Critical thinking on cost benefit analysis of hospital stay

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Introduction

Health care systems across the world are struggling with rapidly mounting costs of health care provision to the whole population, quality assurance as well as universal access to facilities. Patients stay in hospitals only if they required continuous monitoring and specialized equipment or expert care, which cannot be cost-effectively or practicably be offered away from the hospital. If hospital stays do not serve the best interest of the patient or if such stays lead to higher costs than is necessary, then such stays are unnecessary (Epstein, Jha, & Orav, 2011). In order to ensure the efficiency, it is necessary to reduce the out-of-pocket expenses borne by the individual patients, while at once reducing the insurance reimbursements, since these will ultimately drive up the health insurance premiums. The fine print of medical insurance covers makes it difficult for individual consumers to fully understand the implications of hospital stays, but the efficiency implications are massive. This paper seeks to understand the motivations behind the doctors' recommendations, the existent literature on the issue and conduct a sensitivity analysis of the costs implications of the options available to patients, insurance companies, hospitals and physicians (Swayne, Duncan, & Ginter, 2006).

Problem Statement

The patient population that stays in hospitals longer than is needed has increased by as much as 25%, amidst growing efforts to place the elderly in care homes as against hospitals. Figures from the health authorities in the US, Canada and the United Kingdom shows that number of people staying on

in hospitals after they have, or should be cleared to leaves rose by 10% in 2011, with bed blocking increasing by upwards of 29% (Mechanic & Tompkins, 2012). The reasons for the prolonged stays are wide and varied, including the need to find placement homes before they leave; advice by doctors to stay on. This is out of line with the growing efforts to operate different payment systems for clinics, hospitals, post-acute care services, physicians and other classifications of care services. With this, there is limited financial support for forms of care that are not specifically defined by the policies or coordinating care between the defined categories. Policy a analysis indicated that bundling together Medicare and other insurance payments helps in reducing costs as compared to episode-based reimbursements (Jackson & Nolen, 2011).

In accordance with this policy arrangement, insurance companies pay for pre-hospitalization expenses that cover the expenses that are necessary for health examination as well as tests that happen before hospitalization. Consulting doctors are free to recommend tests, analyze or make assessments of the patient’s health at the cost of the insurance company, and insurance covers conventionally cover up to thirty days (Jackson & Nolen, 2011). In addition, post-hospitalization costs include the costs of tracking a patient’s illnesses in the determination of the patient’s conditions. Consulting doctors may carry out diagnostic tests; prescribe drugs and other procedures. Health insurance policies cover for these for a limited number of days. For short inpatient stays, insurance covers two-day stays. However, doctors often prescribe three-day stays, even if it is safe for patients to leave

after two days. The third day is not covered by medical insurance cover, and ultimately ends up as an out of pocket medical expense or an unrecovered cost on the part of the hospital (Epstein, Jha, & Orav, 2011). While doctors understand that cost implications on the patients and potentially the hospital, they deem it desirable to have patients to stay for a third day.

Analysis

Discharging patients is an intricate decisions that must balance the patients current condition, the prognosis of their disease, the possibility of the disease recurring and the cost implications and effects on the capacity of the hospital. In 2011, for instance, upwards of 36 million patients got discharged from various hospitals across the country. In excess of 20% of Medicare discharges were re-admitted in less than 30 days (Swayne, Duncan, & Ginter, 2006). Surveyed doctors blame the strict reimbursements that forces doctors to discharge patients before they ascertain if they are well. The bureaucracy involved has forced patients to find ways around them e. g. by being discharged and then re-admitted, then the policies may cover the expenses as against prolonged hospital stays. Research evidence indicates that longer stays prior to discharges could reduce the rates of re-admissions by up to 50% (Dinescu, Fernandez, Ross, & Karani, 2011). This will however lead to a massive increases in the costs borne by the patients depending on the nature of the disease and medical facility. The costs are borne either by the hospital, the patient or second medical insurance policies.

The 20%, unplanned re-hospitalizations are estimated to cost upwards of $17. 4 billion. This accounted for more than 17% of the hospital

reimbursements from Medicare (Jackson & Nolen, 2011). This shows that while insurance companies refuse to pay for the third day of hospital stay, they end up paying even more if the patients are relapse and have to be readmitted to hospital. While the actual number of re-admissions remains difficult to determine, it is estimated that between 9% to 50% of hospital re-admissions were assessed to be prevented by longer hospital care (Mechanic & Tompkins, 2012). The reduction of the levels of hospital re-admissions remains the target of the United States government, health care providers and insurance companies.

The widely obvious strategy in minimizing the re-admission rates seems increasing the number of days that a patient is hospitalized, which has obvious, immediate increases in the costs on the patient. However, medical practitioners have only preferred an additional day of hospitalization, which will cost the patient, but possibly mean the difference between re-admission and complete healing (Mechanic & Tompkins, 2012). The need of prolonging the hospital stay is only determined by the existence of adequately severe health condition that needs monitoring or therapeutic intervention. Patients may also be required to prolong their stay, even if they do not meet this criterion in order to find means to offer alternative care to the convalescents. The premature discharge of patients to environments that are incapable of meeting their own medical needs that would result in relapsing. The cost-savings from early discharges are subsequently be cancelled out by future utilization of healthcare facilities, including emergency care, nursing facilities etc (Swayne, Duncan, & Ginter, 2006). As shown by numerous observational

studies that have compared patients that received care from primary care physicians or hospitals.

It is possible to ignore the doctor’s recommendation for an additional day of stay, if it is possible to determine an appropriate post-discharge. If it is possible to arrange appropriate post discharge conditions that would help the patient recuperate and completely heal, then the additional stay in the hospital is not necessary (Dinescu, Fernandez, Ross, & Karani, 2011). In order to reach a decision such as this, it is crucial to understand the patient’s condition, rehabilitation potential, the ability to make effective decisions and other factors. Other factors to be considered by the doctors as well as the government and insurance companies include the patient’s cognitive status, functional and activity status, their present homes and support structure and access to medical help. If an adequately safe and helpful environment exists, then there is no reason at all to hold onto the patients that can be discharged.

Mechanic & Tompkins (2012) asserts that the cost savings from earlier discharges are substantial. To begin with, doctors have only been asking for additional day of hospital care in order to be sure of the patient’s condition and prognosis. Patients remain on medication whether when under hospital care or when they are discharged. The costs of drugs and other care will remain unchanged, and the only change in costs stems from the savings on the bed space, while there is reduced congestion in the hospitals to make room for other patients if early discharges are allowed, this is heavily dependent on numerous other factors. In fact, if delayed discharges reduce

the rates of re-admissions, then the bed space will be similarly freed up, and with no adverse consequences on the health and well being of the patients that are discharged (Epstein, Jha, & Orav, 2011).

In a cost benefit assessment exercise that use three different models, the results indicated that there are wide variations in the post-acute care expenditure by the patients. The health care providers that offer care to the targeted patient groups had costs ranging from 40% above the median spending to 100% (Swayne, Duncan, & Ginter, 2006). Incidents of heart attacks for instance, which necessitates high technology and costly equipment use led to upwards of 40% increases in the costs of medication in the event of hospital re-admissions as compared to a prolonged hospital stays. The increased utilization of the post acute care facilities increases the variations in the relative costs of medication. The variations are a pointer to the opportunities as well as partners that bolster quality, while at once reducing the short and long term costs of medication, timely scheduling, accurate decision-making by the doctors and other health care practitioners.

Other literatures have pointed out the necessity to lay a greater emphasis on the physicians' opinions in the care of the patients as against the obsession with cutting costs. Processes exist for discharging of patients, beginning with the planning, medication reconciliation and discharge summary that would always be adhered to by medics.

The decision as to when exactly a patient should be discharged is far from a perfect science, and this if a physician asks for an additional day to keep a

patient under close observation, there is no reason why it should not happen (Dinescu, Fernandez, Ross, & Karani, 2011). The two-day insurance cover policy, in the interest of cost efficiency only serves the very short efficiency needs, but ultimately costly to the entire health care system. If insurance covers are unavailable for an additional day stay at hospitals, it is better for the patients to cater for their own medication as against insisting on leaving. It is however, important to distinguish between the high rates of delayed discharges due to placements from the three-day stays.

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