The Elusive American Quest for Health Care Cost Containment: *Will Health Reform be Enough?*

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“By building on the best reforms to our health care delivery system in the Affordable Care Act and making new improvements to how we deliver care in this country, we will lower health care costs, improve quality, strengthen our economic security, and reduce the deficit.”

Tammy Baldwin, Senator, Wisconsin
• Rising health care expenditures are unsustainable for both public (Medicare and Medicaid) and private (employer based insurance system) sectors.

• Healthcare costs are directly related to our health coverage and access problem

• American competitiveness is threatened

• Health care consumption and expenditures are driving out other, critical investment opportunities and needs
“If you don't know where you are going, you might wind up someplace else”

Yogi Berra
Framing the Healthcare Cost Problem

So, do we have a healthcare cost problem?

How big is it?

What’s driving the problem?
Projections of National Health Expenditures and Their Share of Gross Domestic Product, 2012-2021

Dollars in Billions:

<table>
<thead>
<tr>
<th>Year</th>
<th>NHE in Billions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>$2,809</td>
</tr>
<tr>
<td>2013</td>
<td>$2,915</td>
</tr>
<tr>
<td>2014</td>
<td>$3,130</td>
</tr>
<tr>
<td>2015</td>
<td>$3,308</td>
</tr>
<tr>
<td>2016</td>
<td>$3,514</td>
</tr>
<tr>
<td>2017</td>
<td>$3,723</td>
</tr>
<tr>
<td>2018</td>
<td>$3,952</td>
</tr>
<tr>
<td>2019</td>
<td>$4,207</td>
</tr>
<tr>
<td>2020</td>
<td>$4,487</td>
</tr>
<tr>
<td>2021</td>
<td>$4,781</td>
</tr>
</tbody>
</table>

NHE as a Share of GDP:

- 2012: 17.9%
- 2013: 17.8%
- 2014: 18.2%
- 2015: 18.2%
- 2016: 18.3%
- 2017: 18.4%
- 2018: 18.6%
- 2019: 18.9%
- 2020: 19.2%
- 2021: 19.6%

Annual Increase in National Health Expenditures and Their Share of Gross Domestic Product, 1961-2011

National Health Expenditures per Capita

NOTE: According to CMS, population is the U.S. Bureau of the Census resident-based population, less armed forces overseas and their dependents.

National Health Expenditures per Capita, 1990-2021

$14,103 (2021)

$8,952 (2012)

$2,851 (1990)

Maine Per Capita Health Spending, 1990-2009

Average Annual Growth Rates for NHE and GDP, Per Capita, for Selected Time Periods

### Per Capita Total Current Health Care Expenditures, U.S. and Selected Countries, 2010

<table>
<thead>
<tr>
<th>Country</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>$4,162</td>
</tr>
<tr>
<td>Belgium</td>
<td>$3,969</td>
</tr>
<tr>
<td>Canada</td>
<td>$4,205</td>
</tr>
<tr>
<td>Denmark</td>
<td>$4,300</td>
</tr>
<tr>
<td>Finland</td>
<td>$3,093</td>
</tr>
<tr>
<td>France</td>
<td>$3,835</td>
</tr>
<tr>
<td>Germany</td>
<td>$4,187</td>
</tr>
<tr>
<td>Iceland</td>
<td>$3,309</td>
</tr>
<tr>
<td>Ireland</td>
<td>$3,589</td>
</tr>
<tr>
<td>Italy</td>
<td>$2,852</td>
</tr>
<tr>
<td>Luxembourg^</td>
<td>$4,786</td>
</tr>
<tr>
<td>Netherlands</td>
<td>$4,727</td>
</tr>
<tr>
<td>New Zealand</td>
<td>$3,022</td>
</tr>
<tr>
<td>Norway</td>
<td>$5,188</td>
</tr>
<tr>
<td>Spain</td>
<td>$2,979</td>
</tr>
<tr>
<td>Sweden</td>
<td>$3,561</td>
</tr>
<tr>
<td>Switzerland</td>
<td>$5,270</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>$3,253</td>
</tr>
<tr>
<td>United States</td>
<td>$7,910</td>
</tr>
</tbody>
</table>

^ 2009 data

Notes: Amounts in U.S.$ Purchasing Power Parity, see [www.oecd.org/std/ppp](http://www.oecd.org/std/ppp); includes only countries over $2,500. OECD defines Total Current Expenditures on Health as the sum of expenditures on personal health care, preventive and public health services, and health administration and health insurance; it excludes investment.

What is Driving the Cost Problem?
Contributing Factors to Healthcare Cost Increases

• *Price* and *non-price* factors drive changes in costs and expenditures

    \[ \text{Price X Use} = \text{Expenditures} \]

• Non-price/Use factors:
  – population changes (e.g. aging, demographics)
  – health status (e.g. prevalence of chronic disease)
  – technology/intensity of care (e.g. imaging), and
  – Variations in care and quality (e.g. overuse, underuse, misuse)
People with chronic health conditions such as diabetes and asthma/COPD account for 84% of healthcare spending and 99% of Medicare spending.

Concentration of Health Care Spending in the U.S. Population, 2009

Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals and families, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

What’s Driving the Driving Forces?

• Our system is perfectly designed to produce these results:
  – Few policies and/or incentives to support health. Limited investment in public health
  – Financial incentives encourage overuse (and in some cases misuse) of healthcare and don’t penalize poor quality.
  – Provider versus consumer orientation in the organization and delivery of services
  – The medical-industrial complex: the Wall Street factor.
Efforts to Contain Healthcare Costs: Can We Get it Right This Time?
We Have Been Here Before

The Committee on the Cost of Medical Care

Medicare

1993 – 1994 Clinton Health Reform


1940’s – 1950’s Efforts to Pass National Health Insurance Bills

1970 – 1975 National Health Insurance Proposals

Patient Protection and Affordable Care Act of 2010
The Affordable Care Act: Six Key Reform Strategies

• Expand health insurance coverage
• **Reduce rate of growth in health care costs**
• **Improve quality and efficiency through financing and delivery system reform**
• Build public health capacity
• Build health workforce
• Expand long term care options
Accountable Care Organizations

“A group of health care providers working together to assume shared accountability for the quality and cost of the care they provide to their community with an overall focus on improving health care value”

ACOs contract with employers and health plans and assume responsibility for a population of individuals and for meeting specified budgetary and quality benchmarks.
ACOs: Old Wine in New Bottles?

• Strategy shares DNA with what we used to call “managed care”.

• What’s new?
  – Shift in focus to provider, away from health plans
  – Redesign of delivery systems to revitalize role of primary care.
  – Performance-based payment arrangements that incentivize value-based care: lower cost, higher quality.
Payment Reform Models

Volumes → Value

Payment for service
- Fee-for-service
- Augmented fee-for-service (e.g., P4P)

Payment for event or condition
- Bundled payment (single provider)
- Bundled payment (multiple providers)

Payment for care of a population
- Partial capitation
- Full capitation

Increasing aggregation of services into a unit of payment (e.g. ACO)

Source: T. Valuck, National Quality Forum, 9/14/10
Are We Containing Costs Or Pushing On A Balloon?

The history of cost containment in the US indicates that the system has an unlimited capacity to shift costs. Like squeezing a balloon, the costs that one purchaser saves is shifted to another in higher prices/costs.
Key Steps for Curbing Spending Growth

• Set targets for growth
• Take a system-wide approach
• Move/align payment systems to value-based arrangements with shared risk models
• Protect access for promote greater equity
• Engage citizens and consumers
• Invest in information
Key Challenges to Implementing Strategies

- Hyper-partisanship is paralyzing sensible policy action
- Divide is not new: age old debate about the role of government
- We know what works, we just can’t get there politically.
Overcoming the Politics of Health Reform

Each option is supported by 25% of the public

Slide courtesy Stuart Altman, Ph.D, Brandeis University
Why Health Reform Legislation is Almost Politically Impossible!

Need 60% – 70% Support to Pass Any Major Reform

As a result, those who oppose any reform

Need the support of only one other group.

Slide courtesy Stuart Altman, Ph.D, Brandeis University
Key Challenges to Implementing Strategies

• Shift focus of health policy to communities, away from states and the federal government
• Give clinicians more power to transform care
• Engage patients and citizens
Key Challenges to Implementing Strategies

• Acknowledge what it really costs to take care of growing populations of poor and older people
Final Thoughts:

Americans will do the right thing after they have tried everything else.

Will we let the perfect be the enemy of the good?