
Health-Care Financial Management in a Changing Environment

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Concerns over escalating health-care costs have brought about significant changes in the way health-care organizations and professionals are compensated for their services. Capitation, the payment of a fixed fee to health-care providers in exchange for providing medical care when it is needed, has been a significant element of change in the health-care industry. The purpose of this paper is to propose a framework for the evolution of management accounting systems in a changing health-care environment. This framework suggests that the role of activity-based costing, life cycle costing, and value chain analysis becomes increasingly important as the payment for health-care services moves from fee for service reimbursement to capitation arrangements between insurance companies and health-care providers. Health-care organizations that design and implement accurate costing and evaluation systems will enhance their ability to compete successfully in this rapidly changing environment. J BUSN RES 2000. 48.183-191. © 2000 Elsevier Science Inc. All rights reserved.

Total health-care expenditures between 1980 and 1994 increased 400% from \$250 billion dollars to over \$1 trillion (Standard and Poors, 1995). In response to escalating health-care costs, the health-care industry, led by insurance companies, physicians' groups, and hospitals, has established health maintenance organizations (HMOs) and other integrated delivery systems. Typically, these health maintenance organizations enter into capitation agreements with participating physicians, and/or hospitals, thereby, providing an essentially fixed revenue stream in exchange for some form of guaranteed care for the covered group.

With the emergence of this new way of doing business, the financial focus of hospitals and physicians must significantly

change. Health-care providers (HCPs) that customarily focused on increasing revenues by providing a variety of services and maintaining high occupancy rates must now seek to control costs, while still providing quality service. The impact of this change is confounded by the fact that many HCPs have inadequate cost-accounting systems.

Failure to manage health-care costs and to obtain accurate cost information may leave HCPs ill-equipped to negotiate capitation agreements with provider networks and threaten their ability to remain competitive. Improved cost management systems, such as activity based costing (ABC) that identifies all activities associated with a specific treatment, and their corresponding cost, can improve financial cost management. These systems are expensive to implement, but may allow health-care organizations to more accurately determine and trace costs of services and develop a better understanding of the cost of services provided. Such advanced cost management practices as life cycle costing and value chain analysis provide the opportunity for integrated health-care providers to better manage total health care costs. Life cycle costing could provide integrated networks with the ability to understand total patient health-care cost over the life of an illness or even the patient's entire lifetime. Similarly, value chain analysis can assist health-care providers in managing total patient health-care cost through the elimination of redundant services and increased efficiencies in dealing with other value chain participants, including doctors, hospitals, and insurance companies. To compete in the rapidly changing health-care environment, HCPs must develop an information system that provides financial and nonfinancial feedback in support of more advanced cost management methods. The HCP's ability to develop the information necessary to benefit from life cycle costing and value chain analysis is positively related to the degree of integration within the network.

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The purpose of this paper is to discuss the role of managerial accounting in assisting HCPs to reduce cost and remain competitive. The first section provides an overview of financial trends affecting hospitals and other health-care providers. The second section presents a framework for applying ABC, life cycle costing, and value chain analysis in the health-care setting. Next, a more complete discussion of the application of these tools is provided. Finally, a discussion of control and performance evaluation systems is presented, followed by a summary and conclusions.

The Changing Health-Care Environment

Historically, hospitals have focused on generating revenues through increasing bed capacity, occupancy rates, fee for service rates, and the number of patients treated per day. This focus leads to a strategy of bringing more people into the facility for treatment by providing more and better services. The exact costs of these services to the hospital or their impact on profitability had not been a major consideration. Revenues were increased by marketing the treatment, with little concern for the cost of the specific treatment.

Managed care organizations emerged in response to pressure to slow the increase in health-care costs. These organizations vary in scope from health maintenance organizations (HMOs) to large integrated delivery systems. Integrated delivery systems are conglomerations of organizations that work together to provide health-care services to a population of patients, enabling higher quality care, more specialized services, and lower risks and costs to the provider. These networks usually cover a specific geographic area to provide needed health-care services to a given population. The impetus for integrated delivery systems comes from four different sectors: hospitals, physicians or physician groups, a combination of hospital and physician groups, and insurance companies (Shortall, 1995).

The idea of an integrated network is to develop a network of health-care services through exclusive relationships, capitation agreements, and mergers that will provide quality, convenience, and affordable health-care services to the covered population. A large integrated network should be able to increase cost efficiency by reducing duplicate services and paperwork. In addition, the network provides for a dilution of the risk sharing involved with capitation.

Capitation agreements between insurance companies, hospitals, and physicians provide that a fixed fee be paid per month, per person in the covered group. The fee is determined by an actuarial analysis of the covered population and the anticipated medical costs. One estimate is that, by the year 2,000, 95% of all medical treatment in some geographic regions will be covered under some type of capitation agreement (Carroll, 1995). As capitation agreements become the normal payment structure, revenues become more fixed and predict-

able, making cost control a more significant issue. HCPs traditionally emphasized increasing revenues to increase profits and/or return on investment (ROI). The emphasis is shifting from revenues to controlling costs. Cost control will become the primary financial management responsibility and the way to increase profits.

According to Fromberg (1996), capitation models generally fall into three basic types of contract between the payor, typically the HMO, and the service providers. The first type, with lowest degree of integration, is an agreement between the HMO and primary care physicians, specialists, and hospitals. The primary care physicians are paid on a capitated basis, but specialists are not capitated, and hospitals are paid on a per diem basis. With the next higher level of integration, specialists as well as primary care physicians are capitated. The highest integration occurs in a global capitation model in which the HMO enters into a contract for all health services with a physician-hospital organization.

Capitation can drastically affect the staffing procedures at hospitals. Some hospitals are trying to buy into the practices of primary care physicians and physician groups in order to provide an integrated primary care network to the public (Pallarito, 1994). Capitation also creates an incentive to increase the emphasis on preventative health care; providing the patient with preventative education and treatment to reduce and eliminate illness and disease over the patient's lifetime. Hospital networks that develop wellness programs to promote healthy lifestyles may benefit from lower health-care costs in the future. An example of this approach to health care is discussed by Scott Goodspeed (as reported in Greene, 1995) who indicates that many hospitals are talking about "developing community-care networks to improve the health status of a geographic population." Goodspeed, however, goes on to say, "Unfortunately, there's not enough action" (p. 86). The importance of hospitals developing wellness programs is provided by Carroll (1995) who states that:

Under capitation, we have already received a per-member, per-month rate and are at economic risk for the cost of all services over and above the monthly premium paid by or for the member. The incentives under capitation are to keep the member healthy and to reduce the need for costly acute care services. (p. 28)

Integrated delivery systems with fixed revenues may reduce health-care costs by increasing the number of procedures that are performed on an out-patient basis, while still maintaining occupancy rates at the full-service hospitals. Out-patient costs are significantly lower than in-patient care, and development of new technologies that permit out-patient treatment, or lower cost home health-care options are likely to be encouraged.

Capitation creates winners and losers. Insurance companies support capitation, because their payments to hospitals and physicians are of a predictable, consistent nature, shifting some of the risk of the traditional insurance agreement to the

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