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SOLUTIONS THAT MATTER. HEALTH CARE THAT WORKS.

# WHAT'S DRIVING HIGH HEALTH CARE SPENDING AND HOW DO WE FIX IT?

Health Policy Institute of Ohio Forum

Ani Turner, Center for Value in Health Care, Altarum

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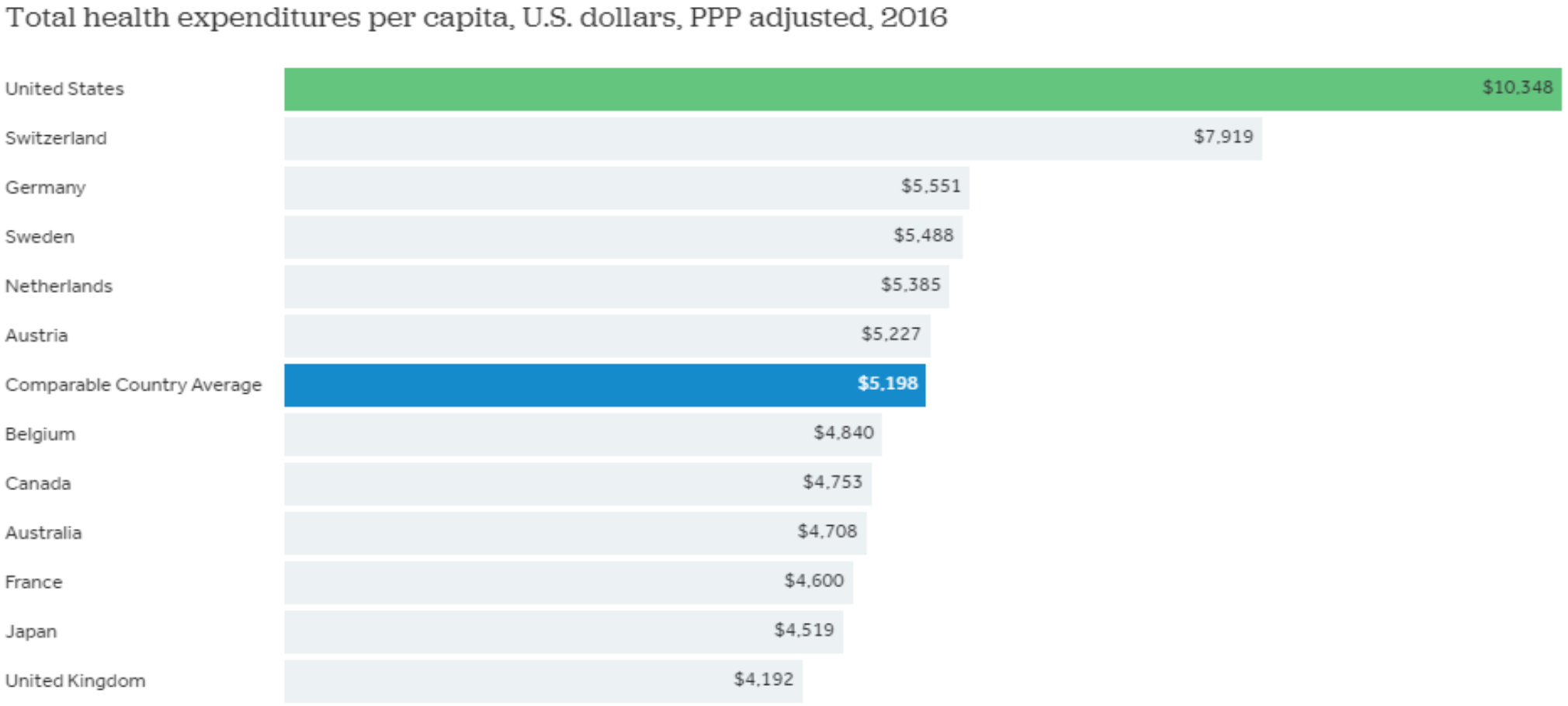
# Key takeaways

1. U.S. leads the world in health care spending – a problem because it's crowding out other priorities, constraining wage growth, and *not producing better health*.
2. We spend more on health care without better health because we pay *higher prices* for drugs and services, make greater use of medical technology, and *invest less in social services* that may be more fundamental to good health.
3. Policy approaches are needed to both *align incentives* and *spread tools and methods* for lowering spending while maintaining health outcomes.

# U.S. spends double per person on health care




Source: Source: U.S. data are from the 2016 National Health Expenditures Account. Comparable country data are from OECD (2017), "OECD Health Data: Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database). DOI: 10.1787/health-data-en (Accessed on March 19, 2017) • Get the data • PNG

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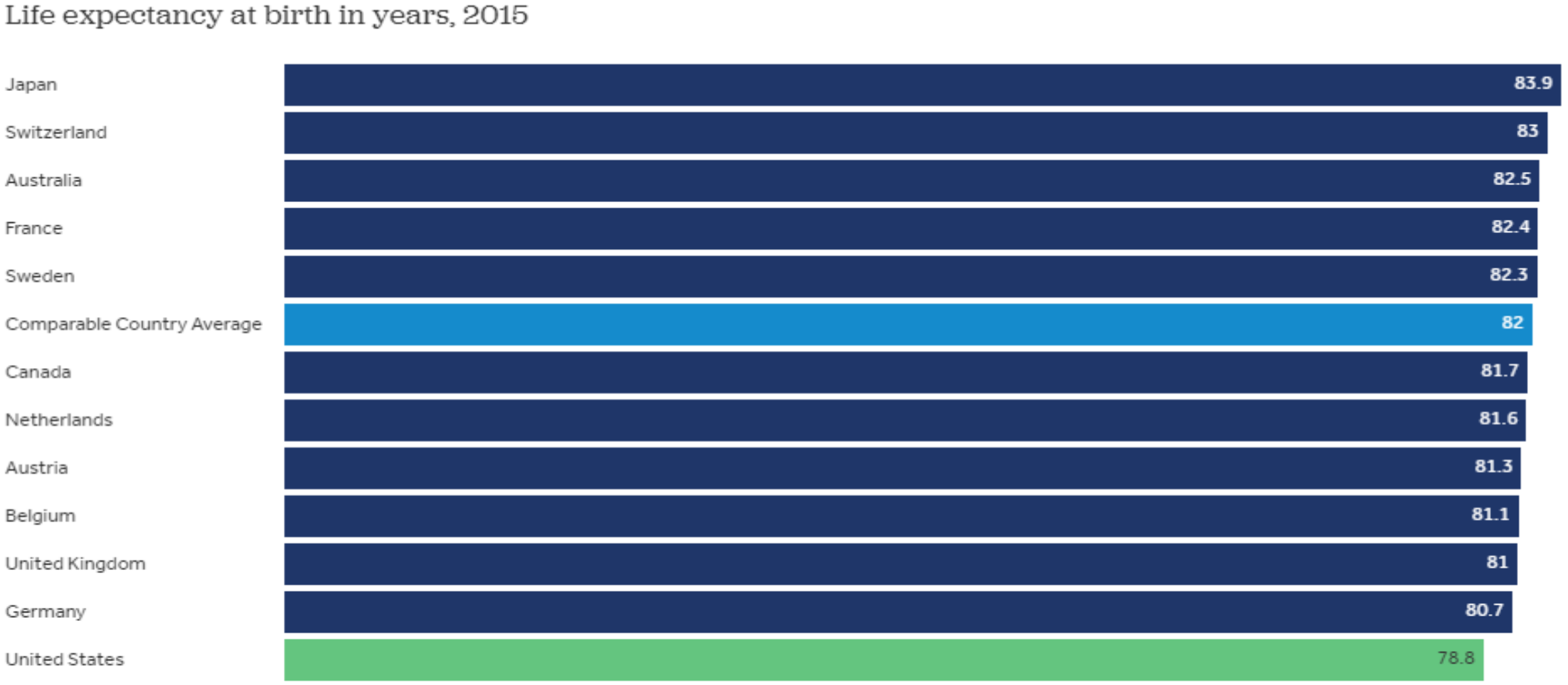
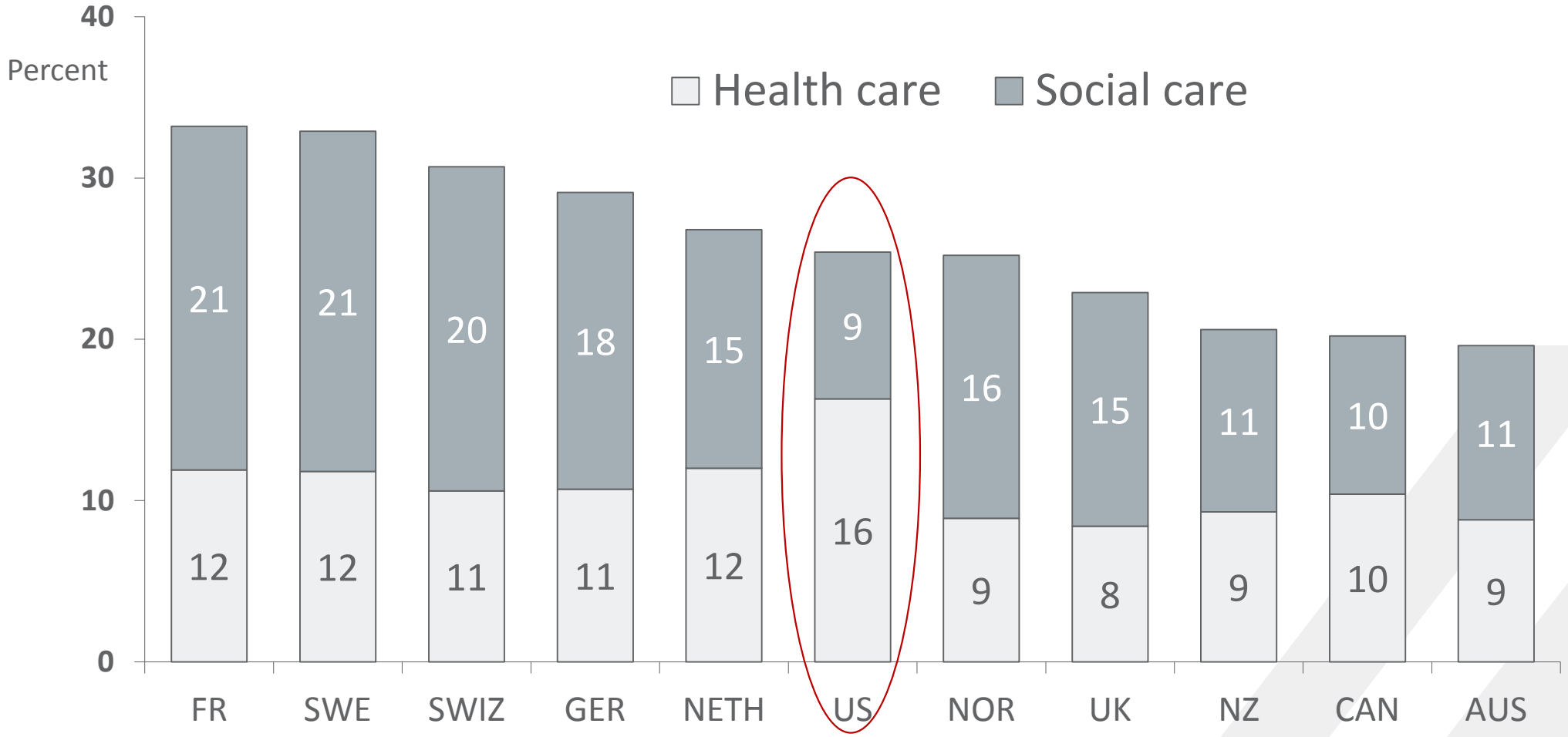
# Why is our high health care spending a problem?

- With two-thirds of health spending publically funded, health spending is crowding out education and other priorities, especially at the state level.
- For the half of the population with employer-sponsored insurance, rising premiums are a bigger share of compensation, constraining wage growth.
- As our population ages, health care spending threatens federal and state fiscal outlooks (10K new Medicare enrollees per day).
- We are not getting good value for our spending: U.S. spends much more on health care, yet has poorer health and lacks universal coverage.

# U.S. life expectancy is lowest of peer nations



# For better health, spend more on social services?




Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

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# What drives health care spending?


- Health status
- Access to care

- Supply capacity
- Practice patterns

- Unit prices paid

# U.S. population less healthy than peer nations

## Lower rates of:

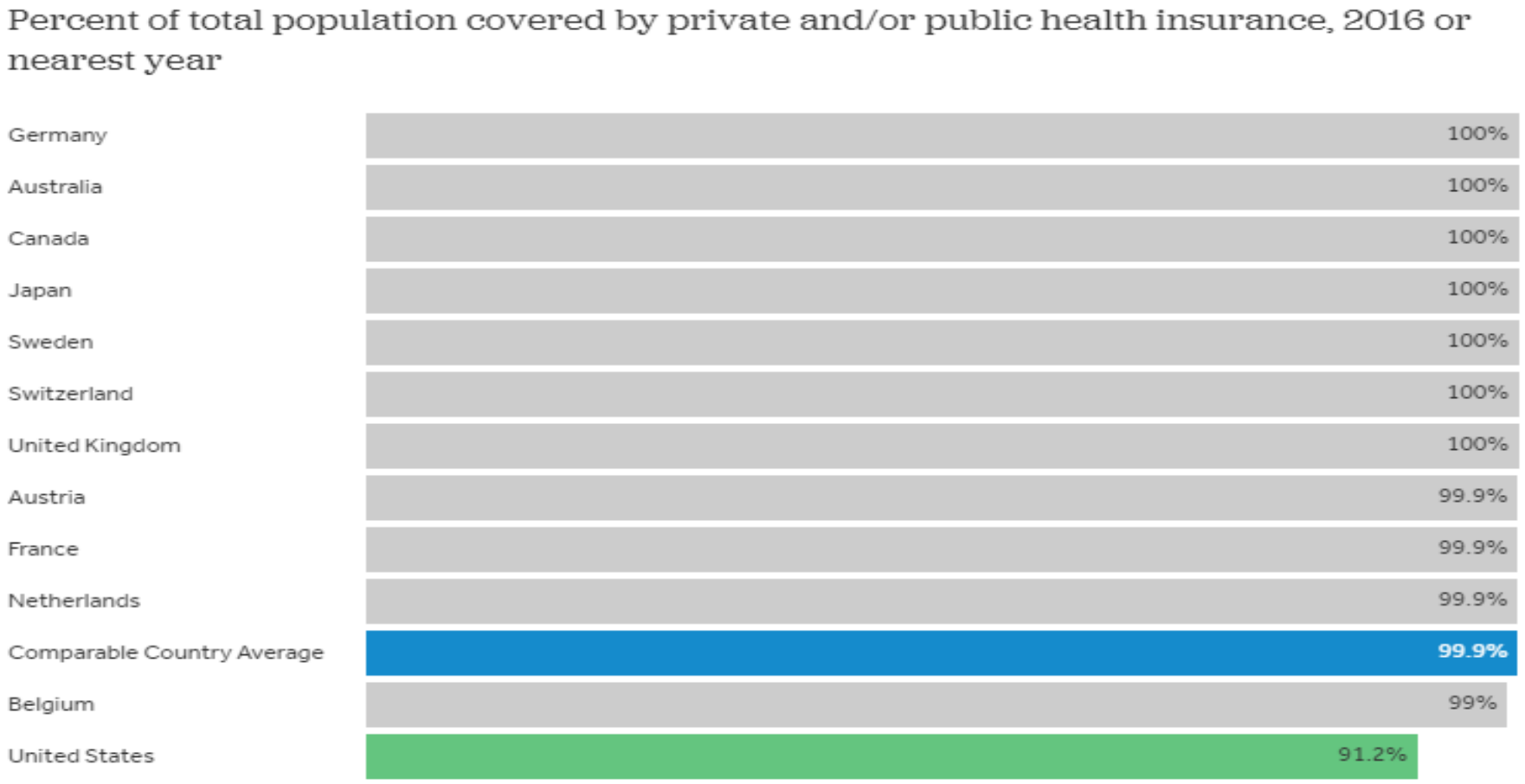
- Smoking per person
- Alcohol intake per person

## But higher rates of:

- Lung cancer and alcohol abuse disease burdens
- Obesity (38% vs 20%)
- Violence, accidents, suicide, drug overdose/poisoning

Source: Rabah Kamal, Cynthia Cox and Erik Blumenkranz, “What do we know about social determinants of health in the U.S. and comparable countries?”, Kaiser Family Foundation, Peterson/Kaiser Health System Tracker, November 21, 2017

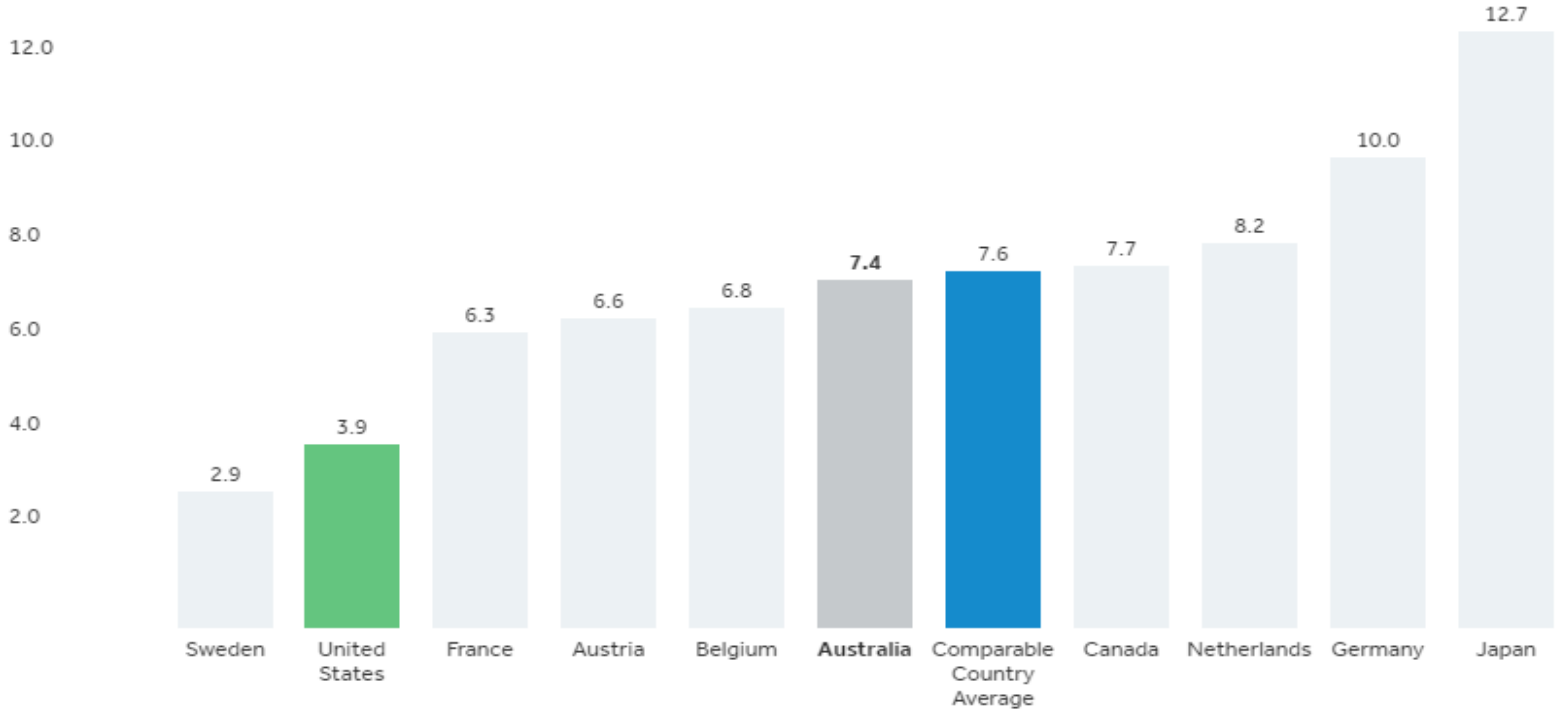
# Americans have less financial access to care



# Overall, U.S. utilization rates are not high

## The U.S. has fewer physician consultations per capita than most comparable countries

Doctors consultations, per capita, in all settings, 2015




In cases where data were unavailable, data from the countries' closest available year are shown. Data not available for the United Kingdom and Switzerland.

Source: : Kaiser Family Foundation analysis of data from OECD Health Statistics and the AHRQ Medical Expenditure Panel Survey (Accessed on 31 January 2018). • Get the data • PNG

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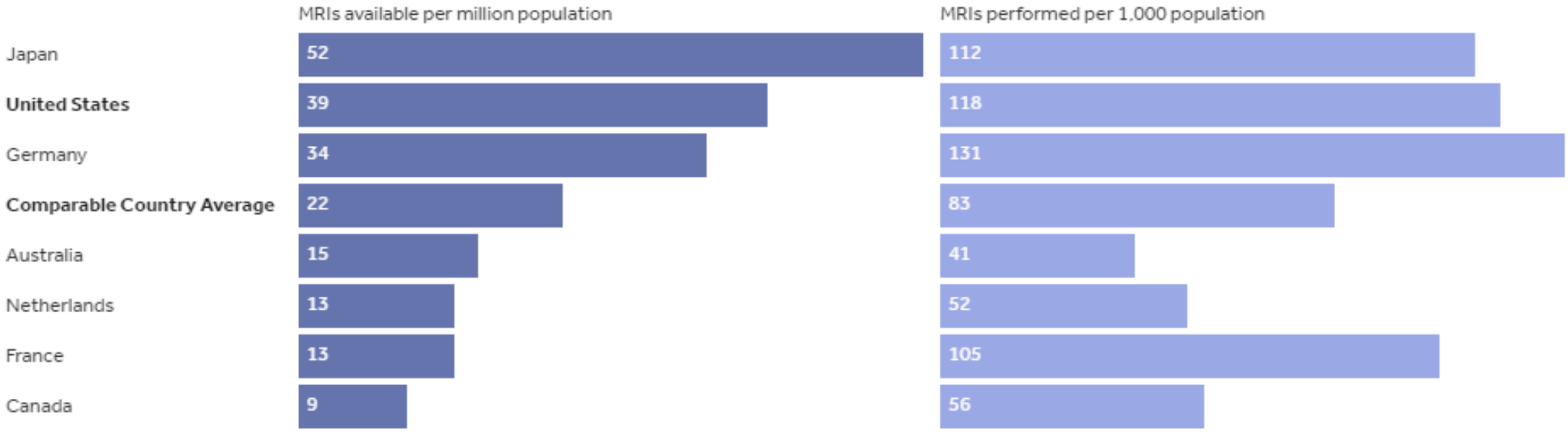
# Although we use more medical technology

## The U.S. leads most comparable countries in MRI availability and use

Number of MRI units available per million population, 2015; Number of MRI exams performed per 1,000 population, 2015




Notes: In cases where 2015 data were unavailable, 2014 data are shown. Austria and the United Kingdom are omitted because data are not available for both indicators. Data not available for Sweden and Switzerland.

Source: Kaiser Family Foundation analysis of data from OECD (2018), "OECD Health Data: Health care resources", OECD Health Statistics (database) (Accessed on January 31, 2018). • Get the data • PNG

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# Prices appear to be main driver of high spending

| | Total hospital and physician costs, 2013[a] | | Diagnostic imaging prices, 2013[a] | | Price comparison for in-patent pharmaceuticals, 2010 (U.S. set to 100)[b] |
|---|---|---|---|---|---|
| | Bypass surgery | Appendectomy | MRI | CT scan (abdomen) | |
| Australia | $42,130 | $5,177 | $350 | $500 | 49 |
| Canada | — | — | — | $97 | 50 |
| France | — | — | — | — | 61 |
| Germany | — | — | — | — | 95 |
| Netherlands | $15,742 | $4,995 | $461 | $279 | — |
| New Zealand | $40,368 | $6,645 | $1,005 | $731 | — |
| Switzerland | $36,509 | $9,845 | $138 | $432 | 88 |
| United Kingdom | — | — | — | — | 46 |
| United States | $75,345 | $13,910 | $1,145 | $896 | 100 |

[a] Source: International Federation of Health Plans, 2013 Comparative Price Report.

[b] Numbers show price indices for a basket of in-patent pharmaceuticals in each country; lower numbers indicate lower prices. Source: P. Kanavos, A. Ferrario, S. Vandoros et al., "Higher U.S. Branded Drug Prices and Spending Compared to Other Countries May Stem Partly from Quick Uptake of New Drugs," *Health Affairs*, April 2013 32(4):753–61.

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# Are prices high because they need to be, or because they can be?

- High input costs
  - High administrative costs (15% versus OECD 5%)
  - High wages (clinicians, nurses, administration)
  - Investments in medical technology, facilities to compete
  - High drug development costs

- Limited ability to constrain prices
  - Private payer prices depend on competition, consolidation
  - Public payer price controls depend on access concerns, political will

# Policy approaches need both “how” and “why”

- Effective tools and strategies to lower costs of treatment and reduce spending, while maintaining health outcomes

and

- Better aligned and stronger incentives for consumers, providers, payers to be motivated to reduce spending

# Who has an incentive to reduce spending?

- Patients?
  - Don’t usually see a price until after service is received
  - When ill and in need, may not be in a position to shop for care
  - May defer to clinician’s expertise and guidance
  - May want to make full use of their health care “benefit”
- Providers?
  - Often don’t know price of services
  - Often are paid more for providing more – no financial downside
  - May be motivated to do more to protect against liability
  - May face pressure from patient to do something

-- continued

# Who has an incentive to reduce spending?

- Private insurers?
  - Can pass along higher costs in premiums
  - May compete more on access to desired providers than cost
  - May face backlash if payment for drug or service is denied
  - Face increasing provider consolidation, weakening insurer bargaining power
- Government payers?
  - Must overcome political pressure from providers and beneficiaries
  - May be legally limited in ability to say “no” based on price/value
  - Must overcome differing ideologies on role of government, freedom of market, “right” to health care

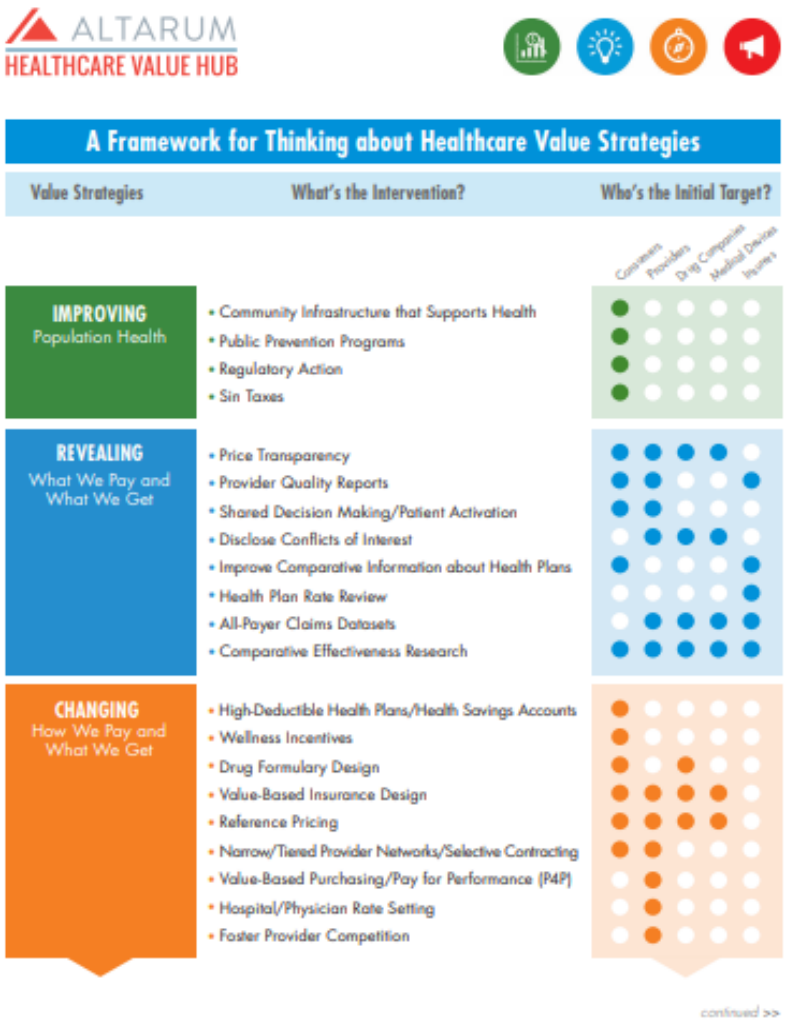
# Policies to align incentives

1. Payment models or policies that incentivize efficiency and outcomes
   - Bundled payments, capitation
   - Readmission penalties, value-based purchasing more broadly
2. Coverage policies that incentivize patients to choose better value care
   - Reference pricing
   - Tiered pharmacy benefits
   - Value-based insurance design
3. Constraints on prices or price growth
   - All-payer rates (Maryland)
   - Site neutral payments
   - Restraints in price growth for public payments (ACA productivity adjustment)
4. Budget constraints (Maryland) or growth targets (Massachusetts)

# Strategies to reduce spending and improve value

1. Reducing “non-value-added” care (harmful, ineffective, or overused services)
2. Removing barriers (licensure, reimbursement) to full productivity of all members of the health care team and to the use of technology solutions such as telemedicine
4. Applying process improvement techniques such as Lean/Six Sigma
5. Communication, respect, relationship between providers and patient
6. Improving transparency on prices and quality, with appropriate comparisons among providers and geographies
7. Investing in upstream determinants of health, including public health, housing, early childhood, education, and safe and healthy physical environments

# More strategies on the Health Care Value Hub





www.healthcarevaluehub.org

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August 28 overview webinar: http://www.healthcarevaluehub.org/index.php?cID=1887

# Key takeaways redux

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