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Health Care Policy and Cost Containment in the U.S.

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Setting the Stage

Even a casual observer would note that health care policy and the health care system in the United States are undergoing profound and pervasive changes. If the decades of the 1960s and 1970s were a period of expansion, characterized by policies to assure access to the increasing power and panoply of health care by the aged, the poor and the disadvantaged, even if that meant a substantial increase in the resources devoted to the health care sector, the period of the 1980s is one of retrenchment. The principal focus of health care policy is cost containment.

The pluralism of the American health care delivery system, characterized as it is by voluntary, religious, proprietary and academic institutions in the private sector coexisting with Federal, State and City health care delivery organizations and financing programs in the public sector, is mirrored in the mix of its financing programs. Public programs, principally at the Federal and State Government level, paid for 40 percent of all personal health care expenditures in 1984 (Figure 1). Private health insurance payments covered an additional 31 percent of health care expenditures. But the bulk of health insurance premiums (approximately two-thirds) which finance health insurance expenditures are paid for by employers in industry as fringe benefits of employment. How to control or ideally to reduce costs, therefore, poses serious policy questions at all Governmental levels as well as for industry.

The various policy approaches designed to control the rapid and malignant growth of health care costs are often referred to as decentralization, privatization and competition. A more analytic perspective indicates the potential usefulness of considering the broad spectrum of policy initiatives to represent three distinct but interrelated approaches:

1) changes in the structure of health care markets to encourage more competitive behavior;

2) changes in financial incentives facing delivery organizations, providers and consumers to encourage more cost conscious, economically efficient behaviors; and

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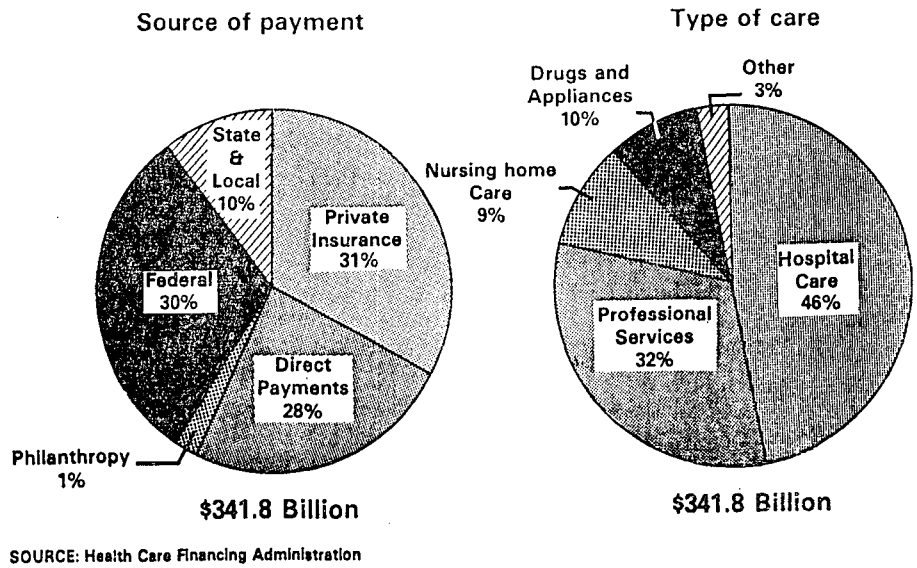


Fig. 1. Personal health expenditures by source of payment and type of care, 1984.

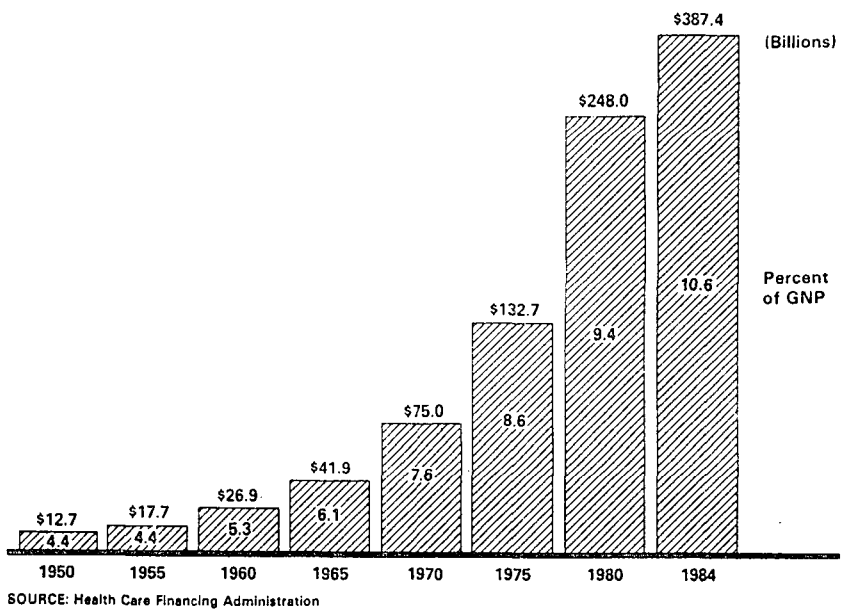


Fig. 2. National health expenditures as a percent of GNP, selected years, 1950~1984.

3) changes in the methods of financing health care to reduce the public burden by shifting a larger share to the consumer.

The introduction of these policies, as reflected in the encouragement and growth of health maintenance organizations, the recently introduced DRG based Prospective Payment System and the various proposals to reduce or eliminate the favorable tax treatment of health insurance premiums, with their emphasis on reducing costs by shrinking the health care sector through greater economic efficiency and increased competition must be seen

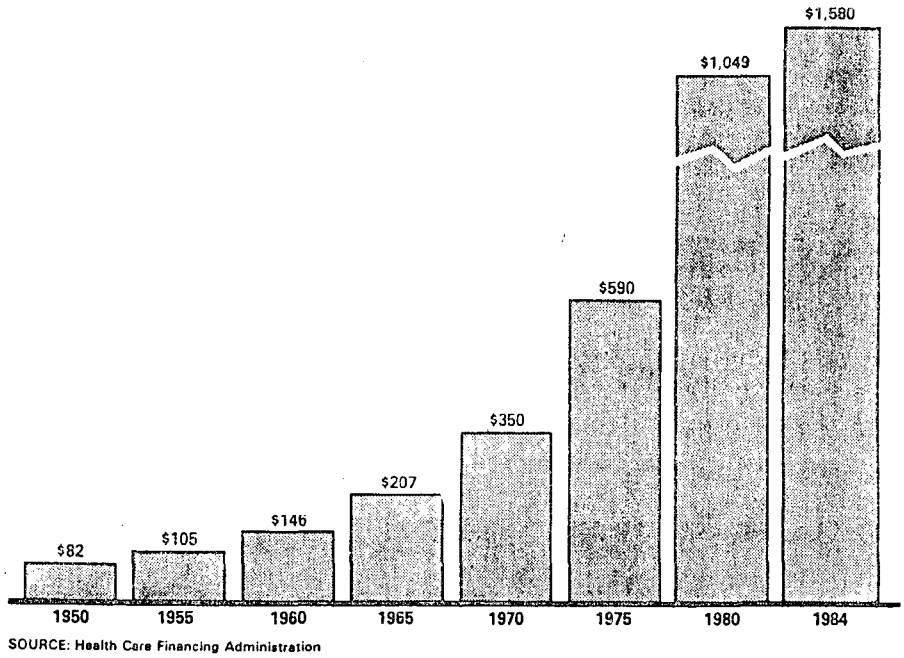


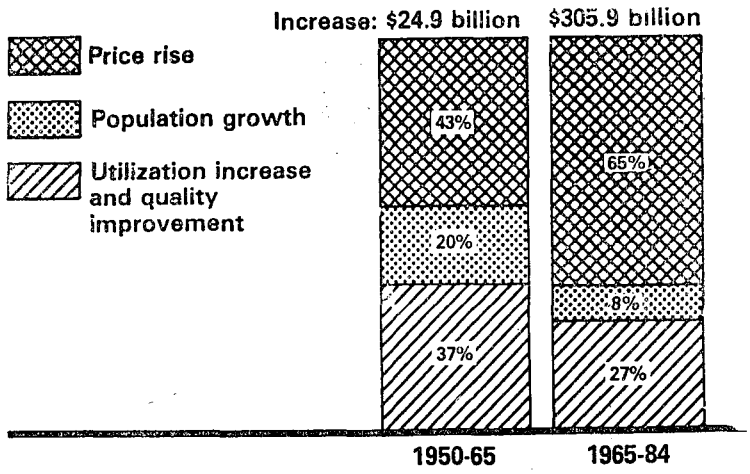
Fig. 3. Per capita national health expenditures, 1950~1984.

in the context of historical cost trends.

Cost trends

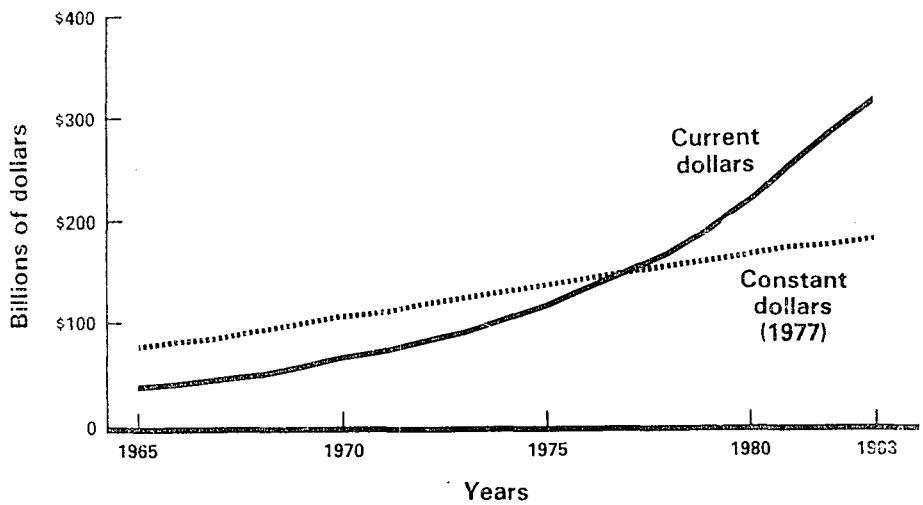
National health care expenditures in 1984 were $387.4 billion, representing 10.6% of the Gross National Product (GNP) (Figure 2). This represents an increase in expenditures of 192 percent in the 10 years since 1975, a level of expenditure more than 9 times as great as it was 20 years ago. It is notable that while the relative share of the health care sector grew by 38.6 percent during the fifteen years between 1950 and 1965, from 4.4 to 6.1 percent of the GNP, its share in the 20 years from 1965 has increased by 73.8 percent, from 6.1 to 10.6 percent of the value of all of the goods and services produced by the U.S. economy. That this pattern is not attributable to dramatic increases in the U.S. population is indicated by the per capita figures. From per capita expenditures of only $82 in 1950, personal health expenditures by 1985 were $1,580 per capita (Figure 3). During the last 10 years alone, per capita health care expenditures increased by more than 2.5 times. Much of this increase in expenditures is attributable to inflation.

When personal health care expenditures are considered, excluding expenditures for investment in capital, medical education and health research and development, 65 percent of the increase between 1965 and 1984 is attributable to increases in the prices of health care services (Figure 4). Well under a third, 27 percent, of this increase is the result of increases in the use of health care services and improvements in its quality while only 8 percent is the result of increases in the population and changes in its composition. Thus,



SOURCE: Health Care Financing Administration

Fig. 4. Sources of increases in personal health care expenditures, 1950~1984.

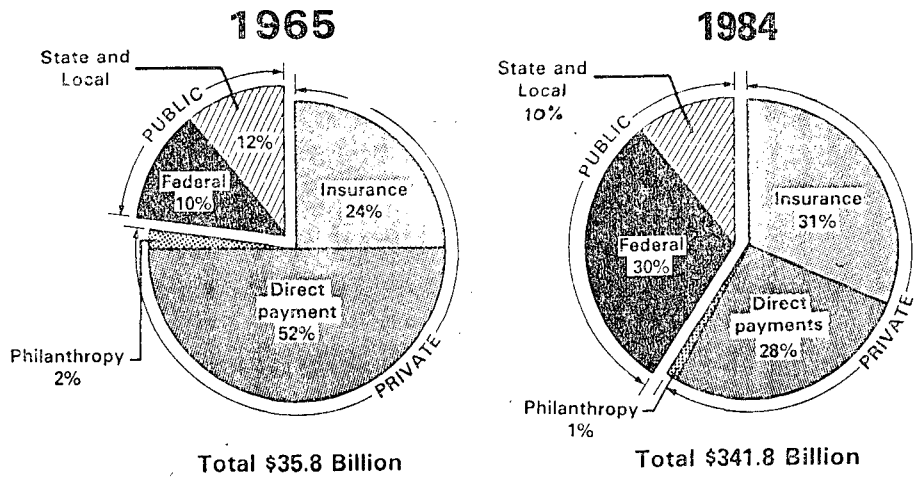


SOURCE: Health Care Financing Administration

Fig. 5. Personal health care expenditures in current and constant dollars, 1965~1983.

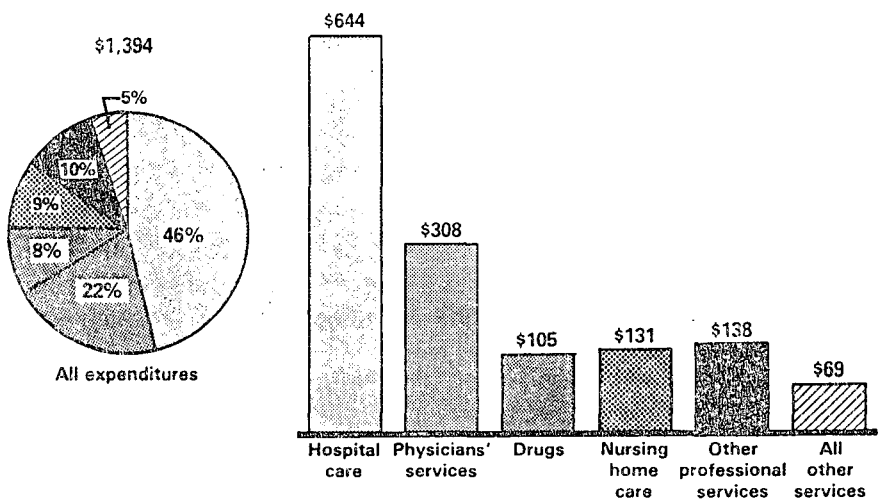
while personal health care expenditures in current dollars increased by 9.5 times between 1965 and 1984 (from $35.9 to $341.8 billion), personal health care expenditures in constant dollars, correcting for the effects of inflation, were still 2.4 times as great in 1984 as they were 20 years previously ($188 versus $77.3 billion) (Figure 5). This same period shows a dramatic shift in the sources of funds used to finance health care.

Increases in health care expenditures during the past twenty years can be related to a variety of reinforcing dynamics, some external to the health care sector such as the general inflationary trend and the aging of the population, and some endogenous to it, such as the increasing supply of physicians, the surplus of hospital beds and the ever increasing diffusion of technology. However, the major dynamic of health care cost patterns



SOURCE: Health Care Financing Administration

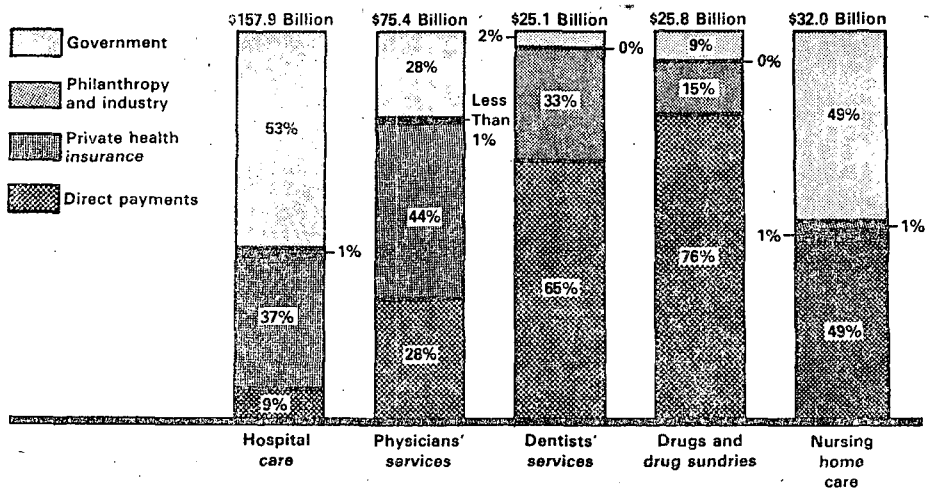
Fig. 6. Personal health expenditures by source of funds, 1965 and 1984.



SOURCE: Health Care Financing Administration

Fig. 7. Per capita personal health care expenditures by type of care, 1984.

during the past 20 years has been the dramatic shift in funding from direct payments by patients to payments by third parties, whether private insurance or public programs, in combination with the cost-based methods by which third parties paid for health care. Whereas in 1965 direct payments for health care represented a little more than half of all health care expenditures, by 1984 direct payments accounted for less than a third (Figure 6). During this period direct payments were displaced by private and public programs so that by 1984, 61 cents of every dollar paid for health care in the United States was paid for either by private insurance or by a Government program. Subsequent to the landmark introduction in 1965 of Medicare and Medicaid,the principal public programs designed to provide financial coverage for health care for the aged and the poor,



SOURCE: Health Care Financing Administration

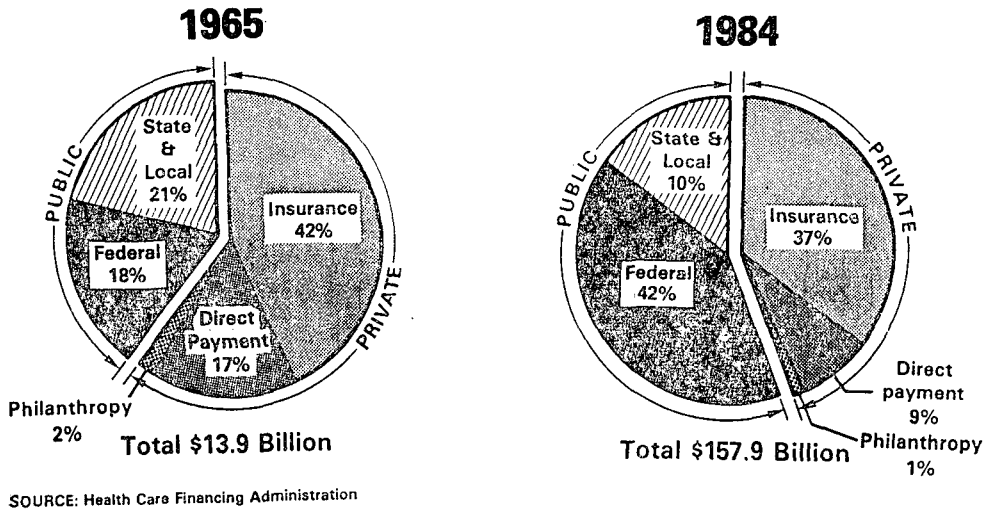
Fig. 8. Personal health care expenditures, by source and type, 1984.

the share of Federal expenditures tripled from 10 percent in 1965 to 30 percent in 1984 (Figure 6). Thus, by 1984 30 cents of every personal health care dollar was paid for by the Federal Government. When methods of financing are considered in terms of the types of care provided, the shift in the sources of funds becomes even more dramatic.

By far the highest percentage of all health care expenditures, almost one-half, is for acute hospital care (Figure 7). Hospital care accounted for 46 percent of all personal health care expenditures in 1984, amounting to $644 per capita, more than twice as large both in terms of percent and absolute amount as the level of expenditures for physician services. However, it should be kept in mind that payment for physician services includes physician services rendered on an inpatient basis as well as ambulatory care. Thus 68 percent of personal health care expenditures in 1984 were for hospital and ambulatory care, including both hospital and physician services. Other professional services, including dental, optometric and psychological professional services accounted for 10 percent of personal health care expenditures and drugs accounted for 8 percent.

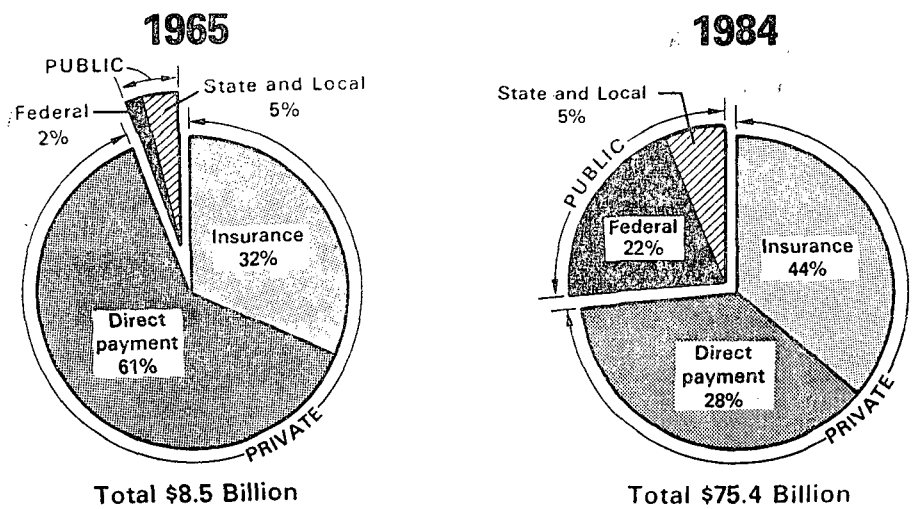
With hospital care accounting for the largest proportion of health care expenditures, it is notable that more than one-half of all hospital care was paid for by Government, with private insurance paying an additional 37 percent (Figure 8). Direct payments, that is to say, payments by patients, were less than 10 cents out of each dollar spent for hospital care. This represents a dramatic shift from 1965 when direct payments for hospital care accounted for 17 percent and the Federal share was only 18 percent (Figure 9). The dramatic shift from 18 percent in 1965 to 42 percent in 1984 of hospital expenditures paid for by the Federal Government represents, of course, the impact of Medicare and Medicaid. The change in the source of funds for physician services has been equally profound. Whereas direct payments by patients accounted for almost two-thirds of physician services in 1965, they accounted for less than one-third by 1984 (Figure 10).

Public programs, however, which paid for only 7 percent of physician services in 1965,



SOURCE: Health Care Financing Administration

Fig. 9. Hospital care expenditures, by source of funds, 1965 and 1984.

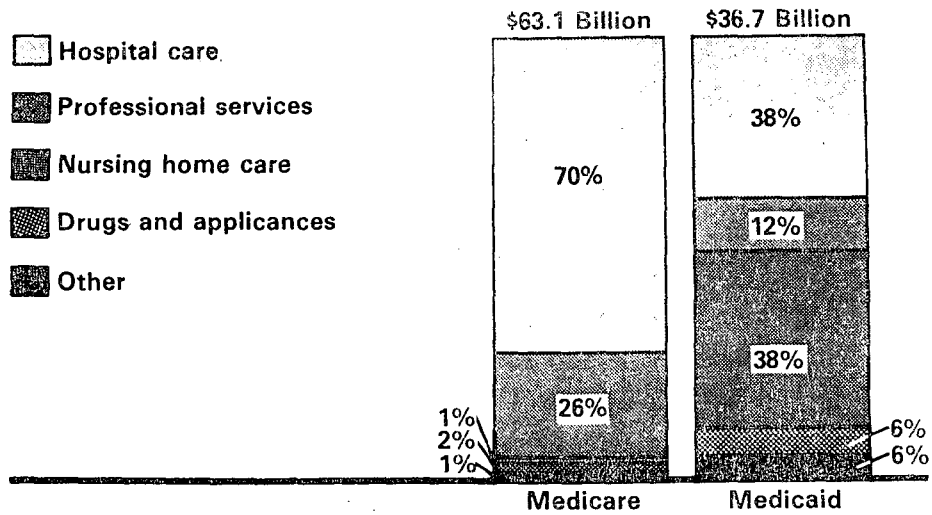


SOURCE: Health Care Financing Administration

Fig. 10. Expenditures for physicians' services, by source of funds, 1965 and 1984.

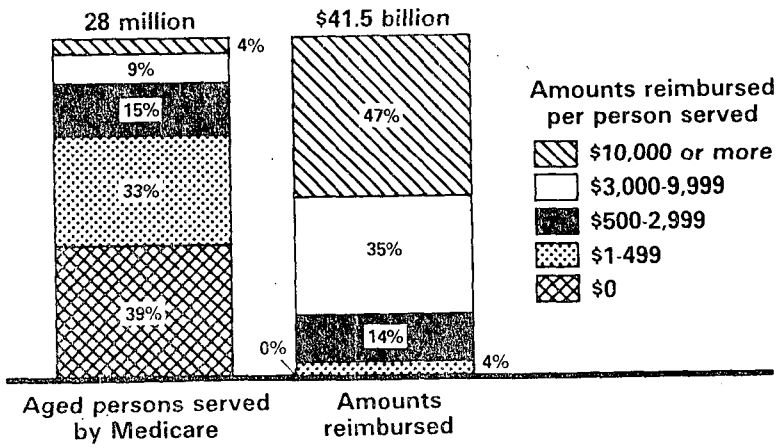
increased to 27 percent by 1984. Within public sector expenditures, all of this increase is attributable to the growth of Federal expenditures from 2 to 22 percent (Figure 10).

It is instructive to consider expenditure patterns by the two major Government programs, Medicare and Medcaid. In 1984, 70 percent of the $63.1 billion outlays by the Medicare Program was for hospital care (Figure 11). Nearly 4 percent of Medicare Program expenditures were for drugs, nursing home care and other services, and 26 percent were for professional services, including care by physicians, dentists and other health professionals. It is particularly notable that the Medicare Program, designed to protect the elderly against the financial consequences of illness and injury, spent only 1 percent of its total expenditures for nursing home care. On the other hand, Medicaid, a



SOURCE: Health Care Financing Administration

Fig. 11. Personal health care expenditures for Medicare and Medicaid, 1984.

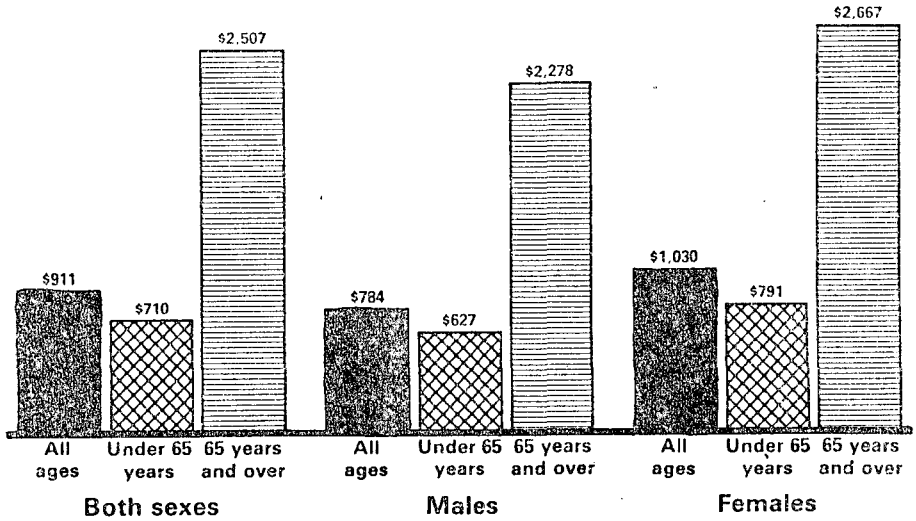


SOURCE: Health Care Financing Administration

Fig. 12. Medicare enrollees and amounts reimbursed, 1982.

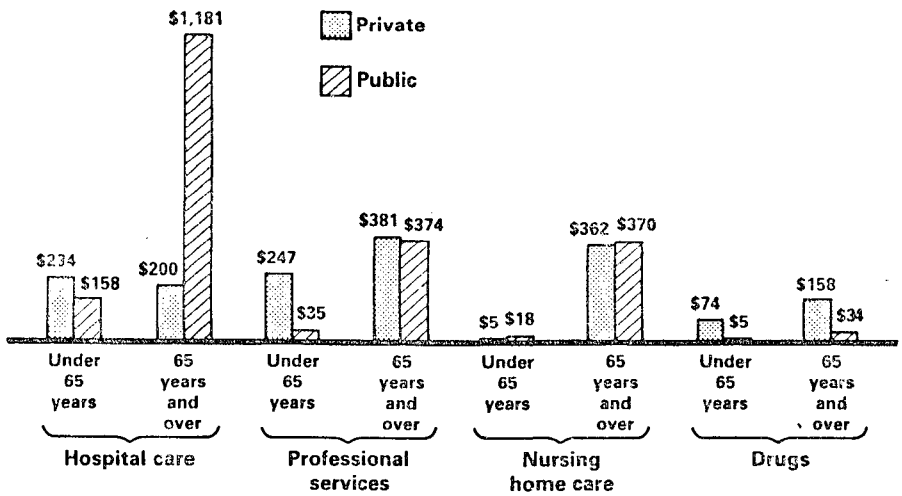
program purportedly designed to provide public health care coverage for the poor, devoted more than one-third of its total expenditures for nursing home care, the overwhelming majority of whose users are the elderly (Figure 11).

Expenditures by the Medicare Program were not only disproportionate in terms of the types of services for which payments were made (Figure 11), but also in terms of the beneficiaries for whom services were reimbursed. According to the latest detailed data, there were 28 million Medicare enrollees in 1982. Of all Medicare enrollees approximately 11 million, or 39 percent, did not use any medical services during the year for which Medicare made any reimbursement (Figure 12). However, that 4 percent of the Medicare enrollee population which during 1982 were sufficiently high users of medical care so that the Medicare Program paid $10,000 or more per person for medical care services, this 4



SOURCE: Health Care Financing Administration and National Center for Health Statistics

Fig. 13. Per capita personal health care expenditures by age and sex, 1980.



SOURCE: Health Care Financing Administration

Fig. 14. Per capita personal health care expenditures by type of care,age,and source of payment, 1981

percent of the enrollees generated 47 percent of all Medicare expenditures. When combined with the next category of users, it is seen that 13 percent of enrollees generated 82 percent of expenditures. Disproportionalities are also present, if somewhat attenuated, when we consider health care expenditures by age and sex.

Health care expenditures per capita for individuals 65 years old and over were more than 3.5 times as great as for individuals under the age of 65 in 1980, the most recent period for which detailed data are available (Figure 13). This pattern is similar both for males and females even though expenditures for females are higher in all age categories. When the sources of funds for these expenditures are considered, it becomes clear that

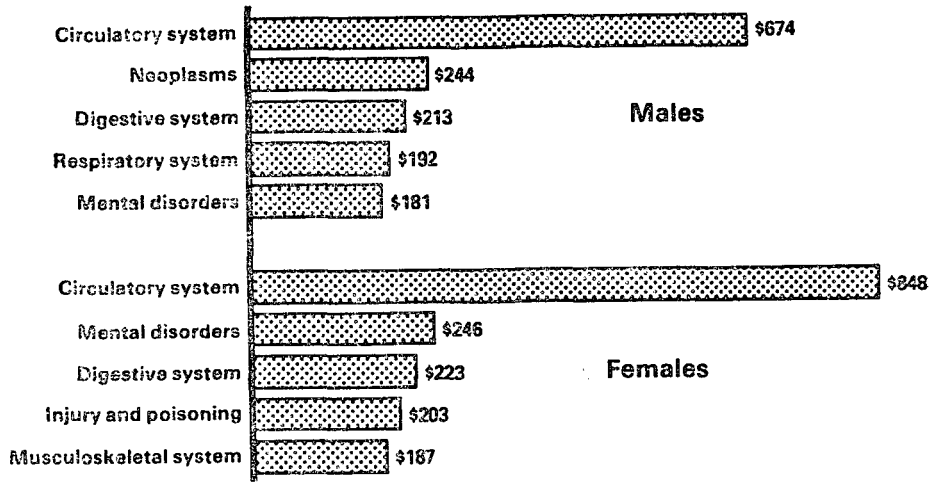
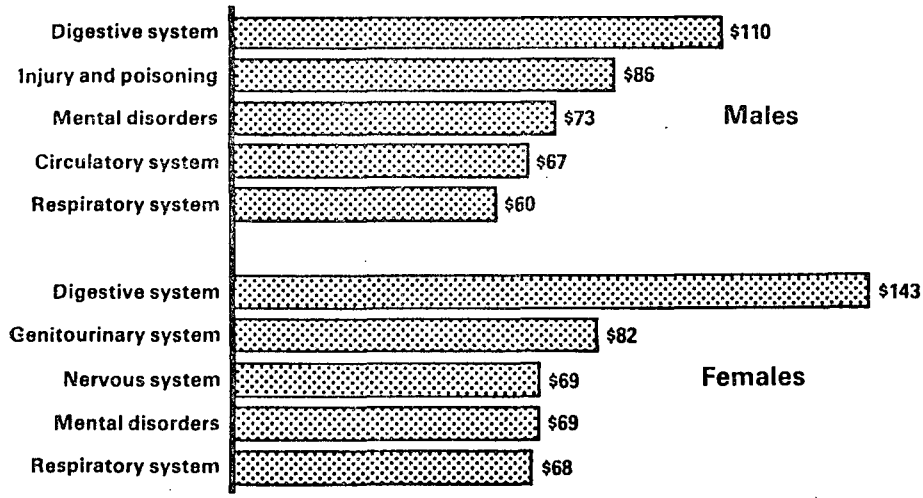


Fig. 15. Per capita expenditures for persons 65 years of age and over by sex, 1980.

on a per capita basis the population 65 years of age and over was the principal beneficiary of public expenditures (Figure 14). In 1981, for example, the most recent year for which such detailed data are available, Government expenditures for hospital care for those 65 years of age and older were 7.5 times as great as hospital expenditures on a per capita basis for people under the age of 65. It might also be noted that while Government programs paid for approximately 50 percent of professional services and nursing home care for the elderly, they paid for only about 18 percent for drugs utilized by the elderly population (Figure 14).

It is instructive to consider the major disease categories that account for 50 percent or more of per capita health care expenditures. Diseases of the circulatory system constitute the largest proportion of per capita expenditures for persons 65 years of age and over regardless of their sex (Figure 15). The relatively higher expenditures for diseases of the circulatory system on behalf of females, as well as the ranking of mental disorders as the second most expensive disease category for females reflect the longer life expectancy for females. While diseases of the digestive system occupy the same third position for both males and females, diseases of the respiratory system, which rank fourth for males, is replaced by injury and poisoning for females. This is attributable to the delayed prevalence of smoking among females in the United States and their longer life expectancy. When the under 65 years of age population is considered, a different pattern emerges.

Diseases of the digestive system rank first in terms of per capita expneditures both for females and males under the age of 65 (Figure 16). In this under 65 years of age population, diseases of the respiratory system rank fifth in terms of expenditures both for males and females. The increased prevalence of smoking by women beginning in the 1940s is now reflected in the parity with males in terms of the importance of respiratory system diseases. But while diseases of the genitourinary system rank number two in



SOURCE: National Center for Health Statistics

Fig. 16. Per capita expenditures for persons under 65 years of age by sex, 1980.

terms of expenditures for females under the age of 65, that ranking is assumed by injuries and poisonings for males (Figure 16).

This brief review of cost patterns indicates the economic context in which current policies are formulated. How successful those policies will be, and with what kind of effects on quality, access, the distributional burdens of health care expenditures, will depend both on the policy mix adopted and its feasibility.

The Policy Mix and Its Effectiveness

The review of health care cost patterns indicated several salient dimensions of the current U.S. health care scene: Health care costs have dramatically increased both in absolute terms and as a percentage of the GNP, with Federal expenditures having increased the fastest; almost one-half of all health care expenditures are for hospital care; a disproportionate share of all expenditures are for the elderly; a relatively small proportion of the elderly, not more than 13 percent, generate more than three quarters of all expenditures for that age group; and of the five most costly health problems regardless of age and sex, at least four, namely diseases of the circulatory system, diseases of the respiratory system, diseases of the digestive system, and injuries and poisonings, are potentially preventable.

The three broad dimensions characterizing current policy initiatives, namely changing the structures of health care delivery, changing incentives, and changing the financing methods, will attain their objective of cost containment only the extent that they will be able to alter both the short run and long run behaviors that have led to the health care scene as it exists today.

Policies to alter the organizational structures of health care delivery rely on the

development of managed care systems in which the provider is at financial risk. Health maintenance organization, (HMOs) preferred provider organizations (PPOs) and similar systems of managed care, whether financed privately or by public programs, are expected to help replace the "anything goes, the insurance will pay" mentality with greater attention to cost-benefit or risk-benefit orientation. Extrapolating from the experience of prepaid group practice, which provides comprehensive benefits on a prepaid, capitated basis to a defined population, clearly indicating that it is possible to provide high quality care with 30 to 40 percent less hospital use than is typical in the fee-for-service system, it is thought that the application of at least some of the elements characterizing prepaid group practices will lead to similar saving in the emerging new organizations. It is also expected that as HMOs increase their market share to 10,20 or 30 percent, as they have done in a number of major urban areas such as Minneapolis-St. Paul, Los Angles, San Francisco-Oakland, and Denver, they will have a salutary indirect effect on the fee-for-service sector and private insurance companies as they will struggle to retain their market shares by reduced premiums and reduced utilization of the most expensive component of health care, the hospital. By whatever acronym these new alterative delivery system are known, their success in terms of reduced health care costs to a great extent depends on their ability to rely on the conservative practice of medicine. In the short run this means eliminating services of questionable clinical effectiveness and chosing the most clinically effective but least-cost intervention modality where clinically appropriate choices exist. In the long-run, however, the most conservative and cost effective medicine implies the alteration of health behaviors, primary prevention, and early diagnosis. To what extent HMOs and the newer managed care systems are likely to introduce and emphasize these approaches whose benefits are seen only in the future, and in some cases the far future, remains to be seen.

The second major thrust of policy is to change financial incentives facing providers and patients. In the private sector, the most direct examples are cost sharing and self insurance. In cost sharing a patient is expected to bear a larger portion of the financial burden associated with the use of health services, based on the assumption that cost consciousness on the patient will encourage more economically rational care seeking behavior as well as greater cost consciousness on the part of the provider. Self-insurance, while increasingly the modality adopted by, for example, corporations on the Fortune 500 list, on the other hand, provides incentives for health insurance benefit managers as well as unions to contain industrial health care costs. Self insurance approaches are frequently combined with elements of managed care systems so that by the implementation of utilization review and monitoring, employers are able to identify high cost behavior patterns both by employees and providers. Mandatory second opinion surgical programs and preadmission certification combined with self-insurance provide both the incentives and the mechanisms for controlling the use of inpatient care, particularly of surgical care. At times such programs are combined with employee oriented incentive mechanisms which provide a share of health care cost savings in the form of year end bonuses to

employees. Thus, private sector policies designed to alter incentives are principally focused on the behavior of clients or patients, but with monitoring programs directed at providers. In the public sector, the principal policy to change incentives is targeted at providers, namely hospitals.

The DRG based Prospective Payment System introduced by the Health Care Financing Administration in 1983, and since then adopted by several state Medicaid programs, is designed to change the financial incentives of hospitals. As the name of the traditional method of "reimbursement" for hospital services employed both by private and public insurance mechanisms implies, it was a retrospective system in which hospitals got paid for the services rendered to individual patients based on the costs or charges of individual services. Within such a system, each additional day of stay and every additional ancilliary service, whether laboratory, X-ray, or inhalation therapy, generated an additional charge for which the hospital was "reimbursed." Under this system, of course, neither hospitals nor physicians had any financial incentives to economize the services rendered, to assure efficient scheduling so as the reduce extended lengths of stay and redundant service ordering, or to increase the economic efficiency of the processes by which those services were produced in the hospital. The DRG based Prospective Payment System (PPS) changes all of that.

Under PPS all patients are grouped into 367 mutually exclusive and exhaustive categories based on their principal diagnosis, whether a surgical procedure was performed or not, and often age and presence of complications or comorbidities. For each such category, or DRG, a payment level is established prospectively, currently based on a regional average estimated cost, adjusted for certain differences in labor costs and the hospital's teaching status. Since the payment for a treated case in each of the DRGs is based on the estimated average resource consumption of cases within that DRG, payment to the hospital for treating patients within that DRG is invariant regardless of the amount of services they receive or variations in their length of stay. (Provision is made for the payment, at reduced rates, for additional lengths of stay of patients with exceptionally long hospital stays, the so called outliers.) Thus, each additional day of stay and every additional service rather than generating additional revenues for the hospital represents an additional cost. Thus, PPS provides hospitals strong incentives to eliminate unnecessary services, to reduce the length of stay, and to improve the efficiency with which services are rendered and produced in the hospital. PPS also raises the specter of reducing services below the appropriate level, leading to the fear that patients will be discharged "quicker but sicker."

Operational experience with PPS is too short to draw definitive conclusions about its effects. However, preliminary data for 1984 and the first half of 1985 show reductions in the length of stay, reductions in hospital occupancy rates, and for the first time since the 1930s when such data were first collected, reductions in hospital employment.

The third component of health care policy initiatives is directed to changing approaches of health care financing. The major policy targets are health insurance premiums and the

current treatment of medical expenses for income tax purposes. Since 60~70 percent of private health insurance premiums are paid by employers for insurance policies that benefit their employees, such payments are properly seen as labor costs from the perspective of employers and indirect earnings from the perspective of employees. Thus, health insurance premiums receive doubly favorable tax treatment since they are considered to be a cost of doing business, and thus reduce corporate earnings, while on the other hand they are not considered as wages, and thus reduce the effective earnings of employees. This favorable treatment of health insurance premiums essentially means that the Federal Government effectively subsidizes the cost of health insurance for the very group which needs it the least, namely those who are gainfully employed. Hence proposals to impose taxes on the value of health insurance premiums paid by employers and to consider such premiums to be taxable income earned by employees.

The effectiveness and desirability of subsidizing medical expenditures by the employed through the favorable consideration of such expenses as exemptions from earned income are also being called into question.

In general, policies designed to alter health care financing approaches aim to reimpose financial discipline both on employers and employees.

CONCLUSION

It is perhaps too early to draw definitive conclusions about the effectiveness of health care policy initiatives currently being implemented or considered in the U.S. However, it is fair to conclude that these policies are directed to:

1) provide incentives to patients, physicians and hospitals to use health care resources more efficiently;

2) alter the characteristics of the health care market by changes in its structures to make the health care system more competitive and therefore more cost conscious; and, above all,

3) reduce Government expenditures for health care.

Simultaneous with these new policy initiatives, the health care sector is experiencing a series of potentially fundamental changes whose combined effects will lead to a system in many respects different from the one with which we are now familiar.

The American health care system, based as it is on its 19th Century origins, unsystematic, individualistic, unorganized and simple in its institutional configurations, is an anachronism in the American industrial landscape. In many ways a cottage industry, innocent of vertical and horizontal integration, our health care sector is out of step not only with the rest of American productive society but is ill suited to meet the institutional needs of an ever more technology dependent system. Hence the rapidly growing trends of privatization, and aggregation into diversified health care conglommerates represent a catching up, a coming of age of the institutional infrastructure that supports modern medicine. That these dominant private sector trends of the past four or five years

have been accelerated by the health policy initiatives originating not only in Washington, but in Detroit, Milwaukee, Houston and every other major industrial city in the United States, cannot be doubted. What can be doubted, or at least questioned, is the ability of these changes to deal effectively with the underlying dynamics of health care costs.

Stressing more cost effective behavior by clients and providers, sqeezing out economic inefficiency, and imposing institutional structures and incentives to assure that both public and private expenditures for health care yield maximum benefits in a humane system of accessible health care cannot be questioned. However, it behooves us to recognize that the most effective way to reduce health care costs is not by changing the system of health care delivery: it is by reducing the need for medical care. In the long run, it is better health habits, a healthier environment, and early primary prevention that are the most cost-effective approaches to reducing health care costs. With the continued expansion of the life span, increasing proportion of the population who are aged, and the still large gaps in access to adequate health care by the disadvantaged, the health care system will continue to face immense challenges. The major challenge of the future is not the technology and availability of crisis medicine, but the development of the technology, philosophy, and practice of prevention.