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GLOBAL CHALLENGES IN HEALTH CARE POLICY AND PRACTICE

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Forces Which Shape Health Policy (1)

Major Demographic Trends:

- Birth-rate and a “sustainable population”
- Rate of 2.1 required to sustain a population
  - United State = 2.1
  - Germany = 1.6
  - Russia = .78
  - France = 1.4

Forces Which Shape Health Policy (2)

Major Demographic Trends (con’t):

- Implications–the so-called “double demographic crisis”
- Average life expectancy in 30 compatible countries–74.1 for males; 80.7 for females
- Germany–74.7 Males; 70.7 Females
- United States–74.1 Males; 79.5 Females

Forces Which Shape Health Policy (3)

Infant Mortality Rates
Deaths Per 1,000 Births

	1960	2000	% Change
U.S.	26	6.9	-73.5
Germany	35	4.4	-87.4
Sweden	16.6	3.4	-79.5
U.K.	22.5	5.6	-75.1
Italy	43.9	4.5	-89.7
Japan	30.7	3.2	-89.6

What Are The Major Global Health Policy Challenges?

- Cost-Containment and Affordability
- Access–for whom and under what conditions
- Quality of Care
- Epidemics (e.g., bird flu, and AIDS)
- Children’s Health Care
- Public Health Education

Rising Health Care Costs in the U.S.

- The U.S. spends about 15% of GDP on Health Care (roughly $1.7 Trillion)
- Annual health care cost increases from 2001-2005 have been around 10% (as much as 15% for things such as prescription drugs and outpatient care)
- The price of employer-sponsored health insurance is rising 10-15% in 2005
- This has led to an increase in people without any health insurance (currently about 45 million)

The Cost Problem Elsewhere

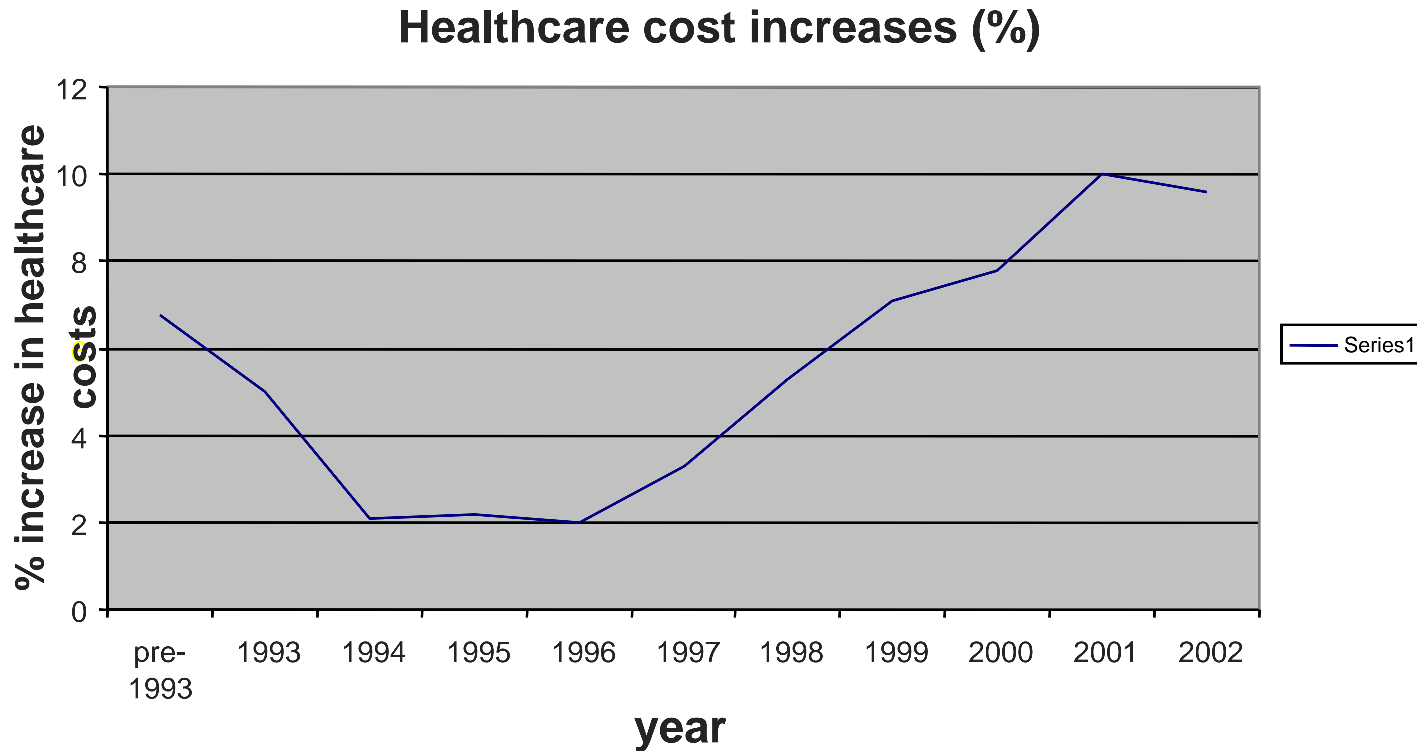
	Total Health Spending Per Capita (1999)	% GDP on Health (1999)	Annual Growth in per capita health spending (90-99)
France	$2,115	9.3	2.1
Germany	$2,361	10.3	1.8
Australia	$2,085	8.6	3.7
UK	$1,569	6.9	3.3
Belgium	$2,181	8.8	3.5
Switzerland	$2,853	10.4	2.7
Netherlands	$2,259	8.7	2.4
U.S.	$4,385	12.9	3.0
OECD median	$1,764	7.9	3.0

Source: Reinhardt, Hussey, Anderson, (2002). *Cross-National Comparisons of Health Systems Using OECD Data*, 1999. Health Affairs, 21(3); 169-181.

More Health Care Cost Trends

- Total health care spending decreased sharply in the early 1990s (93-96), due largely to the effects of Managed Care (see chart, next slide).
- After 1997, however, annual increases returned to pre-managed care levels.
- This was due in part to restrictive legislation, but also to managed care having exhausted its price-discounting capabilities, and the continued introduction of new technology and drugs.
- Annual cost increases peaked in 2001 at over 10%, followed by a period of moderate decline.

U.S. Cost Trends: 1993-2002

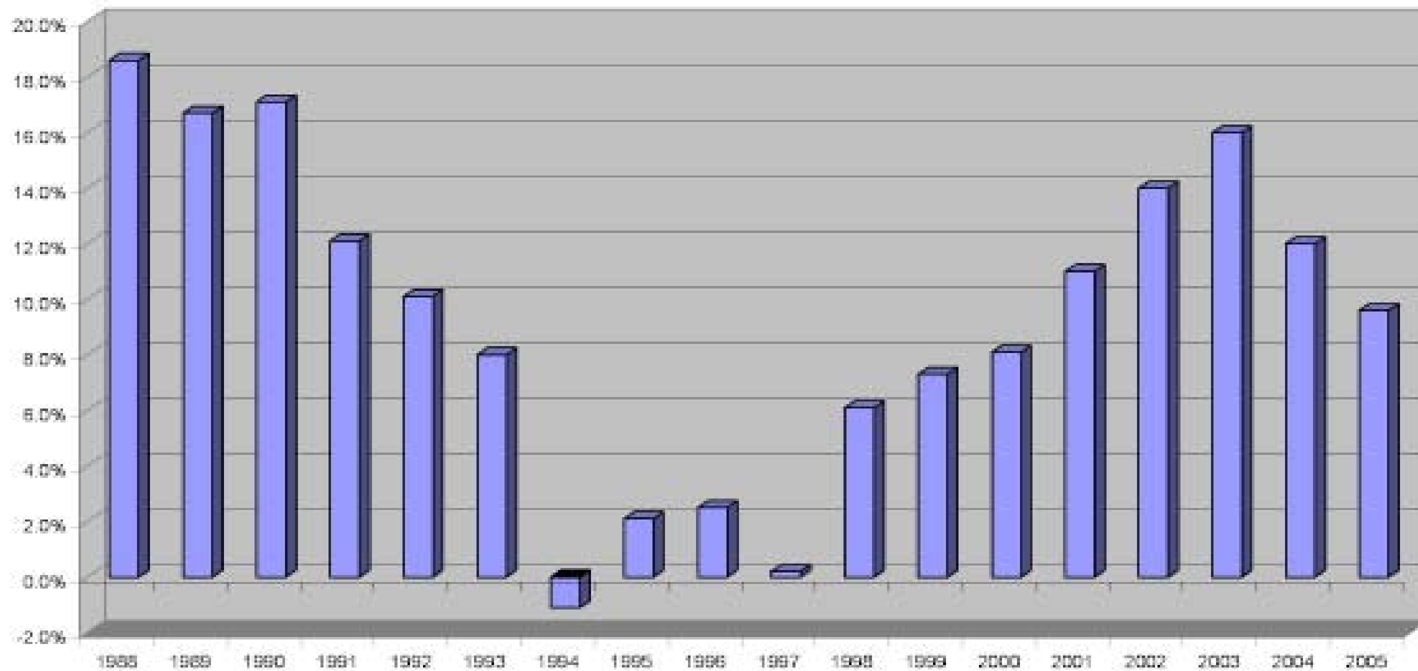


Source: Rich & Erb, (2005). *The Two Faces of Managed Care Regulation and Policymaking*. Stanford Law and Policy Review, 16(1); 233-276.

More Recent Cost Trends: 2003-2005

- The rate of growth in total health care spending (for privately insured) decreased slightly in 2003, to 8.4%.
- In 2004 the rate of growth remained virtually unchanged at 8.2%.
- Hospital cost increases were highest at 10.1%; Prescription drugs at 7.2%; and Physician services at 6.4%.
- The cost of private insurance Premiums increased by 13.9% in 2003, and predictions are for premiums to rise another 10-15% in 2005.

Trends in U.S. Private Health Insurance Premiums 1988-2005



Source: Managed Care National Statistics, 2005. *Premium Increase Trends*. http://www.mcareol.com/factshts/factnati.htm

Options for Cost Containment

- Managed Care
- Utilization Review
- Practice Guidelines
- Incentives for quality / outcomes
- Global Budgeting and Capitation
- DRGs
- Patient Cost-sharing

The Impact of the Implementation of Managed Care Theory

- MCOs are more efficient than traditional indemnity forms – even now, with overall costs increasing, MCOs are less expensive than Fee-for-service plans: 11% vs. 14.5% increase in 2005.
- Evidence shows that they DID control health care costs (in terms of total spending) from 1993 – 1997 (see chart).
- This led to cut backs in hospital inpatient care: 25-30% fewer admissions; 10-20% shorter stays; 20-30% fewer hospital days.
- And more outpatient care comparatively: while costs for inpatient hospital care increased by an average of 8% per year between 2001-03, costs for outpatient care increased by an average of over 12%.
- With MCOs there has been a significant decrease in the use of more costly tests and procedures: 22% fewer expensive tests; more use of less costly alternatives.
- Evidence does not suggest that managed care has reduced the quality of care delivered.

Utilization Review

- Two Types: Prospective and Retrospective – give partial control over medical decision making to MCOs.
  - Prospective UR: Requests for procedures must be pre-approved by a utilization manager.
  - Retrospective UR: Payment for procedures already conducted is contingent on approval by a utilization manager.
  - These strategies stem from the idea that the managed care benefit package is a contract to provide a particular set of services – if the procedure or treatment isn't in the contract, it isn't covered, regardless of the doctor's recommendation.
  - Utilization review has been shown to reduce the cost of hospital care by 11.9% and total medical expenditures by 8.3% -- for patients with high admission rates, hospital expenditures may be reduced by 30%.
  - Newer forms of MCOs are moving away from strict UR, especially the "medical necessity" reviews, and are being replaced with practice guidelines.

Global Budgeting and Capitation

- Capitation – fixed monthly or annual payment per patient: encourages substitution of lower-cost, clinically equivalent alternative therapies on an individual patients basis.
- Global budgeting – fixed payment for a group of patients: encourages efficient overall resource allocation for a covered population of patients.
- Both create a possible incentive for under-utilization, and "blended" payment systems (partial capitation with additional FFS payments) are being developed that balance incentives for too much or too little care.

DRGs

- Diagnosis Related Groups were introduced in the U.S. Medicare program in 1983 as a way of reimbursing hospitals for the average cost of treating a particular medical condition – for episodes that cost less, the hospital could keep the extra payment; when treatment cost more, the hospital covered the extra charges. This provided the incentive for hospitals to efficiently manage the care of each patient.
- In a 1990 study of psychiatric care in the U.S. VA system, DRGs accounted for a 36% decline in length of stay, 29% decline in annual per patient bed use, 8.9% reduction in per diem expenditures, and a 33% decline in cost per episode of care.
- DRGs reduced per patient expenditures in the Medicare program, but because they were not introduced elsewhere in the U.S. health care system, they did not affect overall health care expenditures, partly because of cost-shifting to private insurance.
- By 1992, 10 OECD Countries had introduced payment systems similar to DRGs. All of these countries had higher GDPs, percent of GDP spending dedicated to health, and generally healthier populations than their counterpart OECD countries that did not adopt DRG systems.

More New Ideas: Incentives for Quality / Outcomes

- Balancing cost-consciousness with quality-improvement, the U.S. and other nations have experimented with financial incentives for better care.
  - In the U.S., health plans have experimented with adding financial bonuses for providers who meet treatment benchmarks.
  - In the U.S., Risk-Adjusted Measures of Outcomes (RAMO) are currently used in some states to provide information to consumers about quality of care – these could also be used for outcome-based payment, but this is not yet occurring on a major scale.
  - In the U.K., experimentation with a point system that allocates points for various quality indicators achieved by a physician practice. Providers can earn up to $77,000 in additional payments annually for exemplary treatment records.
  - In Australia, a modified FFS has been developed to reward "best-practice" behavior by providers.

How “Managed Care-like” Strategies have worked Elsewhere

- Many OECD Nations have experimented with cost-containment strategies derived from, or similar to, Managed Care.
  - Coordination / Integration of Care
  - Withholding Schemes
  - Limiting Physician Supply
  - Global Budgets and Indexed Cost Caps
  - Drug Pricing schemes

Coordination / Integration of Care

- Taking a system-wide view, Australia has experimented with incentives to spend public healthcare dollars efficiently across jurisdictions – pooling all public health funds for a population. But, this requires a great deal of coordination and collaboration across agencies.

Withholding Schemes

- “Fundholding” or “budget holding”: groups of physicians assume financial risk for providing a broad array of services – has been used in the UK and New Zealand.
- Withholding arrangements with individual providers are being replaced by arrangements with groups of providers who share the risk.
- New “Blended Payment” methods are also being used that pair capitation or salary payments with additional FFS payments for excess services provided.

Limiting Physician Supply

- In the early 1990s Canada reduced medical school admissions by 11.3%, hoping to stem a perceived over-supply of physicians.
- By 1996, there was general consensus that there was an under-supply of physicians, causing increased waiting times, and medical school admissions were increased by 22.4% until 2002.

Private – Public Arrangements

- Australia has enjoyed some success with contracting public care to private hospitals, with case-mix funding to balance the risk of high-cost patients.
- Canada contracts with private hospitals, and has begun to introduce budgeting schemes originally developed in the public sector, such as global budgets and price schedules.

Drug Prices

- Australia has used a combination of patient cost-sharing, incentives for generic drugs, and negotiating prices with suppliers. This has helped Australia keep drug prices to 50-60% of world drug prices.
- Cost-effectiveness criteria are being applied in Australia in listing and pricing of drugs and controlling their use – this helps ensure that money spent on drugs (even if more costly) is spent for more effective treatment and better outcomes.
- Reference Pricing: full coverage for the price of low-cost, benchmark drugs in therapeutic clusters that are clinical equivalent substitutes. Germany, Netherlands, Sweden, Denmark, Belgium, Australia, New Zealand and others have used this strategy. Evidence from Germany shows that drug prices in the reference group decreased 30% from 1983-1991, while prices for drugs in the non-referent group increased by 25%.

The Future of Cost Containment

- System-wide approaches will be necessary to avoid "cost-shifting" rather than cost containment.
- Multiple approaches will be necessary; individual cost saving schemes will not be enough.
- Options that preserve consumers' choices should be pursued.
- A balanced, coordinated public / private approach may be necessary.

Conclusions