Framework for Health Industry Analysis/Determinants of Utilization of Healthcare Services

Joel Shalowitz, MD, MBA
Professor and Director
Health Industry Management Program
Kellogg School of Management
Northwestern University
## Features of Healthcare System

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Political/Regulatory/Judicial</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Economic</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Social/Cultural</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Technological</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>Demographic</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: Joel Shalowitz, M.D, MBA, 2003
Examples of Domain Influences on Features of a Country’s Healthcare System
Political/Regulatory/Judicial Domain

1. A) Centralization vs. decentralization e.g., regional health authorities in U.K.
   B) Public vs. private options, e.g., Chile opt in/out of public system

2. A) Fee schedules, e.g., U.S. RBRVS for Medicare adopted by private insurance
   B) National budgets, e.g., U.K.
   C) Drug Prices, e.g., E.U.

3. Politically motivated mandates, e.g., U.S. infertility benefits

4. A) Licensure/certification – international
   B) Court Decisions, e.g., E.U. courts confirm rights to seek care across member borders
   C) Laws/Regulations mandating access to care, e.g., U.S. EMTALA

Source: Joel Shalowitz, MD, MBA 2003
Economic Domain

5. A) Poor economy (in countries with private choice) – more government responsibility, e.g., U.S. Medicaid costs
   B) Poor economy in countries without or limited private choice: Payments cut, e.g., China
   C) Good economy in countries with private choice: How much is shifted from public to private sector?
      Good economy in countries without or limited private choice: How much will government expand payments?

6. How much a country spends on healthcare is most closely correlated with GDP

7. Analogous to 5. above but benefits instead of payment budgets.

8. In countries with private choice, as economies fluctuate to what degree is freedom of choice of provider important?

Source: Joel Shalowitz, MD, MBA 2003
Health expenditures and GDP per capita, 1998
US dollars PPP

Social Cultural Domain

9. What are a country’s priorities for its health services e.g., UK, Canada and WHO?

10. To what extent do culture and social issues influence how much is paid, e.g., Sweden?

11. To what extent do culture and social issues influence benefits, e.g., Germany?

12. How do culture and social issues influence portability and freedom of choice, e.g., U.S.?

Source: Joel Shalowitz, MD, MBA 2003
Taxation fair compared to..

• User charges – “it does not charge people for the misfortune of being sick.”

• Private insurance – “does not impose higher costs on those who are predisposed to illness, or who fall sick.”

• Social insurance – “it does not demand that employers bear the majority burden of health costs.”

Gordon Brown, Chancellor of the Exchequer, U.K., March 2002
Identifying policy objectives
Underpinning values

- Universality
- Equity
- Solidarity
- Responsiveness
- Wellness and responsibility
- Efficiency, value for money
- Accountability, transparency

(Commission on the Future of Health Care in Canada, 2001 Romanow Report)
Identifying policy objectives
Health system goals

- Maximizing population health
- Reducing inequalities in population health
- Maximizing health system responsiveness
- Reducing inequalities in responsiveness
- Ensuring health care equitably

13. A) To what extent are safety/efficacy evaluations separate from coverage decisions? E.g., contrast FDA in U.S. from approval process in other countries.
   B) To what extent are procedures (in addition to drugs and devices) evaluated, e.g., NICE in England?

14. What are cost saving vs. cost added technologies, e.g., PTCA/STENT vs. CABG?

15. What technologies are life saving, life enhancing or lifestyle enhancing and how are they prioritized, e.g., U.S. (Oregon Medicaid)?

16. To what extent does technology enable care to be provided at alternate sites?

Source: Joel Shalowitz, MD, MBA 2003
Demographic Domain

17. How does the economy view its obligations to care for the elderly? How are preventive services covered?

18. How much does the country spend on elderly vs. younger population?

19. A) To what extent is country focused on covering acute vs. chronic illnesses?  
   B) To what extent does country focus on preventive services and health (not just sickness) services?

20. A) How are issues of access addressed, e.g., age-related mobility, time, transportation?  
   B) Can care come to people needing it, e.g., home care, telemedicine?

Source: Joel Shalowitz, MD, MBA 2003
CUSTOMERS

[“Everyone” in Government Sponsored System]

Access/Equity

Who Accepts Insurance?
Who is not covered? (How Many Can/Does A Society Tolerate?)
Who has access To coverage?
Who? What is Covered?

Who Accepts Insurance? (includes Payers)

Cost

Volume
Product Cost
Cost Shifting
Who Pays, e.g., Gov’t Mandates for Payment and Buyer Power

Decision to Perform Service or Use Product

Number of Components Per Service
Episode, e.g., Pills per Treatment

Efficiency of Service, e.g.
LOS, Duration of Product Use

Low Cost

Volume

Intensity of Service

Level of Service

Service

Product Leader (Quality)

Site of Service

Technology

Amenities

Inpatient

Outpatient

Drugs

Procedures

Devices

Physician Office

Other, e.g., Surgicenter, Dialysis, Lab

Home

Process

Process Outcome

Outcomes

Other, e.g., SNF

Suppliers

Payer/Regulator

User

Demand

Supply

Price

Volume

Cost Shifting

Who Pays, e.g., Gov’t Mandates for Payment and Buyer Power

Suppliers

Payer/Regulator

User

Demand

Supply

Price

Volume

Other, e.g., Indigent Care

Other, e.g., Military & Government Workers

Other Private, e.g., Associations, Charitable Organizations

Employers e.g., Pay Premiums, ERISA, Sponsor Health Program

Insurance Companies

Private

Public

Customers (includes Payers)

Indigent Care

Elder Care

Care of Others, e.g., Military & Government Workers

[“Everyone” in Government Sponsored System]
CUSTOMERS

Employers
e.g., pay premiums,
ERISA, Sponsor
Health Program

3rd Party
Payers

Public

Private

Individuals

Insurance
Companies

Other
Private, e.g.
Associations,
Charitable
Organizations

Elder
Care

Indigent
Care

Care of
Others, e.g.,
Military &
Government
Workers

Source: Joel Shalowitz, MD, MBA 2003
LOW COST

Supplier

Payer / Regulator

User

Demand

Other

Supply

Price

Volume

Volume

Production Cost

Cost Shifting

Who Pays, e.g., Gov’t Mandates For Payment and Buyer Power

Intensity of Service

Level of Service

Site of Service

Inpatient

Other, e.g. SNF

Outpatient

Physician Office

Other, e.g., Surgicenter, Dialysis, Lab

Technology

Drugs

Devices

Number of Components Per Service Episode, e.g. Pills per Treatment

Decision to Perform Service Or Use Product

Efficiency of Service e.g., LOS, Duration of Product Use

Source: Joel Shalowitz, MD, MBA 2003
Customer Intimate/Total Solution
(ACCESS/EQUITY)

Who Accepts Insurance?

Who Is Not Covered?
(How Many Can/Does A Society Tolerate?)

Who Has Access to Coverage?

WHAT IS COVERED?

WHERE (Distance And Availability of Transportation)

Scheduling/Rationing

Availibility – Services

Providers

Products

Services

15

16

17

18

19

Source Joel Shalowitz, MD, MBA 2003
Product Leader (Quality)

Service

\[ \begin{align*}
\text{Technical} & \quad \text{Amenities} \\
\text{Structure} & \quad \text{Process} \quad \text{Outcome}
\end{align*} \]

Source: Joel Shalowitz, MD, MBA 2003