BENDING THE HEALTH CARE COST CURVE:
Why? And How?

Uwe E. Reinhardt
Princeton University

Proud Alumnus of the
University of Saskatchewan

University of Saskatchewan
Graduate School of Public Policy

BENDING THE COST CURVE IN HEALTH CARE
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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.) THE major economic locomotive, providing millions of middle-class jobs.
ANNUAL DOLLAR CHANGE IN GDP AND HEALTH SPENDING, U.S., 2000-2011

Sources: Economic Report of the President 2012 and CMS Database.
Fraction of dollar growth in GDP contributed by health care:

- 2001: 35%
- 2002: 37%
- 2003: 27%
- 2004: 17%
- 2005: 17%
- 2006: 17%
- 2007: 20%
- 2008: 38%
- 2009: 17%
- 2010: 17%
- 2011: 24%

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

($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 these 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].
NORMAL GOODS IN COMPETITIVE MARKETS

BUYERS’ QUALITY OF LIFE

SELLER’ QUALITY OF LIFE

HEALTH CARE

PRE_SUMED RELATIONSHIP BETWEEN SELLERS’ AND BUYERS’ QUALITY OF LIFE

X

Y
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

\[
\text{Net Social Value Added by the Health System} = \text{Gross Social Value Added by the Health System} - \text{Social Opportunity Costs imposed by the Health System on Society}
\]

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”)

Providers

Government controls on physical capacity
Cost effectiveness analysis (a public good)

Utilization of health care goods and services

Third-Party Payers

Direct utilization control ("managed care")

Payment methods

Patients

Food and Drug Administration
Education in personal health management

Coinsurance and deductibles

Educating and counseling for personal health management

Government controls on physical capacity
Cost effectiveness analysis (a public good)

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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?
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.

Inefficient

Efficient

Y

A

B

C

D

No. of quality-adjusted life years (QALYs) saved per year

Cost per additional QALY saved
Providers

- Government controls on physical capacity
- Cost effectiveness analysis (a public good)

Utilization of health care goods and services

Third-Party Payers

- Direct utilization control ("managed care")
- Payment methods

Patients

- Food and Drug Administration
- Education in personal health management

Third-Party Payers

- Coinsurance and deductibles
- Counseling for personal health management
The Health insurance System

Early childhood development and later education

Environment, Sanitation, Housing, Nutrition, etc.

Income and Wealth

Consumption of Goods and Services

Quality of Life

Health Production

- Patient's ability and willingness to manage his or her health prudently
- Health Production Process
- Health Care
- Health
- Happiness Production Process

Purchased Inputs

- Health Workers
- Equipment
- Supplies
- Structures

Patient's Own Time and Body

The Health Care Production process involves:
- Early childhood development and later education
- Environment, Sanitation, Housing, Nutrition, etc.
- Income and Wealth
- 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/m²)**

- **1994**
- **2000**
- **2008**

**Diabetes**

- **1994**
- **2000**
- **2008**

Obesity Rates by OECD Country, 2005

United States: 30.6%
United Kingdom: 23.0%
Australia: 21.7%
Canada: 14.3%
Germany: 12.9%
Netherlands: 10.0%
Sweden: 9.7%
France: 9.4%
Italy: 8.5%
Switzerland: 7.7%
Japan: 3.2%

Michelangelo’s famous sculpture “David” recently toured the United States and then returned to Italy.
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.
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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

2010 Comparative Price Report
Medical and Hospital Fees by Country
COMPARATIVE PRICES FOR A NORMAL DELIVERY:
Total hospital and physician cost

COMPARATIVE PRICES FOR LIPITOR:

Scans and Imaging Fees:
MRI Scan (US$)

- Argentina: $88
- UK: $167
- Spain: $234
- Canada: $304
- France: $398
- Australia: $439
- Chile: $505
- New Zealand: $603
- Germany: $632
- Switzerland: $874
- USA Federal: $2,500

Legend:
- USA Low
- USA Average
- USA 95th Percentile (Actual Payments)
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

<table>
<thead>
<tr>
<th>Cost per Colonoscopy</th>
<th>In-Network Minimum to Maximum Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>$178 to $431</td>
</tr>
<tr>
<td>Hospital</td>
<td>$716 to $3,717</td>
</tr>
<tr>
<td>ASC</td>
<td>$443 to $1,395</td>
</tr>
</tbody>
</table>
**Table 6.5:**
Payments by One California Insurer to Various Hospitals, 2007 (Wage Adjusted)

<table>
<thead>
<tr>
<th></th>
<th>Appendectomy¹</th>
<th>CABG²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>$1,800</td>
<td>$33,000</td>
</tr>
<tr>
<td>Hospital B</td>
<td>$2,900</td>
<td>$54,600</td>
</tr>
<tr>
<td>Hospital C</td>
<td>$4,700</td>
<td>$64,500</td>
</tr>
<tr>
<td>Hospital D</td>
<td>$9,500</td>
<td>$72,300</td>
</tr>
<tr>
<td>Hospital E</td>
<td>$13,700</td>
<td>$99,800</td>
</tr>
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¹ Cost per case (DRG 167)
² Coronary Bypass with Cardiac Catheterization (DRG 107): tertiary hospitals only.
An illustration from the U.S. health system.

Recent Trends in Hospital Prices in California and Oregon

December 2010
How is it that business leaders put up with this?

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

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:

<table>
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<th>Procedure</th>
<th>2005-2009 Average Annual Rate of Price Inflation</th>
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<tr>
<td>Appendix removal</td>
<td>11.3%</td>
</tr>
<tr>
<td>Balloon angioplasty without heart attack</td>
<td>8.4%</td>
</tr>
<tr>
<td>Cesarean delivery</td>
<td>11.5%</td>
</tr>
<tr>
<td>Hip joint replacement</td>
<td>10.9%</td>
</tr>
<tr>
<td>Normal newborn</td>
<td>10.4%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>9.6%</td>
</tr>
<tr>
<td>Upper spine and neck procedures</td>
<td>11.9%</td>
</tr>
<tr>
<td><strong>Vaginal delivery</strong></td>
<td><strong>14.0%</strong></td>
</tr>
<tr>
<td>Vaginal hysterectomy (excluding cancer or non-malignant tumor)</td>
<td>12.9%</td>
</tr>
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How is it that business leaders put up with this?
How is it that U.S. business leaders put up with this?

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

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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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 healthcare 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.
THE END