



Flattening the Trajectory of Health Care Spending

Insights from RAND Health Research

KEY FINDINGS

- Growth of health care spending is at the core of our nation's long-term fiscal imbalance.
- RAND Health research provides insights into four broad strategies to restrain further spending growth without compromising health care quality: (1) foster efficient and accountable providers, (2) engage and empower consumers, (3) promote population health, and (4) facilitate high-value innovation.

The Policy Challenge

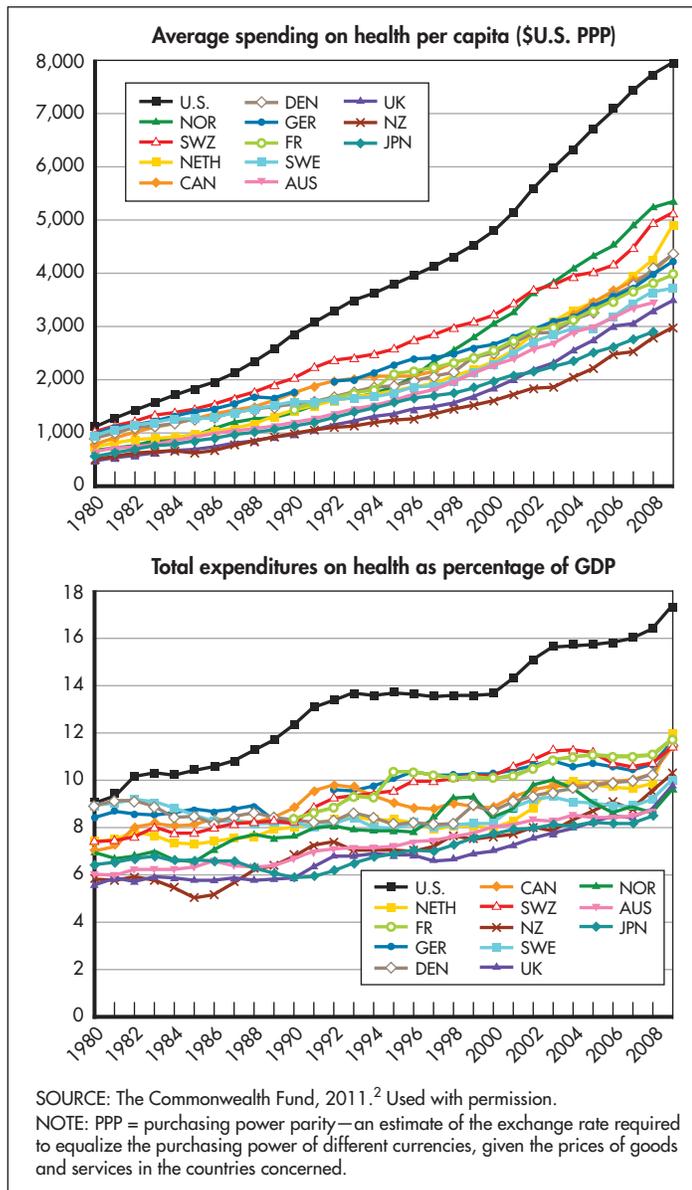
The second Obama administration and 113th Congress must address the relentless growth of health care spending, a major contributor to our nation's long-term fiscal imbalance. With the exception of two years in the mid-1990s, health care spending has outpaced gross domestic product by an average of 2.0 to 2.3 percent per year since 1950.¹ In 2009, a year that the U.S. economy was in recession, Americans spent nearly \$100 billion more on health care than they had the year before. Although the United States devotes a far larger share of its economy to health care than our global competitors, spending continues to grow. Other high-income nations are struggling with spending growth as well, but we stand out from the rest (Figure 1).

Growth of health spending is fueling the federal budget deficit,^{3,4} crowding out other priorities in state budgets,^{5,6} hindering the competitiveness of American businesses,⁷ restraining job growth,⁸ and jeopardizing the finances of American families. A 2011 RAND analysis determined that between 1999 and 2009, rising health care costs wiped out the income gains of a typical middle class family.⁹

The payoff for curbing health care spending will be worth the effort. Victor Fuchs, considered by many to be the father of health economics, was recently quoted as saying, "If we solve our health care spending, practically all of our fiscal problems go away."¹⁰ There is no lack of ideas for how to slow spending, but action is hindered by a lack of consensus.^{11, 12}

This series of research briefs presents insights from RAND Health research about the effectiveness of strategies to constrain growth in health care spending. A summary brief synthesizes findings from more-detailed discussions focusing on four broad categories of policy options: (1) foster efficient and accountable providers, (2) engage and empower consumers, (3) promote population health, and (4) facilitate high-value innovation.

Figure 1. International Comparison of Spending on Health, 1980–2009



In this summary brief and the supporting briefs that accompany it, we present findings from RAND research that address four broad strategies for constraining spending growth in our market-oriented health care system:

- Foster efficient and accountable providers.
- Engage and empower consumers.
- Promote population health.
- Facilitate high-value innovation.

Foster Efficient and Accountable Providers

Although consumers are the recipients of health care services, health care providers drive the bulk of spending through their purchasing decisions (e.g., tests, treatments, hospital admissions) and the fees they charge patients. Thus, the nation cannot hope to control cost growth without active provider participation.¹³ Unfortunately, fee-for-service (FFS) payment, the prevailing approach to reimbursement, gives providers a powerful economic incentive to do more and charge more.

There are a number of ways that motivated providers can deliver better care at lower cost:

1. Focus on value rather than volume. There is widespread agreement that payment policies must change to motivate providers to deliver value (broadly defined as health benefits per dollar spent) rather than volume (the number of examinations, tests, procedures, and treatments). In 2009, RAND quantified the likely effects of eight policy options for reducing spending growth that broadly apply to both the public and private health care sectors. The analysis generated high and low estimates of cumulative savings for 2010 through 2019 (see Figure 2).

Of the eight options examined, the most promising was to change how health care services are paid for. Based on optimistic assumptions, bundled payments, which are designed to encourage providers to coordinate care and practice more efficiently, could reduce national health spending by 5.4 percent over ten years.

The second most promising option, setting hospital prices for all public and private payers, was common in the 1970s and 1980s but was later abandoned. Under the most optimistic assumptions, RAND researchers predicted that it might reduce national health care spending by 2.0 percent. The other six options generated much smaller savings or none at all.

The appeal of shifting from FFS to alternate models of payment must be tempered by the practical challenges. RAND researchers have extensively studied two popular methods, pay for performance¹⁵ and bundled payments.^{16, 17, 18} Although both are appealing in theory, they are proving difficult to implement in practice. So far, evidence of their impact on spending growth is slim.^{19, 20}

Another approach to payment reform, prominently embedded in various sections of the Affordable Care Act (ACA), is formation of accountable care organizations (ACOs)—networks of health plans, hospitals, and physicians that are willing to work together to efficiently meet all of the health and long-term care needs of a defined group of patients. Because the ACA offers financial incentives to providers who embrace this concept, ACOs are proliferating across the country.²¹

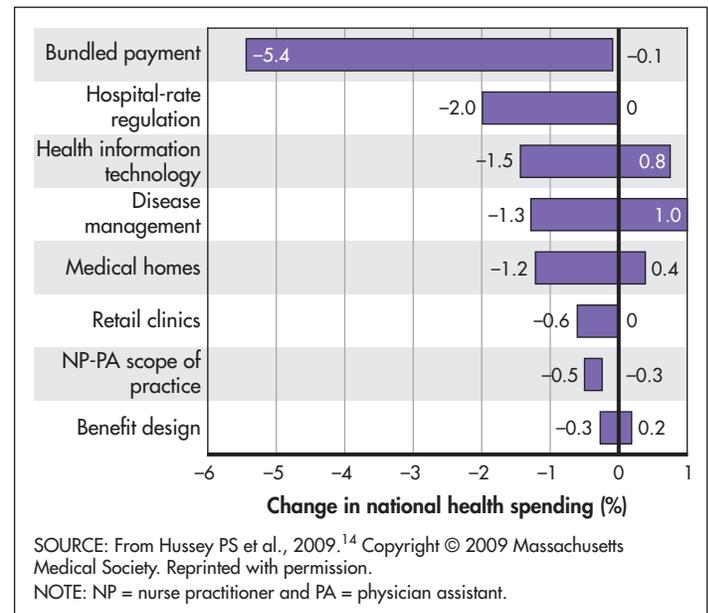
ACOs are so new health system administrators have limited knowledge of how to best structure them, and federal regulators and policymakers have little understanding of how ACOs will ultimately affect performance and costs. Hopefully, pilot efforts will build the required experience base. In California, for example, Blue Shield of California has given \$20 million in grants to 18 provider organizations to develop infrastructure and delivery systems to support ACO implementation.²² RAND Health is evaluating this effort.

2. Eliminate wasteful and inappropriate care. Irrespective of financial incentives, providers should strive to reduce wasteful and inappropriate care. Reducing waste is more than a matter of saving money; it's good medicine.^{23, 24, 25}

The challenge is that one person's idea of "waste" in health care is another person's revenue. The best prospects for success are likely to come through the leadership of medical specialty societies, which can bring their members together to identify ways to reduce waste without compromising care. The Choosing Wisely campaign, now endorsed by 31 specialty societies and more than a dozen consumer-oriented organizations, represents a promising start.²⁶

3. Identify and apply the best available evidence. A rigorously structured process that draws from comparative effectiveness reviews of the best evidence and employs a validated technique to harness expert opinion could generate guidance that physicians can use to determine which procedures are necessary, appropriate, equivocal, or inappropriate in various situations. The most widely accepted technique is the RAND/UCLA Appropriateness Method (see sidebar).^{27, 28}

Figure 2. Estimated Cumulative Percentage Changes in National Health Care Expenditures, 2010 Through 2019, Given Implementation of Possible Approaches to Spending Reform



The RAND/UCLA Appropriateness Method

The RAND/UCLA Appropriateness Method uses a structured process for integrating findings from the scientific literature with clinical judgment to produce explicit criteria for determining the appropriateness of specific procedures.

Ranking of Procedure	Definition
Necessary	Produces substantially more health benefit than harm and is preferred over other available options
Appropriate	Produces more good than harm by a sufficiently wide margin to justify the use of the procedure
Equivocal	Potential health benefits and harms are about equal.
Inappropriate	Health risks are likely to exceed health benefits.

SOURCE: Fitch K et al., 2001.²⁹

When the appropriateness method was first employed 20 years ago, it found that a substantial percentage of the procedures that patients received were not needed.³⁰ Using updated evidence, specialty societies could use the method to reduce waste and improve care.

4. Enhance patient safety. Medical errors cause needless complications, injuries, readmissions, and deaths.³¹ They also increase providers' liability. A RAND study found that reducing the number of preventable patient injuries in California hospitals from 2001 to 2005 was associated with a drop in malpractice claims against physicians.³²

Measures to enhance patient safety and improve quality must be tailored to specific patients and settings. To improve the care delivered to senior citizens, RAND developed the Assessing Care of Vulnerable Elders (ACOVE) indicators.³³ ACOVE has been successfully applied to dementia, end-of-life care, urinary incontinence, and falls. To improve care delivered in hospitals, RAND researchers produced a toolkit to help hospitals strengthen their quality improvement capabilities.³⁴ The toolkit is available on the website of the Agency for Healthcare Research and Quality.³⁵

5. Strengthen primary care. Demand for primary care is growing, but the number of medical school graduates opting for careers in primary care is dropping, in large part because primary care physicians are paid substantially less than specialists.³⁶ Narrowing this differential could attract more medical students into primary care. Currently, Medicare does not pay for care coordination and maintaining stable patient-doctor relationships, although both are valued within HMOs and ACOs. Strengthening primary care could help reorient our health care system from episodic treatment to keeping patients out of the hospital, thereby lowering costs and improving care.³⁷

As useful as these efforts may be, they are unlikely to fully close the primary care gap. In the meantime, the market is responding by creating alternate delivery models to meet specific types of demand, such as acute illness care.³⁸ RAND has extensively studied one such innovation, nurse practitioner-staffed retail clinics, and found that the treatment they provide is of comparable quality and significantly lower cost than treatment of the same condition in an emergency department or doctor's office.³⁹ As time goes on, it is likely that a growing share of primary care services will be provided by nonphysicians, either working independently (e.g., nurse practitioners) or as an extension of a primary care practice. A RAND-led assess-

ment in Massachusetts after the state implemented comprehensive health care reform determined that providers responded to growing demand by hiring more clerical and other support personnel to extend the work of health care professionals, rather than adding more professional-level staff.⁴⁰

Engage and Empower Consumers

In most sectors of the economy, competition drives efforts to enhance quality and tends to keep prices low. But health care does not behave like a normal market.^{41, 42} One of the biggest reasons is that consumers currently play a limited role.

Because health insurance shields many consumers from the financial consequences of their health care decisions, they are less concerned about the cost of care. One study found that in two-thirds of cases, patients were not aware of treatment cost until they received the bill.⁴³

Because consumers are unable to judge the relative merits of different treatment options, they typically defer health care purchasing decisions to their providers.

Five percent of Americans—those with the most serious health problems—drive nearly half of health care spending.⁴⁴ Many in this group are too ill or too overwhelmed by the complexity of our delivery system to shop around for a better deal.

The 70–90 million Americans who are uninsured or underinsured have little to bargain with. In fact, the uninsured are often charged higher prices than everyone else because they do not have an insurance plan to bargain on their behalf.⁴⁵

To level the playing field, two things must happen: First, to be motivated to be more conscious about costs, patients need to have a financial interest in the outcome—“skin in the game.”⁴⁶ The RAND Health Insurance Experiment, completed 30 years ago, demonstrated that when health care is free, more is used, whether it benefits the patient or not. Cost-sharing reduced use, but patients tended to reduce use of appropriate as well as inappropriate services. Therefore, the size and structure of co-payments must be carefully designed to encourage prudent choices.⁴⁷ Value-based benefits, which reduce or even eliminate co-payments for high-value health services and certain chronic disease medications but impose higher cost-sharing on costly services of marginal value, may work better than a one-size-fits-all approach.⁴⁸

To effectively function in a marketplace, consumers not only need to be *engaged*; they need to be *informed*. Today,

many consumers cannot easily access the information they need to make important decisions about care, such as picking a health care provider.⁴⁹ Public cost and quality reports, such as the Five-Star Quality Ratings for Medicare Advantage programs,⁵⁰ are intended to meet this need. In order to have their desired effect, the information they convey must be valid,⁵¹ easy to read,⁵² and presented in a way that is meaningful to consumers.⁵³

Promote Population Health

In 2000, an Institute of Medicine committee noted that the majority of premature deaths in the United States were due to behavioral or environmental causes.^{54, 55} It concluded that initiatives to develop and implement effective interventions to reduce risk behaviors could improve the nation’s health and possibly help lower health care costs.⁵⁶

RAND Health has focused on two of the most important causes of preventable deaths and chronic diseases in the United States—obesity and smoking.^{57, 58} Researchers have studied how peers, coworkers, and environmental cues influence individual decisions to consume too many calories, take up smoking, and make other choices that increase an individual’s risk of developing a costly chronic disease. In many instances, these cues can be modified in subtle ways to discourage youth from starting to smoke and to encourage the general population to make healthier choices about diet and exercise.

Communities and workplaces can be valuable arenas for promoting health. To help communities reduce substance use among their youth, RAND and the University of South Carolina developed Getting To Outcomes™ (GTO),⁵⁹ a toolkit designed to help local organizations develop and strengthen programs. Although GTO was originally aimed at preventing drug and tobacco use, it has also been successfully used to target juvenile crime, teen pregnancy, delinquency, intimate partner violence, and sexual violence.⁶⁰

Employers are also taking action by implementing workplace wellness programs to reduce health care costs and decrease absenteeism. Evidence of the effectiveness of these programs is mixed, but interest in them is growing.⁶¹ Since employers are concerned about rising health care costs, it is likely that more programs of this sort will be offered in the coming years.

Facilitate High-Value Innovation

The United States has long been a world leader in the development and swift adoption of innovative technology, and health care is no exception. The challenge in health care, however, is that existing economic, regulatory, and legal incentives are aligned in a manner that promotes rapid adoption and diffusion of expensive technologies, irrespective of cost. In fact, because of the way health care is paid for today, developers have little reason to create health care technologies for the U.S. market that offer the prospect of providing effective care at substantially lower cost. Recently, a group of RAND researchers outlined challenges to value-enhancing innovation in health care delivery.⁶²

In the final brief in this series, we describe potential steps policymakers could take to realign existing incentives, including identifying changes to existing laws and regulations that could facilitate high-value innovation, enhancing the efficiency of federally sponsored research,^{63, 64, 65} more effectively harnessing the potential of health information technology,⁶⁶ and using states' experiences to assess innovative health policies.

Conclusion

Health care spending is outpacing our economy because providers are financially incentivized to do more, and face both loss of income and heightened legal liability if they do less. Many consumers assume, unwisely, that more care is always better than less. Public health is given short shrift, and innovators are rewarded for producing technologies that command high prices, rather than generate high value.

The strategies outlined in this brief and the accompanying documents are intended to alter the dynamics that drive spending growth. The shift from FFS reimbursement is intended to motivate providers to reduce waste and improve efficiency. Cost-sharing, combined with access to useful information about provider cost, quality, and performance, should encourage consumers to play a more active role in the health care marketplace. A renewed emphasis on population health could reduce the need for costly care. Incentivizing high-value innovation could spark the sort of creative thinking that spawned the modern computer industry and dramatically improved the efficiency of American manufacturing. Together, these strategies could transform our nation's increasingly costly health care system into a functional market and provide Americans with better care at lower cost.

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This research brief was written by Arthur L. Kellermann, Mary E. Vaiana, Peter S. Hussey, Ramya Chari, David Lowsky, and Andrew Mulcahy.
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