniques

- ***Mandatory second surgical opinion. This protocol requires the patient to obtain a second opinion before a nonemergency surgical procedure is undertaken. If the second opinion does not confirm the initial recommendation, it is typically left to the patient to decide whether the procedure should be done.***
- ***Case management. This program identifies high-cost cases. A case coordinator has authority to approve the substitution of some otherwise uncovered services as lower-cost or more-appropriate alternatives to covered services. Home healthcare as a substitute for additional hospital days is an example.***

PHYSICIAN BEHAVIOR

Several types of UM techniques

- ***Discharge planning. This program requires the provider to have a plan in place at the time of admission for the patient's care on discharge from the hospital.***
- ***Gatekeeper. This program assigns a primary care physician to each subscriber. Gatekeeper describes the person in charge of a patient's treatment. A gatekeeper's duty primarily is to manage a patient's treatment. This means the gatekeeper is in charge of authorizing the patient's referrals, hospitalizations and lab studies, or the insurer is not obligated to pay for the services.***

PHYSICIAN BEHAVIOR

Several types of UM techniques

- ***Disease management. This program provides coordination of care across multiple providers for patients with chronic diseases for which there are well-defined practice guidelines.***
- ***Intensive case management. This is an individualized program that targets patients with high-cost and multiple or complex medical conditions.***

PHYSICIAN BEHAVIOR

Clinical Ethics, and Bioethics:

- ***Every society has rules of conduct** describing what people ought and ought not do in various situation. We call these rules morality*
- ***Ethics is the philosophical study of morality**, a rational examination into people's moral beliefs and behavior.*
- ***Clinical ethics address the ethical issues that arise in clinical practice**.*
- ***The traditional model of clinical ethics** was frankly paternalistic (authoritarian).*

PHYSICIAN BEHAVIOR

Clinical Ethics, and Bioethics:

- ***Analysis of principles is best exemplified by the Principles of Biomedical Ethics four core ethical principles:***

1. ***Autonomy (self-determination)***
2. ***Nonmaleficence (do no harming)***
3. ***Beneficence (promoting good)***
4. ***Justice (fairness)***

PHYSICIAN BEHAVIOR

Clinical Ethics, and Bioethics:

- ***Under the influence of bioethics, many health care providers began embracing a more patient-centered model of care that emphasized patient autonomy and informed consent.***
- ***This patient-centered model conceives care as a contract between patient and provider. The emphasis on contracts strikes some as an inappropriate consumerist model that undervalues professional judgment and undermines patient trust in the medical profession.***

PHYSICIAN BEHAVIOR

Clinical Ethics, and Bioethics:

- ***Autonomy (self-determination)*** ***Bioethics has championed informed consent, patient autonomy in doctor-patient relationships and the safety of human subjects in research.***
- ***Beneficence (doing good)*** ***and*** ***Nonmaleficence (doing no harm)*** ***date back to the Hippocratic Oath as medical principles.***

PHYSICIAN BEHAVIOR

Clinical Ethics, and Bioethics:

- ***However, these principles are distinct, not mere opposites. Not doing harm has a certain priority (first, do no harm), because not benefitting someone seems a less serious offense than doing that person harm.***
- ***That priority partly reflects the human tendency more readily to forgive overlooked benefits (errors of omission) than deliberate actions resulting in harm (errors of commission)***

PHYSICIAN BEHAVIOR

Clinical Ethics, and Bioethics:

- ***Nonmaleficence the "do no harm" principle suggests*** ***that an individual's autonomy and freedom may be properly constrained to prevent harm to others.***
- ***Beneficence (promoting good) is closely related to the concept of morality*** ***generally and refers to the moral obligation, generously inspired by religious doctrine, that it is morally correct to take actions that promote the health and welfare of others.***

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THANK YOU