Moving Towards Higher-Value Health Care

Katherine Baicker
Professor of Health Economics
Harvard School of Public Health and NBER

Peculiar Hybrid Financing of US System

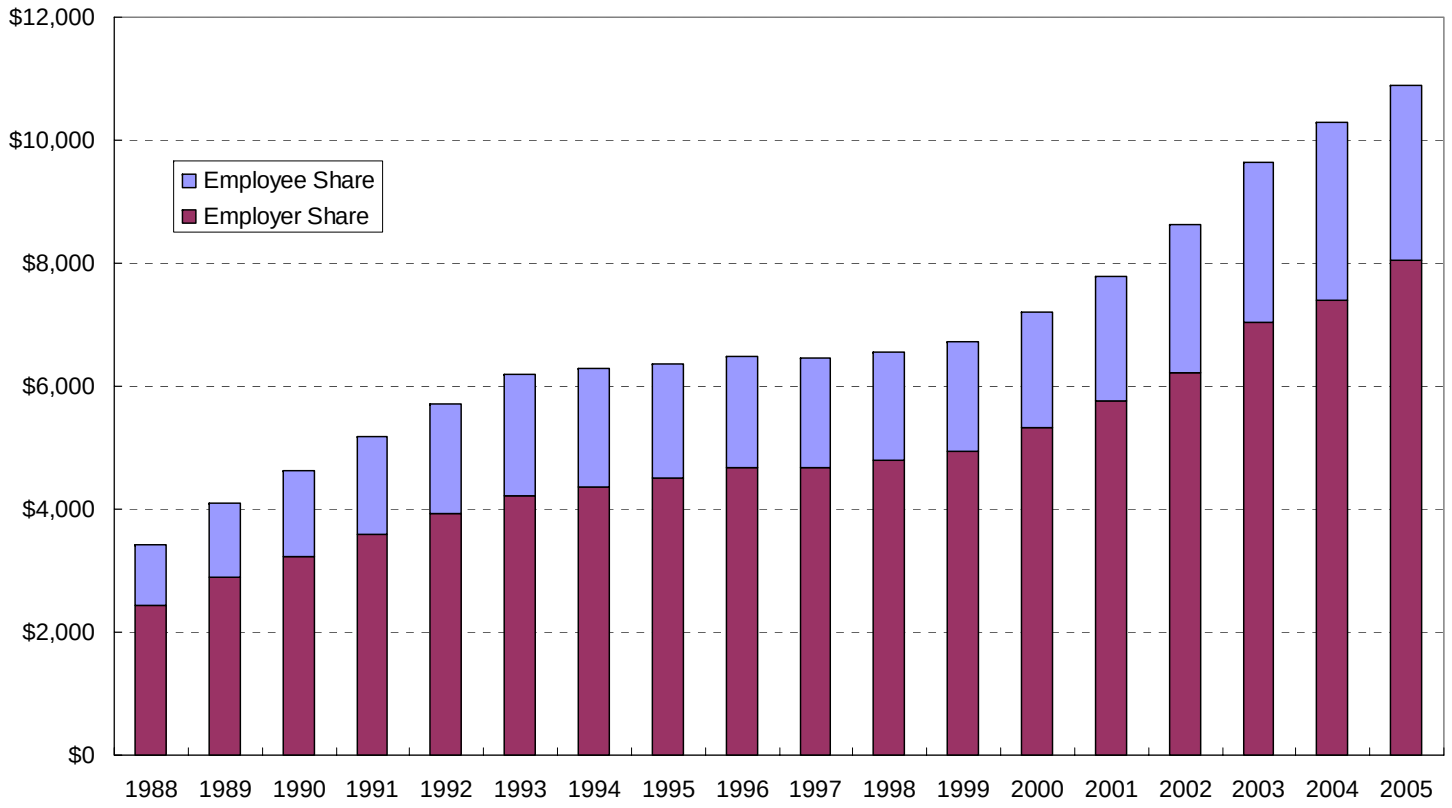
- Public programs
  - Medicare (federal)
  - Medicaid and SCHIP (federal-state)
- Private insurance
  - Employment-based (subsidized)
  - Individual (largely unsubsidized)
- Uninsured (out-of-pocket and subsidized)

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)



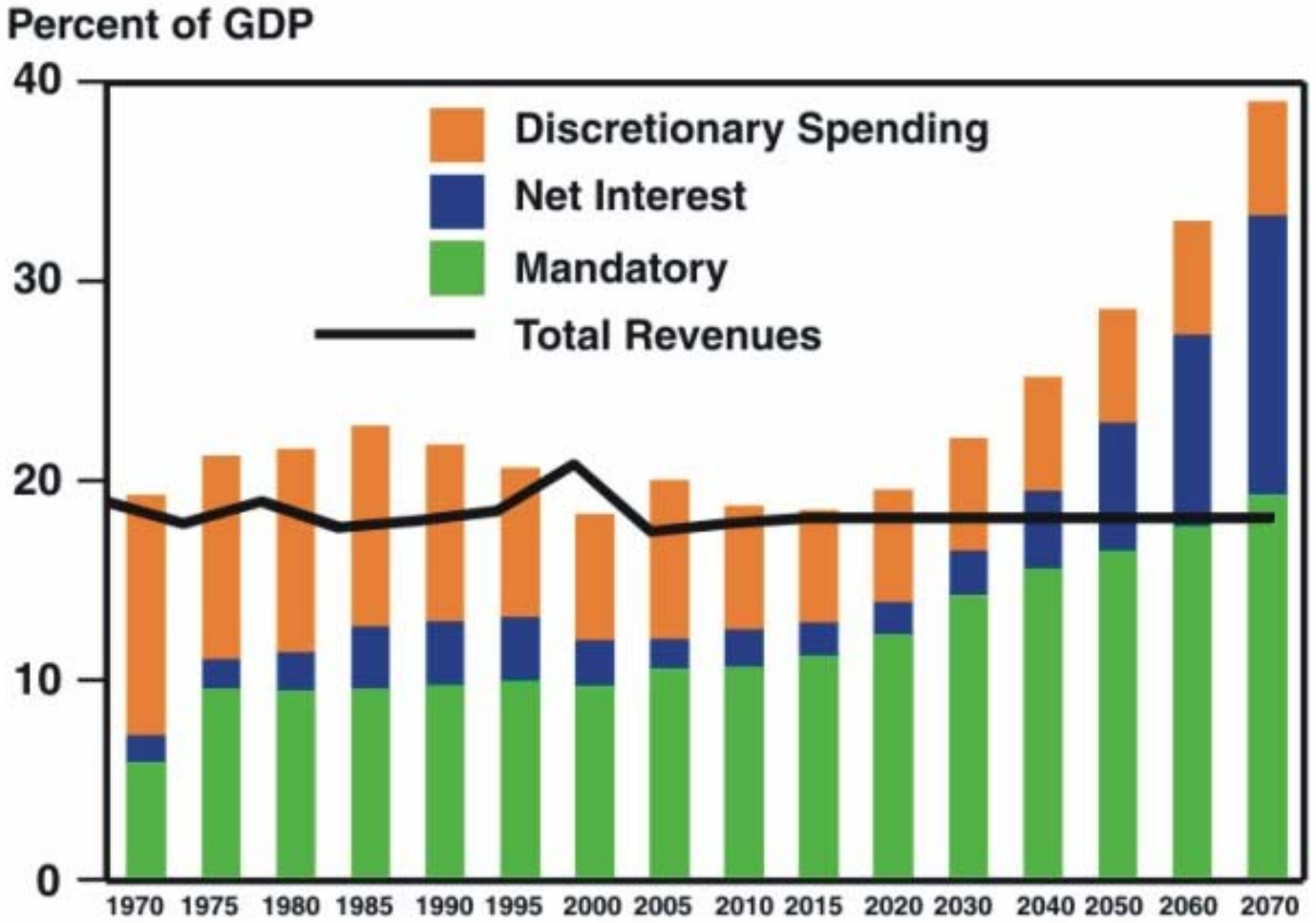
Source: Kaiser Family Foundation/Health Research and Eductaion Trust
Note: The following years were interpolated: 1989-1992; 1994-1995; 1997-1998.

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)
  - 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

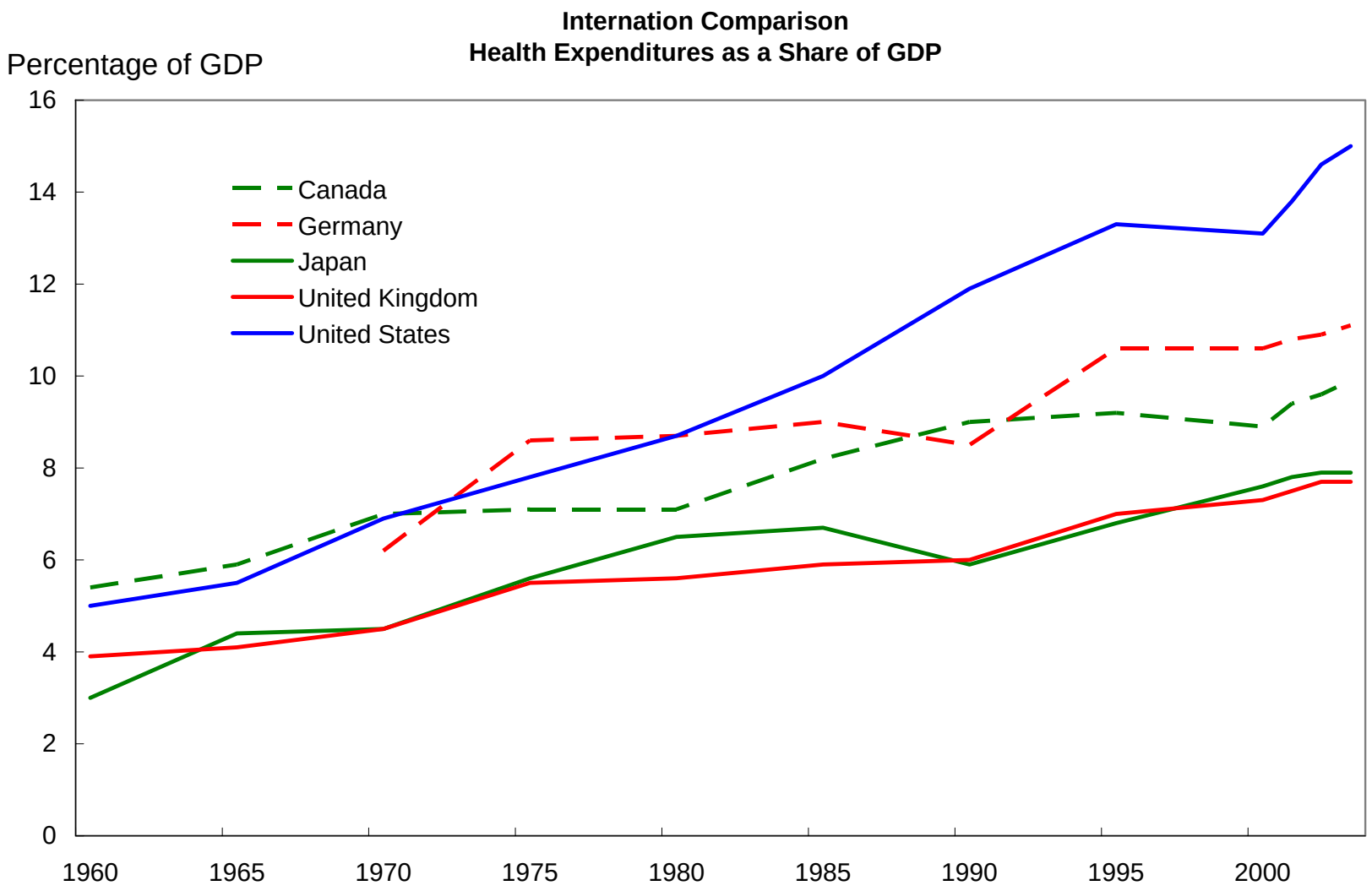


Source: Budget, 2007

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

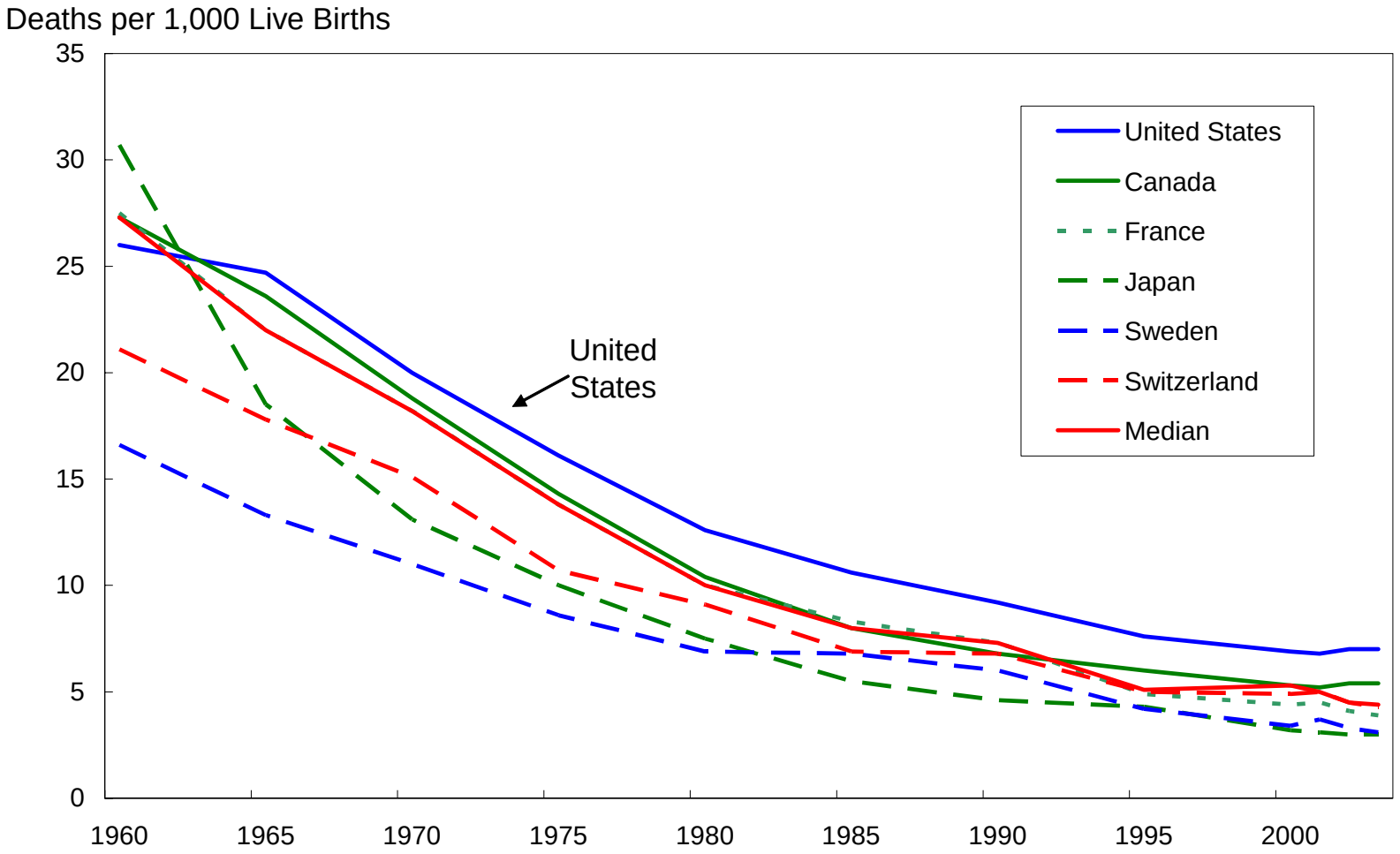
Health Expenditures as a Share of GDP



Source: OECD

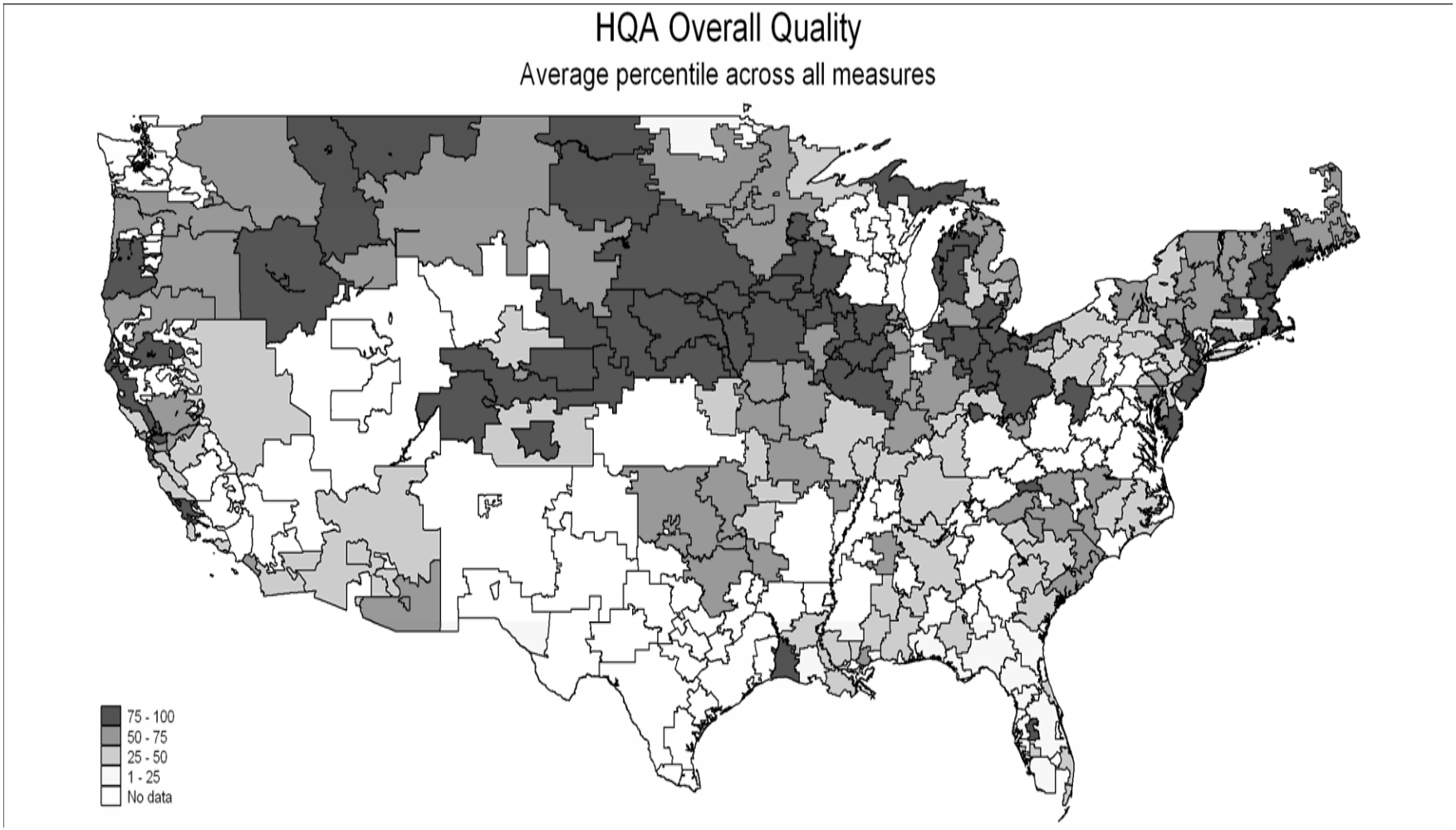
U.S. Infant Mortality Above OECD Median

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



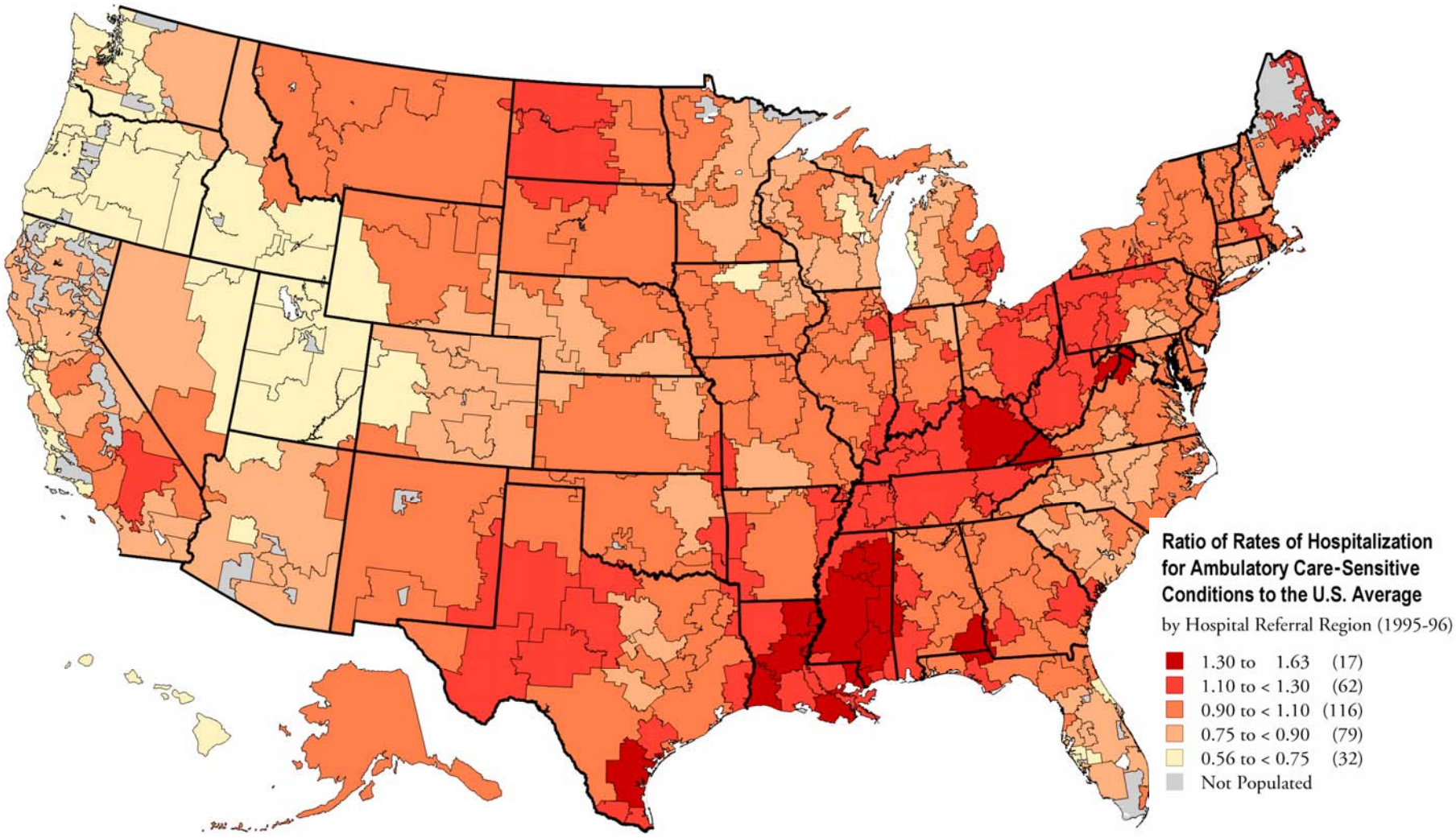
Source: OECD

Considerable Variation in Quality Within US



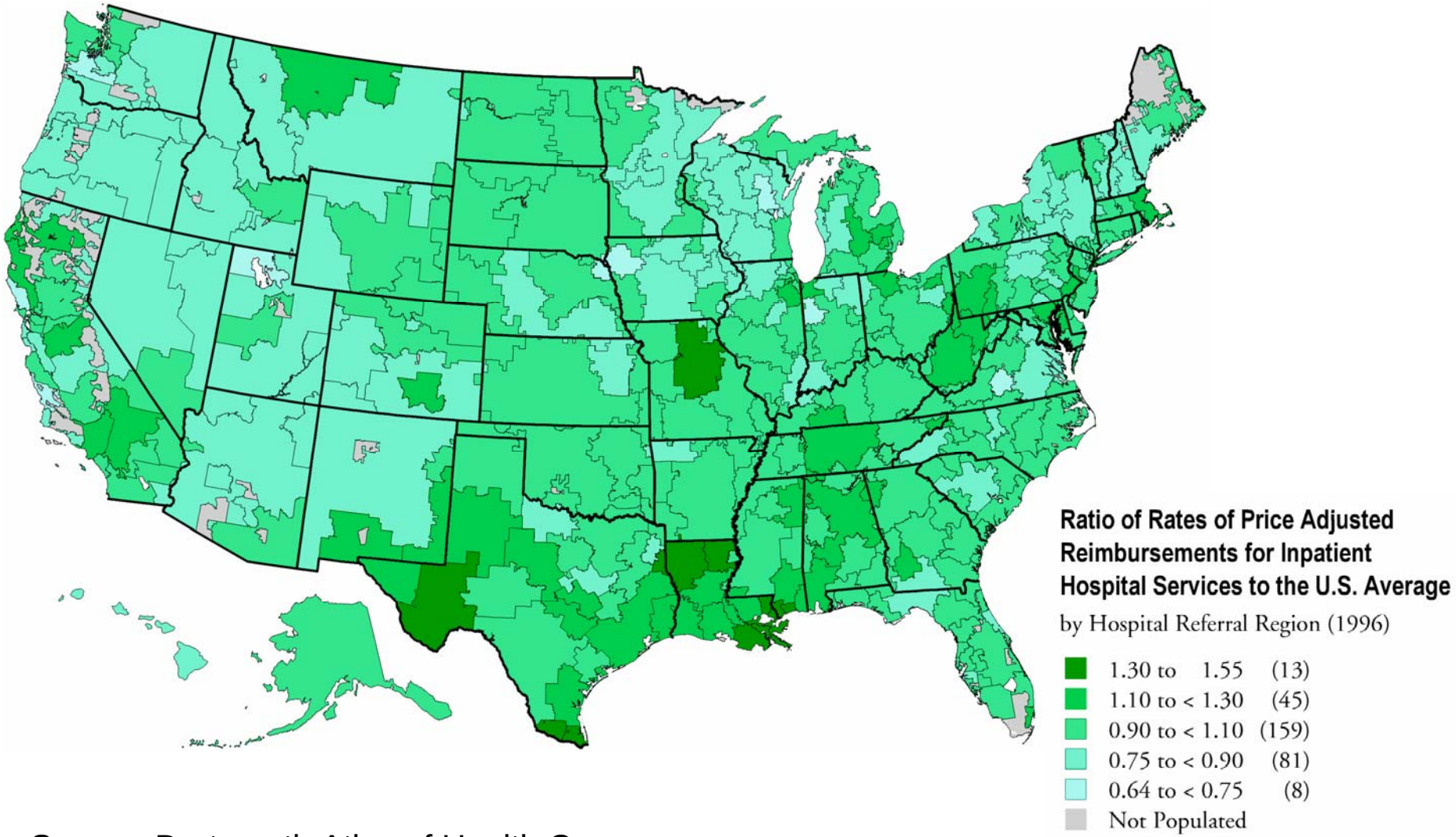
Source: Baicker, Chandra, and Jha

Quality Variation Even within Medicare



Source: Dartmouth Atlas of Health Care

Variation in Medicare Spending

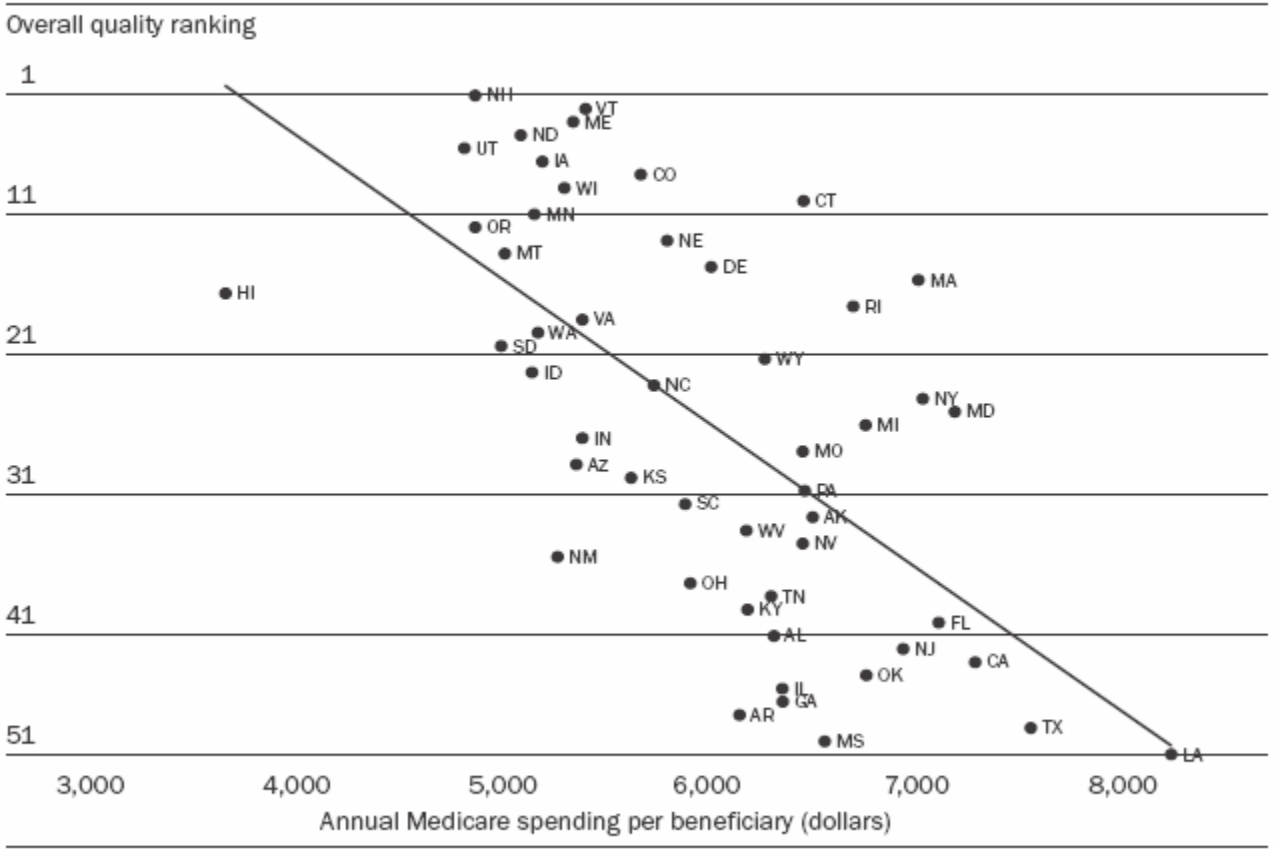


Source: Dartmouth Atlas of Health Care

But Higher Spending ***not*** Associated with Higher Quality

EXHIBIT 1

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



SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
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?