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Ambulatory Care and Healthcare Reform

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As healthcare reformers search for ways to expand access and control costs, there is growing recognition that a key part of any reform must include a change in the way health care is actually delivered. The current fragmented system, which focuses on caring for the ill rather than preventing illness and institutional care rather than prevention and primary care, imposes sizable administrative costs and considerable inconvenience for even the well-insured patient. In the view of many, an important component of healthcare reform is reforming the healthcare delivery system so that care is more integrated, coordinated, patient-centered, cost-effective, and responsive to community needs.[1] If achieved, a reformation of this sort will result in an enormous change in the healthcare system, involving dramatic shifts in all aspects of the system, from financial and legal structures to the individual values of healthcare leaders and consumers. Devising appropriate financial incentives and establishing a regulatory structure that will implement and facilitate these changes will be a critical and difficult part of healthcare reform.

Major shifts in the system of healthcare delivery are not new, however. Change was particularly acute in the 1980s, when healthcare delivery moved out of the inpatient arena and into outpatient facilities and the home. This change substantially altered the type of healthcare services, the place where services were provided, and the nature of the provider furnishing the services. Public and private payment and oversight policies, coupled with

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1. *See* AMERICAN HOSPITAL ASSOCIATION, A HEALTHIER AMERICA THROUGH COMMUNITY CARE NETWORKS: THE AMERICAN HOSPITAL ASSOCIATION'S VISION FOR NATIONAL HEALTH CARE REFORM (May 1992) [hereinafter A HEALTHIER AMERICA].

changes in technology, affected the delivery system in two ways: (1) outpatient and home care rapidly replaced inpatient care, and (2) care sites and ownership patterns rapidly expanded. This article traces the extent and pattern of the changes in ambulatory care during the 1980s and provides lessons for future reform.

GROWTH IN AMBULATORY CARE

During the 1980s, particularly during the latter half of the decade, changes in the system of healthcare cost reimbursement and advances in technology combined to cause a dramatic shift from inpatient to outpatient services. Because inpatient care has traditionally been the most costly type of care for the Medicare system, the first major effort to control Medicare costs—the movement to a Prospective Payment System ("PPS")—focused on inpatient services. Similarly, a major goal of private insurers, utilization review companies, health maintenance organizations, and others was to limit utilization of inpatient services and monitor the quality of inpatient care.

At the same time that payers were using financial incentives to discourage the use of inpatient services, advances in technology and anesthesia made it possible for many procedures and treatments to move safely from the inpatient arena to outpatient centers and even into the home.

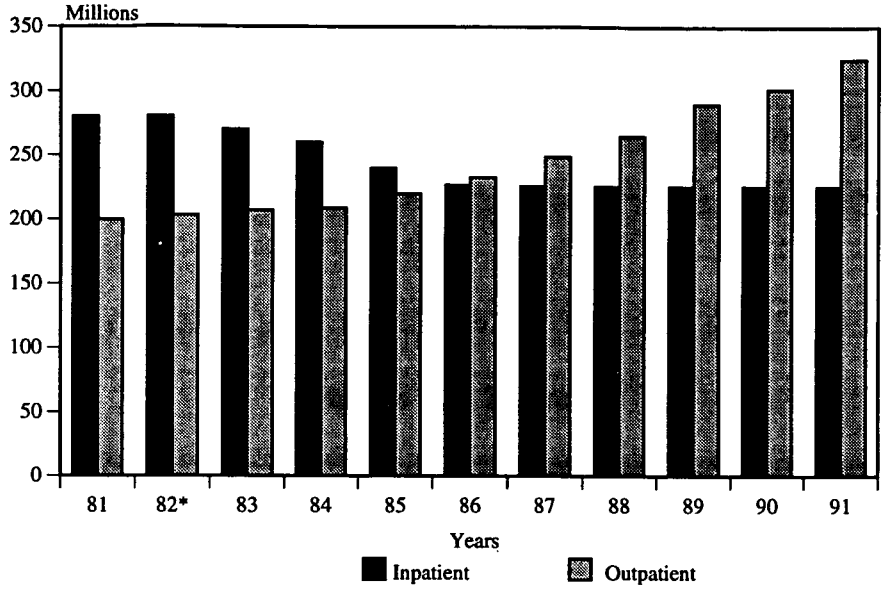
The system's response to these forces has been quite dramatic, as shown in figure 1 on the next page. The total number of outpatient visits grew by approximately six percent per year from 1985 to 1991, reaching slightly over nine and one-half percent between 1987 and 1988. Since the absolute number of hospitals actually decreased during this period, the growth rate per hospital was even higher than these numbers suggest. This pattern contrasts sharply with inpatient statistics: the number of inpatient days declined by slightly less than three and one-half percent between 1985 and 1986, and then remained virtually constant.[2]

The combination of a decline in inpatient days and an increase in outpatient visits resulted in a substantial revenue shift. Outpatient services now generate twenty-three percent of hospital revenues, up

2. AMERICAN HOSPITAL ASSOCIATION, AHA HOSPITAL STATISTICS xiiv-xiv (1992-1993 ed.) [hereinafter AHA HOSPITAL STATISTICS]. *See also American Hospital Association, National & Regional Trends in Outpatient Hospital Care 1980-1990*, AMBULATORY CARE TRENDLINES 1992, Mar. 1992 [hereinafter *National & Regional Trends*]; Anne M. Murphy & Tecla A. Murphy, *Using the Emergence of Primary Health Care in Hospital Strategy and Community Reform*, J. HEALTH & HOSP. L., Nov. 1992, at 321.

Figure 1

Community Hospitals Inpatient Days versus Outpatient Visits, 1981-91

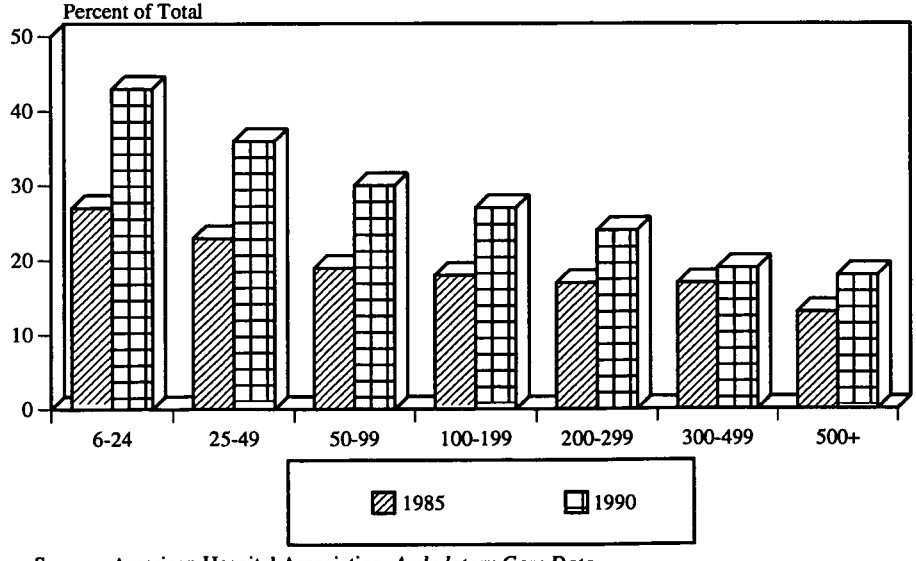


*Outpatient visit data for 1982 has been estimated using statistical techniques in order to compensate for a change in the reporting method for outpatient visits in 1982.

Source: AMERICAN HOSPITAL ASSOCIATION, AHA HOSPITAL STATISTICS (1992).

Figure 2

Outpatient revenues as percent of total, by bed size, 1985 and 1990



Source: American Hospital Association, *Ambulatory Care Data,* AMBULATORY CARE TRENDLINES 1992, Mar. 1992.

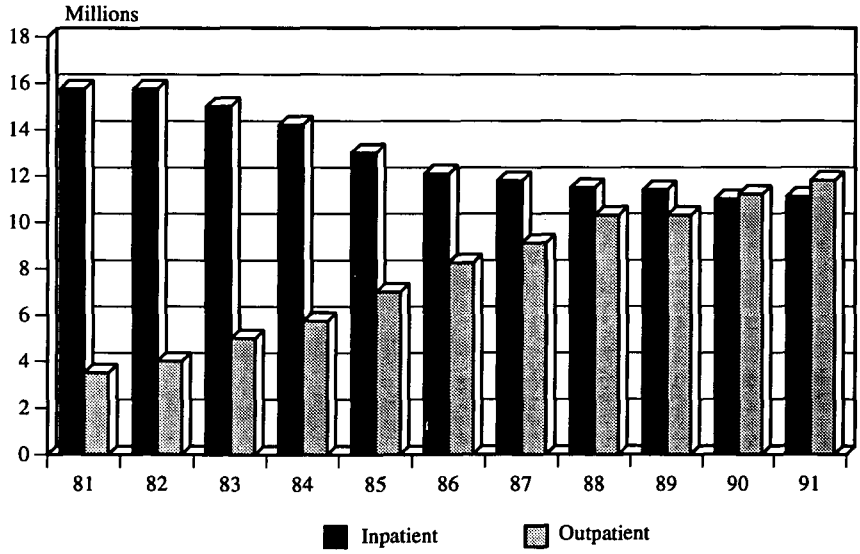
from thirteen percent in 1980. According to some estimates, outpatient services will constitute half of all hospital revenues by the year 2000.[3] In fact, as shown in figure 2, small hospitals approached this half-way mark in 1990.

OUTPATIENT SURGERY

The increase in ambulatory surgery is one of the most dramatic examples of the shift from inpatient to outpatient services. In the early 1980s, surgeries were almost never performed on an outpatient basis; now most surgeries are. Figure 3 shows that hospital-based outpatient surgery has more than tripled since 1980, growing from three million in 1980 to 11.7 million in 1991. By 1991, 52.3% of all surgeries performed in community hospitals in the United States were performed on an outpatient basis.[4] Smaller hospitals moved toward utilizing ambulatory surgery because their hospital staffs tend to perform less complex procedures, which lend themselves to the outpatient arena. By 1990, the smallest hospitals (those with under twenty-four beds) performed seventy percent of

Figure 3

Surgical Operations in Community Hospitals, 1981-91



Source: AMERICAN HOSPITAL ASSOCIATION, AHA HOSPITAL STATISTICS (1992).

3. Murphy & Murphy, *supra* note 2 (citing Howard Anderson, *Is Your Hospital Prepared for Continued Growth in Ambulatory Care?*, HOSPS., June 20, 1991, at 32.).

4. AHA HOSPITAL STATISTICS, *supra* note 2.

their surgery on an outpatient basis; by contrast, only approximately forty percent of the largest hospitals performed their surgery on an outpatient basis.[5]

The development of new technology and anesthesia that are less intrusive and traumatic to the body and that require a much shorter recovery time is one of the most significant forces driving this shift of surgery to the outpatient arena. Advances in endoscopic and laparoscopic surgical techniques contributed to an increase of procedures performed on an outpatient basis in 1988 as compared to 1983. In 1983, only twenty-five percent of surgical procedures were performed on an outpatient basis; by 1988, forty-eight percent of all surgical procedures were performed in an outpatient setting—a total of six million.[6]

Public and private payers have also had a significant role in shifting surgery to outpatient facilities. Capitated payments encourage the use of more cost-effective sites whenever possible. In addition, external review entities, such as case managers, will question the need for inpatient surgery once the outpatient alternative has become accepted medical practice.

Finally, most patients are likely to prefer the outpatient alternative because they view it as less risky and less disruptive to their daily lives. Once the safety and quality standards of a procedure can be achieved on an outpatient basis, clinical, social, and financial forces will push the procedure to the outpatient setting.

An interesting result of the movement from inpatient to outpatient settings is the growth of ambulatory surgery in "freestanding" facilities, which are physically separate from the hospital facilities[7] and may or may not be owned by the hospital. During the 1980s, the number of surgeries performed in freestanding ambulatory surgery centers ("FASC"s), particularly in facilities not owned by a hospital, grew dramatically. Figure 4 shows that the number of outpatient surgeries performed by hospitals, whether on-campus or off-campus, grew by about 60% between 1985 and 1990, from about 7 million to more than 11 million. The number of surgeries

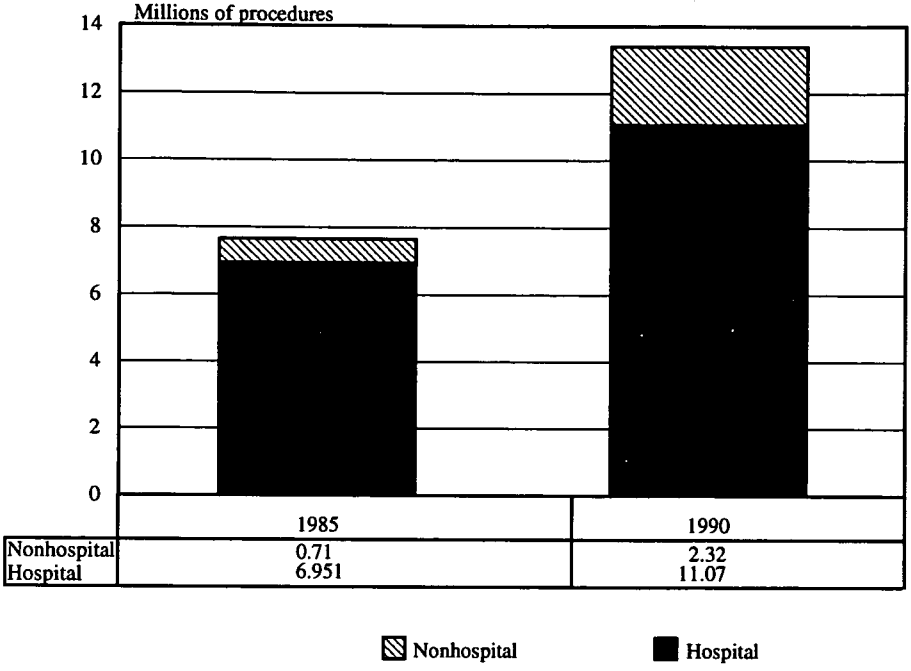
5. American Hospital Association, *Outpatient Surgery Trends 1980-1990*, AMBULATORY CARE TRENDLINES 1992, Apr. 1992.

6. Henry C. Alder & Steven J. Lewis, *Meditrends in General Medicine and Surgery* 38-39, *in* AMERICAN HOSPITAL ASSOCIATION, MEDITRENDS 1991-1992 (1992).

7. Because these "freestanding" ambulatory surgical centers are physically separate from the hospital's other facilities, the Health Care Financing Administration restricts the types of ambulatory surgery they can perform. *See* COLIN P. FLYNN & MARGARET B. SULVETTA, A COMPARATIVE ANALYSIS OF AMBULATORY SURGICAL CENTERS AND HOSPITAL OUTPATIENT DEPARTMENTS 4-7 (The Urban Inst. 1992).

Figure 4

Comparision of surgeries performed by hospital vs. nonhospital facilities



Source: American Hospital Association, *Ambulatory Care Data,* AMBULATORY CARE TRENDLINES 1992, Mar. 1992.

in nonhospital-owned facilities increased even more rapidly during the same period. As a result, the hospital share of outpatient surgeries declined from 90% to 83% during this period.

Changes in reimbursement policy have also led to the growth in FASCs. In 1982, the Health Care Financing Administration ("HCFA") listed 450 approved procedures for FASCs; ten years later, the list had grown to 2,500 procedures. Regulatory factors have also contributed to the growth of FASCs. In many states, the regulations that require hospitals to submit a certificate of need ("CON") application for any construction, whether on-campus or off-campus, do not apply to FASCs. However, some states have begun to apply CON requirements to new types of providers. Finally, FASCs are not subject to the same licensing requirements as hospitals.[8]

8. The continued growth in the 1990s of FASCs that are not hospital-based will depend on the types of changes that take place in the legal and regulatory arena. For example, recent government actions pertaining to self-referral and fraud and abuse could have a chilling effect on the development of physician-owned FASCs.

In short, the growth of ambulatory surgery exemplifies the way in which financial and regulatory incentives in the 1980s promoted not only a shift from inpatient to outpatient care, but a proliferation of new sites for care and new types of providers.

HOME CARE

A related facet of the rapid movement of care beyond the hospital walls is the growth of home care. The growth in hospital-based home care programs has taken two forms: (1) a growth in the number of programs during the first half of the 1980s, and (2) a growth in the average number of visits per program in the second half of the 1980s.

In anticipation of and as an early response to significant inpatient hospital reimbursement changes, the number of hospital home care programs grew dramatically during the first half of the 1980s. In 1980, approximately ten percent of community hospitals operated home care programs; by 1986, over one third did. After 1986, the number of programs remained fairly constant, but the average volume of participation increased dramatically. The average hospital home care program provided 6,239 annual home visits in 1980, 8,256 visits in 1986, and 12,290 visits in 1990.[9]

Several demand factors account for this growth, including an aging population, the growing inability of two-career families to care for their older relatives in time of need, and increased ability to meet patients' preferences of receiving care at home rather than in the hospital setting. Supply-side factors include rapid technological advancements in equipment and changes in pharmaceuticals. Perhaps the most important factor, however, was the growing need for home care follow-up, as inpatient stays were shortened and more surgeries were performed on an outpatient basis. Particularly critical was the growing recognition by many payers that home care can be more cost-effective.[10]

ISSUES RAISED BY THE SHIFT TO AMBULATORY CARE

Delivery and Quality

For the most part, the transformation from inpatient care to outpatient, home, and community-based care is great news for pa-

9. American Hospital Association, *Growth Trends in Hospital Home Care 1980-1990*, AMBULATORY CARE TRENDLINES 1992, July 1992.

10. *See* S. Mitchell Weitzman, *Legal and Policy Aspects of Home Care Coverage*, 1 ANNALS HEALTH L. 1 (1992).

tients. Ambulatory surgery, for example, generally results in less trauma to the body, fewer risks from a local anesthesia than a general anesthesia, and a shorter recovery time.[11] An outpatient facility can be designed to be more patient-centered and have a more patient-friendly system, not only for providing care but for admissions, billing, and other support services as well.

However, as the sites of care and types of services provided continue to evolve, adequate quality assessment mechanisms will become necessary. For example, most ambulatory surgery performed today involves innovative procedures that were unknown when most physicians were in medical school. The difficulty of monitoring quality in freestanding facilities, which are generally not subject to the same accreditation and licensing standards or the same quality monitoring as hospitals, recently prompted a series of investigations by the Office of the Inspector General. The investigations revealed that the amount and type of quality review varies tremendously from state to state. A number of facilities performing significant procedures were subject to only minimal licensing requirements or other quality control.[12] As a result of these investigations, Congressman Wyden (D-Or.) proposed legislation that would require the accreditation of freestanding ambulatory surgery and emergency care facilities.[13]

Coordination and Integration of Care

Other problems have resulted from the dramatic shift from inpatient to outpatient care as well. The increased use of ambulatory services, which resulted in a rapid proliferation of providers, has led to fragmented care. As the number of freestanding "boutique" programs specializing in particular services such as urgent care or ambulatory surgery increases, the delivery system becomes more fragmented. Even within the hospital, the responsibility for outpatient care is often scattered among a variety of uncoordinated units, most of which initially developed as a sideline to the hospital's inpatient services. This fragmentation is compounded by the

11. *See, e.g.*, David A. Gould et al., *Coming of Age: Home Care in the 1990's*, PRIDE INST. J., Winter 1992.

12. OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH & HUMAN SERVICES, SURGERY IN OUTPATIENT SETTINGS: A FOUR-STATE STUDY (1991); OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH & HUMAN SERVICES., SURGERY IN OUTPATIENT SETTINGS: FORMS OF OVERSIGHT (1992).

13. H.R. 6096, 102d Cong., 2d Sess. (1992) (The legislation intended to provide for the certification of ambulatory surgery and emergency care facilities. The bill was sent to the Ways & Means and Energy & Commerce Committees, but was not reported out to the full House before the end of the Congress.).

lack of core data and information systems needed to coordinate and manage patient care needs at the various sites of care including the ambulatory care area, inpatient and outpatient areas of the hospital, and community providers.[14]

Financing and Access

For the healthcare system as a whole, the shift away from inpatient care creates an opportunity to save money. However, the realization and pace of potential savings will depend on many factors, including (1) the expense of new technology and drugs, (2) whether the cost of maintaining an existing facility will permit the building of a new facility, and (3) whether the lower risk and shorter recovery time of ambulatory surgery increases the utilization of elective surgery.

While there is some good news for the healthcare system as a whole, concerns exist about additional strains on the current financing system. In the past, as the number of uninsured grew and public payers began paying a smaller percentage of costs, hospitals with a large number of nonpaying patients shifted costs to private payers in order to make up for losses resulting from nonpayment or underpayment. In other words, hospitals exercised de facto taxing powers by shifting costs to private pay patients as a means of absorbing losses from nonpaying and underpaying patients.

The shift from inpatient to outpatient facilities can erode the hospital's ability to shift costs for two reasons. First, the shift from inpatient to outpatient care appears to occur more quickly with private pay patients than with nonpaying and Medicaid patients, thereby eroding the hospital's "tax base" for cost shifting.[15] Second, many of the new outpatient facilities accept only private pay patients. These facilities, if not owned by a hospital, do not have to cross-subsidize trauma centers, emergency departments, or other expensive service areas.

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14. The lack of comprehensive information systems makes it difficult to evaluate and control utilization of labor, material, and facility resources and difficult to respond to demands for fiscal and utilization information by payers, regulators, and accreditors. *See* DATA COMMITTEE, SOCIETY FOR AMBULATORY CARE PROFESSIONALS, CORE DATA ELEMENTS NEEDED FOR UNIFORM COLLECTION AND ANALYSIS OF AMBULATORY CARE DATA (1993).

15. *See* Irene Fraser et al., *Medicaid Shortfalls and Total Unreimbursed Hospital Care for the Poor, 1980-1989*, INQUIRY, Winter 1991, at 385-92; Irene Fraser et al., Hospital Care for the Poor, 1980-1989: Participation, Unreimbursed Costs and Implications for Access (prepared for delivery at the 1991 Annual Meeting of the Association for Health Services Research, San Diego, Cal., June 1991) (on file with author).

IMPLICATIONS FOR HEALTHCARE REFORM

Reformers of the nation's healthcare system recognize that the "broken" healthcare system will not be "fixed" by simply giving more people access to it. Instead, the manner in which health care is delivered must be fundamentally changed; there must be (1) a focus on wellness rather than the treatment of illness, (2) a realigned continuum of care, placing greater emphasis on and increasing access to preventive and primary care, (3) more patient-friendly and patient-centered systems, (4) greater coordination and continuity of care, (5) more economic discipline on the part of providers, and (6) providers who are clinically and financially accountable to their patients and the community.[16]

The experience of the healthcare system in the 1980s shows that changes in financial incentives, especially changes that reinforce sound medical practice and patient preferences, can dramatically and positively effect the manner in which health care is provided. At a time when many reform proponents feel caught between the twin and often seemingly contradictory goals of expanding access and controlling costs, the possibility of reforming the system of healthcare delivery provides some reason for optimism.

Increasing community-based networks of care and continuing to move health services into outpatient areas, the community, and the home can achieve the goal of enhancing community health and improving access to timely, patient-centered, quality care. However, the shift of care from the inpatient to the outpatient setting during the 1980s shows that structural changes in the healthcare delivery system can have unintended and untoward consequences—a proliferation of care sites and a fragmentation of the delivery system (just as the abandonment of community rating in the insurance industry led to fragmentation in the insurance system). Thus, while the changes needed in the 1990s are a natural extension of changes made in the 1980s, there must be a different emphasis; duplication of services must be minimized and continuity and coordination of care assured. Capitated payments, which are payments to networks to take care of a fixed population for a fixed fee, are the means most likely to be used in achieving these goals. Although a transformation of this sort may seem little short of revolutionary, the 1980s showed that relatively small changes in incentive structures can produce dramatic changes.

16. *See* A HEALTHIER AMERICA, *supra* note 1; Connie Evashwick, *Creating the Continuum of Care*, HEALTH MATRIX, Spring 1989, at 30-39.