

## The Business Case for Quality: Facts and Figures

### Introduction

Aside from being a popular catch phrase, it is often hard to tell what the ‘business case for quality’ entails. Health providers themselves are often unsure of the financial benefits of greater health care expenditures toward quality of care. Research exists about the costs of poor quality healthcare to public and private healthcare payers, employers and society in general. Since little concrete information has surfaced about the costs to individual facilities of providing poor care, boards of directors and administrative staff looking at profit margins and bottom lines often resist change without a demonstrated economic incentive. Making a “business case” for quality improvement is critical to providing the motivation necessary to achieve progress towards a higher quality of care. Effective advocacy in this arena includes identifying and publicizing examples of increased costs to providers due to poor care or when the failure to invest in systemic improvements has led to negative health consequences.

### Definition: Business Case

A **Business Case** for a health care improvement intervention exists if the entity that invests in the intervention realizes a financial return on its investment in a reasonable time frame, using a reasonable rate of discounting. This may be realized as “bankable dollars” (profit), a reduction in losses for a given program or population, or avoided costs. In addition, a *business case* may exist if the investing entity believes that a positive indirect effect on organizational function and sustainability will accrue within a reasonable time frame.

Source: Leatherman, Shelia et. al, “The Business Case for Quality: Case Studies and an Analysis,” *Health Affairs*, Vol. 22, No. 2 March/April 2003.

### Questions to Ask

- Will the proposed innovation actually result in improved care?
- Is the improvement considered a part of the core of health care or an optional feature?
- Is there money to be made, and by whom?
- What non-financial consequences matter?

Source: Leatherman, Shelia et. al, “The Business Case for Quality: Case Studies and an Analysis” *Health Affairs*, Vol. 22, No. 2 March/April 2003.

### Avoidable Hospital Costs Due to Heart Attacks and Stroke

*Failure to follow best practices for 2 conditions comprises more than \$1.5 billion in preventable hospitalizations.*

Measure	Avoidable Costs/Year
Beta-blocker Treatment	\$11,076,204
Cholesterol Management: Control	\$94,249,482
Controlling High Blood Pressure	\$1,242,836,580
Diabetes Care: HbA1c Control	\$178,464,900
Smoking Cessation	\$97,690,642
<b>Total</b>	<b>\$1,642,317,808</b>

Source: National Committee for Quality Assurance, *The State of Health Care Quality: 2003*.

### Avoidable Sick Days Due to Suboptimal Care (U.S. Workforce)

Condition	Sick Days
Asthma	7,542,598
Depression	2,913,800
Diabetes	11,557,340
Heart Disease	7,174,257
Hypertension	11,731,461
<b>Total</b>	<b>40,919,456</b>

*These 41 million sick days equal the equivalent productivity of more than 173,000 workers lost, and an annual cost to American companies of more than \$11.5 billion.*

Source: National Committee for Quality Assurance, *The State of Health Care Quality: 2003*.

## Role of Information Technology

A recent study from the Center for Information Technology Leadership shows that a more effective use of information technology could save hospitals up to \$44 million in reduced medication, radiology, laboratory, and hospitalization costs and could prevent more than 2 million adverse drug events and 190,000 hospitalizations per year. Despite these results information technology is still not widely used in healthcare. For example:

- Over 90% of the annual 30 billion health transactions are conducted by phone, fax or mail rather than by electronic means.
- Only a third of hospitals nationwide have Computerized Physician Order Entry systems completely or partially available. Of those, only 4.9% require their use.
- Although illegible handwriting is known to cause a substantial number of medication errors, fewer than 5% of U.S. physicians prescribe medications electronically.
- 40% of surveyed health care organizations planned to spend 1.5% or less of their total operating budgets this year on IT, and 36% set spending at 2 to 4%. These low percentages can be compared with an average of 8.5% in other industries.

Source: Merkle Foundation, "Connecting for Health: Facts & Stats" [www.connectingforhealth.org/Facts\\_and\\_Stats\\_6.5.03.pdf](http://www.connectingforhealth.org/Facts_and_Stats_6.5.03.pdf) Accessed March 2004.

## Costs to Hospitals from Adverse Drug Events

- Over 770,000 people are injured or die each year in hospitals from Adverse Drug Events (ADEs) which may cost up to \$5.6 million each year per hospital. This estimate does not include ADEs causing admissions, malpractice and litigation costs, or the costs of injuries to patients.
- Patients who experienced ADEs were hospitalized an average of 8 to 12 days longer than patients who did not suffer ADEs, and their hospitalizations cost \$16,000 to \$24,000 more.
- Computerized medication order entry has the potential to prevent an estimated 84% of dose, frequency, and route errors. Hospitals can save as much as \$500,000 annually in direct costs by using computerized systems.

Source: Agency for Healthcare Research and Quality, "Reducing and Preventing Adverse Drug Events to Decrease Hospital Costs," [www.ahrp.gov](http://www.ahrp.gov) March 2004.

## Recommendations

- Boards of directors should apply their time and talent to quality improvement as an obvious priority
- Awareness and education efforts for board members should be expanded with respect to quality improvement activities that can make a difference
- Board members with expertise in quality improvement should be recruited.
- Candor regarding quality issues needs to be encouraged and supported. Discussions among medical staff and administrations of hospitals and health systems should be promoted to disclose systemic issues subject to improvement
- Community collaboration and competition should be encouraged among regional facilities to share information and lessons learned.

Source: Jennings, Jan "When Good People Allow Bad Things to Happen to Good People" Hospital News January 2004.

## Torts and Liability

- HHS estimates that medical liability costs add \$60-\$108 billion to the total cost of health care each year.
- 76% of physicians believe that concerns about medical liability litigation has negatively affected their ability to provide quality care
- 26% of facilities have cut back on services or eliminated some patient care unit as a result of liability concerns.

Source: [www.ama.org](http://www.ama.org), accessed March 2004.

*Caution: Generally cases against healthcare providers where liability has been sustained involves serious issues such as loss of life or permanent injury. Furthermore, malpractice insurance rates are driven by the economic cycle of the insurance industry insurance company projections about costs and estimated earnings, etc. and are not necessarily tied to liability payout experience.*

Source: T. Plunkett, Consumer Federation of America, "Testimony, House Committee on Energy and Commerce" July 2002 [www.consumerfed.org](http://www.consumerfed.org) Accessed April 2004.