Health Care Spending and Spending Growth

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U.S. Health Care Spending in 2009

♦ U.S. spends *a lot* on health care

-- Almost $2.5 trillion

-- $8,086 per person

-- 17.6% of GDP

-- 56% by the private sector and 44% by government
Health Expenditures by Type of Sponsor

- Private Business: 21%
- Households: 27%
- Other Private Revenues: 16%
- Federal Government: 7%
- State and Local Government: 28%

Source: Center for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group

Note: Sum of pieces might not add to 100 because of rounding
Health Care Spending Across Sectors

Source: CMS, Office of Actuary, National Health Statistics Group and Commerce Dept., Bureau of Economic Analysis
Health Care Spending: 2008 → 2009

An unusual year of change

- Spending grew at the slowest rate in 50 years: 4.0% from 2008 – 2009; 4.7% previous year
- Share of spending relative to GDP grew at fastest rate measured: 16.7 → 17.7%
- Increased share reflects 1.7% in GDP (largest since 1938)
Dollars Spent on Health Care Over Time
Changing Composition of Federal Spending (% of Total Spending)
Projected Health Care Spending

National Health Expenditures (billions)

Year


$- $500.00 $1,000.00 $1,500.00 $2,000.00 $2,500.00 $3,000.00 $3,500.00 $4,000.00 $4,500.00 $5,000.00
Projected Health Care Spending as a Percent of GDP
Projected Distribution of Federal Spending in 2020

- Medicare: 22.0%
- Medicaid: 3.0%
- Social Security: 14.0%
- Defense: 14.0%
- Net Interest: 10.0%
- Other Spending: 21.0%
- Other Health Programs: 16.0%
Most People Know --

U.S. spends a lot compared to other countries

But, most don’t know --

Rate of growth in spending isn’t so different
Health Expenditures Per Capita U.S. $ 2007

Source: OECD Health Data 2009. Figures are adjusted to US$ using Purchasing Power Parities - see Annex 2.
Health Expenditure as a Share of GDP, OECD Countries, 2007

Source: OECD Health Data 2009.
The U.S. is Less of an Outlier in Growth Rates
Annual Average Increase, 1960 - 2002

Real % Per Year

Can Fra Ger Jap UK US

Avg = 4.9%

Annual Growth in Health Expenditure and GDP, 2000-2008

Contributors to Health Care Spending

♦ Income
♦ Population Growth
♦ Aging
♦ Medical Inflation
♦ Technology
Health Expenditure Per Capita and GDP Per Capita, OECD Countries, 2007

Source: OECD Health Data 2009
High Spending is *Not* Due to Aging

- No more than 10% of increase in any year is due to aging
- Many European countries and Japan aging faster than U.S.
  -- 16.7% of Europe pop > 65
  -- 21.5% of Japan pop > 65
  versus
  -- 12.6% of U.S. pop > 65
Growth in Spending Reflects Pricing and Non-Pricing Factors

Source: Centers for Medicaid, Office of the Actuary National Health Statistic Group
Cited in Health Affairs, January 2011 30:1
Part of the Answer – How We Adopt/Disseminate New “Technology”

♦ Challenging for all countries

♦ Particularly a challenge for U.S.
  -- Few direct controls on spending
  -- Limited controls on new technology distribution
  -- Few controls on specialty choices
Many “Perverse” Incentives in U.S.

♦ Tax treatment for employer-sponsored insurance

♦ Pervasive use of 3rd-party payment w/o direct controls on spending, utilization, technology

♦ Extensive use of fee-for-service reimbursement

♦ Liability concerns for physicians and hospitals
Private Sectors Efforts to Slow Spending

- Generating/sharing information on clinical effectiveness
- Using data to focus on variations on quality and cost
- Using new payment models to reward value rather than volume
- Encouraging healthier life-styles with behavioral “nudges”
Using new payment models to pay for value not volume

Case study from a large national private payer, showing savings opportunity between ‘Quality & Efficiency’-designated physicians versus others

Incremental Medical Cost Savings

Local Area Average

-15%  -10%  -5%  0%  5%  10%

Q&E Only -5%

Q&E and PR -11%

Non Q&E 9%

20% medical cost savings versus baseline are typically seen

Q&E = ‘Quality & Efficiency’ Designation using objective evidence-based standards
PR = ‘Practice Rewards’ additional payment incentive for performance
Using Consumer Incentives and Behavioral ‘Nudges’ to Influence Healthy Lifestyles (1)

Case study of incentives for smoking cessation

- 878 people from 85 worksites across US
- Randomized Controlled Trial
- Information about smoking cessation programs vs. information plus incentives
  - $100 for completion of program,
  - $250 for cessation within 6 months
  - $400 for 12 month cessation
  - Incentives discontinued after 12 months

**Quit rates still nearly triple after 18 months**

Many Challenges

-- Which reimbursement changes will “work”
that is: $\uparrow$ Quality/ $\downarrow$ cost

-- How to best measure “efficiency” in health care and how to encourage its production

-- How to encourage healthier lifestyles

-- Right trade-offs between market concentration and market power