Healthcare Cost Containment: A Survey Of Healthcare Financial Managers

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ABSTRACT

Federal and state governments, as well as third party payees, have created incentives for cost containment policies within healthcare settings. The purpose of this study is to determine the extent healthcare financial managers (HCFMs) believe various healthcare reform measures and cost containment strategies are effective and to descriptively compare the perception of effectiveness by type of organization (for profit, not for profit, and outside CPA/consulting firm). Eighty-four HCFMs, from 36 states, agree that the majority of healthcare reform measures are moderately or very effective. In general, accounting practices that HCFMs have direct decision making authority over were deemed effective (i.e. accounting systems that reduce administrative costs) regardless of type of agency employed. Surprisingly, accounting systems that provide more accurate allocation of indirect-overhead costs were not considered effective by not-for profit organizations. On the other hand, analyzing variances between expectations and actual cost/revenue, closely monitoring supply and equipment costs, and reducing administrative costs were rated effective by all three groups.

INTRODUCTION

Delivery of healthcare in the United States has undergone unprecedented change. The impetus for much of the change has been attempts at controlling spiraling costs. Even though the Health Security Act of 1993 was not enacted by Congress, national debate raised awareness of the industry's need for change. From the mid-1980s to present, declining inpatient census, shortened length of stay and significant changes in reimbursement have contributed to the closure or merger of many hospital units and the development of alternative treatment settings (Greenberg, 2001).

Effective management of healthcare resources is important in keeping costs contained. Hospitals are the largest sector of health care expenditures. For example, nursing is the largest and most labor-intensive component of hospital costs. On average, nursing accounts for more than 50% of hospital operating budgets (Caroselli, 1996). Therefore, hospitals are the primary target of efforts to curb rising costs in health care.

Federal and state agencies, as well as private third party payers have developed reimbursement policies designed to encourage cost reduction by healthcare providers. As a result of a highly competitive cost containment environment, health care organizations have been forced to manage their resources more efficiently. Cost categories examined for potential cost savings include physician use of resources, patient expenses, organizational and operational expenses, supplier cost, and labor cost. As the U.S. health care system undergoes fundamental changes in structure and processes, healthcare financial managers (HCFM) have emerged as an important part of the healthcare reform. There is increasing recognition that HCFMs have significant potential for providing leadership in health care delivery restructuring.

PROBLEM STATEMENT

The literature on cost containment tends to rely on case studies from local or regional hospitals. Little is known about cost containment strategies employed by health care organizations providing a variety of services at multiple locations. And no study was found in reviewing the literature that examines the perceptions of health care

financial managers concerning the impact of cost containment practices related to recent healthcare reform measures. Therefore, the purpose of this study is to examine trends in perceptions of healthcare financial managers regarding the effectiveness of cost containment strategies in light of state and federal regulatory efforts and changes in the reimbursement policy of third party payers.

Objectives

Objectives included the identification of the perceived effectiveness of cost containment strategies used by healthcare organizations. Comparisons were made regarding healthcare financial managers' perceptions of the effectiveness of cost control measures among Healthcare Financial Managers within a) not-for-profit healthcare organizations, b) for-profit healthcare organizations, and c) healthcare management consulting agencies.

Methods

A descriptive survey was conducted among healthcare financial officers across the United States to examine their perceptions of the effectiveness of health care reform on cost containment of patient care. A descriptive, comparative research design was employed for this study. Respondents were accessed by creating a mailing list of chapter officers contained within chapter information through the Healthcare Financial Management Association website: surveys were sent to 617 Healthcare Financial Managers (HCFM) with surveys returned by 84 Healthcare Financial Managers from 36 states.

Packets contained a cover letter, the Healthcare Reform Survey, a Demographic Data Sheet and a stamped return envelope. To ensure protection of human rights, the research proposal was reviewed by the Institutional Review Board (IRB). Participation was voluntary and consent was assumed upon receipt of a returned questionnaire. Descriptive statistics were computed for each item of the survey questionnaire. Perception of the effectiveness of various healthcare reform initiatives were examined using mean, standard deviation, and cross tabulations depending on the level of data generated.

Instrument

The Healthcare Reform Survey was developed from an extensive review of the literature and interviews with healthcare financial managers. In general, survey items reflect the extent HCFM believe that financial management, resource allocation, activity planning, and quality assurance have been effective at reducing healthcare costs. Subjects were asked to rate the effectiveness of each reform initiative as Not Effective (1); Moderately Effectively (2); or Very Effective (3). Content validity was determined by five content experts; two healthcare financial managers and three nurse executives. The questionnaire was pilot tested with twelve healthcare financial managers and nurse executives. Feedback was provided about the clarity of the questions, effectiveness of instructions, completeness of response sets, and time required to complete the questionnaire. Minor revisions to grammatical structure of items were subsequently made.

Factor analysis with varimax rotation was undertaken to examine the underlying relationships of the items of the Healthcare Reform Survey and yielded four distinct factors: accounting systems; expense tracking systems; cost shifting patterns and resource management. Eight items reflect Accounting Systems, four reflect expense tracking systems, three reflect cost shifting and two reflect resource management. Cronbach's alpha was used for estimating internal consistency reliability. The internal consistency of the Healthcare Reform Survey- Effectiveness was $\propto$=.87.

Sample

The survey respondents were 84 healthcare financial managers. Nineteen packets were returned undelivered. Therefore the response rate was 14%. The majority of HCFMs were male (n=59), had a mean age of 47.5 years (SD=6.9), and were involved in HCFM for an average of 19.8 years (SD=6.7). As shown in Table 1, the majority of HCFM were male, white, with areas of concentration in accounting or finance. When asked if they had a family who had received healthcare in the last year, 79 (94.0%) responded yes.

Table 1: Professional Characteristics of Healthcare Financial Managers

Characteristics	N	%
Gender		
Male	59	70.2
Female	25	29.8
Ethnic Background		
White	60	71.4
African American	1	1.2
Hispanic	3	3.6
Other	20	23.8
Marital status		
Married	72	85.7
Single	5	6.0
Divorced	5	6.0
Living with Significant Other	1	1.2
Missing	1	1.2
Educational background		
BA degree	33	39.3
MBA	32	38.1
Master's degree non business	9	10.7
Doctorate	2	2.4
Other	6	7.1
Type of healthcare agency		
not for profit	40	47.6
for profit	17	20.2
consulting firm	27	32.1
Areas of Concentration*		
General Business	22	26.2
Finance	36	42.9
Healthcare management	24	28.6
Accounting	59	70.2
Economics	5	6.0
Auditing	7	8.3
Other	13	15.5

*Note: Some HCFM marked more than one area of concentration

Respondents were asked to what extent they believed healthcare reform initiatives were effective for cost containment. Table 2 summarizes the responses for each type of employment setting. Responses for each type of healthcare financial agency (not for profit, for profit, and CPA/consulting) are reported as not effective, moderately effective and very effective.

Trends in responses were analyzed and compared. In general, HCFMs agree that the majority of healthcare reform measures were moderately effective. Healthcare reform measures deemed not effective tended to be those that the HCFM had less control over, such as decreased coverage for various drug therapies and increased physician accountability. On the other hand, those measures that HCFM have direct decision making over were deemed more effective (i.e. accounting systems that reduce administrative costs) regardless of type of agency employed. Surprisingly, accounting systems that provide more accurate allocation of indirect-overhead costs were not considered effective by not-for profit organizations (42.5%). One explanation may be that not-for-profit organizations do not typically ask unit directors to examine their overhead cost in light of revenue.

Table 2: Effectiveness of Healthcare Reform Initiatives

	Not for Profit n=40 n (%)	For Profit n=17 n (%)	CPA/Consulting Firm n=26 n (%)
Accounting systems that provide more accurate costing of healthcare services			
Not Effective	8 (20.0)	4 (23.5)	7 (26.8)
Moderately Effective	25 (62.5)	7 (41.2)	14 (53.8)
Very Effective	7 (17.5)	6 (35.3)	5 (19.2)
Improved monitoring of nursing and staff productivity			
Not Effective	2 (5.0)	3 (17.6)	3 (11.5)
Moderately Effective	27 (67.5)	9 (52.9)	17 (65.4)
Very Effective	11 (27.5)	5 (29.4)	6 (23.1)
Accounting systems that identify the kinds and amounts of personnel resources needed to care for patients			
Not Effective	7 (17.5)	3 (17.6)	7 (26.9)
Moderately Effective	27 (67.5)	8 (47.1)	17 (65.4)
Very Effective	6 (15.0)	6 (35.3)	2 (7.7)
Accounting systems that provide information on cost behavior patterns (i.e. variable vs. fixed cost) for improved decision making			
Not Effective	10 (25.0)	2 (11.8)	7 (26.9)
Moderately Effective	27 (67.5)	13 (76.5)	13 (50.0)
Very Effective	3 (7.5)	2 (11.8)	6 (23.1)
Shifting delivery of care to home settings			
Not Effective	4 (10.0)	4 (25.0)	4 (14.8)
Moderately Effective	27 (67.5)	9 (56.3)	17 (63.0)
Very Effective	9 (22.5)	3 (18.8)	6 (22.2)
Shifting of healthcare services to outpatient services			
Not Effective	4 (10.0)	3 (17.6)	-
Moderately Effective	21 (52.5)	7 (41.2)	17 (63.0)
Very Effective	15 (37.5)	7 (41.2)	10 (37.0)
Restriction of coverage for various drug therapies			
Not Effective	19 (47.5)	10 (58.8)	9 (33.3)
Moderately Effective	15 (37.5)	6 (35.3)	16 (59.3)
Very Effective	6 (15.0)	1 (5.9)	2 (7.4)
Accounting systems that closely monitor salary and wage expenditures			
Not Effective	7 (17.5)	2 (11.8)	7 (28.0)
Moderately Effective	27 (67.5)	10 (58.8)	14 (56.0)
Very Effective	6 (15.0)	5 (29.4)	4 (16.0)
Accounting systems that provide more accurate allocation of indirect/overhead cost			
Not Effective	17 (42.5)	4 (23.5)	8 (32.0)
Moderately Effective	19 (47.5)	10 (58.8)	10 (40.0)
Very Effective	4 (10.0)	3 (17.6)	7 (28.0)
Increased nurse/staff accountability for cost containment			
Not Effective	3 (7.5)	2 (11.8)	2 (7.7)
Moderately Effective	26 (65.0)	8 (47.1)	17 (65.4)
Very Effective	11 (27.5)	7 (41.2)	7 (26.9)
Accounting systems that provide for the analysis of variances between budgeted expectations and actual cost/revenue			
Not Effective	4 (10.0)	2 (11.8)	5 (20.0)
Moderately Effective	24 (60.0)	12 (70.6)	16 (64.0)
Very Effective	12 (30.0)	3 (17.6)	4 (16.0)
Accounting systems that closely monitor supply and equipment costs			
Not Effective	4 (10.0)	1 (5.9)	3 (11.5)
Moderately Effective	25 (62.5)	13 (76.5)	18 (69.2)
Very Effective	11 (27.5)	3 (17.6)	5 (19.2)

Reexamination of staffing patterns to address staffing needs (i.e. mandatory overtime; cross training)			
Not Effective	7 (17.5)	3 (17.6)	5 (20.8)
Moderately Effective	24 (60.0)	11 (64.7)	15 (62.5)
Very Effective	9 (22.5)	3 (17.6)	4 (16.7)
Increased physician accountability for cost containment			
Not Effective	4 (10.0)	6 (35.3)	9 (34.6)
Moderately Effective	20 (50.0)	4 (23.5)	14 (53.8)
Very Effective	16 (40.0)	7 (41.5)	3 (11.5)
Improved utilization review systems that monitor the necessity and appropriateness of care			
Not Effective	3 (7.5)	3 (17.6)	4 (15.4)
Moderately Effective	26 (65.0)	8 (47.1)	15 (57.7)
Very Effective	11 (27.5)	6 (35.3)	7 (26.9
Budgeting techniques that identify key performance areas and track the cost of achieving specific goals			
Not Effective	5 (12.5)	2 (11.8)	13 (15.7)
Moderately Effective	24 (60.0)	12 (70.6)	50 (60.2)
Very Effective	11 (27.5)	3 (17.6)	20 (24.1)
Accounting systems that assist in determining the kinds of facilities, programs, equipment and medical specialties needed to develop strategically			
Not Effective	9 (22.5)	3 (18.8)	10 (38.5)
Moderately Effective	22 (55.0)	8 (50.0)	10 (38.5)
Very Effective	9 (22.5)	5 (31.3)	6 (23.1)
Accounting systems that reduce administrative cost (i.e. expediting and simplifying insurance verification, billings, collections, and payments)			
Not Effective	4 (10.0)	1 (5.9)	4 (15.4)
Moderately Effective	20 (50.0)	8 (47.1)	11 (42.3)
Very Effective	16 (40.0)	8 (47.1)	11 (42.3)

DISCUSSION

This study examined the extent HCFMs believe healthcare reform initiatives are effective for cost containment given recent healthcare reform initiatives. While the sample size was small, HCFMs, leaders in their professional organization (Healthcare Financial Managment Association), from 36 states participated in the study. This nationwide study represents one of the few surveys of HCFMs and their perceptions of impact of reform initiatives to reduce the growing cost of healthcare in the country.

HCFMs have had to help providers make significant adjustments in operating structure to accommodate the rapid shift from DRG reimbursement to managed care plans. The accounting systems in place in organizations are aimed at tracking and managing costs. Financial managers have been charged during the last decade with setting pricing for the services provided. Cost accounting has facilitated not only the pricing of services, but the communication of relevant cost separated into meaningful categories (Berger, 2002**;** Gapenski, 2002**;** Finkler, & Kovner, 2000).

In this study, HCFMs felt most accounting systems were moderately or very effective. Accounting systems that provide more accurate allocation of indirect cost was not rated overwhelmingly effective by any type of HCFM. However, analyzing variances between expectations and actual cost/revenue, closely monitoring supply and equipment costs and reducing administrative costs were rated effective by all three groups. Tracking/monitoring systems were also deemed effective by HCFMs. Specifically, budgeting techniques that identify key performance areas and track the cost of achieving specific goals was rated effective among all three groups. Managers are encouraged to examine variances in their budget on a regular basis. This action provides HCFMs with a record of activities in case the budget deviates from the financial performance expected.

Since health care has a high proportion of labor costs associated with delivering care, accounting systems that monitor income and expenditures directly related to care are deemed effective. In healthcare, the challenge for managers is to deliver the best possible care with the best clinical outcomes without overspending for the services that need to be provided (Berger, 2002). Many issues have an impact on appropriate staffing of patient care. Simply changing the number of nurses per patient may not be the only or most cost effective strategy to provide safe and effective patient care (Bower, 2000).

Physicians are usually considered the toughest group to train to appropriately document expenditures. They often do not work for the healthcare institution, they may be resistant to changes in documentation, and frequently do not understand that better documentation means better reimbursement (Berger, 2002). This may explain why, in this study, HCFMs, deemed attempts to increase physician accountability associated with cost containment less effective than other cost containment measures.

Of all strategies to reduce costs associated with healthcare, more HCFMs felt restriction of coverage for various drug therapies the least effective than any other cost containment strategies. Specifically, over half of the HCFMs working for for-profit agencies felt this measure was not effective. This may be explained by the fact that as new drugs are developed, escalating costs associated with their marketing may be a variable that is not easily managed in the model of delivery.

In a consumer-driven system, employers, health plans, and insurance companies will increasingly rely on plan design to moderate cost increases (Altman and Levitt, 2002). In this study HCFMs felt that shifting delivery of care to home/outpatient settings was moderately effective. It is estimated that in addition to continued shifting of care, new health account models will attempt to address rising costs associated with monthly premiums and varying levels of point of service choice and tiered payments. What is not known is the cost to the families who care for family members. Future studies need to examine family intervention models that facilitate caregiver support which in turn theoretically reduces the need to return to the hospital during noncoverage periods (i.e. within a certain time frame after discharge from hospital).

A long term plan is needed to develop strategically. Accounting systems that determine kinds of facilities, programs, and equipment needed to develop strategically was more likely to be deemed moderately or very effective by for profit and not for profit HCFMs than HCFMs who work as CPAs/consultants. The fact that CPAs/consultants were less inclined to agree with resource management analysis is because these HCFMs are not employed by the organization and do not necessarily have a vested interest in the strategic plan for the whole organization.

It is understood that HCFMs have to understand the factors that affect the finances of the healthcare industry. This study attempts to describe similarities and differences among HCFMs working in not for profit, for profit, and CPA/consultant firms. Acknowledging that HCFMs believe that accounting systems responsive to healthcare reforms are effective, validates and contributes to the ongoing efforts of HCFMs to continue to use their expertise to maximize revenues, and minimize costs in order to provide competitive, caring patient care.

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