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U.S. Health System Cost Performance - Achieving Savings and Value: What are the Options?

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Senior Vice President
The Commonwealth Fund

Session: How Should We Rein In Health Care Costs And When Should We Start?
American Public Health Association Annual Meeting
Washington, DC
November 5, 2007

How Should We Rein in Health Care Costs and When Should We Start?

- **How?**
  - **Focus on value: access, quality and costs**
  - **Aim at total costs for the nation, not shifting costs to other budgets**
  - **Strategic focus on factors that lead to high costs without value or to rising costs amenable to policy**
- **When should we start?**
  - **Now. Incremental savings accumulate over time**
  - **It takes time to move towards a more effective, equitable and efficient health system**

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Towards a High Value U.S. Health System

- **Why are U.S. costs so high and rising rapidly?**
- **Which factors are amenable to policy?**
- **What are federal/national policy options that could achieve savings and improve value?**
  - **Value = Greater access, better quality and health outcomes with similar or lower resource costs**
  - **Savings = Slowing the growth and moderating expected future cost trends**

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The United States from an International Perspective

- **Highest costs in the world**
  - **Increasing much faster than wages or incomes**
  - **Average family premium exceeds minimum wage worker annual income**
- **Rising uninsured and underinsured**
- **Public programs under stress**
- **Quality widely variable**
  - **Little relationship between quality and costs**
  - **Where you live matters**
- **International evidence – not getting high value in return; we should expect more**
  - **U.S. often lags not leads on health indicators**
  - **Other countries often have better or equal outcomes/lower costs**

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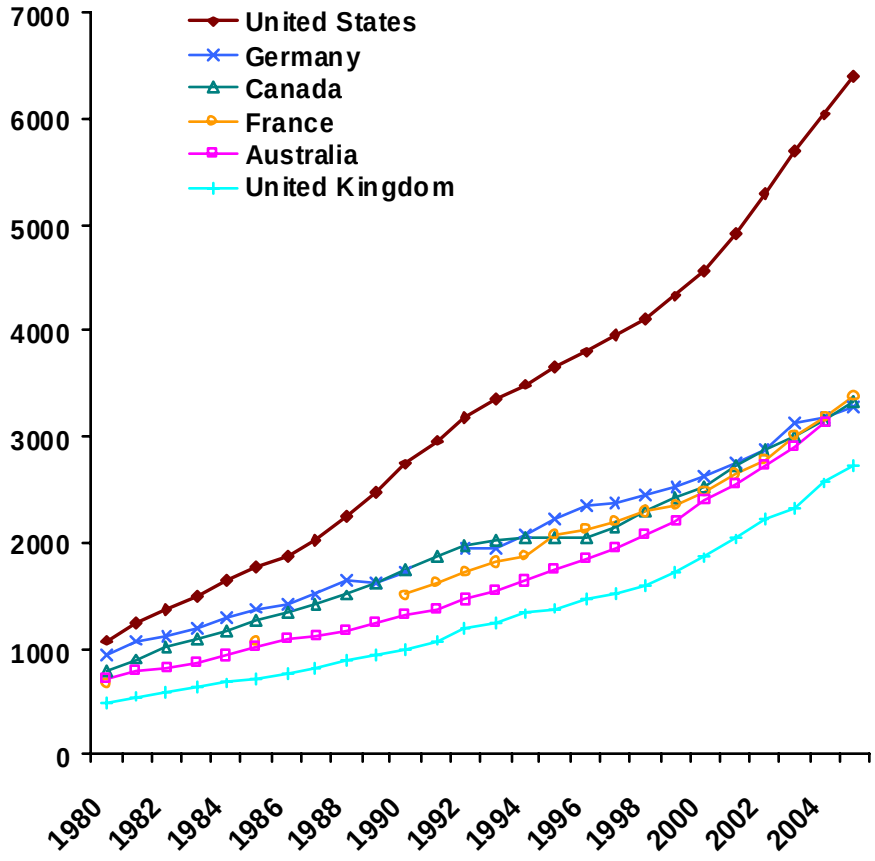
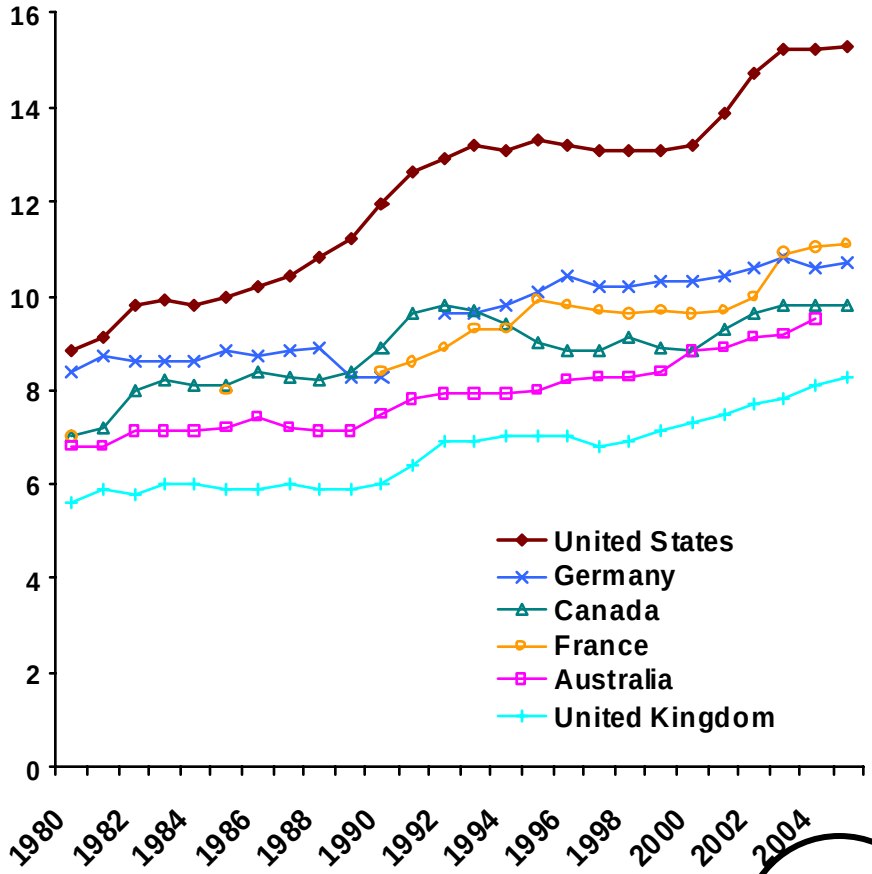
International Comparison of Health Spending,[5] 1980–2005

U.S. Expenditures Projected to Reach 20% of GDP in Ten Years

Average spending on health per capita ($US PPP)



Total health expenditures as percent of GDP



Data: Based on OECD Health Data 2007.

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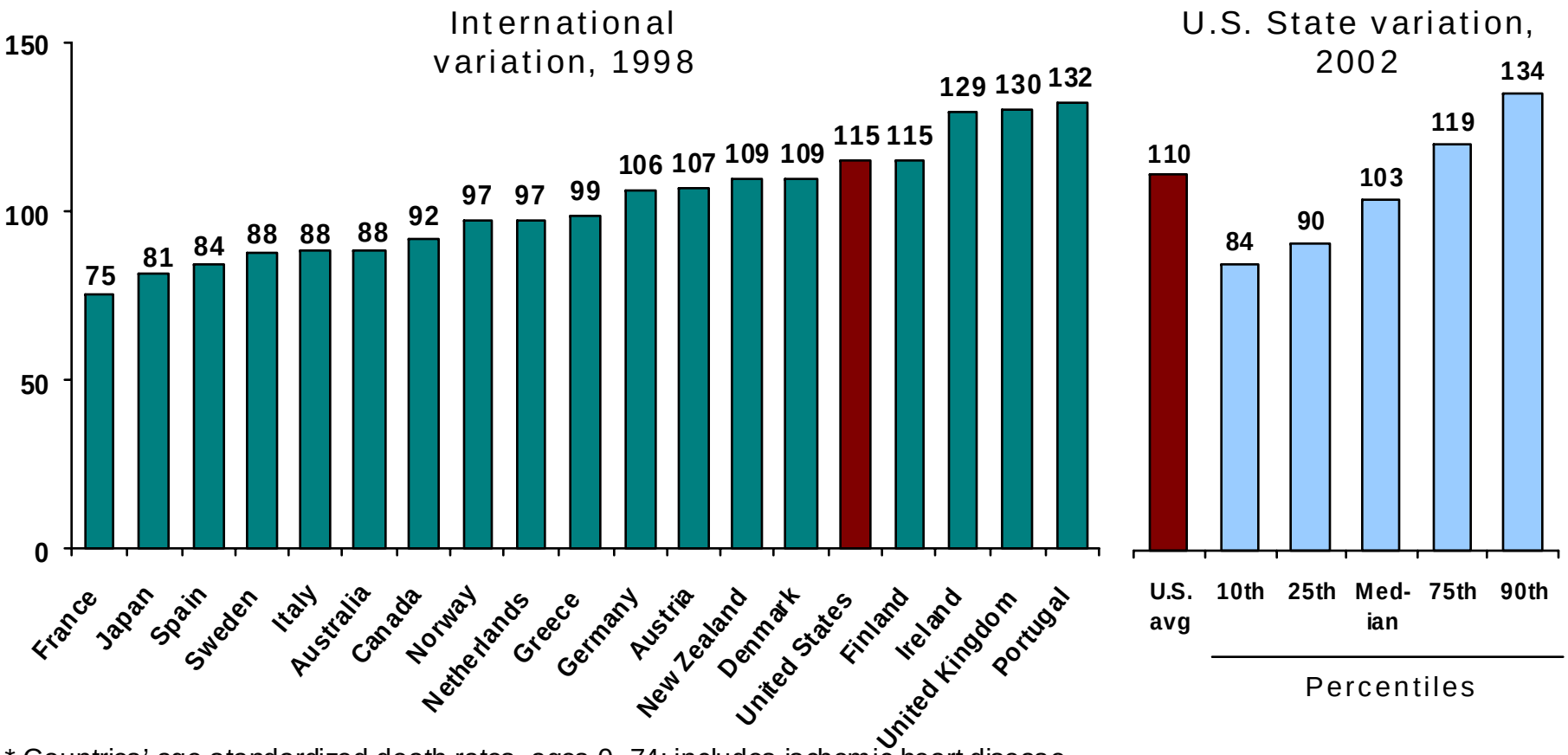
Mortality Amenable to Health Care

Mortality from causes considered amenable to health care is deaths before age 75 that are potentially preventable with timely and appropriate medical care

Deaths per 100,000 population*

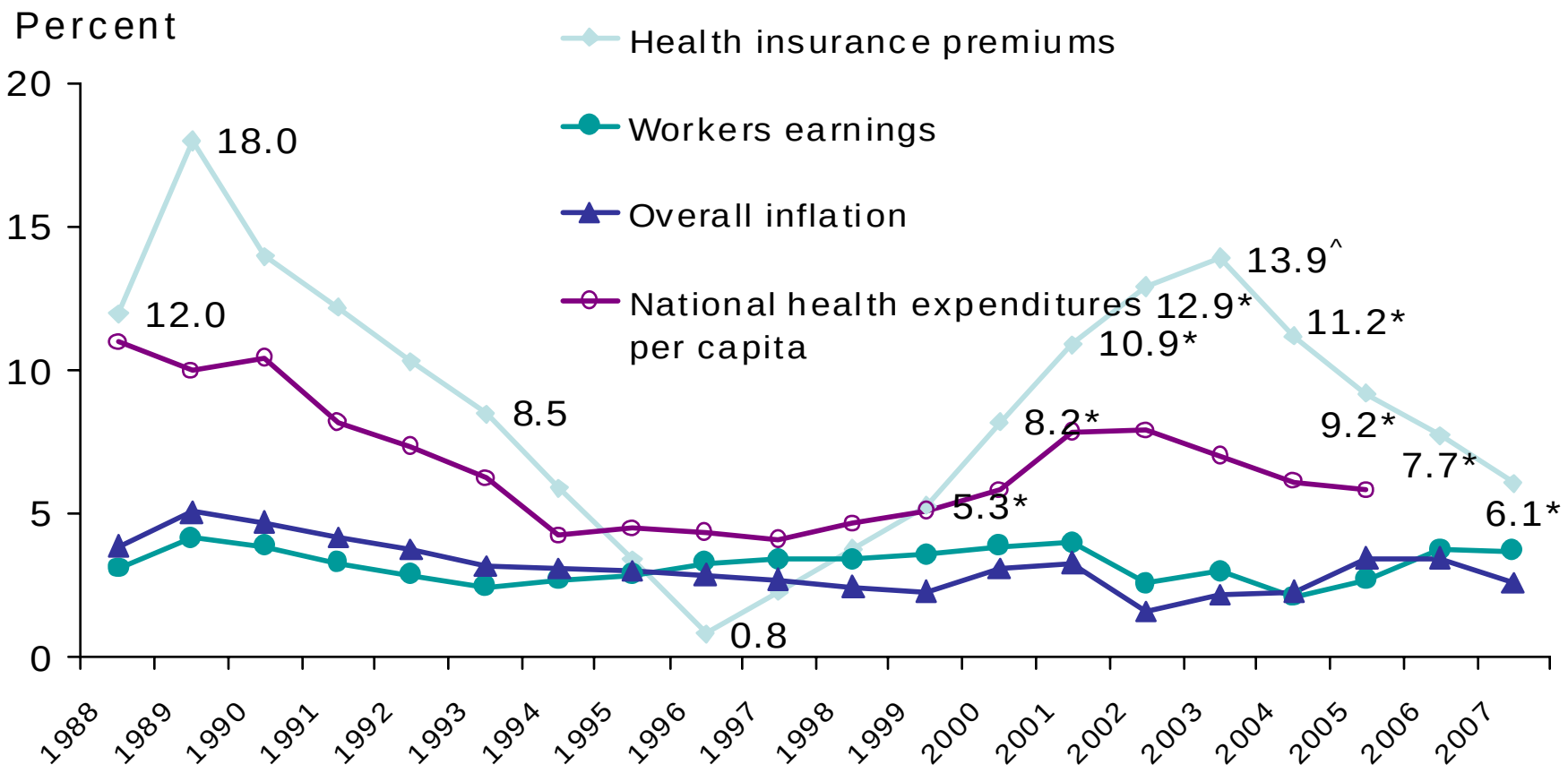


* Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease.
See Technical Appendix for list of conditions considered amenable to health care in the analysis.
Data: International estimates—World Health Organization, WHO mortality database (Nolte and McKee 2003); State estimates—K. Hempstead, Rutgers University using Nolte and McKee methodology.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

Increases in Health Insurance Premiums Compared with Other Indicators, 1988–2007

Annual single premium = $4,479 Annual family premium = $12,106



Source: G. Claxton, et al., "Health Benefits in 2007: Premium Increases Fall To An Eight-Year Low, While Offer Rates And Enrollment Remain Stable," *Health Affairs*, September/October 2007. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007, and Commonwealth Fund analysis of National Health Expenditures data.

*Estimate is statistically different from the previous year shown at p<0.05.

^Estimate is statistically different from the previous year shown at p<0.1.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. .

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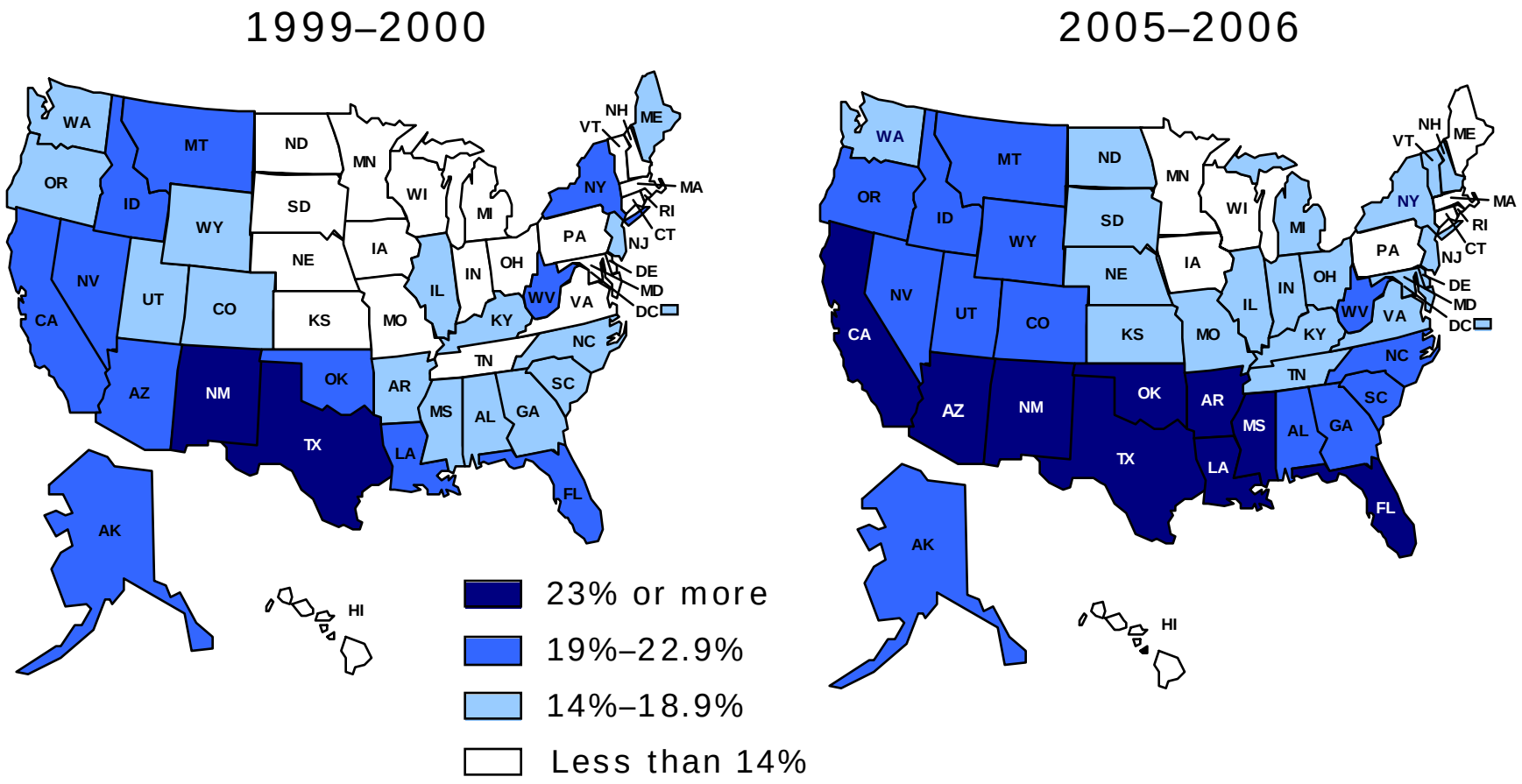
Number of Uninsured Up from 38.4 to 47 Million Adults Under-65 Account for Most of the Increase Percent of Adults Uninsured Up from 17.3 to 20.1%



Data: Two-year averages 1999–2000, updated with 2007 Current Population Survey correction, and 2005–2006 from the Census Bureau's March 2000, 2001 and 2006, 2007 Current Population Surveys.

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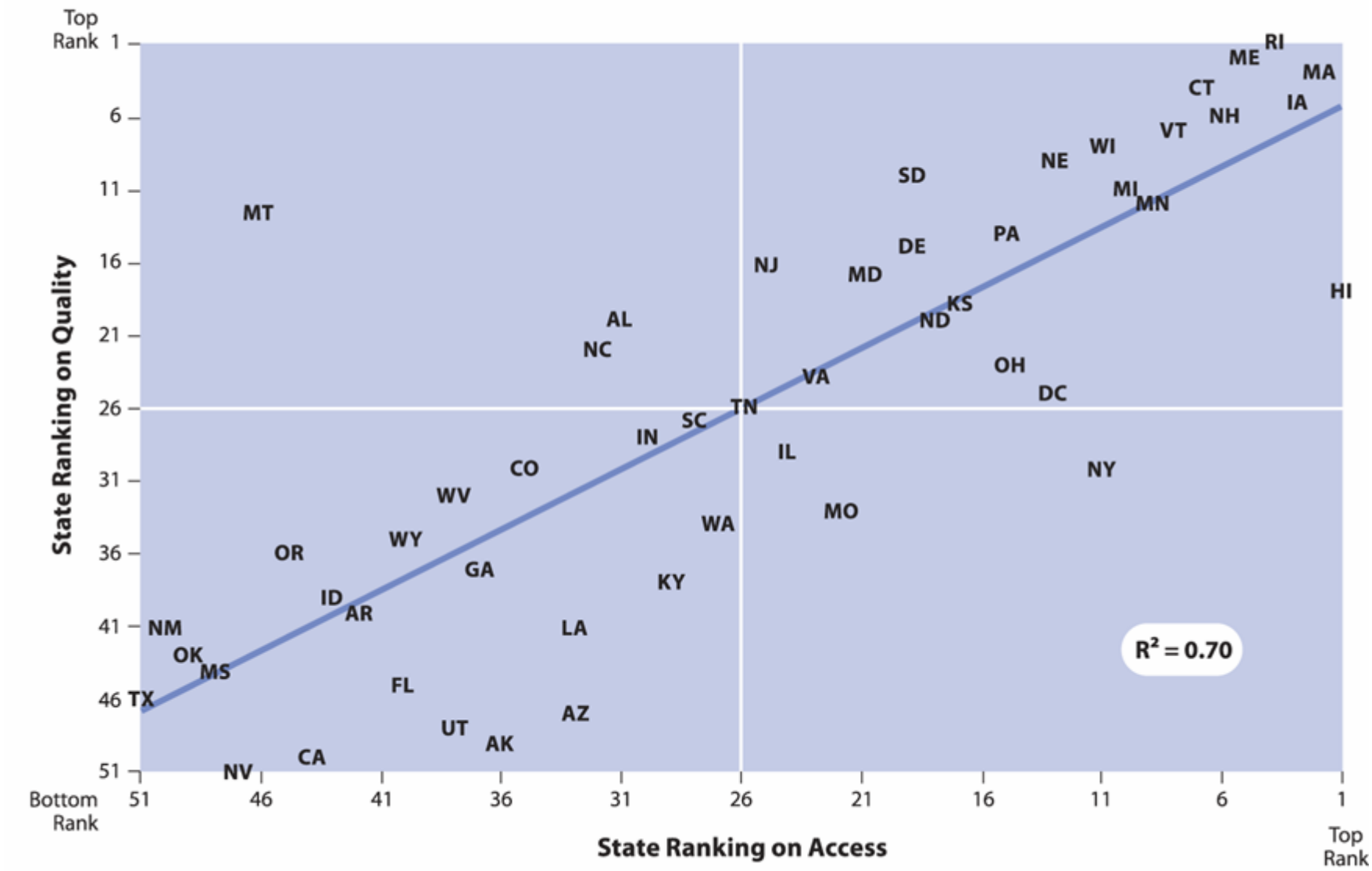
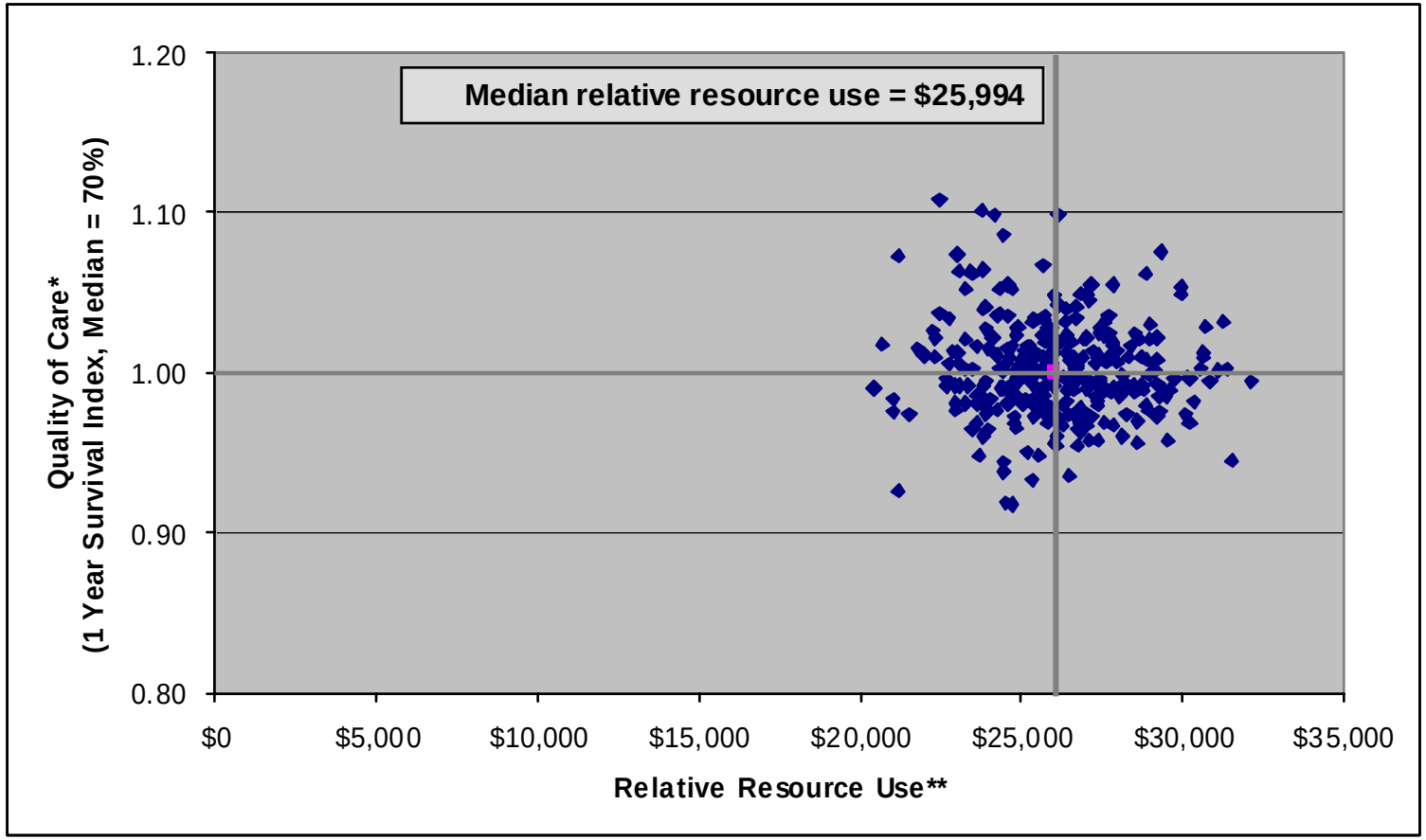
State Ranking on Access and Quality Dimensions



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Variability: Quality and Costs of Care for Medicare Patients Hospitalized or Heart Attacks, Colon Cancer, and Hip Fracture, by Hospital Referral Regions, 2000–2002



* Indexed to risk-adjusted 1 year survival rate (median = 0.70).
** Risk-adjusted spending on hospital and physician services using standardized national prices.
Data: E. Fisher and D. Staiger, Dartmouth College analysis of data from a 20% national sample of Medicare beneficiaries.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

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Why Are U.S. Health Care Expenditures High and Increasing More Rapidly than Incomes?

- **Projections: National expenditures expected to double over next 10 years – from $2 trillion to $4 trillion, rising from 16 to 20% of GDP**
- **Factors contributing to high levels and increasing costs without value (Inefficient care)**
  - **Overuse, inappropriate use, duplication or ineffective care**
  - **Access barriers; lack of prevention; complications of disease**
  - **Payment incentives that reward doing more without consideration of value or quality/outcomes**
  - **Weak support of primary compared to specialized care**
  - **Inadequate information systems**
  - **Poor care coordination**
  - **Safety concerns: adverse drug events, infections, etc.**
  - **High overhead costs: insurance administrative complexity**
- **Factors contributing to long-term trend increases – amenable to policy**
  - **New technologies without comparative information on clinical or cost effectiveness to guide decisions about adoption**
  - **Rising rates of chronic disease – public health**
  - **Incentives: few leverage points to encourage more efficient care**

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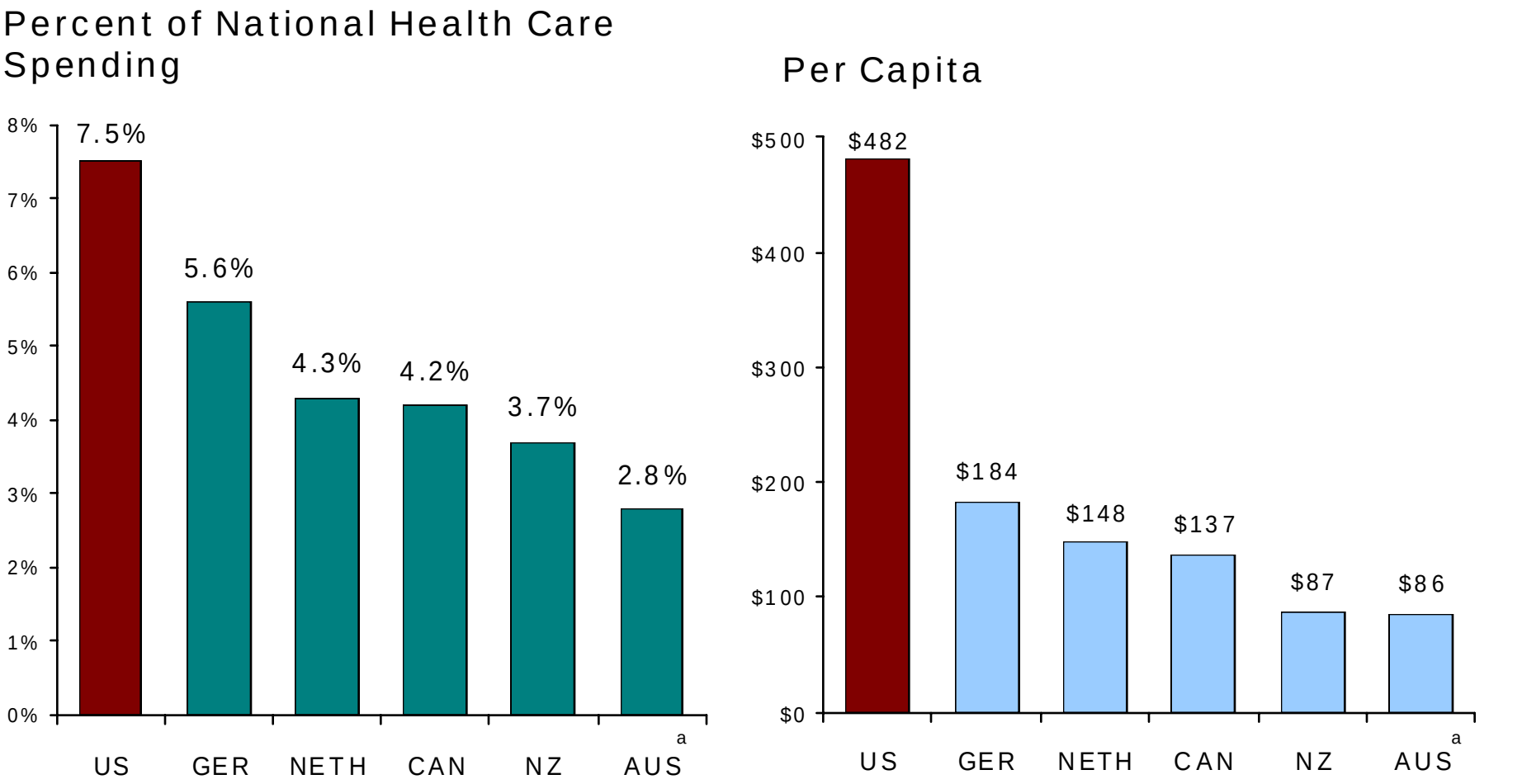
Spending on Health Insurance Administration in 2005



[a]2004

Data: OECD Health Data 2007.
Source: Frogner and Anderson, *Multinational Comparisons of Health Systems Data*, Commonwealth Fund forthcoming.

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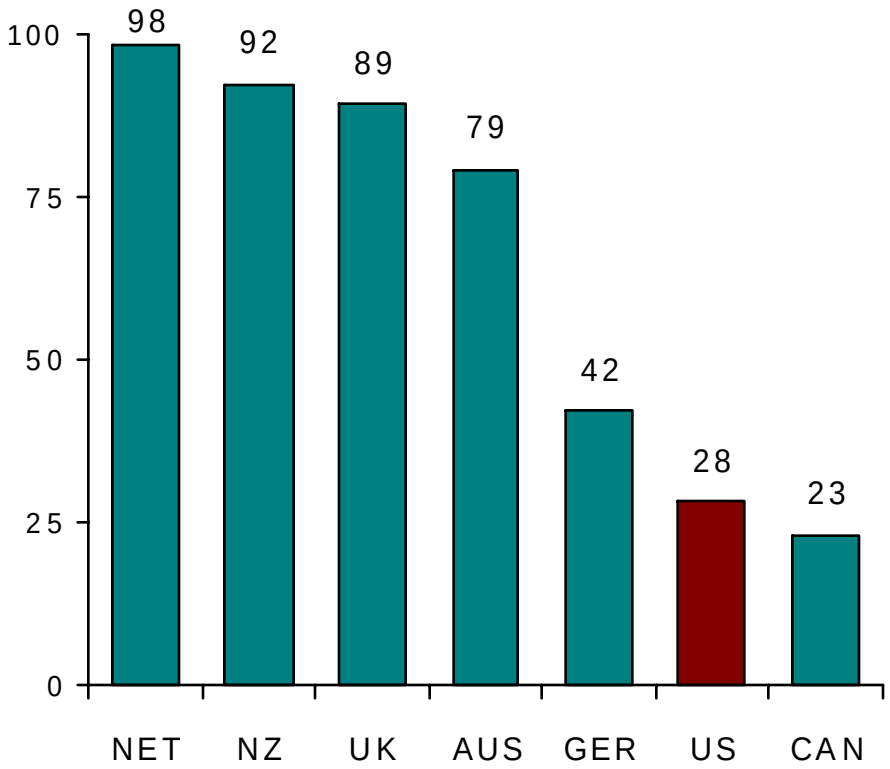
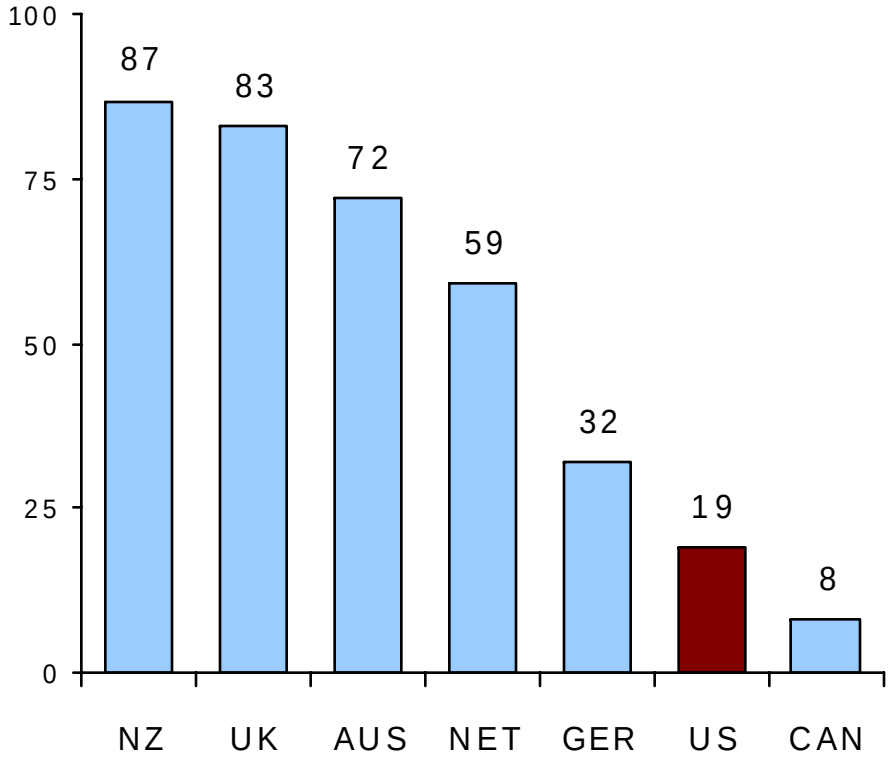
Where is the U.S. on IT?
Only 28% of U.S. Primary Care Physicians Have Electronic Medical Records; Only 19% Have Advanced IT Capacity in 2006

Percent reporting EMR



Percent reporting 7 or more out of 14 functions*



*Count of 14: EMR, EMR access other doctors, outside office, patient; routine use electronic ordering tests, prescriptions, access test results, access hospital records; computer for reminders, Rx alerts, prompt tests results; easy to list diagnosis, medications, patients due for care.

Data: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians

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Weak Primary Care Foundation

- **Access a concern – including access after-hours**
- **High rates of ER use**
- **High rates of admissions to the hospital for potentially preventable complications of chronic disease**
- **Fragmented and poorly coordinated care**
  - **Lack of "medical homes" that are accessible and support coordination**
  - **Lack of systems to follow-up on care during transitions**
  - **Chronic care**

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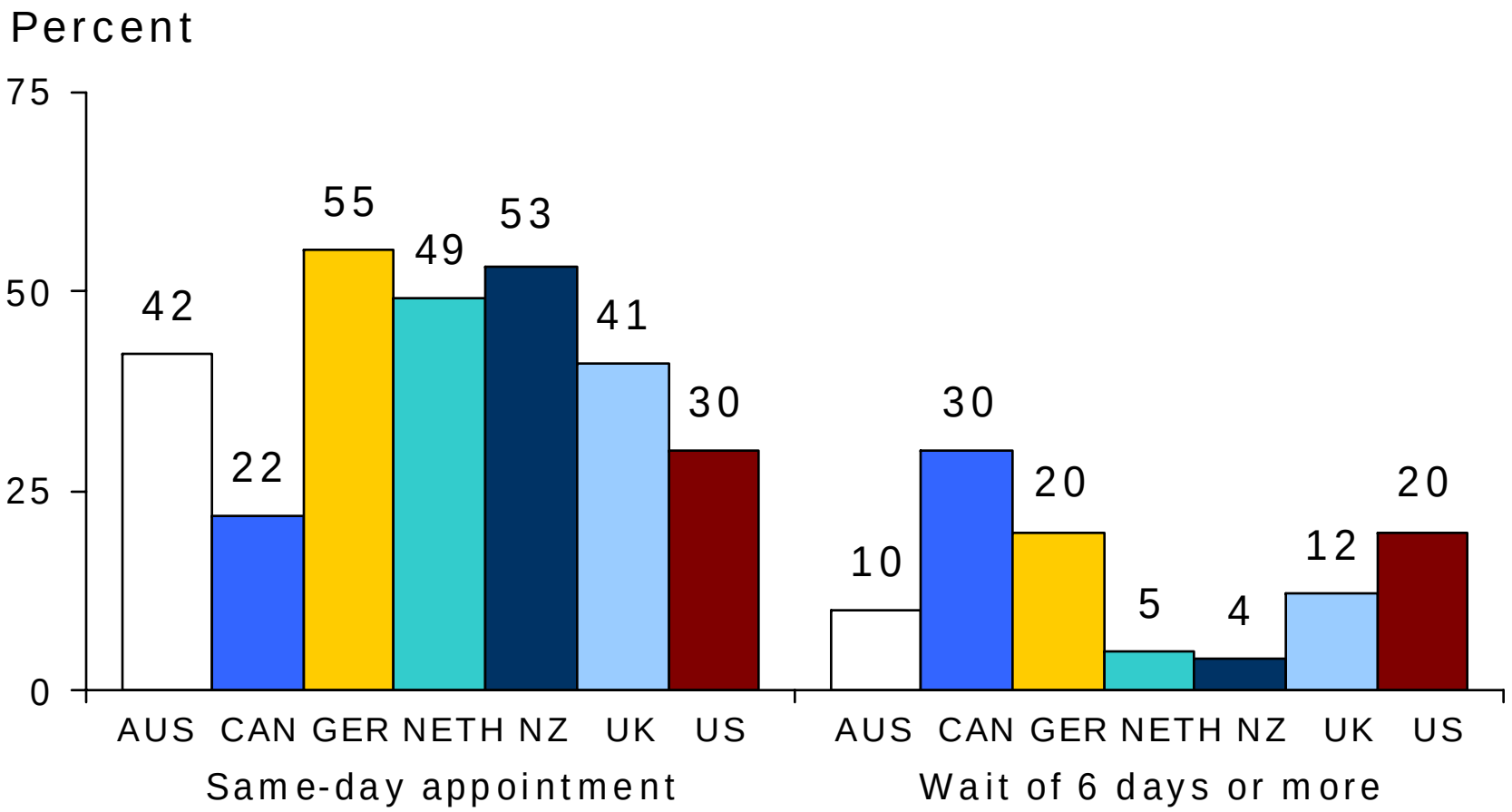
Access to Doctor When Sick or Need Medical Attention



Data: 2007 Commonwealth Fund International Health Policy Survey
Source: C.Schoen et al., "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive, Oct. 31, 2007.

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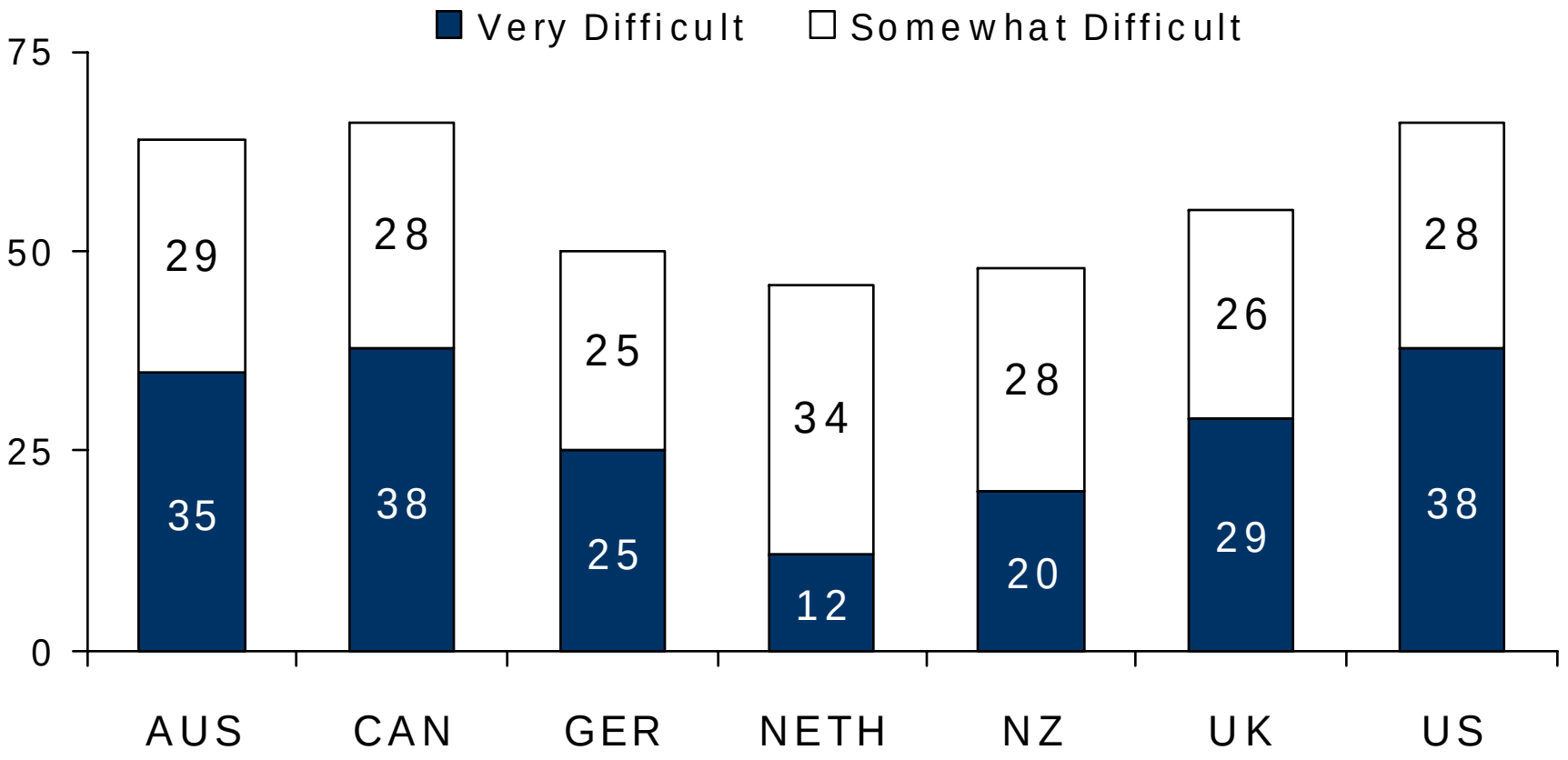
Difficulty Getting Care on Nights, Weekends, Holidays Without Going to the Emergency Room

Percent reporting very or somewhat difficult



Data: 2007 Commonwealth Fund International Health Policy Survey
Source: C.Schoen et al., "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive, Oct. 31, 2007.

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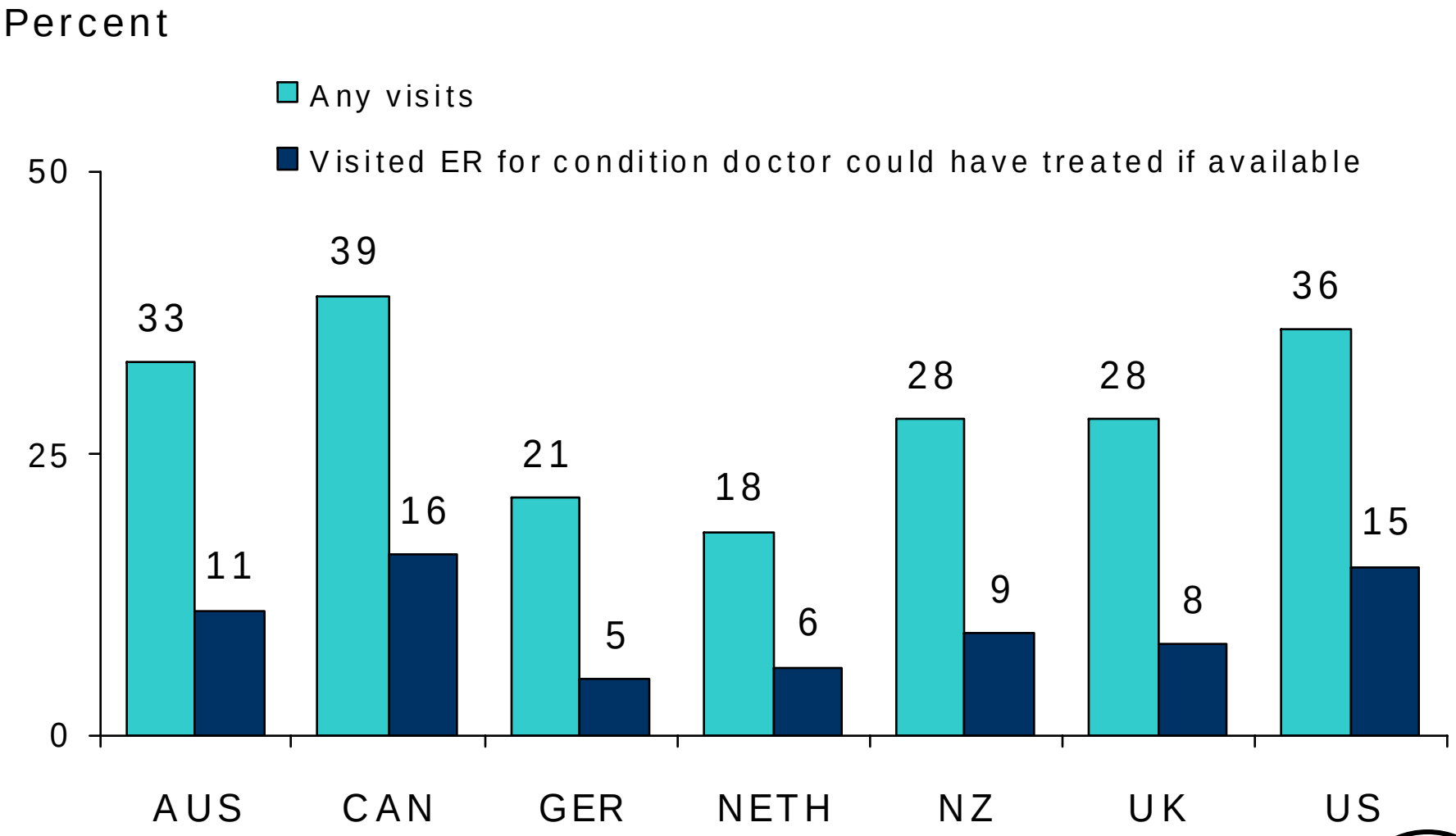
Emergency Room Use in the Past Two Years



Data: 2007 Commonwealth Fund International Health Policy Survey
Source: C.Schoen et al., "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive, Oct. 31, 2007.

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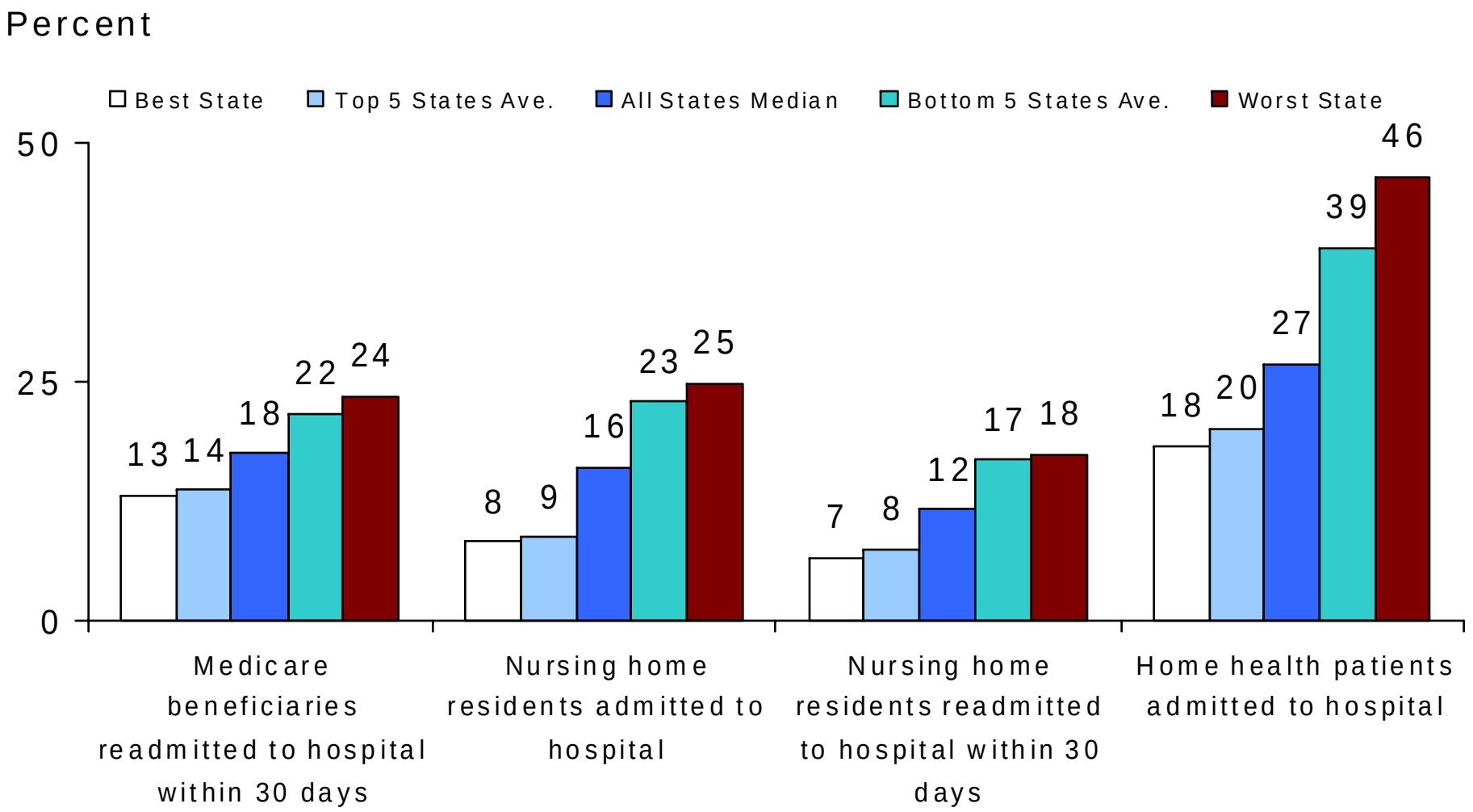
State Variation: Potentially Preventable Hospital Admissions Indicators



DATA: Medicare readmissions – 2003 Medicare SAF 5% Inpatient Data; Nursing home admission and readmissions – 2000 Medicare enrollment records and MedPAR file; Home health admissions – 2004 Outcome and Assessment Information Set

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

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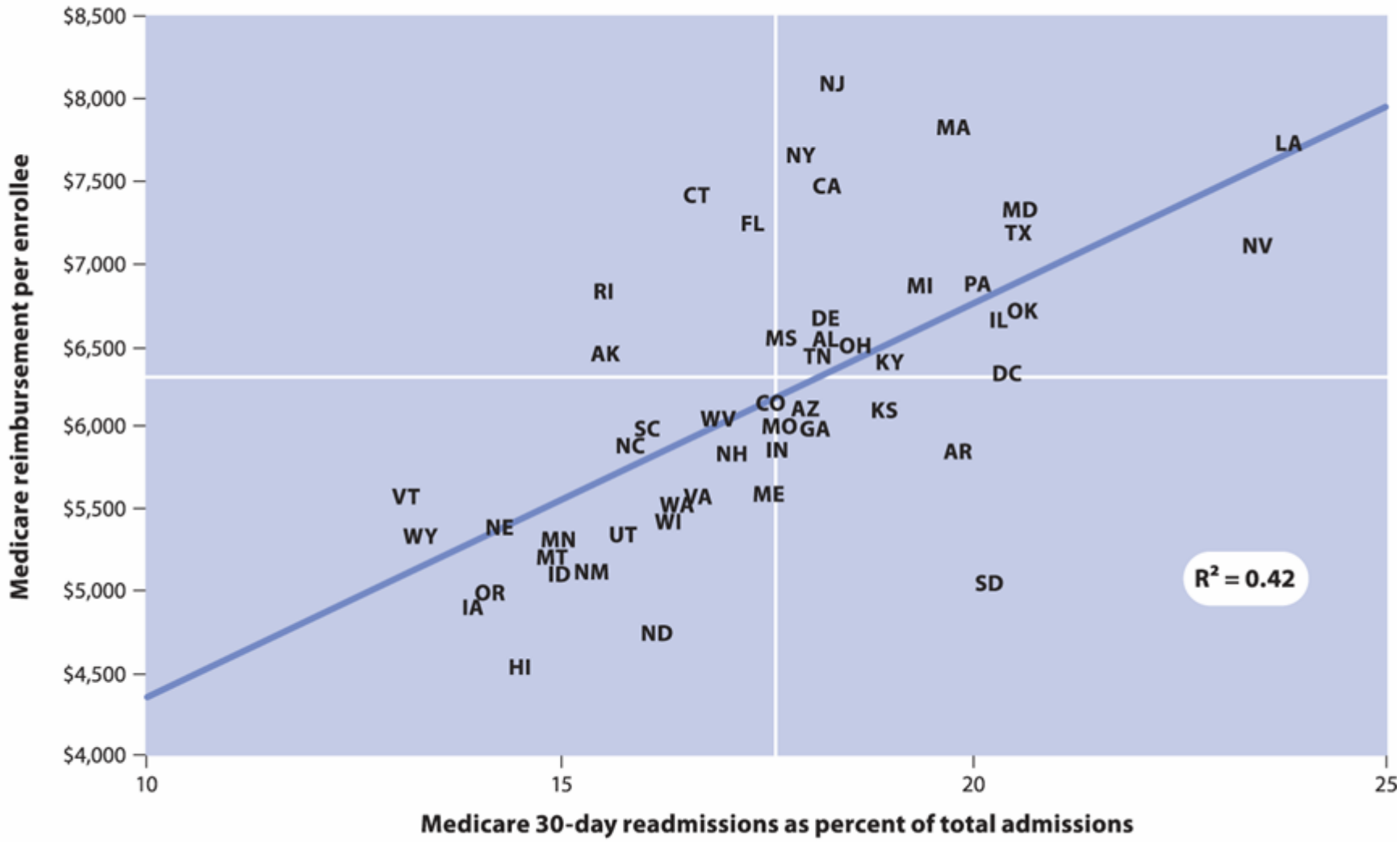
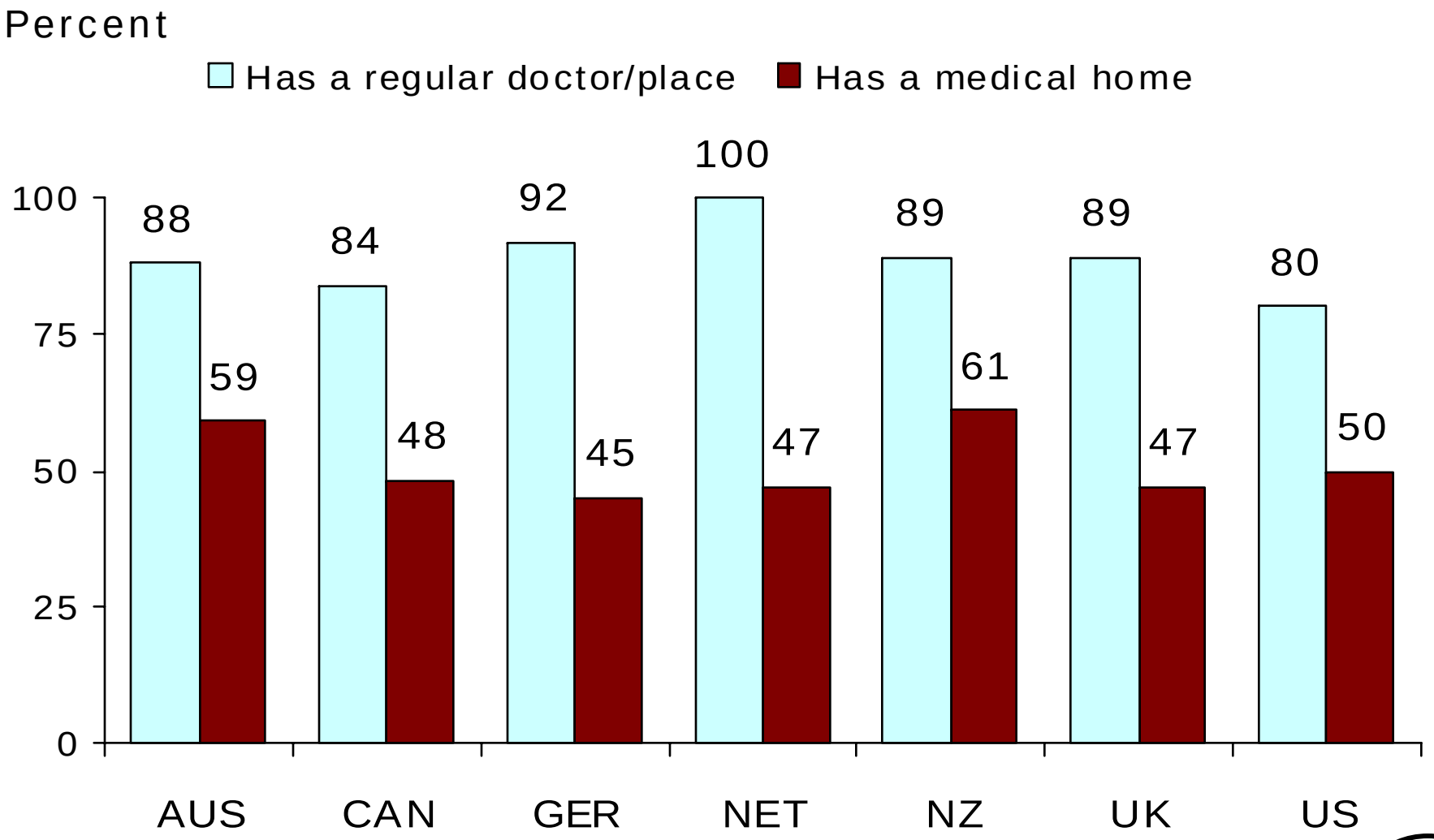
AVOIDABLE HOSPITAL USE AND COSTS

Medicare Reimbursement and 30-Day Readmissions by State, 2003



DATA: Medicare reimbursement – 2003 Dartmouth Atlas of Health Care; Medicare readmissions – 2003 Medicare SAF 5% Inpatient Data
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Adults with a "Medical Home"



Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care.
Data: 2007 Commonwealth Fund International Health Policy Survey
Source: C.Schoen et al., "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive, Oct. 31, 2007.

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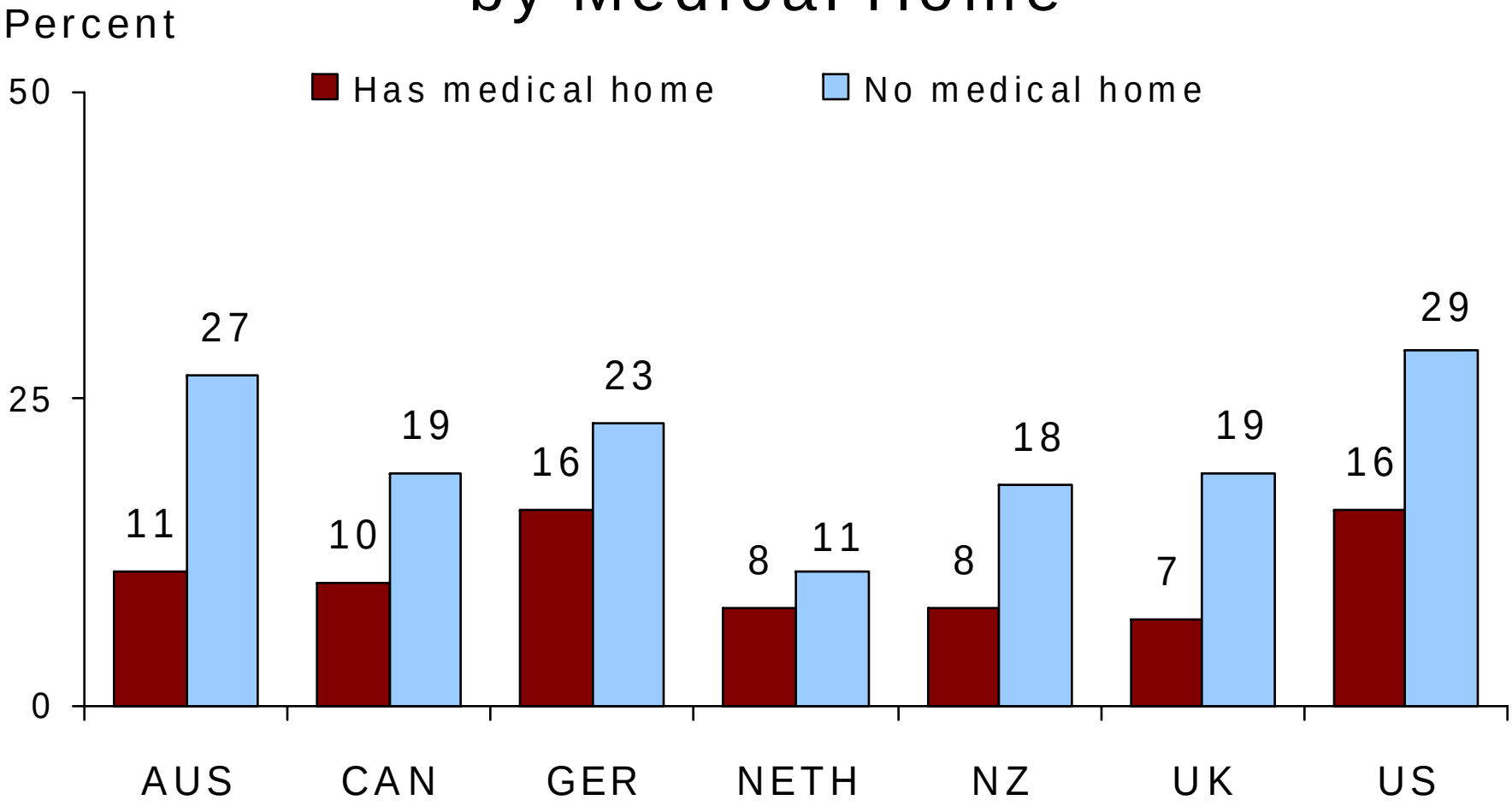
Coordination Problems: Medical Records Not Available During Visit or Duplicative Tests, by Medical Home



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Source: C.Schoen et al., "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive, Oct. 31, 2007.

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Adults With A Medical Home

- **Less likely to report:**
  - **Experiencing a medical error**
  - **Difficulty getting care after hours and weekends**
  - **Test results or records are unavailable at appointments**
  - **The doctor ordered unnecessary duplication of tests**
  - **Receiving conflicting information from different providers**
- **More likely to report that their regular doctor:**
  - **Explains things understandably**
  - **Spends enough time with them**
  - **Involves them in decisions**
  - **Helps them decide on specialists**
  - **Provides specialists with information about their conditions**
  - **Gives them a plan for self-management**
  - **Sends reminders for preventive or follow-up care**

Source: C.Schoen et al., "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive, Oct. 31, 2007.

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Developing Strategies to Achieve Saving and Improve Value

- **Focus on total health care expenditures – public and private (not just shift costs)**
- **Coherent federal, state, and private payer policies will maximize return (collaboration)**
- **Cumulative effects: savings accumulate over time**
  - **One-time savings and moderating trends both yield substantial gains over time**
- **Investing: some policy options may require investments for future yield**
- **Value criteria: Population health focus**
  - **Improve health outcomes, quality and access with more effective, safe, efficient care**

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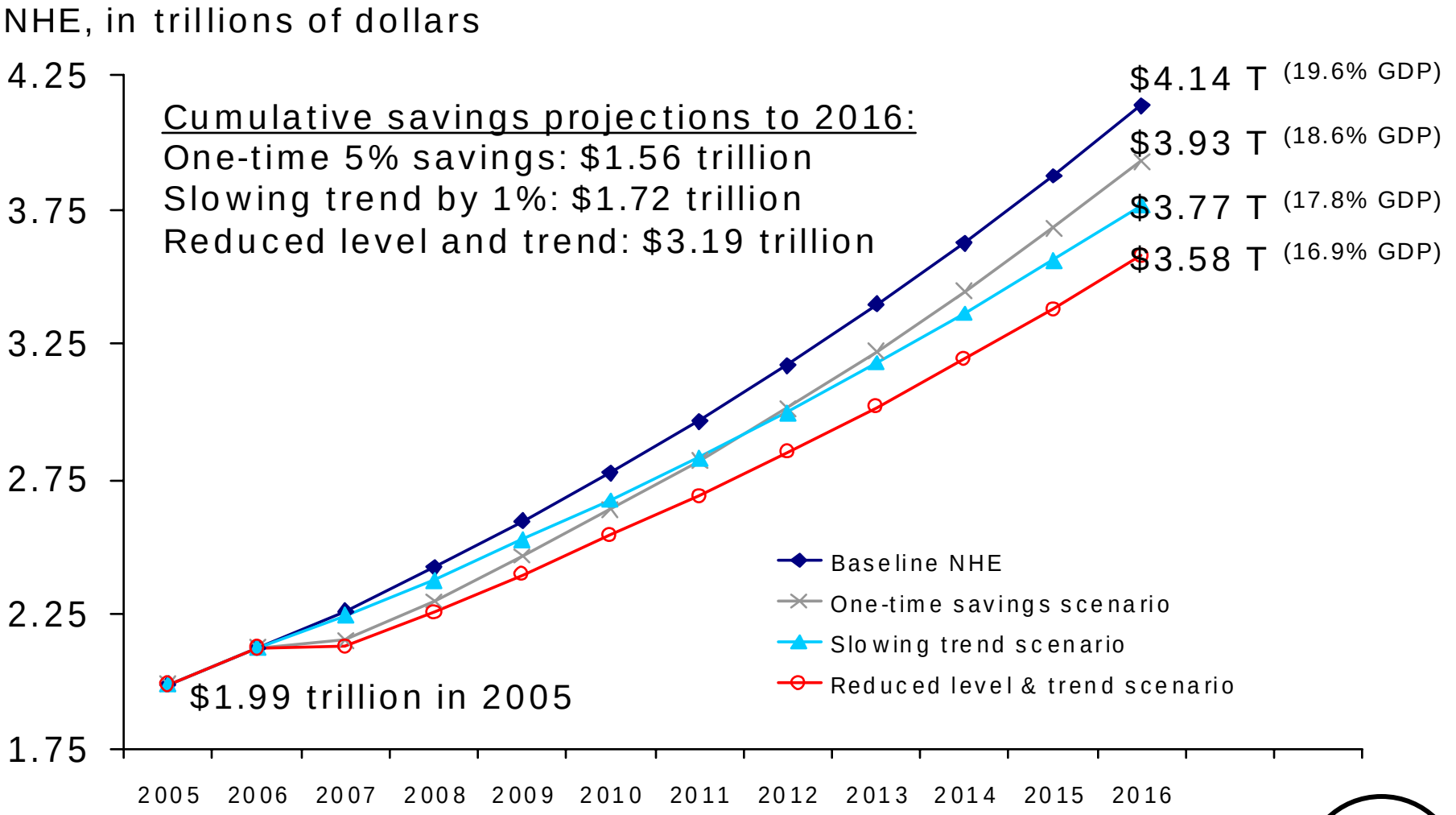
Growth in National Health Expenditures (NHE) Under Various Scenarios



Source: The Commonwealth Fund; Data from J. Poisal et al., "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact," *Health Affairs* Web Exclusive (Feb. 21, 2007): w242-w253.

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Achieving Savings Options Report

Commonwealth Fund Commission on A High Performance Health System

- **Strategic Approaches that Focus on Improved Value and Moderating Projected Cost Trends**
  - **Better information**
  - **Health promotion/disease prevention**
  - **Incentives aligned with health system quality and efficiency**
  - **Administrative costs and pricing**
  - **Universal health coverage**
- **Analysis of 20 options, including combinations of strategic approaches. To be released December 2007**

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Key Findings

- **It is possible to achieve savings *and* improve health system performance**
- **Federal Medicare payment changes by themselves can be effective – but changes involving all payers would be much more effective**
- **Individual options produce incremental savings – but sets or combinations can produce substantial savings**
- **Extending insurance to all is necessary but not sufficient; insurance design matters**
- **Savings accumulate: starting sooner rather than later makes a significant difference**

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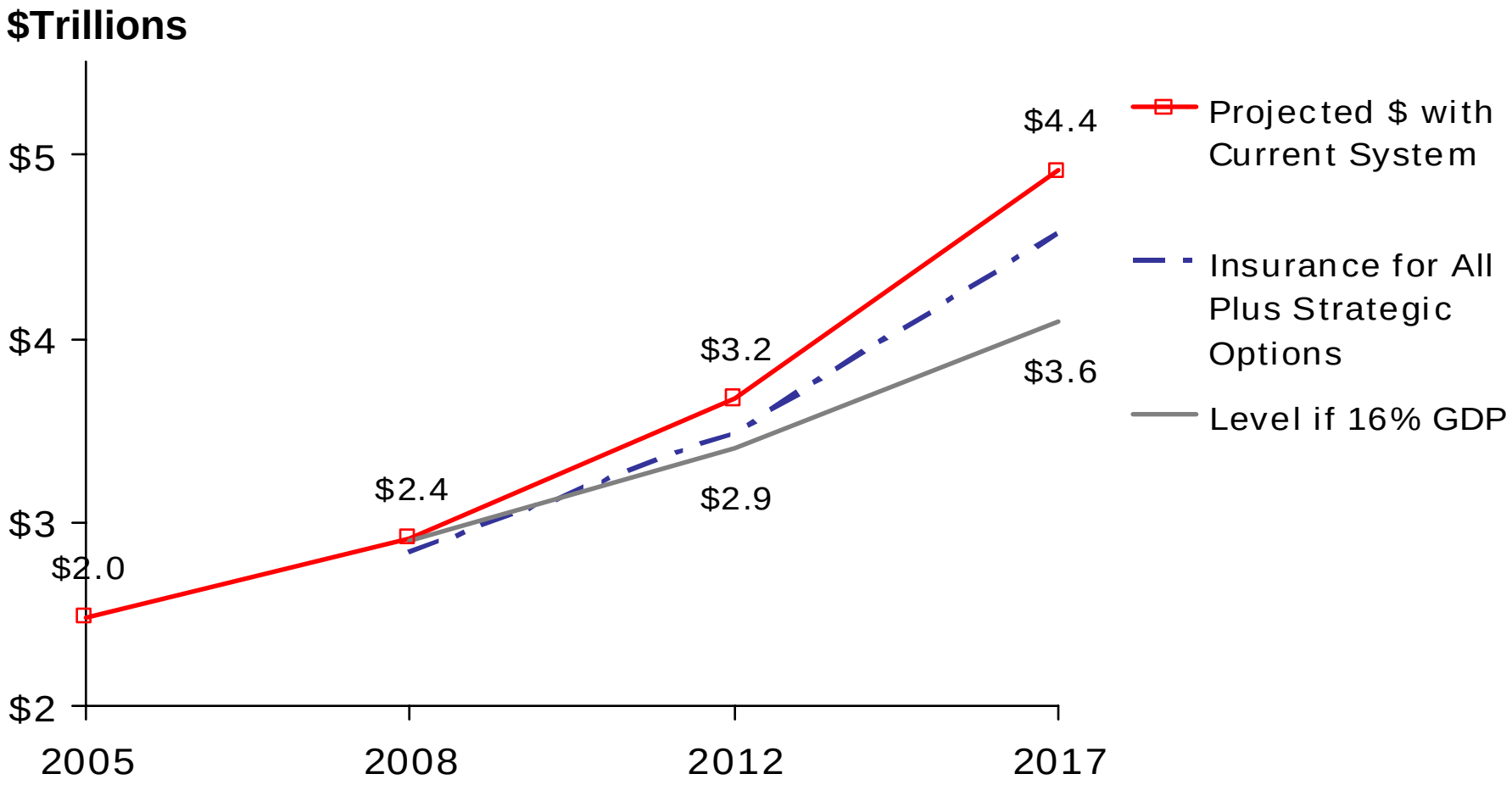
National Health Expenditures, 2008 - 2017 Projected and Various Scenarios



Source: Preliminary estimates, Commonwealth Fund forthcoming Achieving Savings Options report. Based on projected expenditures absent policy change and Lewin Group modeling estimates.

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Building Consensus to Move to A High Value Health System

- **Current directions absent policy change:**
  - **Costs expected to go to 20% of GDP and uninsured/under-insured to move up the economic ladder**
- **Essential to build consensus and to develop a coherent set of policies**
  - **To achieve net national savings, there may be a significant spending shifts across payers**
  - **Reductions in future costs will mean reduced expected revenue for some sector of the current health system**
  - **No "magic bullets"**
- **Aiming higher: Why not the best?**
  - **U.S. has the resources and technology**
  - **Strategic policies with focus on value and national gains could move the U.S. toward a higher value care system**

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Related Commonwealth Fund Reports

- ***Towards a High Value U.S. Health System: Strategic Options to Achieve Savings in National Health Expenditures with Improved Health Outcomes and Access for All*, The Commonwealth Fund Commission on a High Performance Health System, forthcoming December 2007.**
- ***A High Performance Health System for the United States: An Ambitious Agenda for the Next President*, The Commonwealth Fund Commission on a High Performance Health System, forthcoming November 2007.**
- **K. Davis, C. Schoen, S. Guterman et al., *Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?,* The Commonwealth Fund, January 2007.**
- **C. Schoen, R. Osborn, M. Doty et al., "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive, October 31, 2007.**
- **S. Collins et al., *Roadmap to Health Insurance for All: Principles for Reform*, The Commonwealth Fund, October 2007.**

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