Moving Towards Higher-Value Health Care

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Peculiar Hybrid Financing of US System

• Public programs
  – Medicare (federal)
  – Medicaid and SCHIP (federal-state)

• Private insurance
  – Employment-based (subsidized)
  – Individual (largely unsubsidized)

• Uninsured (out-of-pocket and subsidized)
Rising Costs have Made Reform of US Health Care System a Priority

- Concern about risk of uninsurance
  - More than 47 million uninsured

- Public and private budget pressures
  - National health expenditures 16% of GDP (projected to be 20% in 2016)
    - Private costs
      - Private health insurance premiums increasing at more than 3 times the rate of inflation in recent years
      - Out-of-pocket costs (for insured and uninsured)
Private Insurance Premiums

Employer-Provided Health Insurance Premiums for Family Plans (1988-2005, adjusted for inflation)

Source: Kaiser Family Foundation/Health Research and Education Trust
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  - Private costs
    - Private health insurance premiums increasing at more than 3 times the rate of inflation in recent years
    - Out-of-pocket costs (for insured and uninsured)
  - Spending on public programs
    - Federal Medicaid and Medicare spending projected to consume 9.4% of GDP in 2050
    - Hidden public spending through tax code – expensive, and creates an unlevel playing field
Public Budgets

Relative stability of past spending masks underlying shift towards entitlement spending and unsustainable growth in Medicare spending

Source: Budget, 2007
Higher-value Care

• Costs and uninsurance dominate public debate, but should be concerned with value, not level
  – Higher spending driven not by changes in number of physician visits or hospitalizations, but by intensity of treatment
  – Dulled incentive to develop cost-saving technologies when most consumers not evaluating costs vs. benefits

• National and international evidence that we could be getting more for our spending
Health Expenditures as a Share of GDP

Internation Comparison
Health Expenditures as a Share of GDP

Percentage of GDP

16
14
12
10
8
6
4
2
0


Canada
Germany
Japan
United Kingdom
United States

Source: OECD
U.S. Infant Mortality Above OECD Median

Infant Mortality Rates (per 1,000 Live Births) by OECD Country, 1960-2003

Deaths per 1,000 Live Births

Source: OECD
Considerable Variation in Quality Within US

HQA Overall Quality
Average percentile across all measures

Source: Baicker, Chandra, and Jha
Quality Variation Even within Medicare

Source: Dartmouth Atlas of Health Care
Variation in Medicare Spending

Source: Dartmouth Atlas of Health Care
But Higher Spending *not* Associated with Higher Quality

**EXHIBIT 1**
Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001

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**NOTE:** For quality ranking, smaller values equal higher quality.

Source: Baicker and Chandra (Health Affairs 2004)
Some Causes of Inefficiency

• Public side:
  – Medicare reimbursement primarily based on quantity, not quality
  – Resources for the uninsured spent on inefficient modes of care

• Private side:
  – Two biases in tax subsidy of employment-based insurance
    • Biased against people buying insurance on their own, rather than through employer
    • Biased against people buying basic plans, rather than more expensive ones

• Information on prices and quality is often not available
Consequences of Inefficient Spending

• Health care dollars not allocated to highest value uses
  – Reimbursement rates drive health consumption decisions
  – Rising ranks of uninsured break down risk-pooling and lead to inefficient care for uninsured

• Slower wage growth
  – Rising health insurance premiums have reduced wage growth by as much as 25% in the past five years
  – May exacerbate job-lock

• Increasing pressure on taxpayers to finance government-provided insurance
  – Rapidly rising deadweight loss
  – Current path of spending growth is unsustainable
Prospects for Reform: Some Areas of Agreement

• Financial pressures and rising ranks of uninsured creating atmosphere for compromise (and extremes are off the table) . . .

• . . . But view of specifics often driven by ideological perspective on single-payer public system

• Uncontroversial:
  – Ensure availability of more information on prices and quality
  – Encourage investment in information technology to improve quality (and lower cost)
  – Promote healthy lifestyles, investment in prevention
Improving Incentives: Much Debate over Reform Specifics

• More controversial:
  – Private side:
    • Level playing field for different types and sources of insurance? Role of employers?
    • Mandate insurance coverage? What plan? What’s affordable for low-income population? What about chronically ill?
  – Public side:
    • Change reimbursement to reward high quality care (pay for performance)?
    • Promote competition from private health plans in provision of public insurance?
    • Expand eligibility for public programs?
  – Role of state governments?