Gerald Faverman, Ph.D. • *Chairman of the Board*
Robert J. Kleine • *Editor*

August 7, 1992

Public Sector Reports

Michigan **COMMENTARY**

Digging Deeper Into Hospital Cost Increases

By Peter Pratt, Senior Consultant for Health Policy

Misunderstanding of the true reasons for rapidly rising health care costs has been an unacknowledged barrier to significant health care reform. Health policy discussions are dominated by statements like "Hospital costs are increasing at an unacceptably rapid rate" that, while true enough in general, are fodder for misguided specific reform proposals. Before meaningful reform can occur, all parties must recognize that hospital costs are not monolithic; they have components that are within and outside hospitals' control.

In "Why Do Hospital Costs Continue to Rise?" (*Health Affairs*, Summer 1992), John Ashby, Jr., and Craig Lisk delve into the black box of hospital costs, performing the most detailed analysis to date of the factors that determine hospital cost increases. Ashby and Lisk confine themselves to hospital operating costs per case, so they do not consider directly the effects of increased utilization and population growth. While their methodology may be beyond the ken of most health policy makers, the article's findings make it required reading for anyone wishing to confront rising health care costs.

Hospitals have little control over the single largest factor in their increasing costs, economywide inflation, which accounts for 40 percent of the annual growth in their costs. (For the record, in the years of this study, 1985 to 1989, total hospital costs rose an average of 9.3 percent annually, hospital operating costs per case rose 8.9 percent, and general inflation rose 3.8 percent.) Another 17 percent is attributable to hospital-specific price inflation. This simply means that hospitals purchase goods and services whose prices are rising faster than the prices of those that other industries and consumers buy. The authors state that most hospital-specific inflation can be explained by "rapidly rising wages . . . linked to the well-chronicled shortage of RNs and other professional personnel." They also note that wages grew "substantially" for hospital personnel who are not direct patient care givers: Average salaries in administration, data processing, and medical care evaluation rose just as quickly as those for employees in patient care departments.

The authors extend their analysis of hospital labor costs by analyzing the "skill mix" of employees. This proves revealing. Through 1985 and 1986, hospitals substituted more highly trained professionals for less highly trained personnel (RNs for LPNs, for example) and hired more technologists, occupational, respiratory, and physical therapists, and dietitians. This trend stopped abruptly after 1986, most likely because of shortages and rising wages.

Ashby and Lisk also clarify the role of medical liability premiums and pharmaceuticals in driving up hospitals' nonlabor costs (an annual average of 8 percent of hospital cost inflation). These two categories alone explain why the cost of hospital goods and services (excluding labor) rise faster than general inflation; collectively, all other goods and services have risen less than general inflation, largely because of hospitals' extensive joint purchasing activities.

The second largest component (21 percent) of hospital cost increases is the growing complexity of cases that hospitals must treat. For the most part beyond hospitals' control, patient complexity reflects the aging of the population, medical advances such as transplants and cancer therapy, and higher incidence of diseases, such as AIDS, that require extensive and varied therapies.

The intensity of service that hospitals offer is responsible for 20 percent of their average annual increase in costs. This includes the much-vaunted proliferation of technology. A separate study, however, contends that major technological advances explain only one-third of the rising costs in this area. The remaining

Public Sector Consultants, Inc.
Knapp's Centre • 300 S. Washington Sq. • Suite 401
Lansing, MI 48933-2134 • (517) 484-4954

two-thirds "is due to small technological improvements and to changes in practice patterns—a greater number or complexity of services provided for given medical conditions," Ashby and Lisk explain. The authors make an important distinction between patient complexity, which is due to factors outside hospitals' and physicians' control, and service intensity, which is not necessarily beyond their control. Intensity of service touches upon increasing utilization and the fractious issue of whether more intense services improve the quality of care: "No one really knows to what extent greater service intensity has . . . improved medical outcomes. But there is a growing body of evidence indicating that many tests and procedures are not necessary or at most are of very limited value," they conclude.

The authors note that significant changes in the relative importance of these components have occurred between 1985 and 1987 and 1987 and 1989, changes that suggest hospitals are doing a better job of controlling costs. Economywide inflation accounts for almost half of hospital annual average price increases between 1987 and 1989. The cost of hospitals' goods and services, including wages, explained 20 percent of rising costs in the same period. Patient complexity remained about the same between 1985 and 1987 and 1987 and 1989, but intensity of services shrank considerably, from 28 percent to 13 percent of the annual average increase, which suggests that even as far back as 1987, variations in practice patterns and utilization were brought under better control.

Ashby and Lisk conclude their article by linking their findings to policy proposals. Acknowledging that hospital cost increases above general inflation were half in 1990 what they were in 1986 and 1987, they still see more opportunity for cost containment. While praising hospitals' significant gains in productivity (which account for a 6-percent decline in hospital inflation), they lament that hospitals are "providing more services per patient, beyond what would be expected to treat a sicker and more complex mix of patients." The progress that hospitals made on this front between 1987 and 1989 "must be maintained and extended." Fittingly, they call for more funding for research on quality, clinical effectiveness, and medical outcomes.

They also call for tort reform, which they see as integral to the reduction of hospitals' non-labor costs. Singling out rising pharmaceutical costs, they say that drugs "contribute more to hospital-specific price inflation than all other goods and services hospitals purchase combined." Action beyond the hospital and other providers may be necessary to curb growth in this area.

Ashby and Lisk's article may not be earth-shattering in its revelations; certainly, we have heard much of this discussion in one place or another for years. Rather, the value of this piece lies in its ability to bring all those discussions together and clarify the issues. As one might expect, no single provider bears all or even most responsibility for controlling costs. The authors' policy implications push us toward looking most at improving the quality of care as a means of controlling costs, which is certainly preferable to myopic cost cutting for its own sake. The authors are to be credited for reaffirming that essential point about health care reform.

© 1992