



Data Brief

COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

Health Care Spending: An Encouraging Sign?

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ABSTRACT: A federal report on national health care spending in 2005, published in *Health Affairs*, indicates that spending slowed for a third straight year and, as a percentage of gross domestic product, held nearly constant from 2004 to 2005. Though the news is encouraging, spending growth in 2005—6.9 percent—continued to outpace inflation and growth in wages for the average U.S. worker. Clearly, rising health care costs continue to be a major concern. The Commonwealth Fund Commission on a High Performance Health System has stated that the nation must strive to achieve greater value while simultaneously decreasing the rate of growth of health spending. Among the steps that could achieve these goals are: increasing transparency and public reporting of cost and quality information, rewarding quality and efficiency, and expanding the use of information technology and systems of health information exchange.

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Background

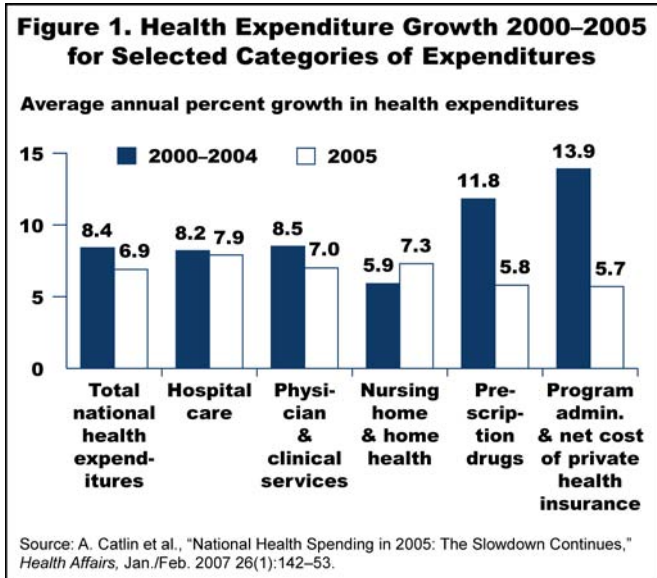
A report on national health care spending in 2005, prepared by the Centers for Medicare and Medicaid Services (CMS) and published in *Health Affairs*, indicates that “. . . spending slowed for the third straight year in 2005.”¹ Also encouraging was that health spending as a percentage of gross domestic product (GDP) held virtually constant from 2004 to 2005, rising just slightly from 15.9 percent to 16.0 percent.

But any celebration is premature. In 2005, the United States spent \$1.988 trillion on health care, up from \$1.859 trillion in 2004. That works out to a staggering \$6,697 per person—a hefty bill for households, employers, and government. Even the spending growth reported by CMS—6.9 percent—continues to outpace inflation and growth in wages for the average U.S. worker.

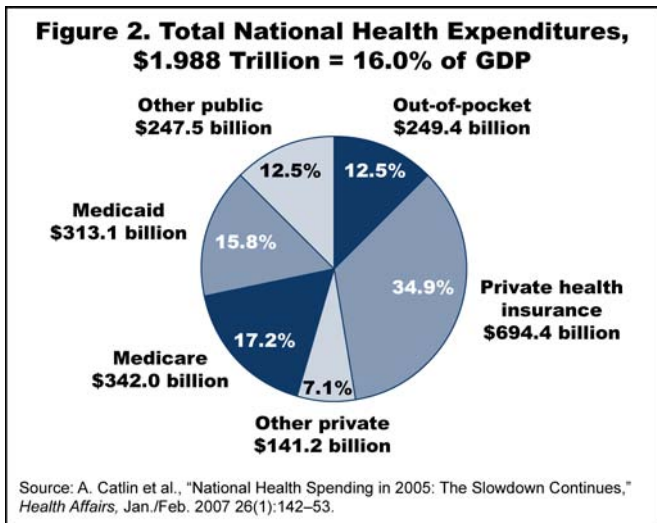
Spending growth in the categories of hospital care (7.9%) and nursing home and home health care (7.3%)—and especially the subcategory of home health care services (11.1%)—was particularly worrisome. By contrast,

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growth in spending for prescription drugs (5.8%) declined markedly from prior levels; the 2005 results will serve as an important baseline for judging the effect of Medicare’s prescription drug benefit, now one year old (Figure 1).

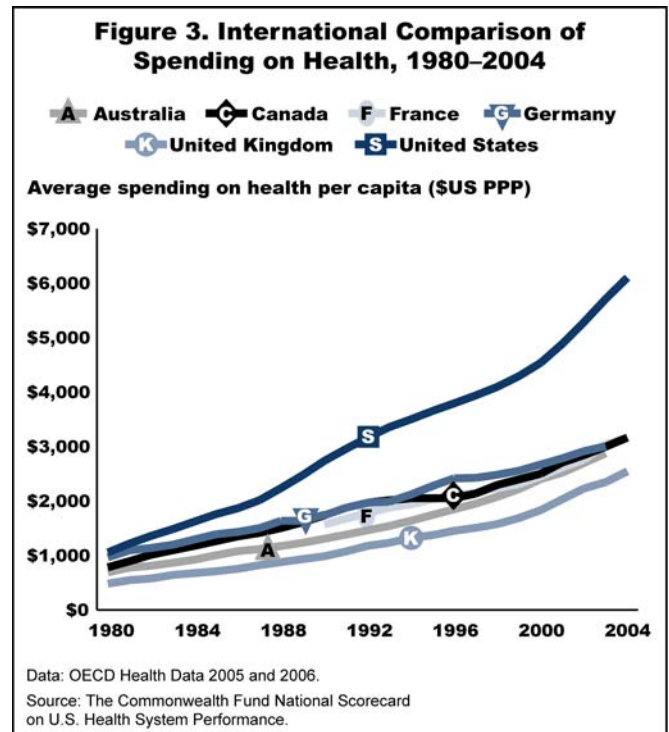


The federal government accounted for 32 percent of the total amount spent in 2005, and state and local governments accounted for 13 percent. Thus, the federal, state, and local governments paid 45 percent, or nearly half of all health care expenditures (Figure 2). Although the U.S. health



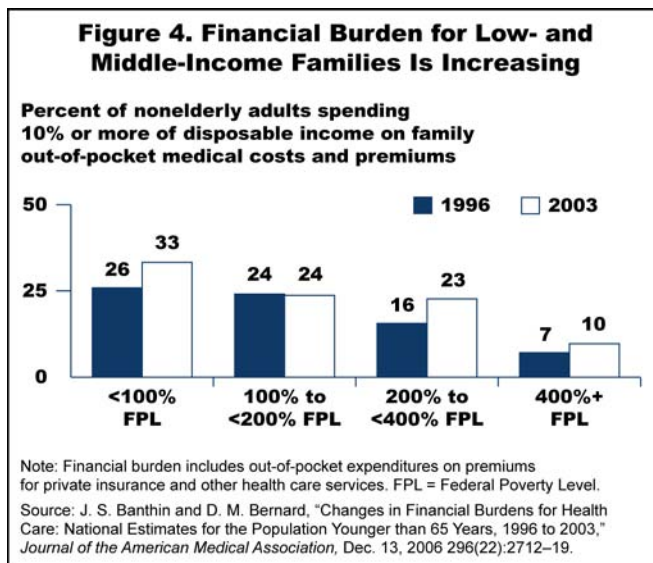
system is often considered to be a private one, that really applies only to the delivery of services. When it comes to spending, ours is very much a public–private system.

So what is the bottom line? Rising health care costs continue to be a major concern. The U.S. spends twice as much per person as other industrialized nations (Figure 3). As the Commonwealth Fund Commission on a High Performance Health System has noted, the nation needs to undertake a major drive toward greater value and efficiency throughout health care.²



Driving Toward Value in Health Care

There is growing recognition that while the U.S. leads the world both in health care spending per capita and spending as a percentage of GDP, our system does not produce better outcomes.³ The Fund’s Commission on a High Performance Health System believes the nation must strive to achieve greater value per dollar spent *and* to decrease the rate of growth of health spending. The high and ever-rising cost of health care in the

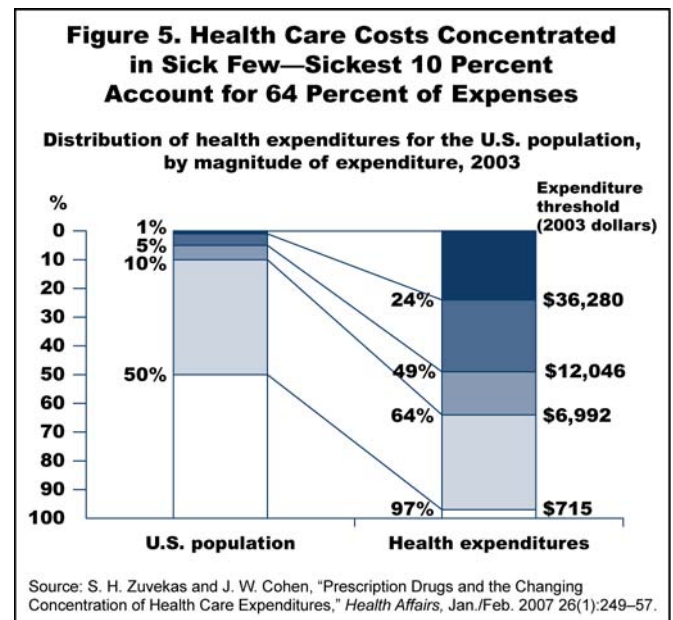


U.S. increases financial burdens on patients and contributes to Americans' growing medical debt (Figure 4).^{4,5,6} In turn, these problems negatively affect access to care and quality of care.⁷ The Commission, recognizing that coverage, access, quality and efficiency of care are all interrelated, has stated that the country will need to address these problems simultaneously.⁸

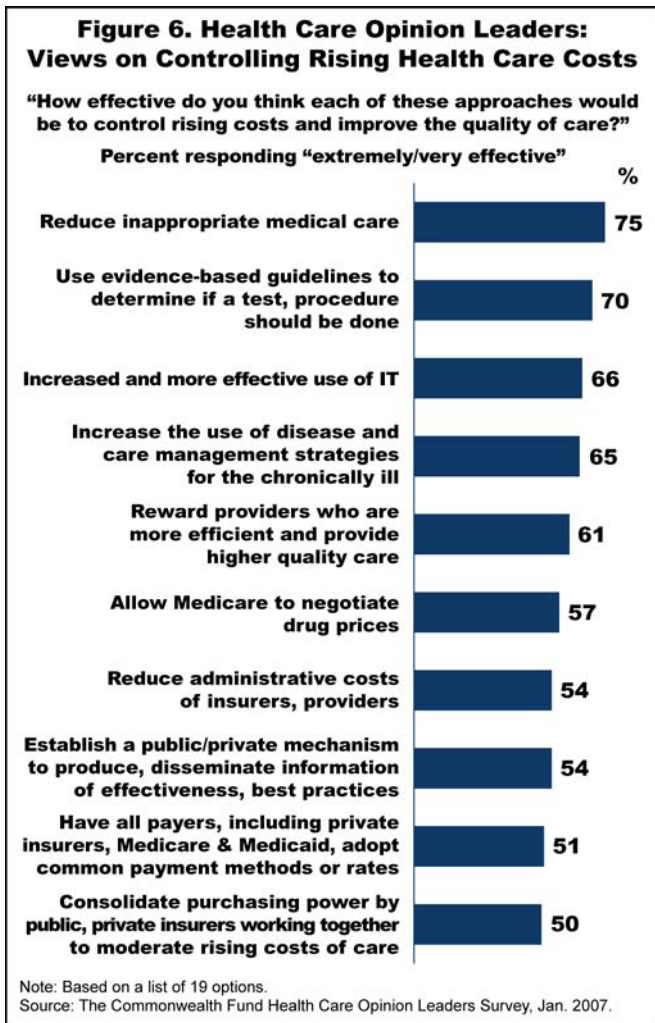
The U.S. prides itself on having a market-driven health care system. But the market for health care does not work in the same way as other markets. While most other industries continuously drive down their production costs and pass efficiencies on to customers, health care does not. In truth, there is really very little competition in the U.S. health care market. Health care is primarily delivered locally or regionally, and in most regions there are relatively few competing hospitals or health plans.⁹ And while in most local areas there are many independent physicians (certainly in urban areas), there is very little information available to patients to help them make their choices.¹⁰

Some stakeholders argue that one reason the health care market does not work well is that the customer—the patient—has too little “skin in the game.” That is the rationale behind “consumer-directed,” high-deductible health plans, which are sometimes paired with tax-favored health savings

accounts. Enrollment in these plans has been low, however. People who enroll tend to be healthier, and enrollees who are not healthier tend to forgo necessary services.¹¹ Furthermore, these plans, even if they are useful for some people, are unlikely to address the major issues in health spending growth, since the 10 percent of the population who are the sickest and most costly account for 64 percent of all health spending (Figure 5).¹²



It is tempting to think that an easy way to reduce health spending is to simply cut out waste, such as inappropriate or unnecessary care and duplicate tests. Indeed, eliminating inappropriate medical care was the option for controlling rising health care costs most favored in a recent survey of health care opinion leaders (Figure 6).¹³ Certainly, there is evidence that the highly specialized and fragmented health care system in the U.S. is especially prone to inefficient, poorly coordinated, and unsafe care. In 2006, 42 percent of adults reported one or more of the following: their physician ordered a test that had already been done; their physician failed to provide important medical information or test results to other doctors or nurses involved in their care; they incurred a medical,

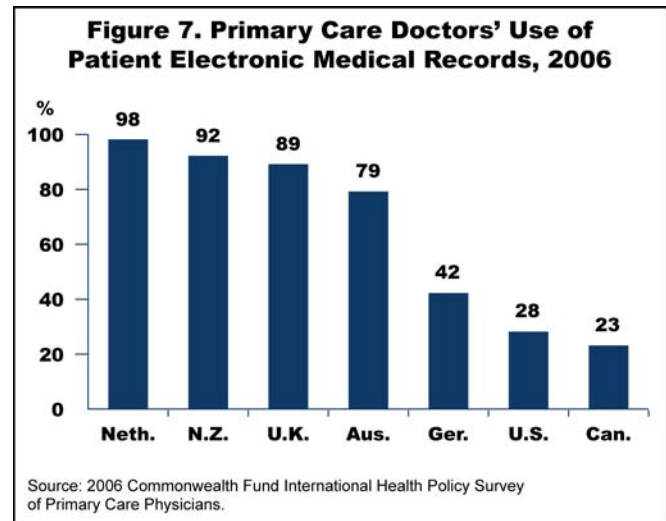


surgical, medication, or lab test error; or their physician recommended care or treatment that, in their view, was unnecessary.¹⁴

In practice, however, specifying which care is truly necessary is a major task, limited by both a lack of evidence to support “evidence-based medicine” and a lack of systems for providing the information patients and physicians need to avoid wasteful care. Despite being the world’s leader in health care spending, we are a laggard in the adoption of health information technology (Figure 7).¹⁵

Finally, we must recognize that one person’s wasteful expenditure is another’s income. A payer’s spending on tests and procedures, after all, provides profit to others—physicians, hospitals, pharmaceutical companies, manufacturers of medical equipment,

and various vendors of medical services. These and other powerful interests have a stake in our currently high and rising level of health spending, and it is not uncommon for one to point a finger at others as the source of blame. Needless to say, getting all stakeholders to participate in solutions will be a daunting task.



Achieving a High-Performance Health System

Are there steps that can be taken to improve the efficiency of care? The Commonwealth Fund Commission on a High Performance Health System has described several possibilities: increasing transparency and public reporting of cost and quality information, rewarding quality and efficiency, and expanding the use of information technology and systems of health information exchange.¹⁶

Among these, transparency and public reporting are supported by the Administration and by leading experts.¹⁷ Furthermore, half of health care opinion leaders believe that making information on the comparative quality and costs of hospital and physician care available to the public would be extremely or very effective in controlling rising costs.¹⁸ The patient needing hip replacement surgery wants to know which surgeons get the best results, while the insurer wants to know which surgical teams do the job at the lowest cost. Both

kinds of information enable patients and insurers to make decisions based on value, and that, in turn, enhances both quality and efficiency throughout the health system. But lists of prices for individual services are not likely to be intelligible to the consumer, or even to the physicians ordering services. To spur further public reporting on costs of care, it will be important to aggregate costs across episodes of care.

Interest in rewarding providers for high quality and efficiency—ranging from pay-for-performance programs to tiered networks—is on the rise. The availability of information on performance, facilitated by better information technology, will be essential to the success of such efforts. One model to study is the United Kingdom's successful General Practitioner Contract—a pay-for-performance program that draws on data from the National Health Service's electronic information systems.¹⁹

There is no consensus about whether wider adoption of health information technology would actually reduce overall medical care expenditures for the U.S. health care system. However, there seems little question that it would improve health system performance and could potentially lower overall costs. Just a few of the advantages of health information technology include:

- improved legibility of medical charts and prescriptions;
- greater ability to provide physicians with decision support, including reminders and prompts to help clinicians make the most appropriate diagnoses, choose tests efficiently, and prescribe and apply appropriate treatments; and
- easier retrieval and aggregation of patients' information, which helps to reduce duplicate tests and hospital admissions (e.g., by having information accessible to emergency room physicians), improve patient care,

facilitate referrals and secure transfer of responsibility for moving patients from one physician to another, reduce medical errors, and better manage chronic conditions and improve care coordination.

To achieve these benefits, an initial investment is necessary. So are centralized functions for setting technology standards and managing information exchanges that enable patient data from multiple sources (e.g., hospitals, pharmacies, and labs) to be aggregated, shared, and analyzed, all with appropriate privacy protections in place.

Conclusion

In all likelihood, our health care system will continue to be a public-private one in which market forces and competition are valued. Some have suggested redefining the basis on which health care providers compete so that competition depends upon higher quality and greater efficiency in providing an episode of care.²⁰ This depends on better information and information systems. Although there have been more efforts to improve transparency, increase public reporting, and reward performance, the continued rise in health spending and growth in the numbers of uninsured and underinsured Americans make it imperative that these efforts accelerate.

The news that increases in spending growth have been moderating over the past three years would be truly good news if there were reason to believe it was the result of a planned effort to bring health spending in line and to increase the value of care delivered. As previously noted, federal, state, and local governments are now footing almost half of all health spending in the U.S., a percentage that is likely to rise as baby boomers become eligible for Medicare and people with marginal incomes lose their private health coverage. For this reason alone, public officials should consider a much more active leadership role in accelerating the changes suggested above.

NOTES

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