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Research Summary: What Does a Hospital Stay Really Cost?

The Productivity Implications of Care Quality

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Employers know that when a health plan member spends the night in the hospital, it impacts health care benefit expenses. They also recognize that hospital stays often result in missed work days and lost productivity when the patient is an employee.

However, productivity losses do not necessarily end with a patient's discharge. A new study co-authored by Stanford Ph.D. candidate Adelina Wang[1] (supported by IBI as part of the Thomas Parry Research Fellowship) links longer-term productivity losses to the quality of care hospital patients receive.

Where employees get care can impact their financial health

By linking Danish workers' labor market outcomes to their stays in different hospitals, the authors find wide variation in patients' earnings in the three years following an inpatient admission. All else equal, patients admitted to the lowest-quality hospitals saw their earnings decrease by almost four percentage points more than patients admitted to the highest-quality hospitals. Patients of lowest-quality hospitals also had lower rates of post-admission labor force participation.

Importantly, patients admitted to lower-quality hospitals may need longer-term financial support compared to patients admitted to higher-quality hospitals. The amount of transfer payments from the Danish government—which can be seen as analogous to either disability or unemployment insurance payments in the U.S.—was greater after a stay in a lower-quality hospital than after a stay in a higher-quality hospital. This suggests a link between quality of care and an employees' capacity to resume their usual work activities over time.

[1] Anne-Line Koch Helsø, Nicola Pierri, and Adelina Yanyue Wang, "The Economic Impact of Healthcare Quality," Chapter of Anne-Line Koch Helsø's PhD dissertation, Labor Supply and Earnings: In old age, in bad health, and across generations, Department of Economics, University of Copenhagen, December 10, 2018.

The good news for Danish patients (and their employers) is that the link between hospitalizations and earnings was weaker in the latter years of the study (2008-2010) than in the earlier years (2000-2002). This suggests that overall care quality improved over the study period. It is also consistent with the premise that the availability of good care has tangible benefits for productivity as well as for patients' health-related quality of life.

Why does a Danish study matter to U.S. employers?

The focus on care quality and labor market outcomes (rather than simply costs or access to care) gives the study's findings relevance beyond Danish health care and employment contexts. Even in countries where employers pay little or no share of their employees' health care expenses, they always bear the productivity losses of illness-related lost work time. In this respect, patients' and their employers' interests in making the right care decisions are always aligned.

The implications for helping employees choose care wisely make the findings of particular relevance for U.S. employers, despite the differences in the health care systems of the United States and Denmark. Most of the care Danish citizens receive is free at the point of service (the health care system is funded by a national tax) and there are few restrictions on which hospitals (almost all of which are publicly owned) they can use.[2] Though Danish employers may enjoy a productivity benefit when their workers get good care, they may have less leverage in steering their employees to higher-quality providers.

By contrast, as payers for much of their employees' healthcare treatments (directly if self-insured, or indirectly through their insurance policy's experience rating), U.S. employers are, *in principle*, better positioned to make sure that higher-quality care is chosen more often than not. For example, when it comes to scheduled inpatient procedures, imposing higher copayments or coinsurance on services of lower quality or provided by lower-quality facilities may heighten patients' sensitivity to both prices and quality.

The catch, of course, is that for this steering strategy to work, service quality must be reflected in transparent, easily comparable prices. However, evidence for a correlation between health care price and quality is limited.[3] As it stands, patients frequently make decisions about their care with few reliable information resources about either quality or price. The implications for their physical and financial health are serious enough. But the Danish study reminds us how U.S. employers stand to lose twice—by paying for treatments of suboptimal value and by losing an employee's labor—if an employee chooses "wrong."

Employers can help improve plan members' care options

Avoiding productivity losses and unnecessary health care spending may require U.S. employers to wield more influence as intermediaries of patients' treatment options, in ways both subtle and direct. A growing number of health plan sponsors are providing transparency tools that help members compare providers' clinical outcomes and costs for specific services. Employers could also drive demand for the inclusion of patients' lost work time, work resumption, and functional limitations following inpatient admissions as metrics of care quality—potentially by underwriting their development for inclusion in transparency tools.

Designing health plans along value-based principles—for example, creating incentivization and reimbursement policies that favor centers of excellence—is another approach. Employers with access to integrated data on

[2] Commonwealth Fund, "International Health Care System Profiles: Denmark," accessed July 3, 2018. < https://international.commonwealthfund.org/countries/denmark/>

[3] Health Care Cost Institute, "The Price-Quality Paradox in Health Care," April 2016, < http://www.healthcostinstitute.org/files/Data%20Brief%203%20-%20April%202016.pdf>

healthcare treatment and disability insurance claims may be especially well positioned to evaluate the volume of disability absences associated with facilities used by their employees.

Finally, in efforts to encourage the use of high-quality providers, employers should communicate with their employees as if they are business partners with aligned financial interests. Most disability insurance policies pay only a portion of a claimant's wages during episodes of leave—meaning that the longer it takes for an employee to recover from a stay in the hospital or an episode of temporary work disability, the more earnings they lose. Communications materials that emphasize the relationship between high-quality care and higher earnings may help secure broader buy-in for efforts to steer members to high-quality providers.

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Founded in 1995, the Integrated Benefits Institute (IBI) is a national, nonprofit research and educational organization focused on workforce health and productivity. IBI provides data, research, tools and engagement opportunities to help business leaders make sound investments in their employees' health and wellbeing. IBI serves more than 1,300 member companies representing over 20 million workers.

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