BENDING THE HEALTH CARE COST CURVE:

Why? And How?

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BENDING THE COST CURVE IN HEALTH CARE

Saskatoon, Saskatchewan

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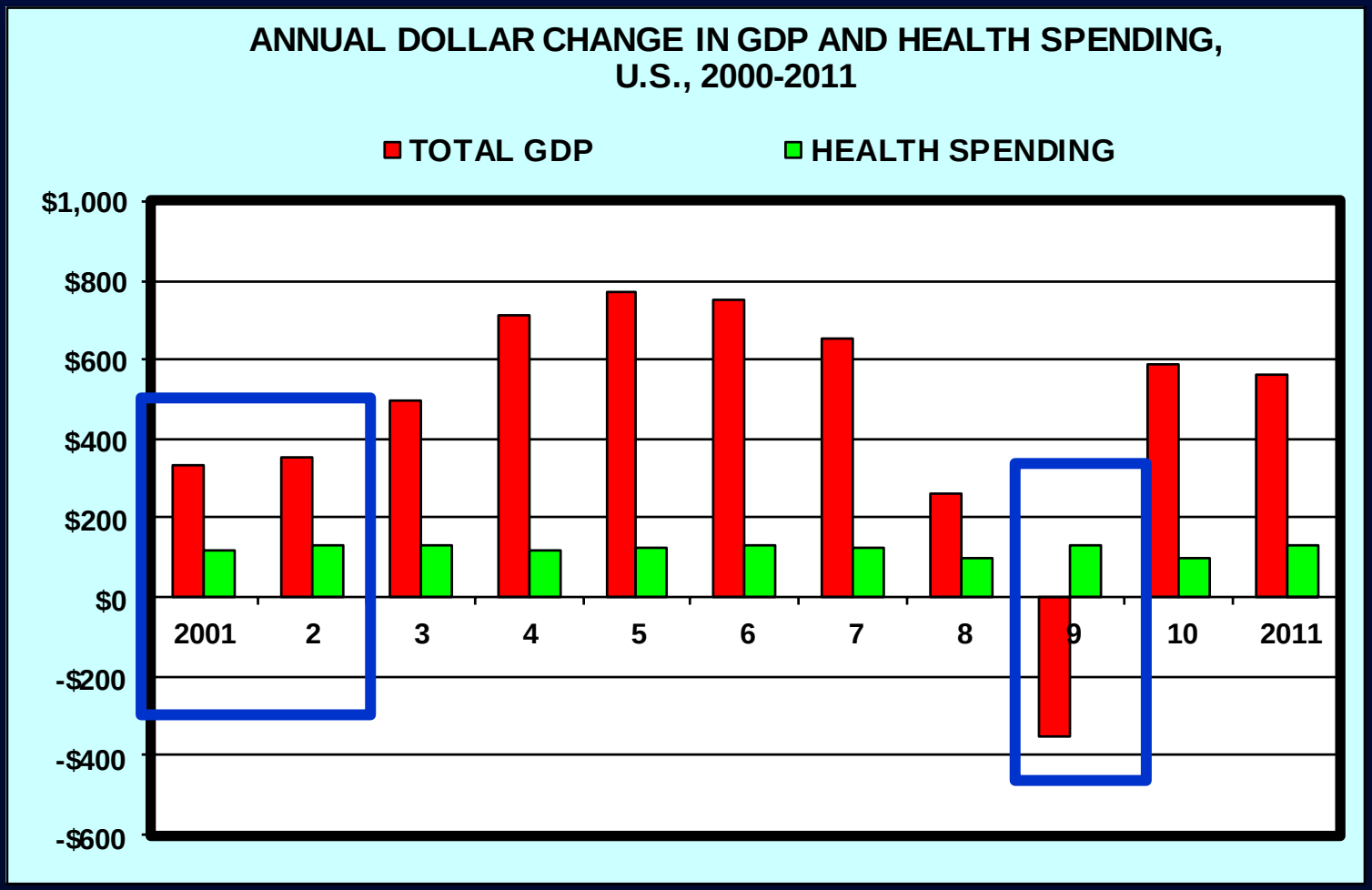
C

I. IF YOU'RE NOT TOTALLY CONFUSED BY YOUR HEALTH SYSTEM, YOU'RE NOT THINKING STRAIGHT

Think about it!

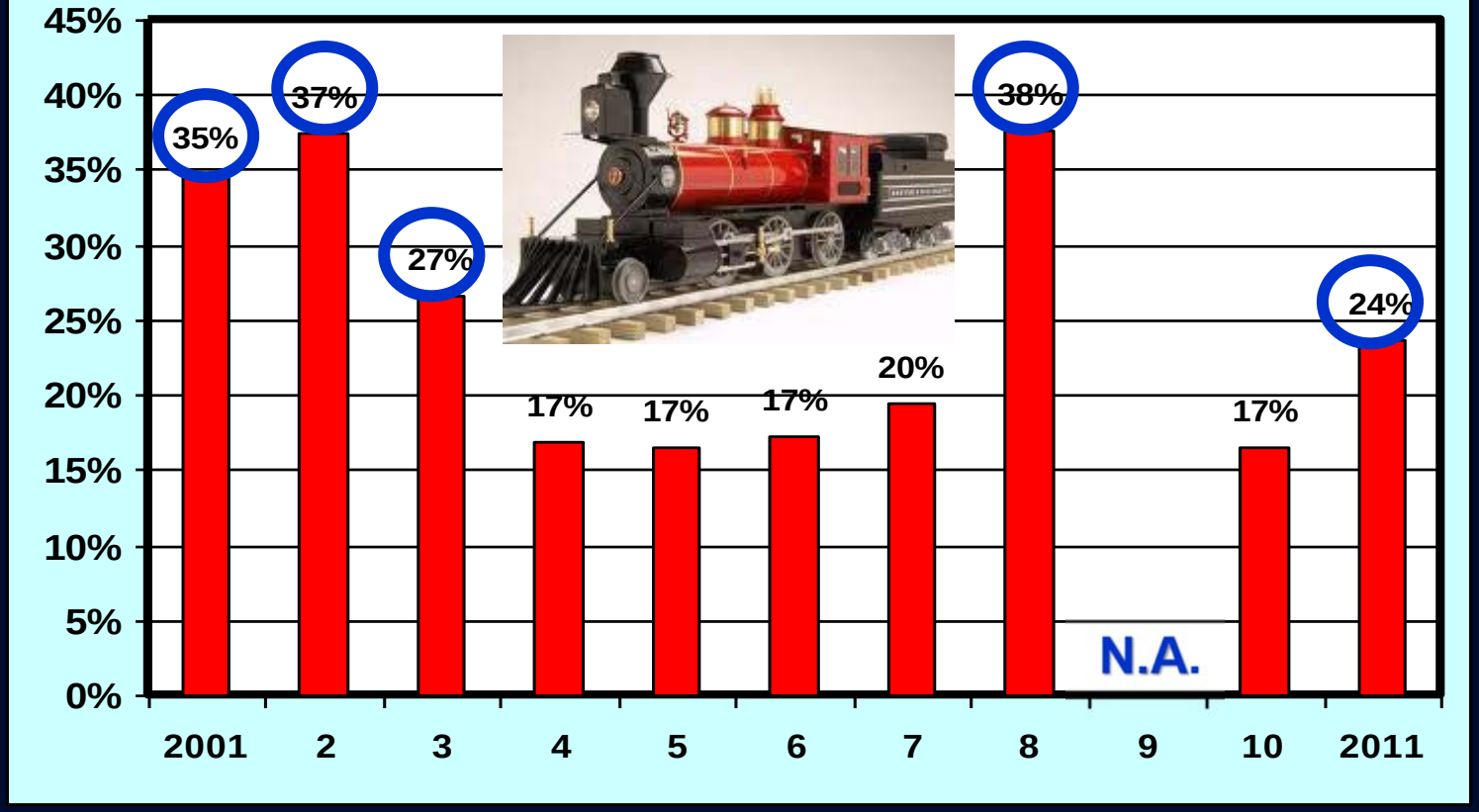
Your nation's health-care system is:

1. **Quite frequently, the provider of wondrous cures from illness.**
2. **An outlet for human creativity, not only in technology, but also in private and social entrepreneurship.**
3. **In many nations (certainly the U.S.) <u>THE</u> major economic locomotive, providing millions of middle-class jobs.**



Sources: Economic Report of the President 2012 and CMS Database.

FRACTION OF DOLLAR GROWTH IN GDP CONTRIBUTED BY HEALTH CARE



Sources: Economic Report of the President 2012 and CMS Database.


The McGraw-Hill Companies
BusinessWeek
What's Really Propping Up the Economy
Health care has added 1.7 million jobs since 2001. The rest of the private sector? None.
BY MICHAEL MANDEL
(P. 54)

So with all these good attributes of the health-care system, why do people constantly pick on it -- why are we having a conference on

BENDING THE HEALTH-CARE COST CURVE ?

After all, we never have conferences on

- ***BENDING THE FAST-FOOD COST CURVE*, or**
- ***BENDING THE FASHION COST CURVE* or**
- ***BENDING THE BEER COST CURVE***
- ***ETC.***

Usually everyone celebrates when spending in these sectors rises, because it creates GDP and jobs.

Many providers of health care – and their patients as well – constantly and plaintively raise this questions.

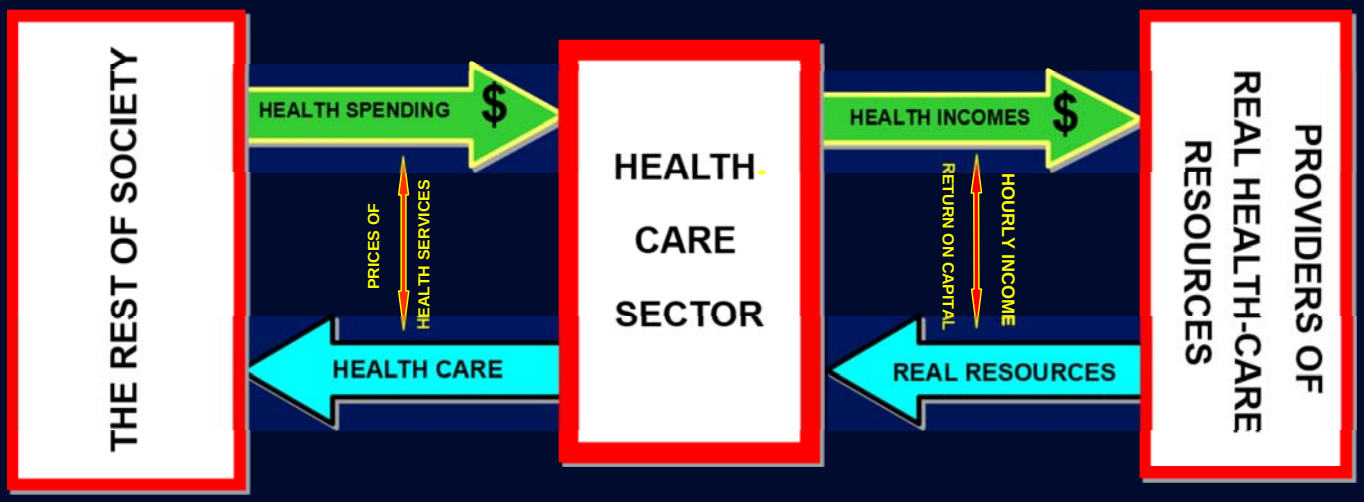
We owe them a thoughtful answer.

II. SO, WHY PICK ON HEALTH CARE?

THE DUAL OBJECTIVES PURSUED IN THE HEALTH-CARE SECTOR

The Health Care & Health Facet

The Income--Employment Facet



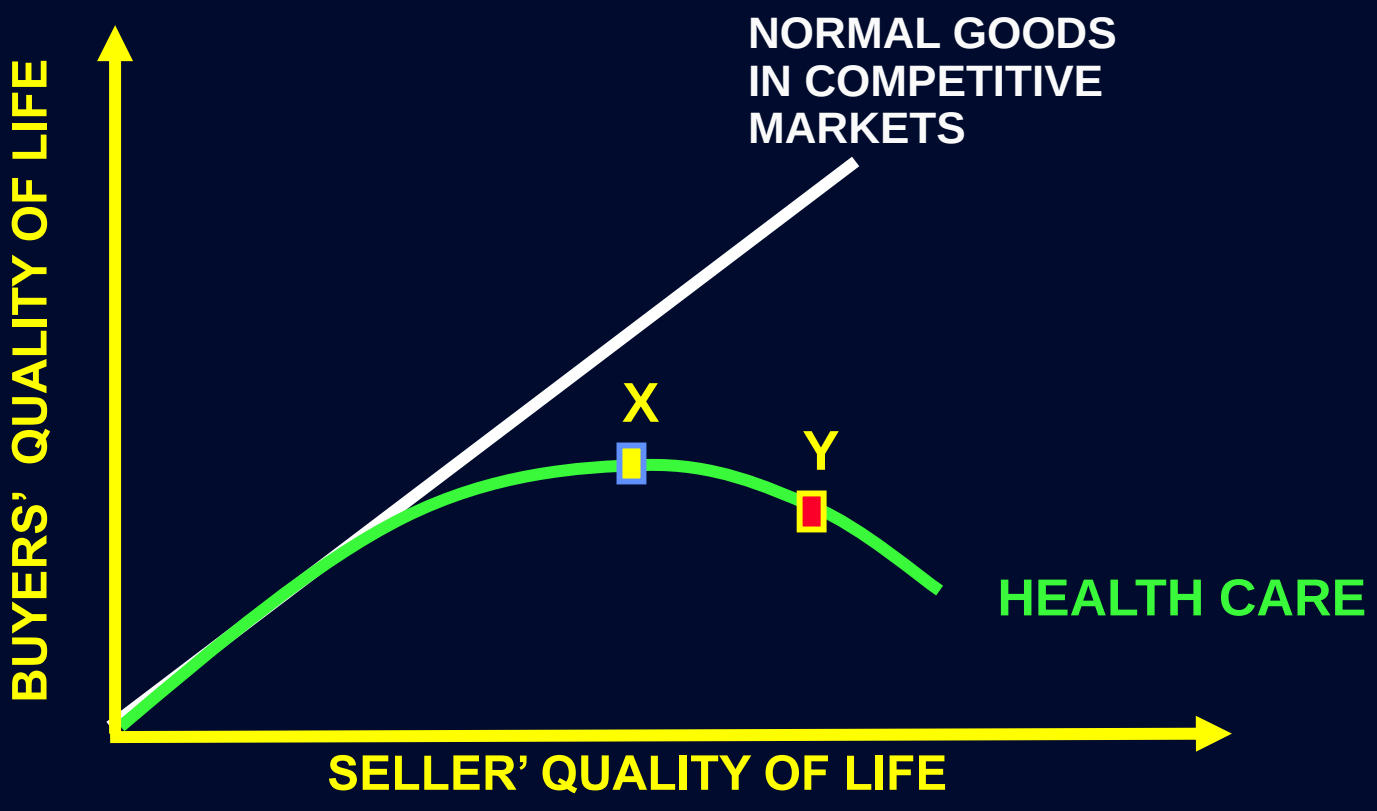
OBJECTIVE I:
Enhance quality of patients' lives

OBJECTIVE II:
Enhance quality of providers' lives

THE DEFINITION OF A "PATIENT"

patient (pa'shent) - *n.* 1. A person under medical treatment. [Middle English *pacient*, from old French *patient*, from Latin *patients*, from *pati*, to suffer.] 2. *A biological structure yielding cash [BSYC] .*

PRESUMED RELATIONSHIP BETWEEN SELLERS' AND BUYERS' QUALITY OF LIFE



We can make no such assumption for health care, because of

1. **Asymmetry in possessing relevant information;**
2. **Pervasive conflicts of interest in health care that can lead to exploitation of that asymmetry;**
3. **Private or public third-party payment.**

Together, these features cast suspicion on the clinical and economic legitimacy of health-care spending and the relationship between the quality of life of providers and that of patients, especially if financing is taken into account.

Next, in most nations a large fraction of health spending flows from tax-financed public budgets, and willingness to pay added taxes has diminished around the world.

Therefore, within this constraint, we must be mindful of the opportunity costs of added health spending.

"The Social Net Value Added" by Health Care – not to be confused with its "Gross Value Added" -- probably has turned negative

Net Social Value Added by the Health System = **Gross Social Value Added by the Health System** - **Social Opportunity Costs imposed by the Health System on Society**

Health care providers and their patients-- and the producers of medical technology -- naturally focus on this gross value added.

Increasingly, however, leaders in business and government think of these opportunity costs of health care.

And what are the Social Opportunity Costs of Health Care?

- Neglecting the education of our young
- Neglecting investments in science and R&D
- Neglecting our fraying infrastructure
- Neglecting our national security
- Impairing our general standard of living

Finally, there is the power of what in the U.S. is known as Stein's Law**:**

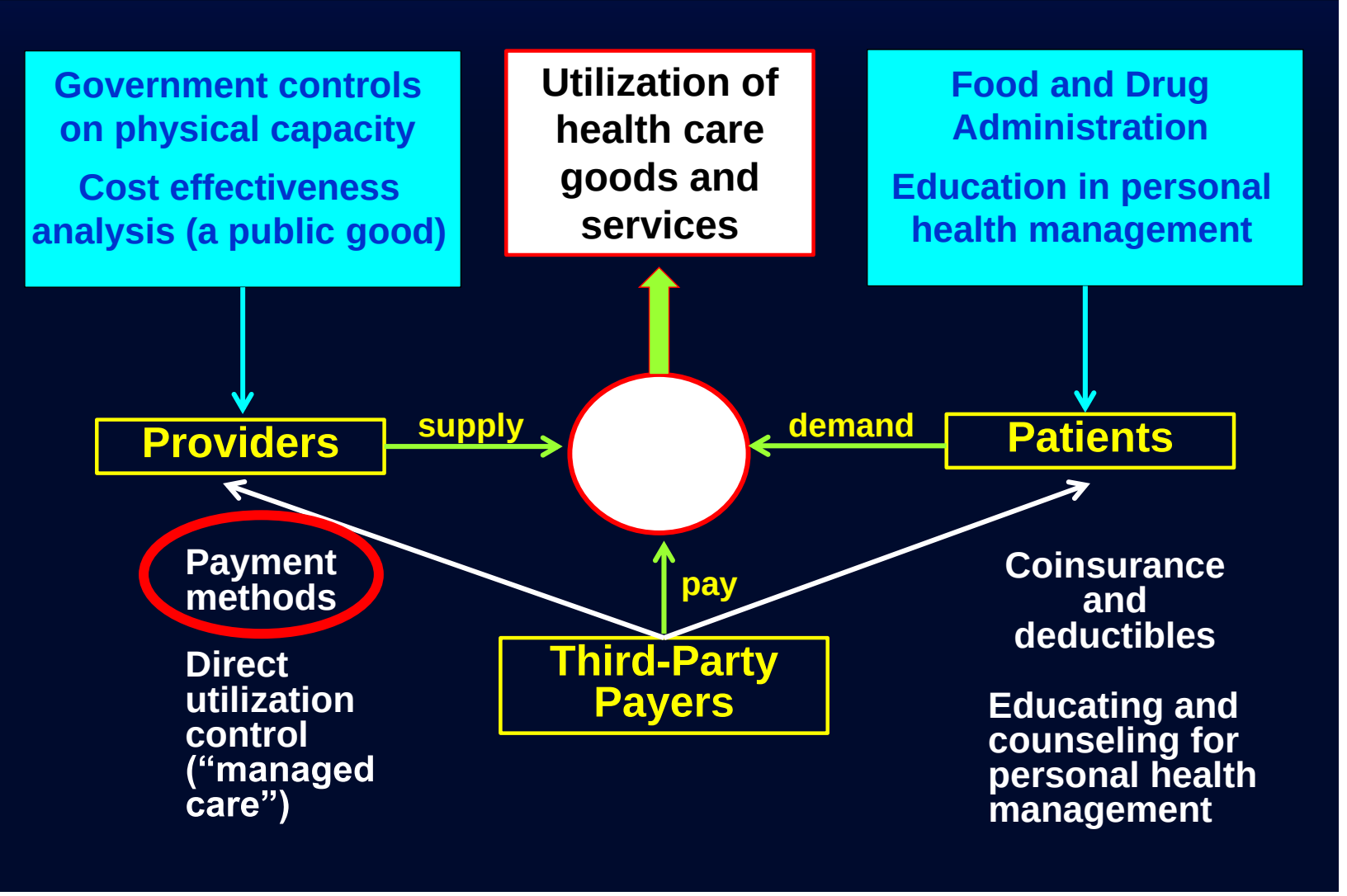
If a trend cannot possibly go on, it probably won't.

We are obliged to bend the cost curve to validate

Stein's Law.

II. SO LET'S TALK ABOUT BENDING THE COST CURVE

A. Controlling the flow of real resources ("utilization")

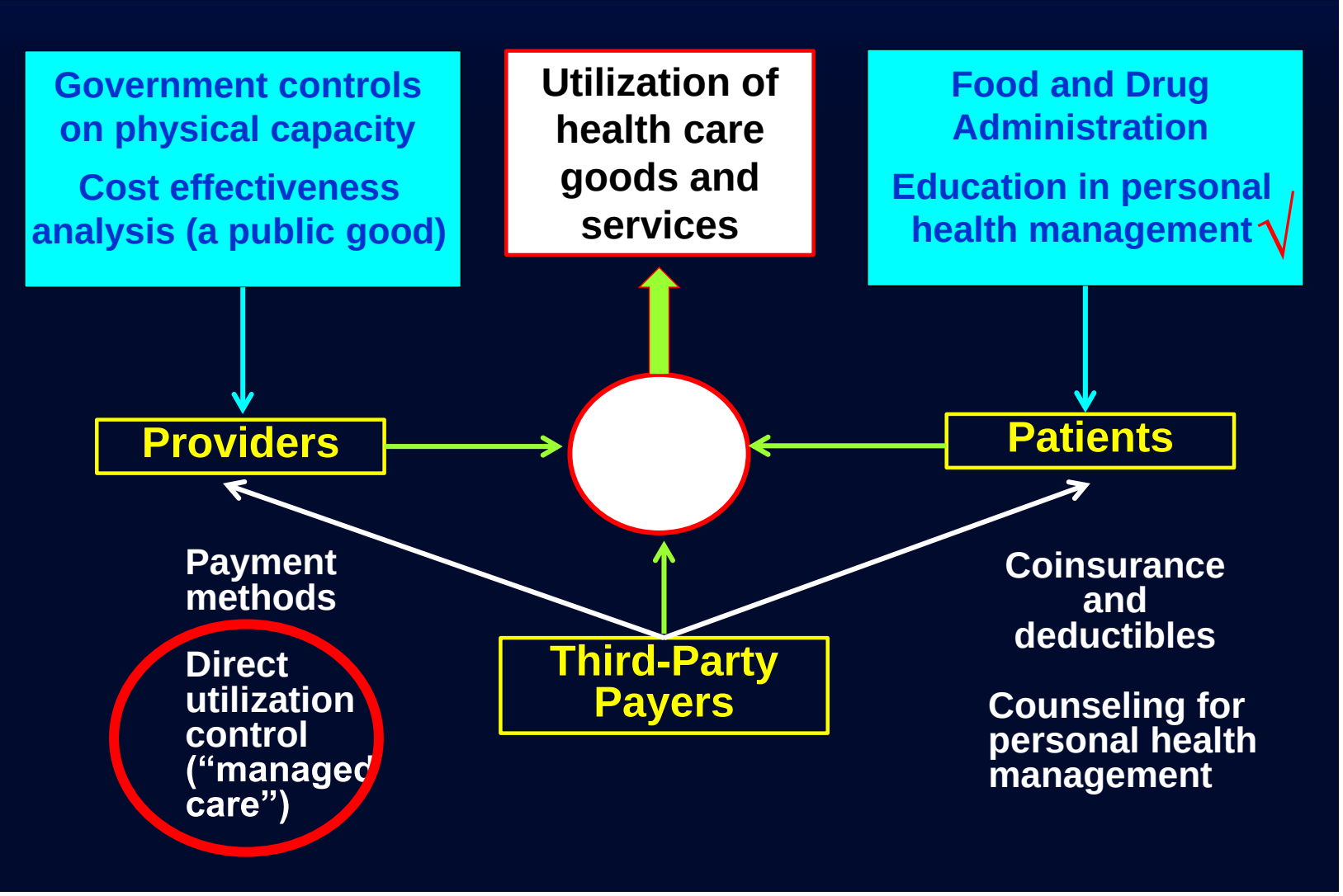

Government controls on physical capacity
Cost effectiveness analysis (a public good)
Utilization of health care goods and services
Food and Drug Administration
Education in personal health management
Providers
supply
demand
Patients
Payment methods
pay
Coinsurance and deductibles
Third-Party Payers
Direct utilization control ("managed care")
Educating and counseling for personal health management

ALTERNATIVE PAYMENT SYSTEMS FOR HEALTH CARE

METHOD OF DETERMINING FEE LEVELS	- BASE FOR PAYMENT -			
	Fee-for-Service (FFS)	Evidence-Based Case Payments (Bundled Payments – e.g., DRGs)	Annual Capitation per Patient at Risk	Budgets (Institutions) or Salary (Personnel, including Physicians)
Free-Market Price Setting between Individual Providers and Payers	A	B	C	D
Negotiations between Associations of Payers and Providers	E	F	G	H
Unilateral Administrative Price Setting (usually by Government)	I	J	K	L

Given the wonderful single-payer platform God gave Canada, has Canada been a world leader in payment reform?

Or is it still wedded to fee-for-service for doctors band per-diems for in[patient facilities – both of which carry with them dubious financial incentives?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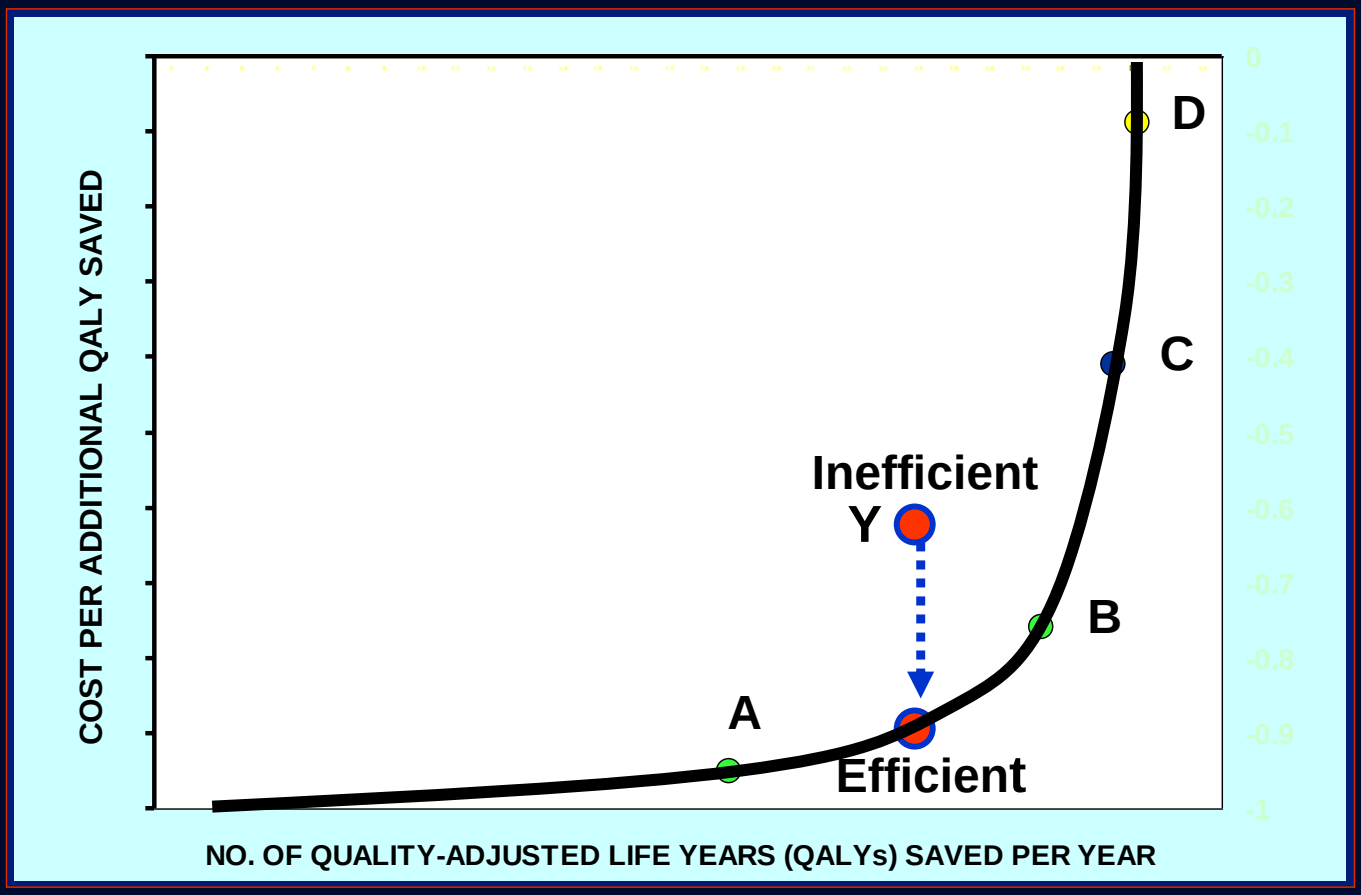
Third-Party Payers
Coinsurance and deductibles
Counseling for personal health management

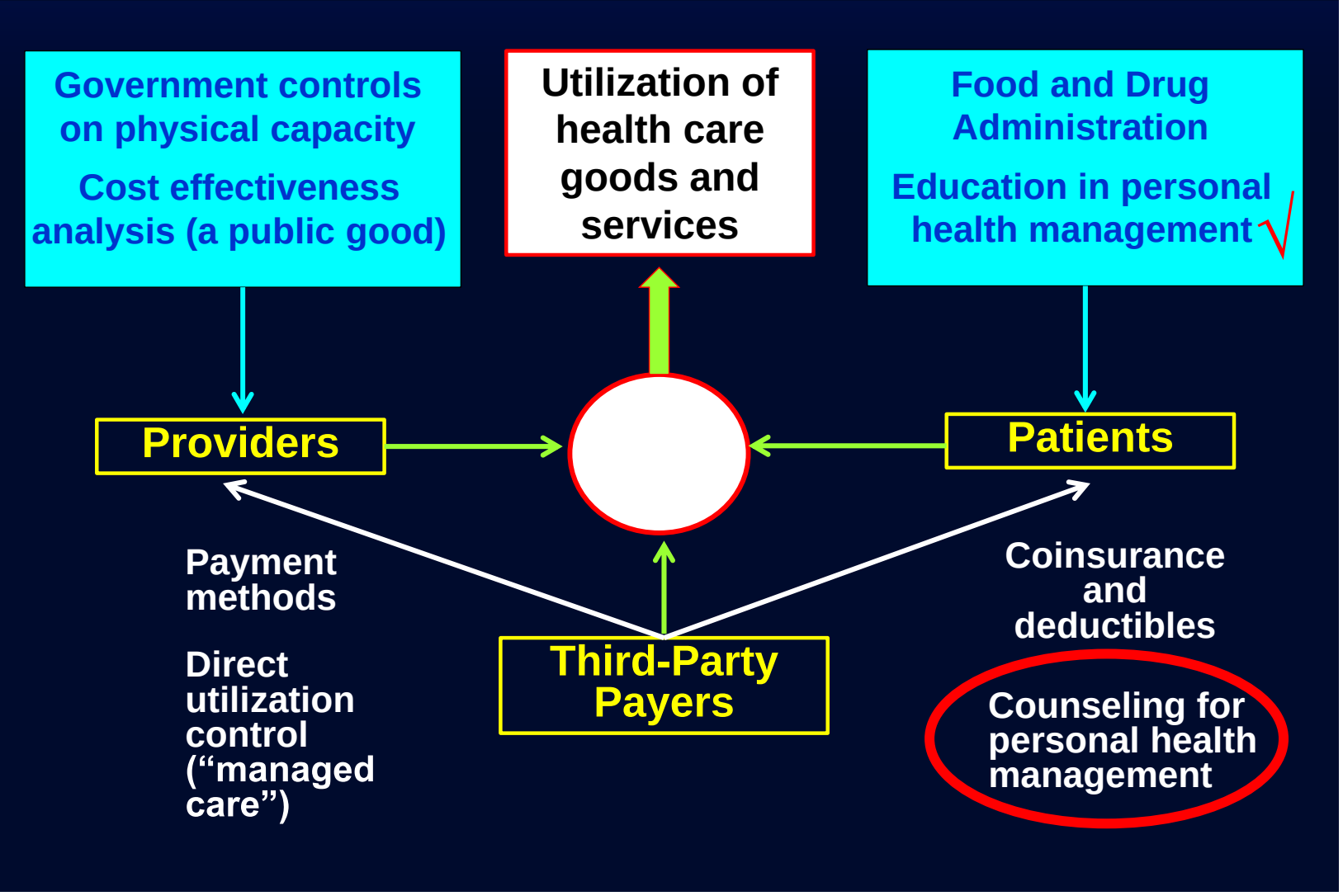
Once again, given the wonderful single-payer platform God gave Canada, has Canada been a world leader in health-care technology assessment (HTA)

If not, what's the excuse?

Granted, this can get dicey!

THE COST-EFFECTIVE SUPPLY CURVE FOR QUALITY-ADJUSTED LIFE YEARS WRESTLED FROM NATURE BY A HEALTH SYSTEM

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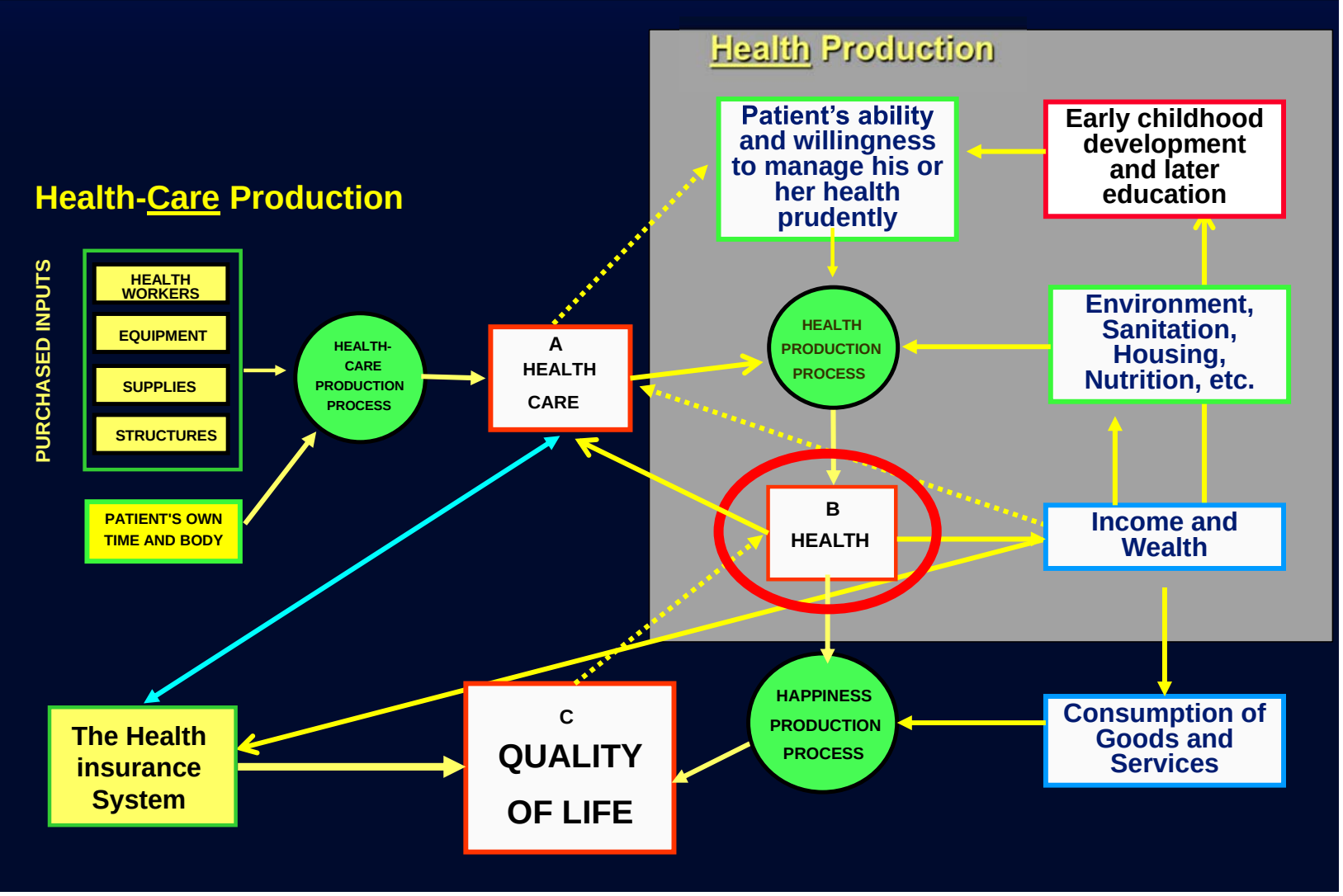

Health Production
Patient's ability and willingness to manage his or her health prudently
Early childhood development and later education
Health-Care Production
PURCHASED INPUTS
HEALTH WORKERS
EQUIPMENT
SUPPLIES
STRUCTURES
HEALTH-CARE PRODUCTION PROCESS
A HEALTH CARE
HEALTH PRODUCTION PROCESS
Environment, Sanitation, Housing, Nutrition, etc.
PATIENT'S OWN TIME AND BODY
B HEALTH
Income and Wealth
The Health insurance System
C QUALITY OF LIFE
HAPPINESS PRODUCTION PROCESS
Consumption of Goods and Services

The relationship between spending on preventive health care and the long-run growth path of total health spending is complex.

Whether it reduces costs depends very much on the type of prevention and how well it is targeted on risk classes.

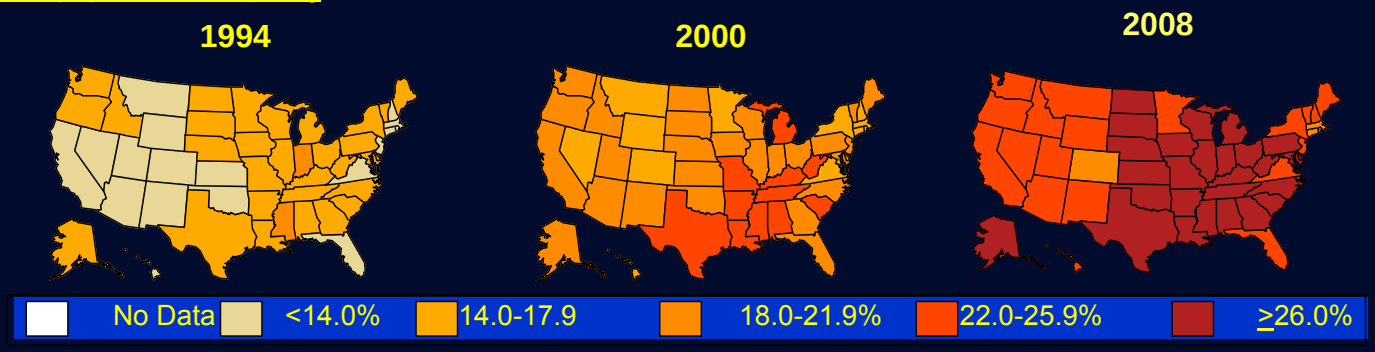
There is a large body of research, however, showing that, *ceteris paribus*, more obese people have annual health expenditures much in excess of non-obese persons.

Health Production American Style*

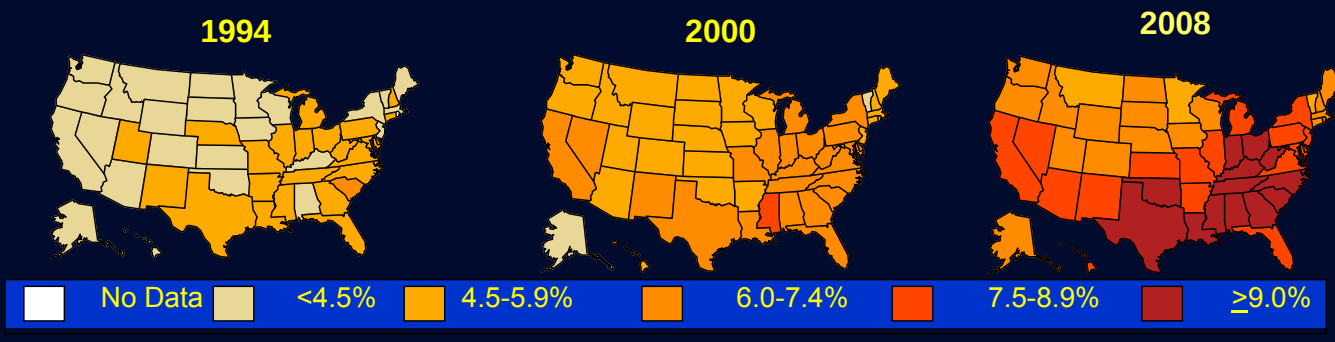
* Saskatchewan, too

Age-adjusted Percentage of U.S. Adults Who Were Obese or Who Had Diagnosed Diabetes

Obesity (BMI ≥30 kg/m^2)

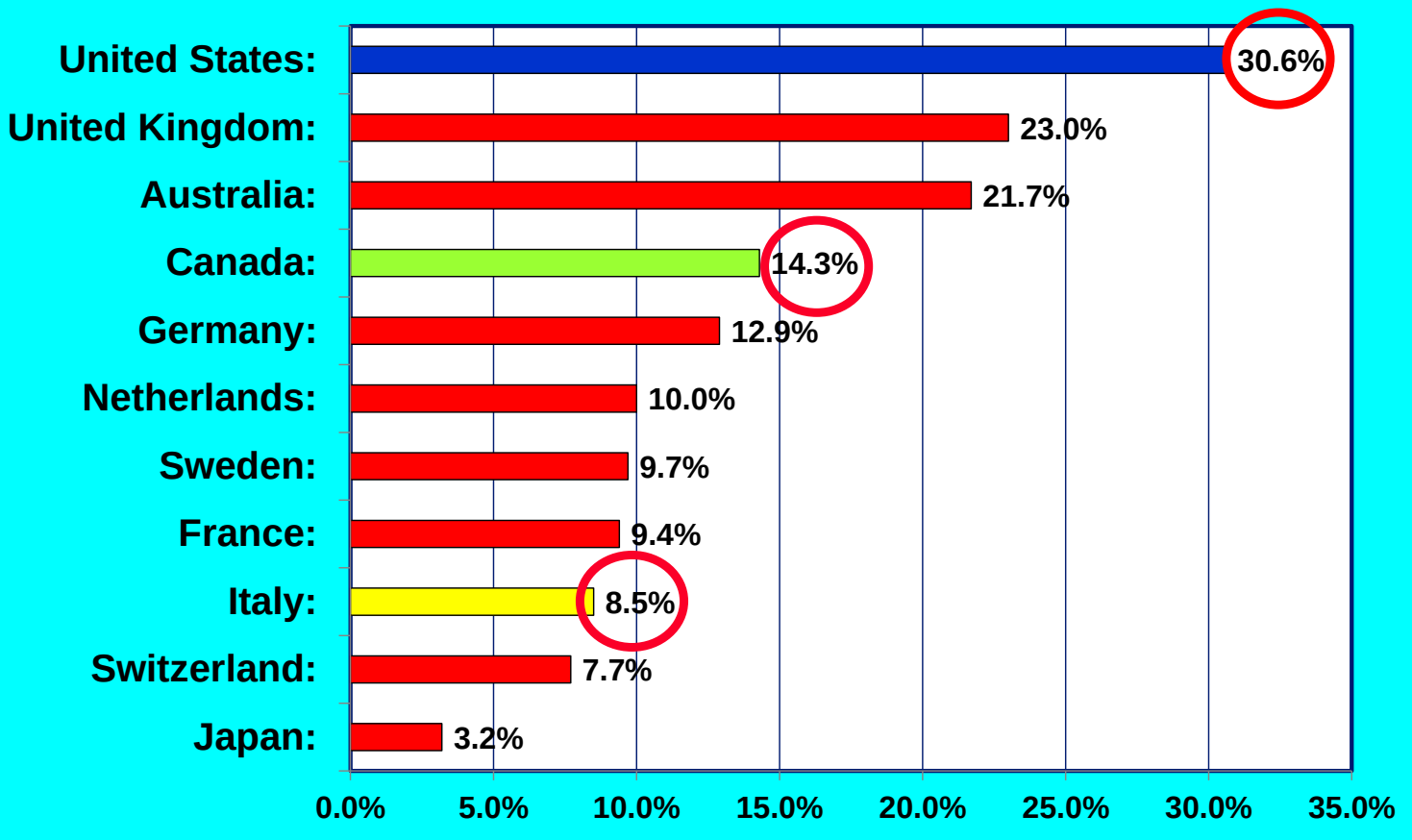


Diabetes



CDC's Division of Diabetes Translation. National Diabetes Surveillance System available at http://www.cdc.gov/diabetes/statistics

Obesity Rates by OECD Country, 2005



SOURCE: OECD DATA, www.nationmaster.com/graph/hea_obe-health-obesity

Mic□elangelo's famous sculpture "Davi□" recently toure□ the United States and then returned to Italy.

As it left Italy

After U.S. Tour

Does every Canadian now have access, as surely all Canadians should have, to his or her electronic health record (HER), an electronic communications link between patients and primary-care physician?

I can see in the U.S. methods to provide patients with powerful financial incentives (positive or punitive) to manage their health better.

Discovery Inc. in South Africa.

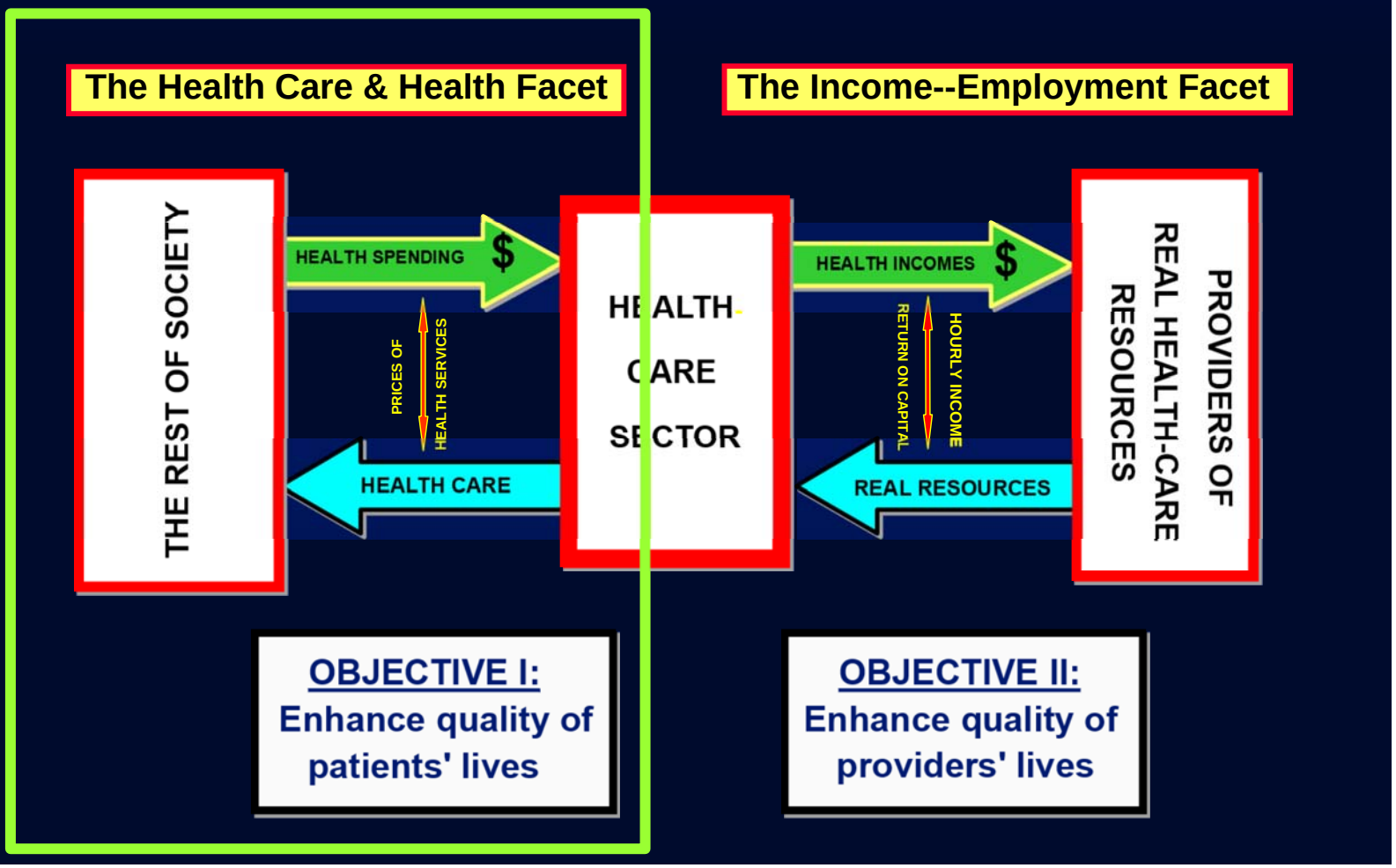
II. SO LET'S TALK ABOUT BENDING THE COST CURVE

A. Controlling the flow of real resources ("utilization")

B. Controlling prices in health care

Control over prices depends crucially on the way a health system allocates relative market power to the payment side and the supply side of the health system.

THE DUAL OBJECTIVES PURSUED IN THE HEALTH-CARE SECTOR



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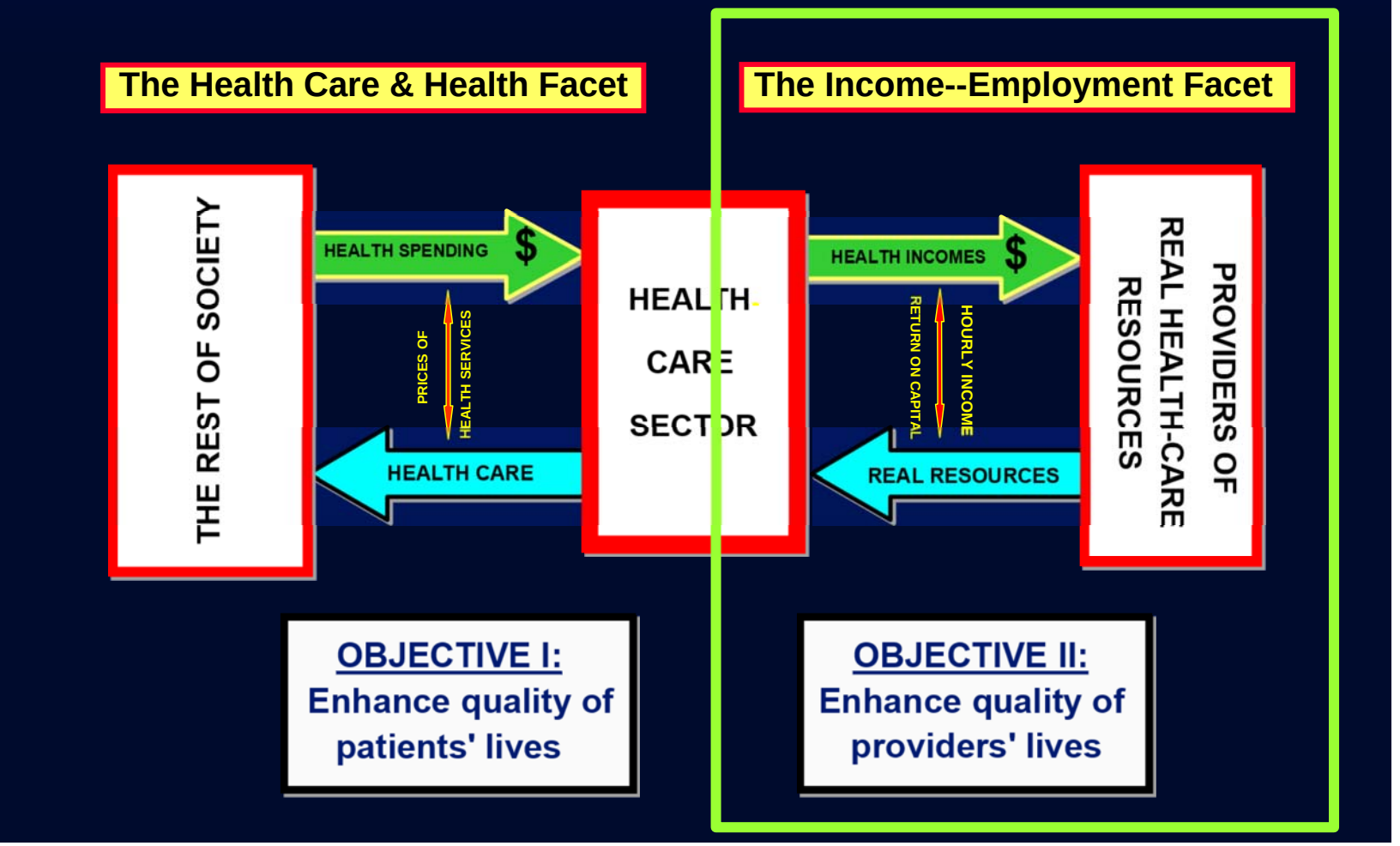

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It's The Prices, Stupid: Why The United States Is So Different From Other Countries

Higher health spending but lower use of health services adds up to much higher prices in the United States than in any other OECD country.

by Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan

PROLOGUE: In Fall 1986 *Health Affairs* published the first of nearly two decades' worth of reports summarizing the state of health care spending in industrialized countries that are members of the Organization for Economic Cooperation and

international federation of health plans

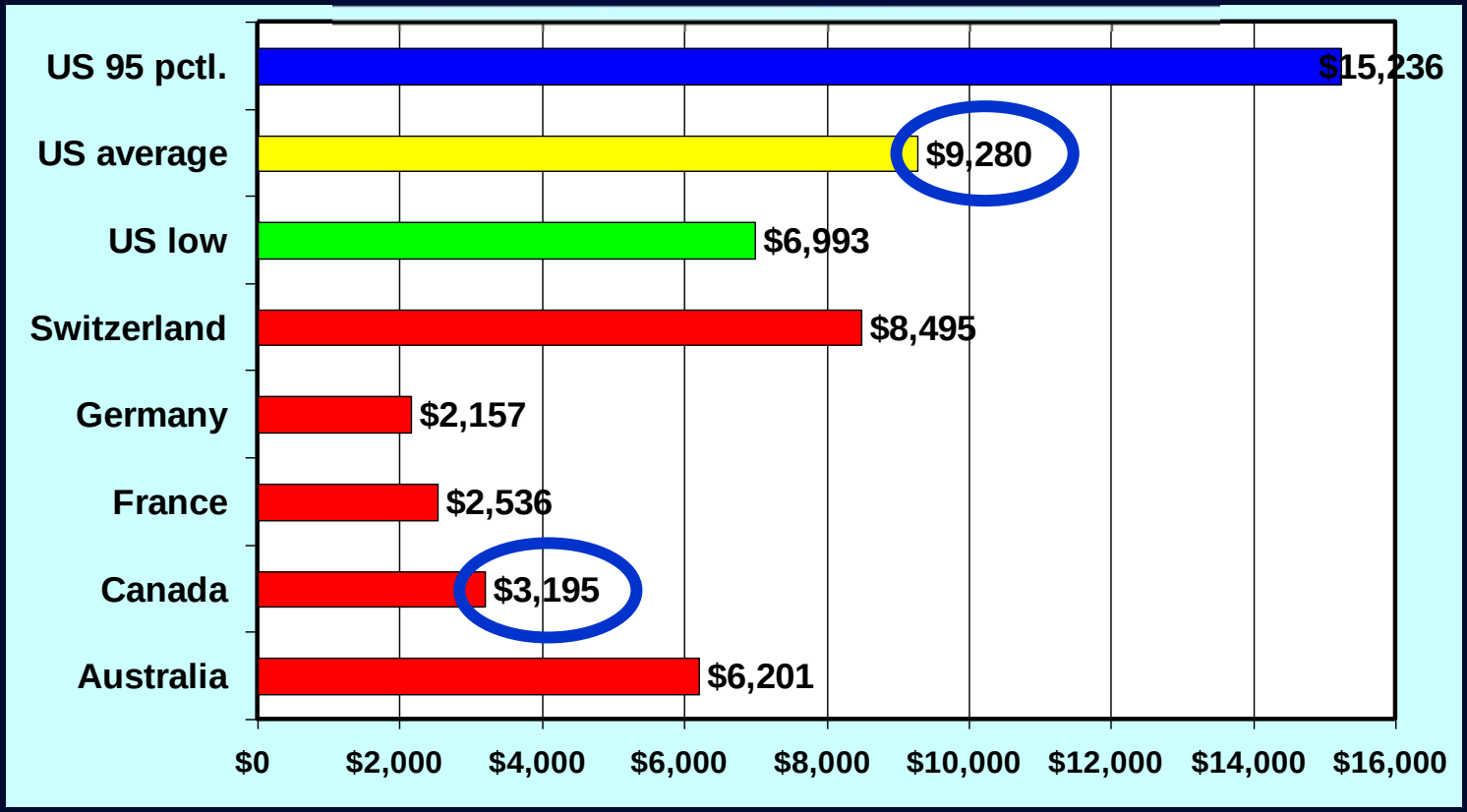
International Federation of Health Plans

2010 Comparative Price Report

Medical and Hospital Fees by Country

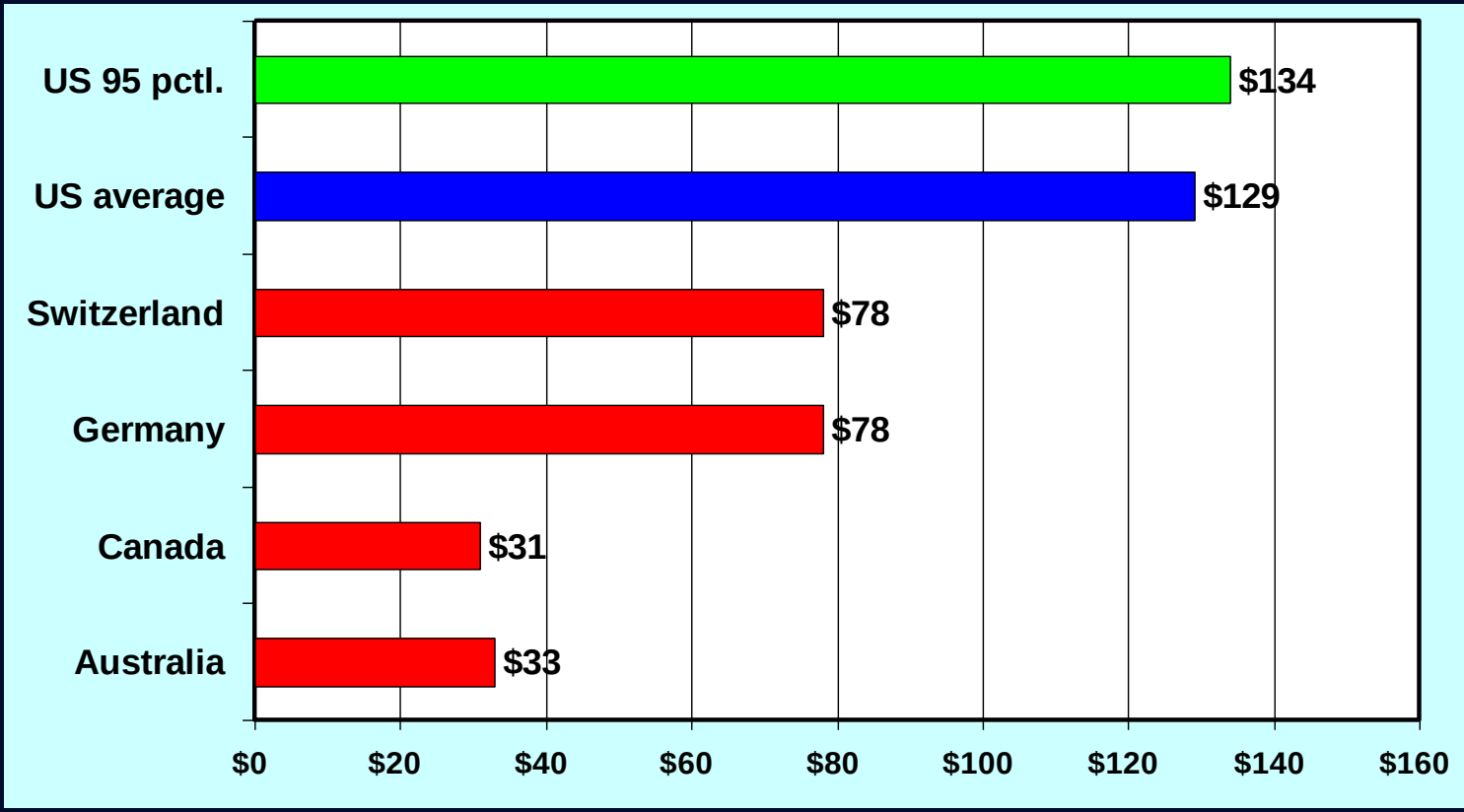
COMPARATIVE PRICES FOR A NORMAL DELIVERY:

Total hospital and physician cost



SOURCE: International Federation of Health Plans, *2011 Comparative Price Report.*

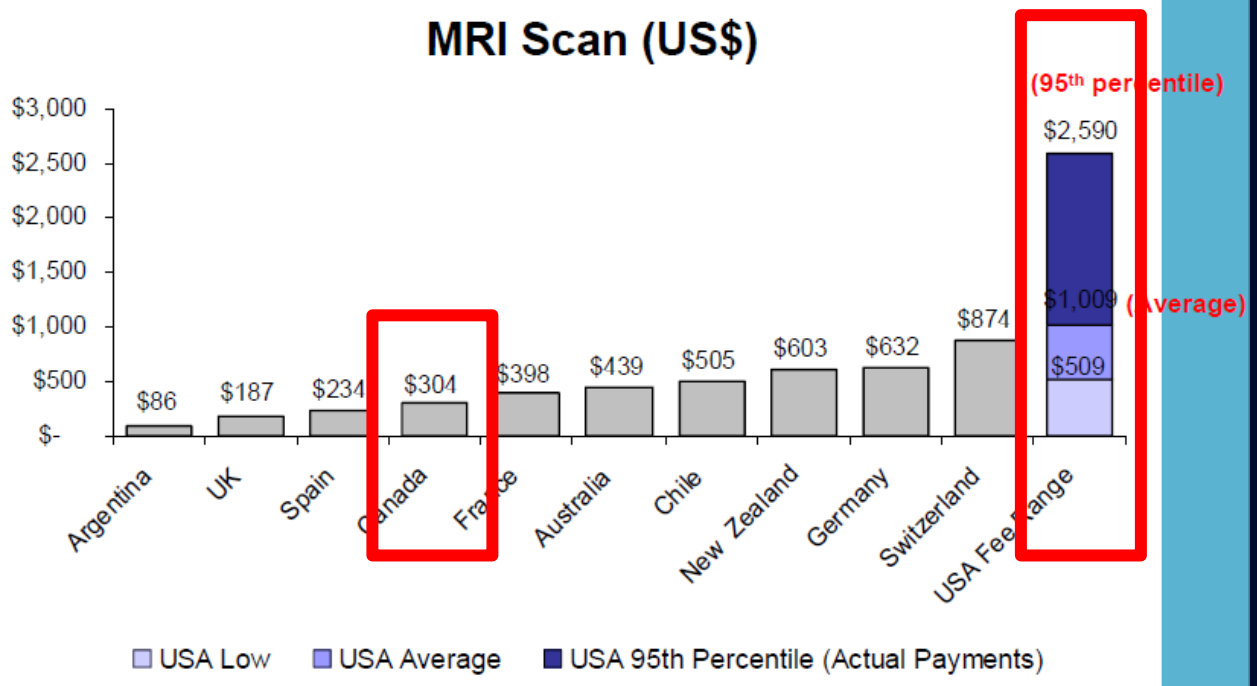
COMPARATIVE PRICES FOR LIPITOR:



SOURCE: International Federation of Health Plans, *2010 Comparative Price Report*.

FOR ILLUSTRATIVE PURPOSES ONLY

Scans and Imaging Fees:



But the variation of prices for identical procedures within the U.S. – even within a single state – dwarfs cross national variations.

These variations do not seem to be related to corresponding variations in costs or quality, but merely to the relative market power of payers and providers.

Table 6.3:

Large New Jersey Insurer's Payment for Colonoscopies Performed in Hospitals and Ambulatory Surgical Centers – Minimum Cost Per Procedure versus Maximum Cost Per Procedure

Cost per Colonoscopy	In-Network Minimum to Maximum Range
Physician	$178 to $431
Hospital	$716 to $3,717
ASC	$443 to $1,395

Table 6.5:

Payments by One California Insurer to Various Hospitals, 2007 (Wage Adjusted)

	Appendectomy[1]	CABG[2]
Hospital A	$1,800	$33,000
Hospital B	$2,900	$54,600
Hospital C	$4,700	$64,500
Hospital D	$9,500	$72,300
Hospital E	$13,700	$99,800

[1] Cost per case (DRG 167)
[2] Coronary Bypass with Cardiac Catheterization (DRG 107); tertiary hospitals only.

AHIP
Center for Policy and Research

An illustration from the U.S. health system.

December 2010

Recent Trends in Hospital Prices in California and Oregon

Figure 2b. Oregon Statewide Average Reimbursement for Knee Joint Replacement, 2005-2009

How is it that business leaders put up with this?

Source: Office for Oregon Health Policy and Research (OHPR).
Note: Data from nine private health insurance plans.

In Oregon, hospital prices faced by commercial insurers for common discharge categories also grew very rapidly between 2005 and 2009:

How is it that business leaders put up with this?

	2005-2009 Average Annual Rate of Price Inflation
Appendix removal:	11.3%
Balloon angioplasty without heart attack:	8.4%
Cesarean delivery:	11.5%
Hip joint replacement:	10.9%
Normal newborn:	10.4%
Pneumonia:	9.6%
Upper spine and neck procedures:	11.9%
Vaginal delivery:	14.0%
Vaginal hysterectomy (excluding cancer or non-malignant tumor):	12.9%

Figure 2a. Oregon Statewide Average Reimbursement for Normal Vaginal Delivery, 2005-2009

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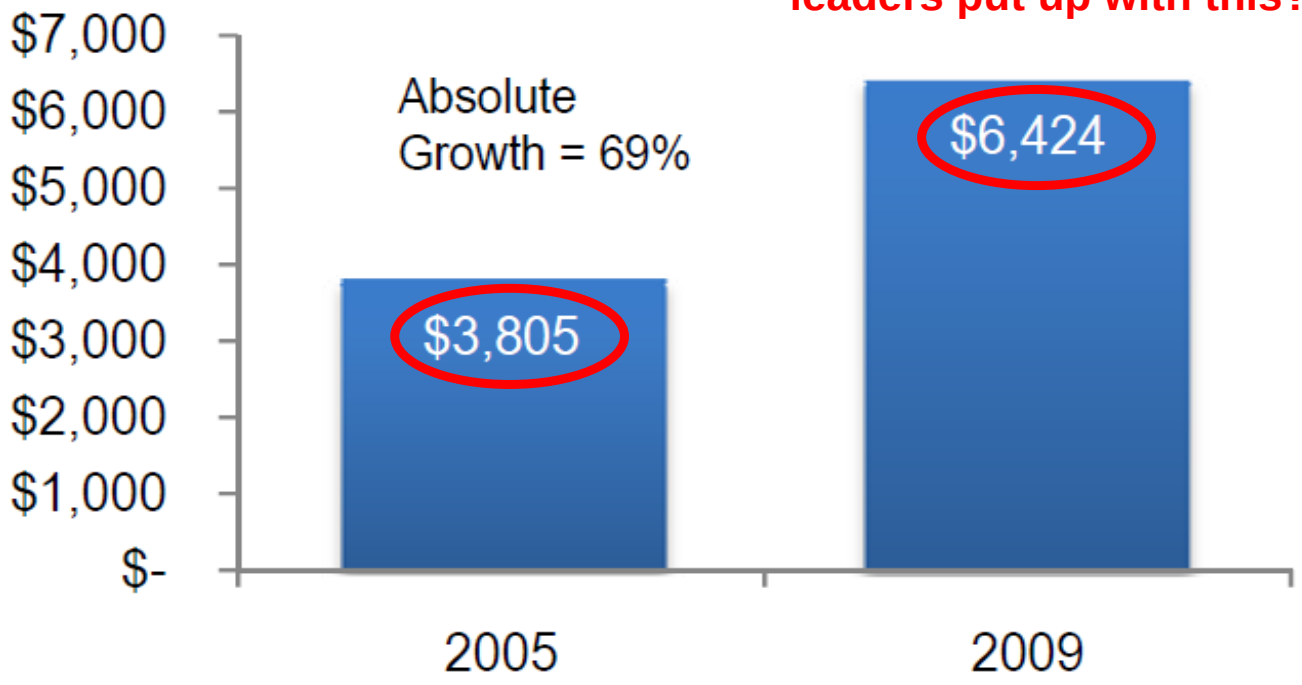
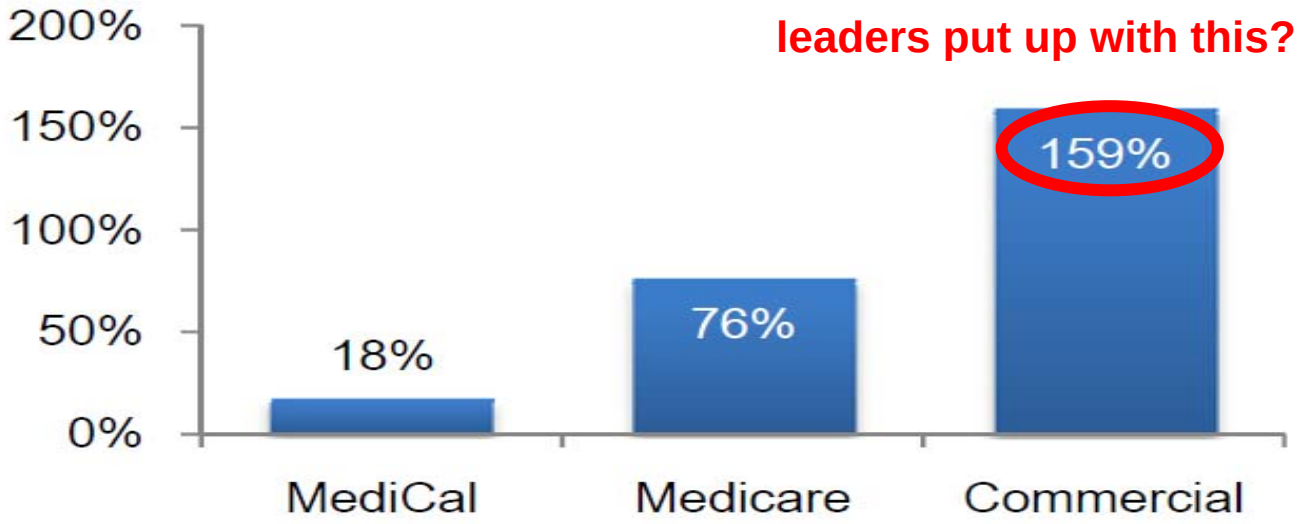


Figure 1. Statewide Absolute Growth in Net Inpatient Revenue per Day, California Hospitals, 2000-2009

How is it that U.S. business leaders put up with this?



Source: State of California, Office of Health Planning and Development (OSHPD). Calculations by AHIP Center for Policy and Research.

My proposal is that if a nation insists on having multiple insurance carriers that compete with one another, they should be made to compete on quality only and that prices within regions should be uniformly paid by all payers and received by all providers.

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By Uwe E. Reinhardt

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HEALTH AFFAIRS 30,
NO. 11 (2011): 2125–2133

ANALYSIS & COMMENTARY

The Many Different Prices Paid To Providers And The Flawed Theory Of Cost Shifting: Is It Time For A More Rational All-Payer System?

ABSTRACT In developed nations that rely on multiple, competing health insurers—for example, Switzerland and Germany—the prices for health care services and products are subject to uniform price schedules that are either set by government or negotiated on a regional basis between associations of health insurers and associations of providers of health care. In the United States, some states—notably Maryland—have used such all-payer systems for hospitals only. Elsewhere in the United States, prices are negotiated between individual payers and providers. This situation has resulted in an opaque system in which payers with market power force weaker payers to cover disproportionate shares of providers' fixed costs—a phenomenon sometimes termed *cost shifting*—or providers simply succeed in charging higher prices when they can. In this article I propose that this price-discriminatory system be replaced over time by an all-payer system as a means to better control costs and ensure equitable payment.

Uwe E. Reinhardt (reinhardt@princeton.edu) is the James Madison Professor of Political Economy and a professor of economics and public affairs at Princeton University, in Princeton, New Jersey.

THE END