Controlling Health Care Costs through Public Transparent Processes: The Conflict between the Morally Right and the Socially Feasible

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Patient Protection and Affordable Care Act (PPACA)

- Major impact on access to health care
  - By 2019, 94 percent of Americans will be covered (up from 83 percent now)
    - Legal residents under the age of 65
- Little impact on health care cost inflation
  - Costs will rise 6.7% a year between 2015 and 2019 instead of 6.8% a year
- Same combination of impact on access and costs with Medicare, MA reform

Cost containment

- If PPACA neglected cost containment, how can we address the problem in the future?
  - Scholars regularly—and rightly—propose public, transparent processes for deciding limits on coverage
  - But Americans cannot make explicit choices when life-and-death decisions are at stake
    - Either public transparent processes never make the difficult choices, the difficult choices that are made unravel, or the processes are discarded

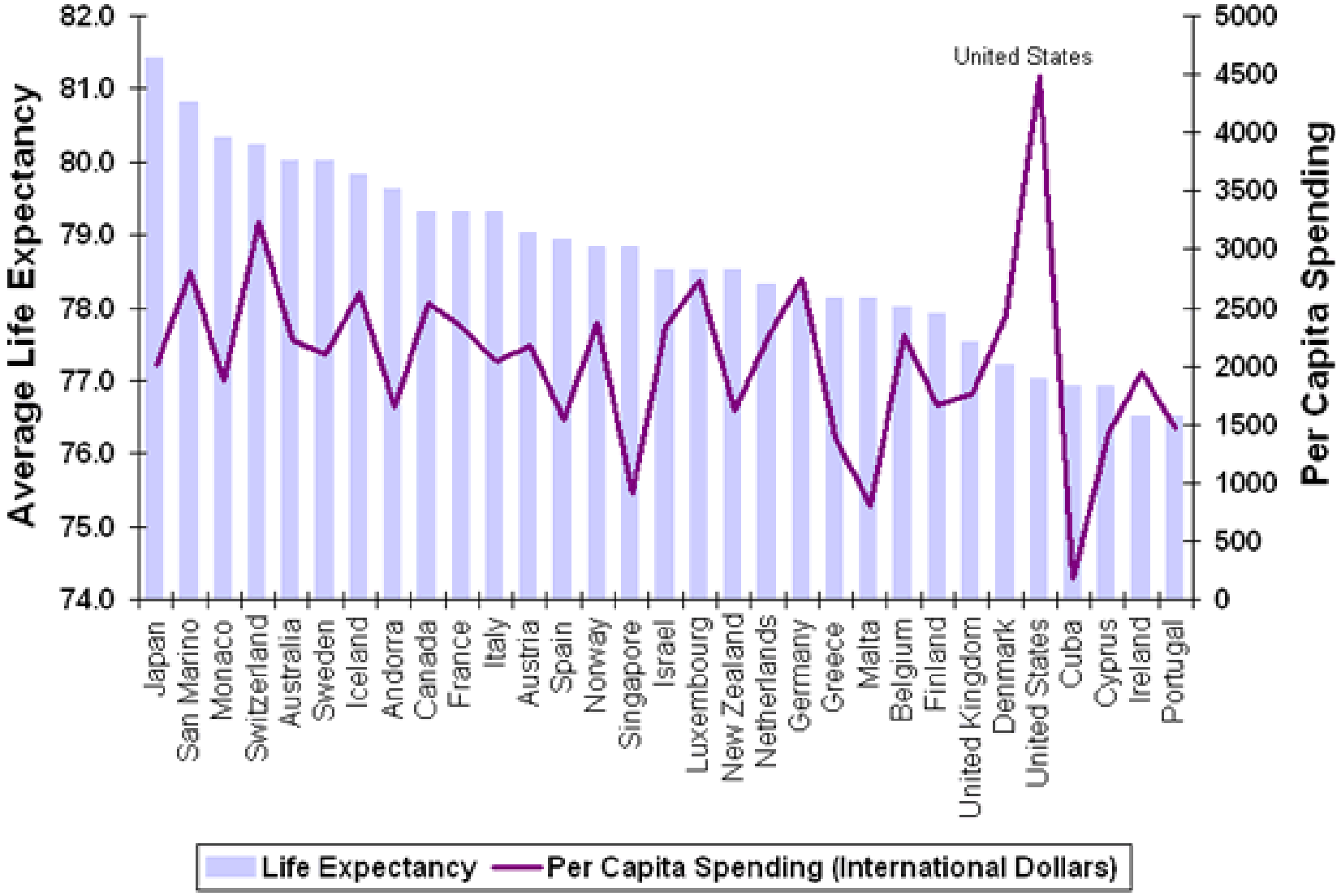
The highest spending country

- **Health care spending in economically-advanced democracies**

US	$7,290/capita	16% of GDP
Switzerland	61% of US	67% of US
Canada	53% of US	63% of US
Germany	49% of US	65% of US
Japan	35% of US	51% of US
New Zealand	34% of US	57% of US

  - OECD Health Data 2009 (2007 data except 2006 for Japan)

The Cost of a Long Life



Inadequate return on our health care $

- US health system is less efficient than systems in:
  - Spain, France, Germany, Austria, Italy
  - UK, Denmark, Norway
  - Japan, China, Australia
  - Canada, Mexico, Colombia, Venezuela
    - Evans, et al., 323 BMJ 307 (2001)
- US patients treated in higher-cost communities have similar outcomes to US patients in lower-cost communities

Higher prices in US

- Costs are higher in US in large part because prices for health care services are higher
  - Governmental buyers of health care in single-payer systems can bargain more effectively than can US insurance companies with doctors, hospitals and pharmaceutical companies
  - Hospital mergers have led to greater negotiating leverage for sellers of health care
    - Peterson & Burton, Congressional Research Service (2007)

Physician incentives to over-provide care

- **Fee-for-service reimbursement => quality-insensitive physicians and hospitals**
  - **When physicians and hospitals are paid more to do more, regardless of outcome, they'll do more**
    - **Especially when they lose money on higher quality care (Urbina, NY Times, Jan. 11, 2006)**
  - **Example of clinic that switched from salary to commission on fees generated; doctors scheduled more appointments and ordered more blood tests and x-rays**
    - **Hemenway, 322 NEJM 1059 (1990)**

PPACA and cost control

- Many different provisions designed to contain costs
- Largest savings through reductions in Medicare reimbursement
- Serious question whether all of the provisions really address the cost problem
  - PPACA doesn't take on the major drivers of higher costs other than to some extent through demonstration projects or pilot programs

Next steps for cost control

- I'll discuss a strategy common to a wide range of proposals for reform
  - The creation of an independent commission that will decide how to ration our limited health care dollars through a public, transparent process
    - Apply general guidelines to specific choices
      - Should persons with dementia be given heart valve replacements?
      - How long should one's life expectancy be for a liver transplant?

Public, transparent processes

- Ruger's shared health governance paradigm
- Fleck's informed democratic consensus model
- Daschle's Federal Health Board
- PPACA's Patient-Centered Outcomes Research Institute
  - Proposals differ in terms of who has responsibility for deciding
  - All provide for a public, transparent process

Public, transparent processes

- But public, transparent processes for life-and-death decisions provoke intolerable social conflict
  - Calabresi and Bobbitt, *Tragic Choices*
- Inevitably, some important social values will be sacrificed
  - If we favor patients who will receive greatest benefit, we disfavor patients with the greatest need
- We therefore try to disguise rationing choices

Public, transparent processes

- Failed public, transparent processes
  - Allocation of kidney dialysis
  - Oregon Health Plan
  - Certificate-of-need legislation
  - Managed care
  - Breast cancer screening guidelines revision in 2009
  - Bone marrow transplants for breast cancer
  - UK's National Institute of Health and Clinical Excellence (NICE)
- What about Health Technology Assessment in WA?

Using non-transparent processes

- Protect against pitfalls of non-transparency
  - Arbitrary and biased decision making
- Reform the economic incentives that drive doctors and other providers to provide too much care
  - Pay physicians salary or capitation (with quality-based bonuses)
  - Minimize outside sources of income that encourage more care
  - Reduces the need to ration and provides a non-transparent process for rationing

Using non-transparent processes

- Too little care from salary and capitation?
  - Monitoring of physician practices
  - Bonuses for higher quality care
  - Malpractice liability
- Managed care experience reassuring

OECD

- Organisation for Economic Co-operation and Development (www.oecd.org). The 33 member countries include:
  - U.S., Canada, Mexico, Chile
  - Denmark, Norway, Sweden, Finland
  - U.K., France, Germany, Netherlands, Switzerland
  - Portugal, Spain, Italy, Greece, Turkey, Israel
  - Hungary, Czech Republic, Slovak Republic, Slovenia, Poland
  - Japan, Korea
  - Australia, New Zealand