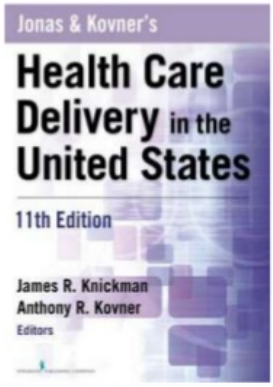

Jonas and Kovner's Health Care Delivery in the United States, 11th Edition

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CHAPTER 12: HEALTH CARE COSTS AND VALUE

KEY WORDS

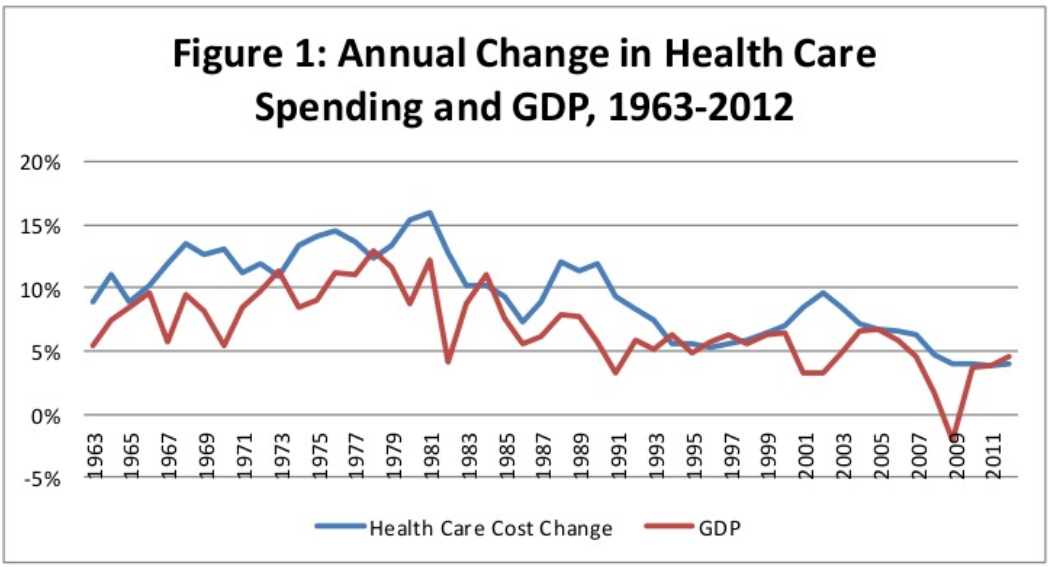
rationing
value-based purchasing (VBP)
overconsumption
medical malpractice
defensive medicine
electronic medical records (EMRs)
accountable care organization (ACO)
centers of excellence (COE)

LEARNING OBJECTIVES

- Understand potential contributing factors to the growth in health care costs in the United States over the past 60 years
- Explain value in terms of health care

inflation-adjusted dollars. Per capita spending grew more than 550 percent in real terms between 1963 and 2012 reaching nearly $9,000 per person in 2012. Importantly, the average annual growth in health care spending between 1963 and 2012 was nearly 9.5 percent, while nominal GDP growth during this period was 6.8 percent – meaning that health care spending grew faster than other economic activity over the past five decades. The implication of these trends is that health care is an increasing share of all spending in the economy, and trying to understand why this is occurring is important.

Figure 1 shows how expenditure growth follows the pattern of GDP growth but that health expenditure growth relentlessly exceeds GDP growth (US GDP changes come from the Bureau of Economic Analysis). Interestingly, the only time this is not true is in the 1993 to 2000 time period when there was a substantial effort to change the organization and financing of health care during the Clinton administration. When these efforts eventually failed, expenditure growth spurted back up.



Why is there so much concern about the growth in health care expenditures in the United States? The important reason is because a great deal of health care expenses are paid by government and employers. And, the growth impacts these two key sectors of our economy greatly.

The federal government, each State government, and many local governments each spend a great deal of their tax revenues on health care. The federal government finances 1) the Medicare program that provides insurance for elderly Americans, 2) over half of the Medicaid program that pays for health care received by low-income Americans, 3) Veterans and Defense Department health care expenses, and 4) the costs of extensive research, public health, and training activities. State governments pay for as much as half of the Medicaid program directly as well as extensive activities in public health and regulation. Local governments generally support public health expenditures and some safety net medical care.

In 1963, governments (federal, state, and local governments) only financed about $6 billion (equivalent to about $46 billion today) of total health care spending. This spending represented only about 3% of total public spending. By 2012, governments were spending nearly $1.2 trillion (of the $2.8 trillion total) on healthcare, comprising more than 19% of total public spending. There are two key concerns with this growth in government costs. First, these costs are putting great strains on taxes paid by workers and employers and this strain is seen by many as decreasing the vibrancy of our economy. Secondly, the large share of tax dollars allocated to health care is crowding out expenditures on other important needs in our economy such as expenditures on education and infrastructure. This is especially true at the state and local levels where government spending on health has increased by 154% over the past 40 years but expenditures on education have been "crowded out" and increased by just 74% over this period.

Health care costs are not purely a public finance issue, however. Private businesses – which purchase health insurance for employees and their families – frequently cite increasing costs as problematic. For example, the cost of health insurance is cited as the top concern of small business owners for 2008 and 2012 (NFIB 2012). As a result, as health insurance costs have increased, employers provide fewer salary increases because such resources are instead devoted to increased health insurance costs (again, health expenditures are "crowding out" expenditures on salaries). Additionally, fewer employers continue to offer group health insurance to employees – or limit dependents of employees who can access coverage. (For example, in August 2013 United Parcel Service began excluding health insurance coverage for spouses able to access health insurance at their own places of employment.) Buchmueller et al. (2013) find, for example, that while employers offered health insurance to over 112 million employees in 2000, this number had declined to 108 million employees in 2011, or 4 percent fewer workers covered in one decade. Beyond simple financial costs, studies find that increasing health insurance costs decreases full-time employment and also decreases hours worked for employees that work part-time (Baicker and Chandra 2005; Sood, Ghosh, and Escare 2009). Health care costs are implicitly part of national discussions about unemployment and job creation.

Of course, health spending also is a burden on American families which—despite the large expenditures by government and employers—also pay a sizable amount for health care in their family budgets.

Table 1: Average Annual After-Tax Expenditures by Consumer Units/Households, 2012

Category	Average Annual Expenditures, 2012	Change from Prior Year
Housing	$16,887	0.5%
Transportation	8,998	8.5

more of its GDP to health care spending (9 percent) than other Western developed nations, but the difference was not extraordinary. By 2011, however, United States spending as a share of GDP far exceeded other comparable nations (see Table 3). Certainly other nations have experienced increased health care spending, but the United States is unique in the degree of its increase – far outpacing even the nation with the second largest growth.

Table 3: Health Care Spending as a Percentage of GDP for OECD Countries

	1980	2011	Increase	Rank Increase
US	9.0%	17.7%	8.7%	1
Sweden	8.9	9.5	0.6	21
Denmark	8.9	10.9	2.0	19
Germany	8.4	11.3	2.9	14
Ireland	8.2	8.9	0.7	20
Netherlands	7.4	11.9	4.5	4
Austria	7.4	10.8	3.4	11
Switzerland	7.3	11.0	3.7	10
Norway	7.0	9.3	2.3	18
France	7.0	11.6	4.6	3
Canada	7.0	11.2	4.2	7
Japan	6.5	9.6	3.1	13
Iceland	6.3	9.0	2.7	16
Finland	6.3	9.0	2.7	16
Belgium	6.3	10.5	4.2	6
Australia	6.1	8.9	2.8	15
New Zealand	5.9	10.3	4.4	5
Greece	5.9	9.1	3.2	12
United Kingdom	5.6	9.4	3.8	9
Portugal	5.3	10.2	4.9	2
Spain	5.3	9.3	4.0	8

Source: 1980 data from Chandra and Skinner (2012); 2011 data from OECD

To return to the primary issue – if the US spent significantly more on health care and received significantly better health outcomes, then health care cost growth might not be considered problematic. However, according to the OECD the US ranks 26th out of 36 member

countries for life expectancy, and just below the OECD average life expectancy (see Figure 5 in Chapter 1A). When fatal injuries are removed, the US life expectancy rankings improve dramatically, but they are still only comparable with other OECD nations. Further outcomes (such as infant mortality) are also at best only comparable with other nations despite our spending. On these measures of outcomes, therefore, it does not appear the US system is getting results for this increased spending.

A more nuanced view of United States health care spending, however, is to consider that our increased costs are related to quality of life issues rather than just to life extension. For example, in the US it is not uncommon for patients in their 70s to have expensive surgeries (such as knee or hip replacements) so that they can maintain or return to physical activities, while such procedures would not be as common abroad. Hence, health care value relative to outcomes largely tied to longevity in these international comparisons is frequently defined in a very limited way.

The Value of Health Care Spending

One major problem with discussions about health care spending is that "value" is difficult to define, let alone measure. And, very often people mistakenly think that cutting cost is the central way of producing value. Third-party payers often argue that the "value" they add is reducing payments to health care providers, thereby reducing the cost of health care to the employer, taxpayer, or individual who is the actual payer. Many health care professionals who think and work on quality issues, by contrast, focus on ensuring that consumers get the best treatment available at the correct time (RWJF 2013). Yet value is not just about cost or just about patient outcomes; rather, value is best defined as the best patient outcomes relative to the amount

of money we as individuals or as a society are able to and/or are willing to pay to stay healthy or recover from illness. This conception of value focuses on results and not merely the inputs used to achieve these results. It is possible to increase "value" by improving the quality, outcomes, and patient experience of medical care and it is possible to increase value by achieving the same quality, outcomes, and experience at a lower total cost by improving efficiency.

So what has been our experience with improving value? Across some dimensions, the quality of medical care and outcomes are improving markedly in the United States (see chapter 13 (Clancy)). Deaths associated with strokes and other types of heart diseases are down substantially and most would agree this is due to improvements in medical know-how, pharmaceuticals, and emerging technology. Cancer mortality also is improving due to better treatment approaches. Longevity after age 75 also is higher in the United States than in many other countries, again perhaps due to the health services associated with medical care. And, disparities in health outcomes between people of color and white Americans decrease after age 65 and most experts associate this with the near universal accessibility of medical care that happens when people become eligible for Medicare.

In addition, beginning around 2008, health care expenses did increase more slowly than in prior years. This trend seems to have started with the deep recession at the start of this period but also seems to be related to a flurry of efforts among health care providers to restructure their approaches to health care delivery (see chapter 11). This slowdown, however, may be temporary. Health care costs increased significantly at the end of 2013 (increasing nearly 6 percent in the final quarter) and the beginning of 2014 (increasing nearly 10 percent in the first quarter).

On other dimensions, however, there are serious concerns about the value of medical care. Most importantly and as mentioned above, despite spending vast sums of money on medical care, the health of Americans is not very good compared to that of residents of other developed countries in the world. If we are not getting "health" and "longevity" as outcomes associated with our large medical care investment, why are we spending so much on medical care?

The best answer to this question from a value perspective is that Americans seem to highly value "getting better" after they become seriously ill, even at advanced ages and even when the value of treatments is highly uncertain and has a chance of ending up hurting more than helping a condition. However, we cannot really prove that Americans value medical care as much as it appears because—as economists emphasize—we can only really be sure that value exceeds costs when people actually pay the costs to get a service.

What needs to be kept in clear focus is spending on medical care does not address the key determinants of the overall health of a population. The best way to keep people healthy is through public health initiatives, prevention initiatives, and social policies that make healthy choices possible and likely. These strategies are not what the medical care enterprise is about; medical care restores health more than it assures that a population is healthy over its lifespan. A key question for public policy is to think through how much should be spent to create population health and how much should be spent on "recovery" oriented medical care (see chapter 5).

Emerging data show that many other developed countries spend more per capita than the United States on social programs that encourage health and well-being and less per capita on

medical care. And, these developed countries end up with higher health status over the life-cycle than the United States does.

Addressing the Challenge of Reducing Health Care Expenditures That Do Not Have Value

. A first step in efforts to increase the ratio of value to costs in medical care delivery is to consider what expenditures do not create value and what steps might eliminate or reduce these expenses. We consider three broad categories of expenses: waste in production, overconsumption of services, and high prices of labor and inputs.

Waste

A large part of what leads to high health care costs in the United States is caused by the uncoordinated approach we use to take care of people with medical problems and the lack of attention to efficiency in producing care to make people better. "Waste" in these analyses is most frequently defined as those health care services that do not benefit patients. For example, Berwick and Hackbarth (2012) estimate that 20% of all health care expenditures are wasted. They identify overtreatment, the lack of care coordination (which may lead to hospital readmission and/or medical complications, or duplicate tests), the failure to execute best practices (that might lead, for example, to less than optimal outcomes), administrative complexity (for example, incompatible health information systems, third-party payers requiring different insurance forms for similar procedures, etc.), and outright fraud and abuse (which includes money devoted to determining and stopping such efforts) as the primary sources of waste. The Institutes of Medicine (IOM) (2012) estimates waste at one-third of all health care spending, citing largely unneeded procedures that actually reduce the quality of life. If these

estimates are correct, this suggests that the US wastes between $560 billion and $950 billion (or between $1,700 and nearly $3,000 per capita) annually on health care that could be eliminated with no harm to consumers. The IOM estimates that administrative complexity alone costs in excess of $360 billion annually.

Statistics suggest that the lack of coordination of care among patients with the most complex medical conditions affects our health care spending significantly. Just 5% of the total population incurs one-half of all costs, and 20% of the total population is responsible for 80% of total spending (Commonwealth Fund 2013). Chronically ill patients might have heart conditions, mental health issues, or diabetes (as some examples) – and frequently multiple diagnoses. As these patients move among various specialists, hospitals, outpatient providers, long-term care facilities, home care, etc., there often is not an effective way to make sure these services all are needed or delivered efficiently.

Emerick and Lewis (2013) cite over-screening and treatment as a fundamental aspect of waste in health care. As technology and advances in medical condition diagnoses have made detection of potential health problems easier and less invasive, it also increases the likelihood of detecting non-threatening medical conditions that pose little risk to the patient. For example, screenings may find lesions or potentially cancerous cells on organs – leading the medical provider to treat the patient (with surgery, medicine, etc.). Yet, these medical conditions may not be problematic and lead to health complications. As such, they lead to increased costs with no certainly of accompanying increase in value. As one example, US patients receive heart surgeries and angioplasties at more than twice the rate of patients in other countries, yet our health outcomes are identical (see OECD Health Policies and Data). Hospital visits for chronic health

conditions are far more frequent in the US as well; hospitalization rates for diabetes and asthma, for example, are also nearly twice as high as other nations (OECD Health Quality Indicators).

Overconsumption

In a normally functioning marketplace, the costs of all these additional services would be borne by consumers. Hence, if the consumer valued the services, he or she would choose to purchase them. Health care spending, however, is not like other goods or services bought and sold in a competitive marketplace. Importantly, consumers in health care do not make most decisions about which services to consume – doctors do. Most doctors want to do everything to help a patient, which increases the health care services consumed. In addition, because third-party insurance programs cover the vast majority of consumers (patients), the goods and services consumed by patients are largely financed by these insurers. As a result, patients may consume more health care than is optimal because they do not face the total cost of the good or service. This moral hazard (as economists refer to it) leads to overconsumption of health care, or patients not taking sufficient care to prevent incurring health care costs – because they do not bear the costs.

Defensive Medicine

If over-diagnosis and treatments drive up health care spending with uncertain increase in health benefits, why do they occur? While these may not improve health outcomes, health care providers may want to protect themselves from medical malpractice claims that they did not "do enough" to help patients. One study estimates that malpractice and defensive medicine cost approximately $56 billion annually – or less than 3% of total health care spending (Mello et al. 2010), while another estimates that it costs between $120 billion and $216 billion – or 5-9% of

total spending (AIM 2004). These costs include not just the insurance premiums paid by doctors and health care providers, but also the legal fees, settlements, and judgments of such suits. However – and what the monetary figures fail to capture – is that even the hint of malpractice is enough to ruin the careers of medical providers and the reputations of health care institutions. For most health care providers, the fear of a lawsuit is greater than the fear of lost revenue for providing a non-covered service or test. Providers will default to increasing number of services as a result. Hence, defensive medicine may be perfectly rational from the perspective of a provider.

Given the potential for malpractice lawsuits, it seems logical for primary care physicians to refer patients to specialists to protect themselves professionally from malpractice exposure and also to ensure patient health outcomes. This referral itself drives up health care spending. Further, we have a system in place that pays these specialists more than primary care physicians – even for the same services. The Relative Value Scale Update Committee (RUC) is an American Medical Association (AMA) panel that recommends to Medicare the relative value of health procedures. The federal government (through CMS and, in the past, HCFA) uses these recommendations in the setting of payments for Medicare patients; however, these rates also influence non-Medicare payers as well and, as a result, have a large impact on payments to physicians. The RUC have largely advocated for (and the federal government has accepted) payment increases to specialists. Thus, referrals to specialists lead to patient visits that are more costly compared to primary care physicians, and drive up health care spending as a result.

Fee-for-Service Rather Than Fee-for-Value