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Ambulatory care visits and quality of care: does the volume-control policy matter?

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Abstract

Using claims data from the Bureau of National Health Insurance (BNHI) in Taiwan and primary data collected from 940 patients who visited their physicians at out-patient clinics to complete questionnaire, we investigated the effects of the hospital volume control policy on the frequency of visits, medical expenses and patient satisfaction. We found that the volume control policy on ambulatory care decreased physician fees and increased both the number of visits and co-payments. However, it did not result in any change in the total medical expenses. A shift in ambulatory care expenditure from BNHI to patients did not improve patient satisfaction. While the patients were comfortable with the waiting line, they were not satisfied with the providers' strategy of limiting quota of visits during a period of time.
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1. Introduction

1.1. Taiwan's NHI and medical expenditure

Taiwan implemented its National Health Insurance Program (NHI) in 1995 to provide affordable quality, and universal coverage for the benefit of every citizen. Because participation in the program is mandatory, 96% of the total population receives coverage, including almost eight million Taiwanese who previously had no health insurance [1,2]. NHI develops a comprehensive point system schedule, in which there are already more than 10,759 items listed. In addition, BNHI is in the process of combining its 23,000 approved pharmaceuticals into groupings and determining pricing methods (Lai, personal communication, December 22, 2004).

The Bureau of National Health Insurance (BNHI) pays medical expenses on a fee-for-service basis and its beneficiaries participate in a co-payment program.

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The fees are calculated using different methods. Some services and procedures, such as for enteritis, hypertension, and diabetes mellitus, are paid on itemized fee-for-service payment system; others such as hemodialysis, vaginal deliveries, and cesarean sections, are paid on a per-case basis. The case payment has been up to 174 items by 2004. Patients are allowed to have free choice of providers with a co-payment (10% for inpatient care, <20% for outpatient care, and no deductible). Extra co-payments are required for ancillary tests and medicines exceeding certain amounts. Also, providers, including hospitals, are paid mainly based on an itemized fee-for-service payment system.

The total ambulatory care expenditure amounted to NT$ 224.3 billion in 2002, which is 66% of the total medical expenses. In the same year, inpatient care costed the country NT$ 115.4 billion, which is 34% of total medical expenses. Annual ambulatory care visits grew to 14.81 per capita in 2000 from 13.87 in 1996 [3].

1.2. Volume control and cost containment

Since most BNHI funds are spent on ambulatory care, the BNHI has tried different methods including cost sharing at the point of service, diagnosis related groups, global budgets, utilization management, and supply limits to suppress the rapid growth of health care expenditures. From 1986 to 1999, almost every year, medical centers and regional hospitals grew over 10% in their volumes of ambulatory patients and physician fees, whereas community hospitals were around 8% [4]. It will harm the quality of patient care eventually if hospitals continuously increase their volume without improving their numbers of physicians, and necessary equipments and plants. On January 1, 2001, therefore, BNHI implemented a volume control policy to contain costs and to improve the quality of ambulatory care for regional hospitals and medical centers. By means of such control policy, referrals of some trivial severity of illness patients from medical centers or regional hospitals to the community hospitals are expected. A good referral system will assist medical centers and regional hospitals to take more care of the intensive or acute patients, which is one of their important social missions. Additionally, the referral system has an advantage of changing patient behavior by not squeezing them into medical centers or regional hospitals just for minor diseases. Although the policy is for regional hospitals and medical centers, it is recognized that this policy may have influence on both hospitals and physicians since most of the physicians are employees of hospitals in Taiwan.

The volume control policy sets a threshold for ambulatory care visits. The physician would be paid NT$ 213 for treating a specified number of patients. Beyond that number, the physician would be paid down to NT$ 120. For example, one physician has 55 patients within a section (defined by morning, afternoon, or evening sections); however, his/her threshold was set up by 50 patients. Then his/her payments will be the sum of 50 patients multiplied by NT$ 213 and 5 patients multiplied by NT$ 120. The final reimbursement payment for this physician in the particular section will be NT$ 11,250. Nevertheless, if the previous example followed the original payment method, NT$ 207 per visit, the total will be NT$ 11,385. The difference is not much when there is only one physician within one section; however, there will be a significant distinction when amounted to all physicians and all sections. BNHI (2002) estimated that the volume of ambulatory care would be around 81% of previous volume of ambulatory care [4].

The threshold is determined by a formula, calculated by weighting ambulatory care visits from previous year, staffed beds, and numbers of physicians with a weighted sum of multiplying 2/3, 1/6, and 1/6, for the respective components. A detailed description of the formula is referred to Appendix A. To make sure, this policy would not have negative influence on patients who need urgent medical attention, emergency services, immunization, dialysis care, home care, psychiatric rehabilitative care, work related injury, flu vaccine for elderly, and chronic care services were excluded. Community hospitals and independent practice clinics have been exclusive of this policy due to the continuously decline of their growth rates since 1990. In particular, the amount of community hospitals is bringing down with lightning speed, with 108 hospitals closing down during 7 years from 1994 to 2002 [5].

The purpose of this study is to contribute to the literature on cost containment mechanism by examining the effect of volume control policy on frequency of ambulatory care visits, medical expenses, and patient satisfaction. More specifically, taking the perspective

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