
4. A Framework for Change

No great improvements in the lot of mankind are possible, until a great change takes place in the fundamental constitution of their modes of thought.

John Stuart Mill

Contents

	<i>Page</i>
Introduction	67
Organization of the Following Chapters.	68

A Framework for Change

INTRODUCTION

The following chapters examine policies that have been or could be used to restrain the costs of medical technologies in the Medicare program. Several points underlie the analyses in these chapters.

First, the impact of medical technologies on the costs of medical care should not be assessed in isolation from the effects that such medical technologies have on patient care. The impact of cost-containing measures on quality and access is one of the more difficult policy issues to be faced, because the Medicare program was instituted on a payment basis that had few controls on costs. Now that costs are a primary concern of Federal policy makers, some restrictions on quality and access are likely to occur. Nevertheless, there is substantial evidence to suggest that inappropriate use of medical technology is common and raises costs without improving quality of care.

Methods of controlling the costs of medical technologies can vary widely and have varying impacts. Direct methods, for example, are methods that are intended to control the use of specific medical technologies on a technology-by-technology basis. Such methods could be used: 1) to control the actual adoption or use of particular technologies, as in the coverage *process* that assesses specific technologies before they are approved for payment; or 2) to provide information on the costs of technologies so that payment for their use could be more reasonably related to their costs. Indirect methods include methods that use the payment mechanism to provide broad incentives to medical care providers not to over-utilize medical technologies and to make patients more cost conscious in their use of medical services. Indirect methods are now considered the major means through which long-term cost-containment objectives might be achieved. Particularly when used in conjunction with indirect methods, however, some direct methods, such as review of capital spending, utilization review, and some

other types of technology assessment activities, may also be valuable.

Second, there are interactions between Medicare and the rest of the U.S. health care system. Because of its size and scope, the Medicare program's policies and procedures affect all aspects of health care delivery, including financing, administration, organization, and personnel. Furthermore, the program affects the content and costs of health care by its influence on the development, adoption, and use of medical technology. Medicare's leverage in the health care system is partly due to the fact that Medicare alone finances over one-third of the country's hospital care, the setting where technology use is concentrated (1.5). It is also partly due to the fact that other third-party payers often follow Medicare's example.

Nevertheless, it is important to keep in mind that the Medicare program is only one of many public and private institutions that have an influence on the development and diffusion of medical technology. Other important influences are the Food and Drug Administration, National Institutes of Health, manufacturers of drugs and medical devices, hospitals, private health insurers, and professional medical societies. Thus, for example, the leverage of using Medicare-specific payment policies to influence the development and diffusion of medical technology may be limited.

Third, because of spillover effects from one part of Medicare to another, policy mechanisms involving only one part of the Medicare program may have serious limitations in terms of containing costs or affecting the adoption and use of technology. Medicare's hospital payment system based on Diagnosis Related Groups (DRGs), for example, excludes physician services and outpatient care. These exclusions provide financial incentives for the shifting of technologies and costs

out of inpatient hospital settings, while leaving physicians' incentives to use medical technology unaffected. Any cost-containment effort must take into account the fact that physicians play a central role in determining what services are provided to patients, both in hospital settings and in non-hospital settings. Most—if not all—cost-containment strategies depend on the ultimate influence of physicians for their success. Cost-containment strategies can be targeted directly at physicians—although such strategies are regarded by most observers as short-term and inadequate approaches—or they can be directed at the practice of medicine through changes in the organizational and financial arrangements under which physicians provide care. For the success of strategies that depend on incentives rather than on direct regulation, it is essential that physicians believe that the incentives are advantageous.

Fourth, the social and political climate today is quite different from that in 1965, and now that Medicare's goal of improving access to health care for the Nation's elderly has been largely achieved, the primary focus of policy makers is on containing Medicare costs. The intent of the original Medicare law (Public Law 89-97) was to increase elderly persons' access, by removing financial barriers, to mainstream medical services, particularly to needed hospitalization (318). The concern about access to medical services was also prominent when disabled persons and those with end-stage renal disease were added to the list of eligible beneficiaries. There was far less concern about the cost of the services than there was about the

problems of access, primarily because there was little reason to be concerned. Early principles in addition to improving access included assuring beneficiaries freedom of choice of providers and not interfering in the practice of medicine. Unfortunately, Medicare's adherence to these original principles has contributed to the current cost crisis. Today, in part because the original goals have been largely—though certainly not entirely—attained, the overriding goal for policymakers is to solve the problem of controlling Medicare costs. The challenge is to achieve that goal without diminishing past success.

The aforementioned points are closely intertwined. The relationship between cost containment and its effects on quality and access to medical care is but one example. Equally problematic is the widely held belief that specific policies that could be implemented in the short-term and directed at specific segments of the health care system will provide only temporary relief in medical care cost inflation. On the other hand, long-term success is increasingly dependent on broad but still untested ideas of the kinds of strategies (e.g., "competitive" systems, alternative delivery sites and organizations) that could lead to adequate cost containment. One fundamental dilemma, therefore, is whether policy makers can be precise about cost-containment processes for which the desired outcomes are quite limited, while still exploring the kinds of processes that would lead to the desired long-term or broader cost-containment outcomes.

ORGANIZATION OF THE FOLLOWING CHAPTERS

Chapter 5 examines the potential of linking Medicare's technology-specific coverage policy with technology assessment activities as a means of influencing the adoption and use of specific medical technologies for the ultimate purpose of containing Medicare program costs. In the past few years, assessment of the health effects—i.e., safety and efficacy—of some technologies has become part of the process of arriving at coverage decisions. Two current issues are whether

costs should be considered in Medicare coverage decisions and whether coverage of new technologies should be limited to specific sites and providers. This chapter provides information on the Medicare coverage process and technology assessment as practiced in the public and private sectors, and analyzes the strengths and limitations of the current coverage process, technology assessments, and possible linkages between the two processes. It also discusses the role of coverage

policy and technology assessment under Medicare's DRG hospital payment system.

Chapter 6 discusses the implications of the DRG hospital payment system' for the adoption and use of medical technologies. These implications are varied and to some extent unknown. Much will depend on the way in which the system is implemented and the refinements that will follow. DRG payment levels, especially relative to the speed with which hospitals can reduce costs, will have a major effect on the ability of hospitals to adopt new medical technologies. The way in which capital is paid for will also be an important influence in determining how much and what kinds of new technologies are adopted. Chapter 6 also includes a discussion of alternative approaches to hospital payment and of the implications of these approaches for medical technology.

Chapter 7 describes the Medicare physician payment system and analyzes the impact of proposals to limit physician payment or increasing beneficiary cost-sharing under Part B on medical technology adoption and use. Physicians determine the amount of medical services provided and decide when patients need to be hospitalized, discharged, or provided other types of institutional and noninstitutional care. This chapter examines evidence of excessive use of technologies and methods of enhancing cost consciousness among physicians. Such methods include programs to help ensure appropriate technology use by physicians that might be incorporated in the Medicare program. For example, the law authorizing DRGs also puts into place a mechanism for quality assurance and utilization review by requiring hospitals to contract with regional peer review organizations.

¹The recent changes in Medicare's hospital payment system established by the Social Security Amendments of 1983 (*Public Law 98-21*) are more extensively discussed in OTA's July 1983 technical memorandum *Diagnosis Related Groups (DRGs) and the Medicare Program. Implications for Medical Technology* (343).

Except for the imposition of minor restraints on the rate of increase of payment levels, Medicare's charge-based method of payment for physicians' services under Part B has been little changed since 1966. This method provides financial incentives to physicians for increased technology use by the way that fees are set and by the coding system used. The achievement of the cost-containment objectives of the DRG-based payment system for hospital services could be partially impeded through movement of some technologies and services out of the hospital setting. For that reason, the law establishing the DRG system requires that data necessary to compute the amount of inpatient physician charges based on DRGs be collected and that the Department of Health and Human Services report to Congress on the prospects of including physicians in DRG payment. The possibility that changes in Medicare payment for physicians' services may lower beneficiaries' access to medical care is also examined, principally through an analysis of the implications of changing physician assignment policy in the Medicare program.

Chapter 8 explores mechanisms other than hospital or physician payment that Medicare could use to foster the appropriate adoption and use of medical technology. These include stimulating competition among providers of health care by encouraging the development of alternative sites and organizations of care such as health maintenance organizations, home health care, and ambulatory surgical centers, and the use of vouchers and other methods.

Examination of these four areas—current Medicare coverage policy and related technology assessment activities, changes in hospital payment, changes in physician payment, and other methods to encourage the appropriate adoption and use of medical technology—lead to the final chapter of this report. Thus, chapter 9 presents OTA'S conclusions and policy options.