



Why is U.S. healthcare spending so high?

What we can and can't learn from international comparisons

Ashish K. Jha, MD, MPH

January 10, 2019

 @ashishkjha



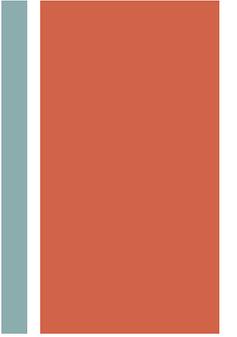
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+ Agenda

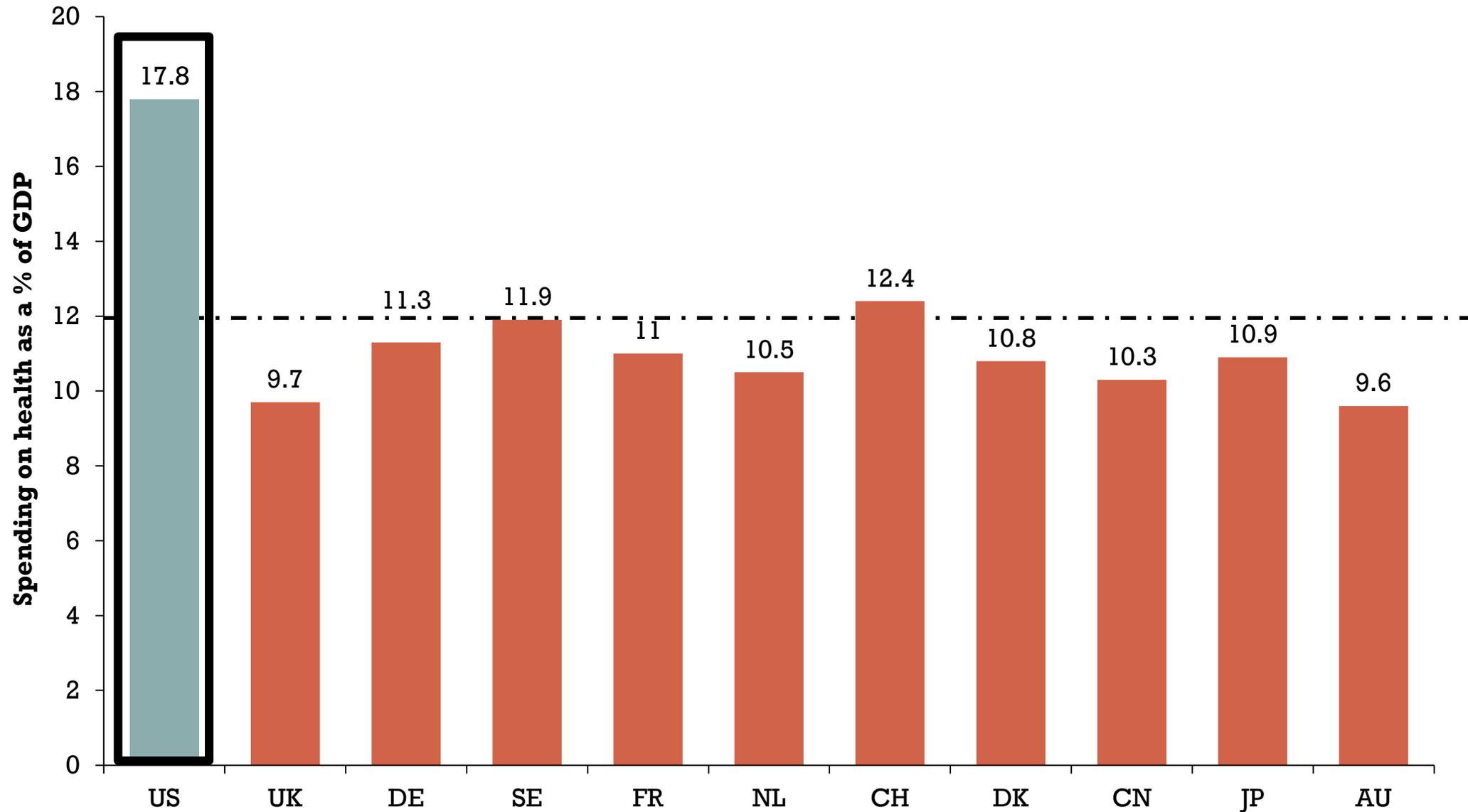
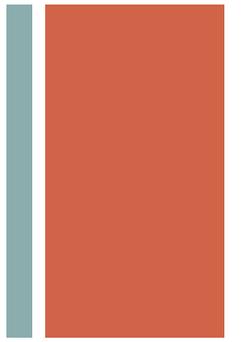


- We spend a lot on healthcare
- Why do we spend so much more than others?
- Tradeoffs: what does our higher spending give us?
- What about quality and outcomes?
- How do we think about value in the international context?
- States as laboratories of innovation

+ US healthcare spending



+ Total healthcare spending, 2016



+ Why?

+ Why so much *more*?



Clinical Review & Education

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Health Care Spending in the United States and Other High-Income Countries

Irene Papanicolas, PhD; Liana R. Woskie, MSc; Ashish K. Jha, MD, MPH

IMPORTANCE Health care spending in the United States is a major concern and is higher than in other high-income countries, but there is little evidence that efforts to reform US health care delivery have had a meaningful influence on controlling health care spending and costs.

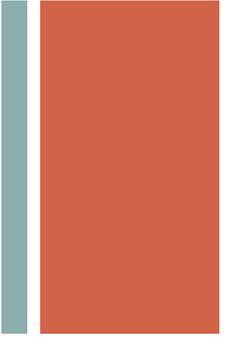
OBJECTIVE To compare potential drivers of spending, such as structural capacity and utilization, in the United States with those of 10 of the highest-income countries (United Kingdom, Canada, Germany, Australia, Japan, Sweden, France, the Netherlands, Switzerland,

- ← Viewpoint page 977 and Editorials pages 983, 986, 988, and 990
- + Animated Summary Video
- + Supplemental content and Audio
- + CME Quiz at

+ Comparing healthcare spending

■ Our approach:

- Compared US to 10 other very high income countries
- Data source: mostly OECD, some CMWF
- Data verified by national statistics offices and/or experts



+ Why so much *more*?



$$\text{Total Spending} = \text{Quantity} \times \text{Price}$$

+ Hypothesis #1

+ “Our culture of overuse”

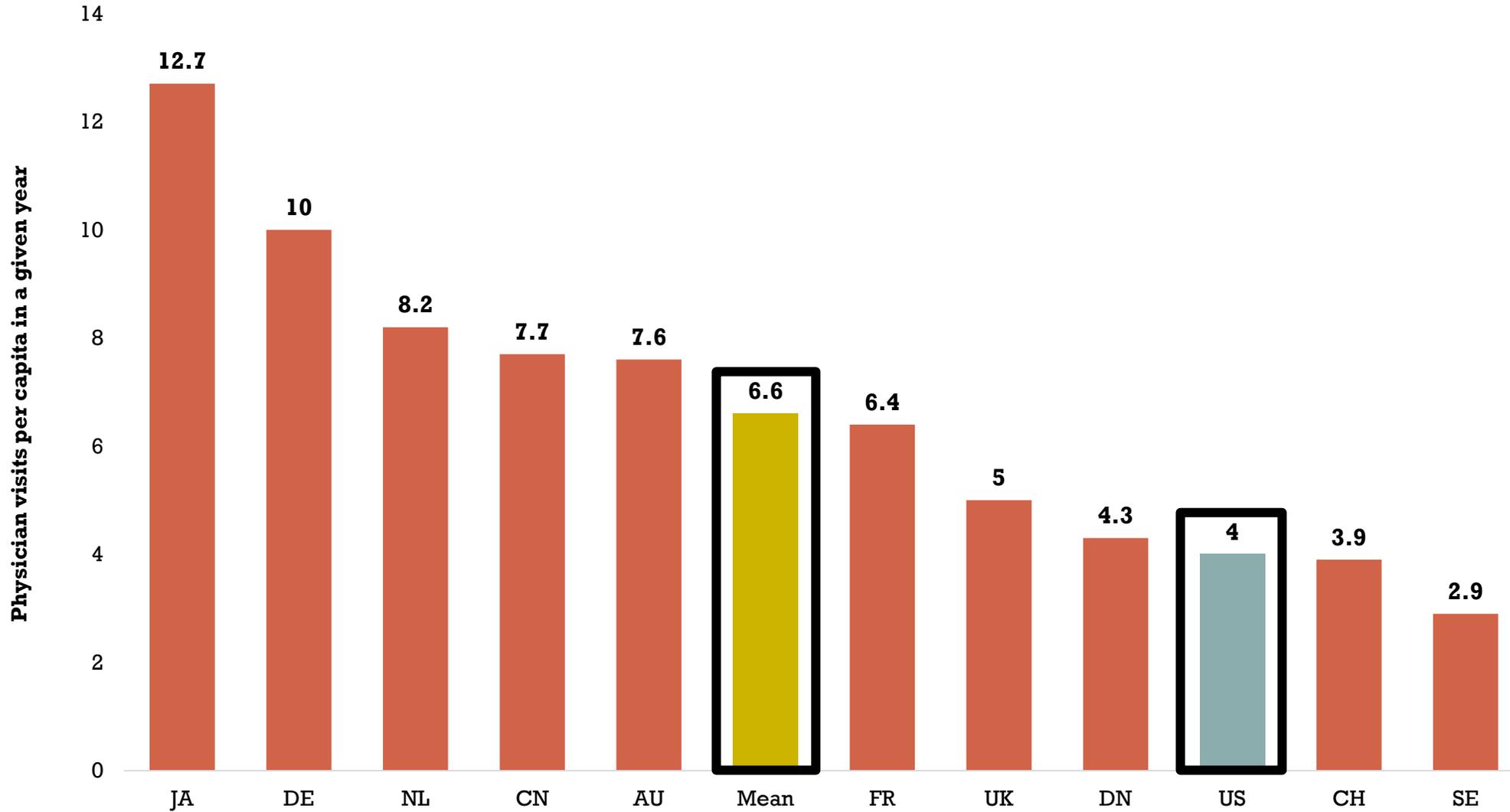


$$\text{Total Spending} = \text{Quantity} \times \text{Price}$$

+ Overutilization #1

“We are quick to go to the doctor”

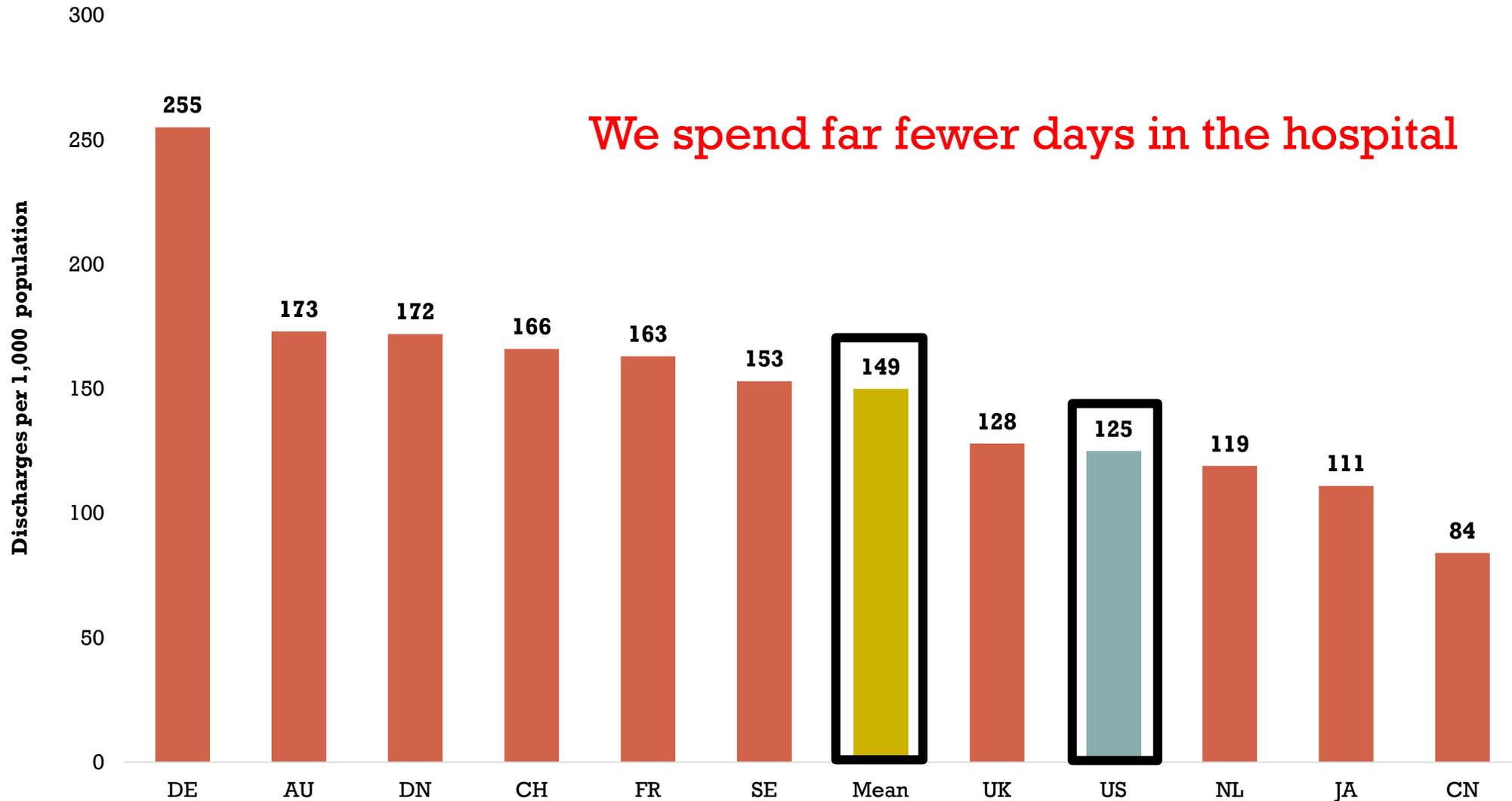
+ Doctor visits



+ Overutilization #2

Not enough prevention and primary care leads to too many hospitalizations

+ Hospital discharges

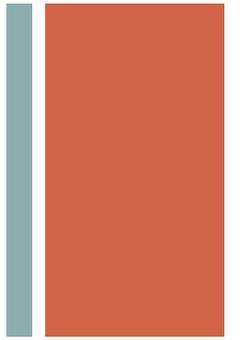
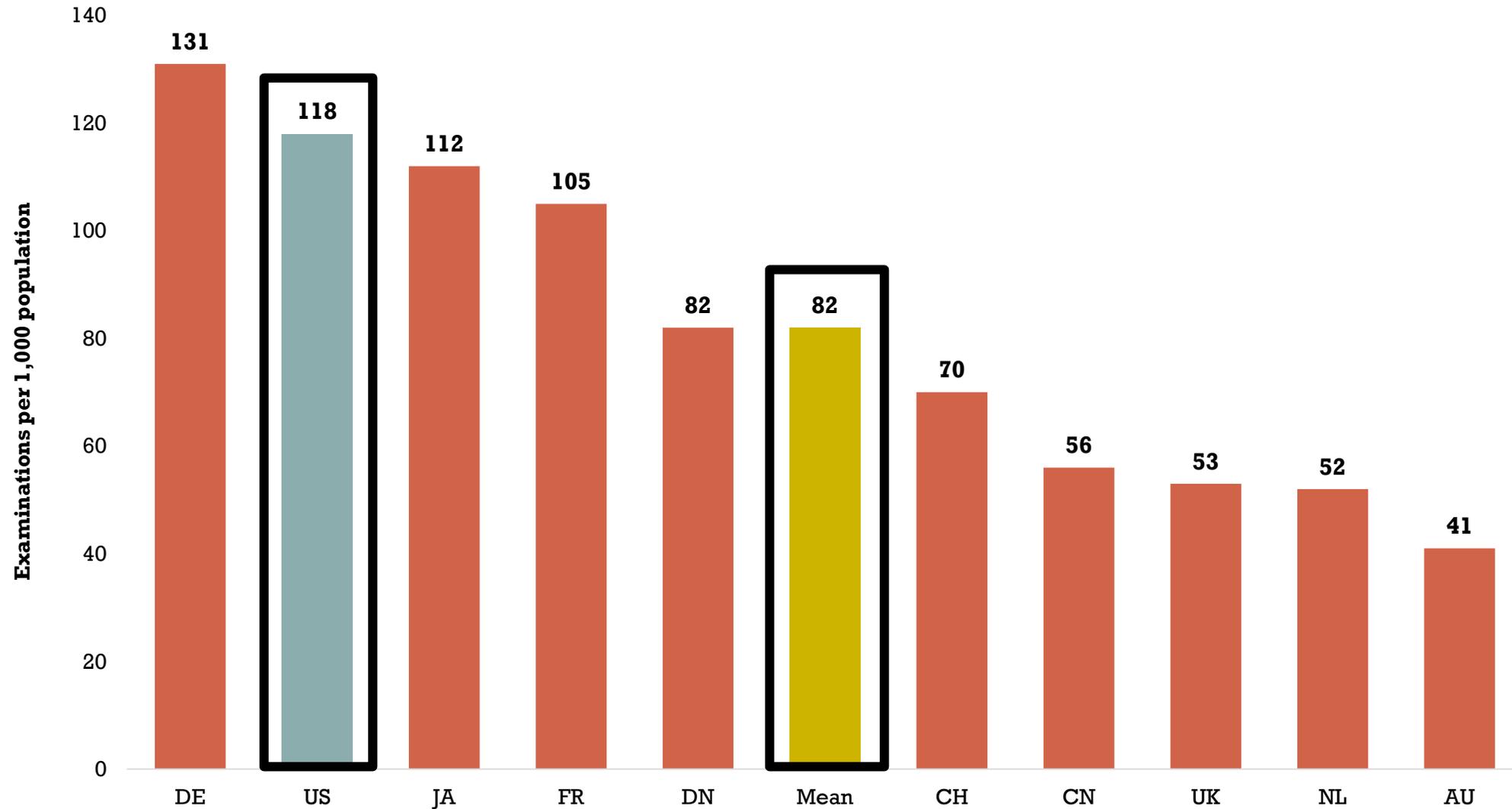


+ Overutilization #3

We use too many tests and procedures*

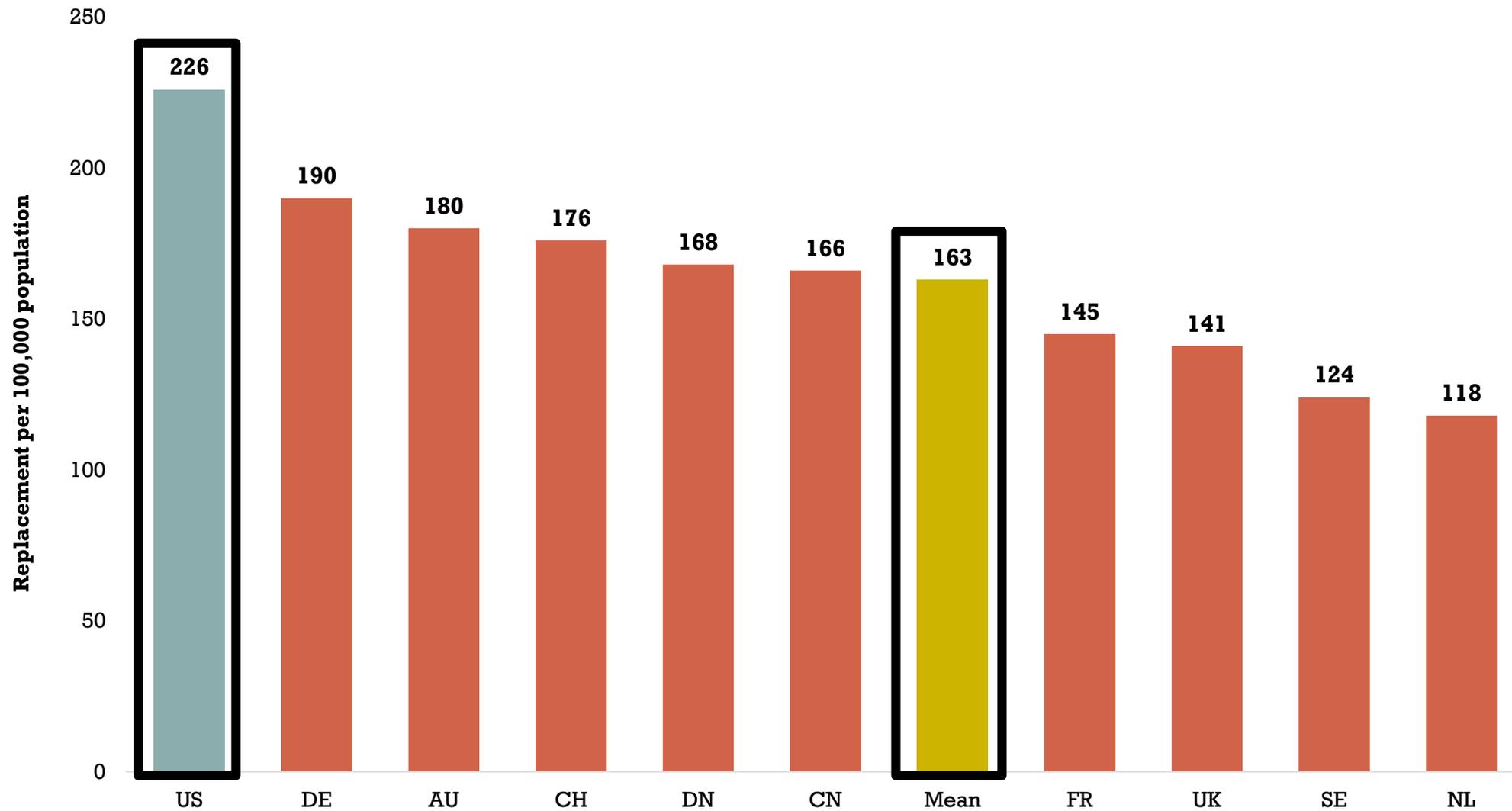


+ MRI examinations

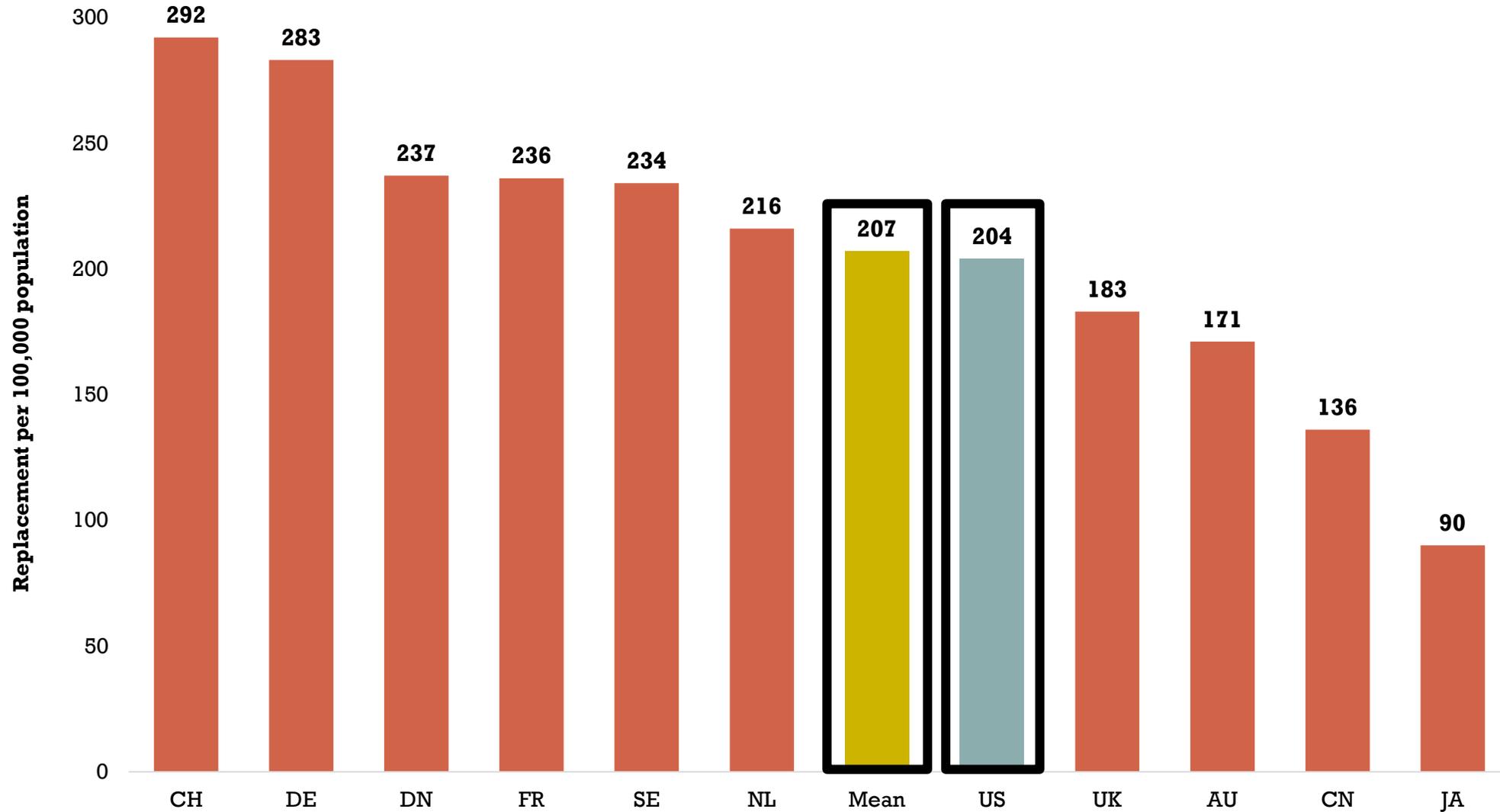




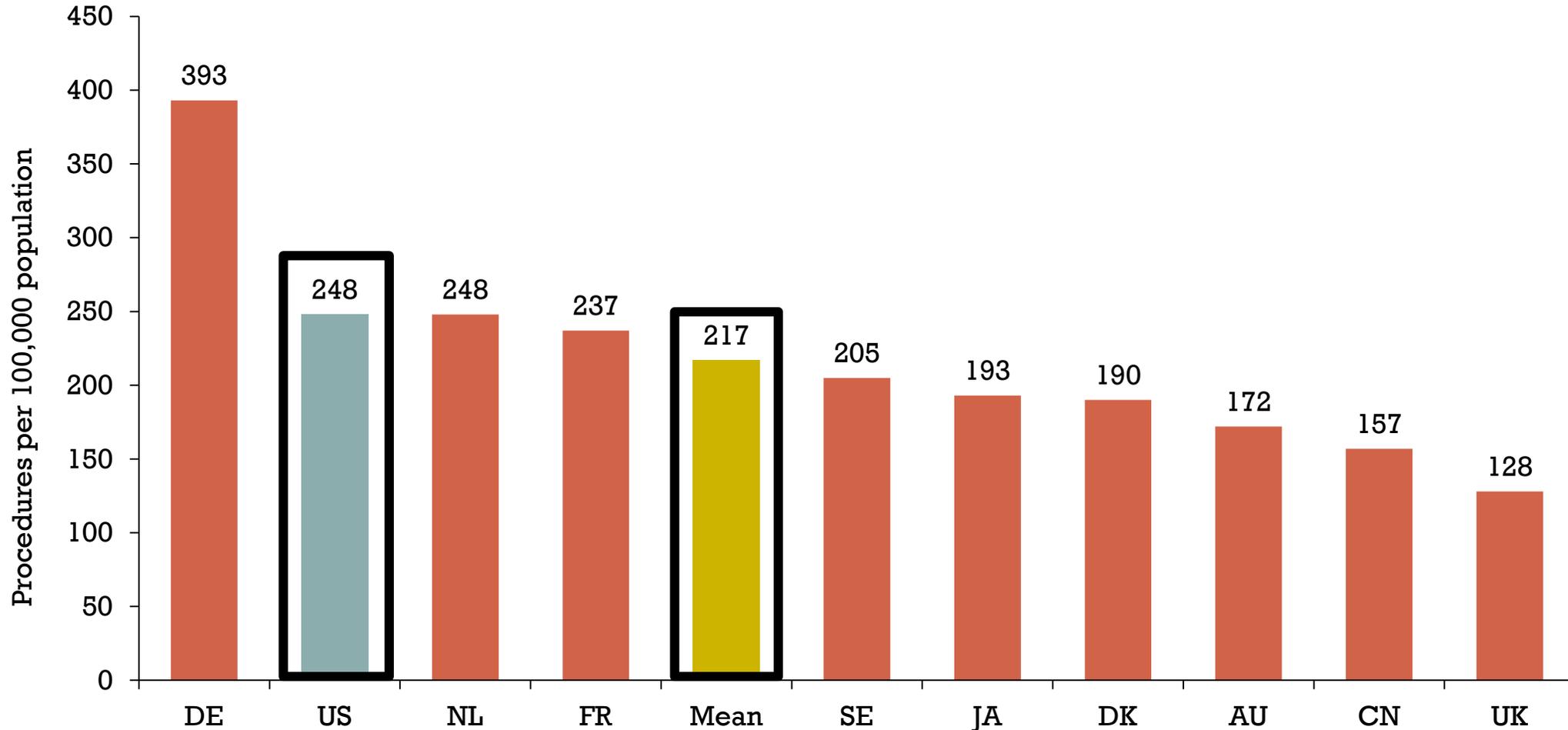
+ Total knee replacement



+ Total hip replacement

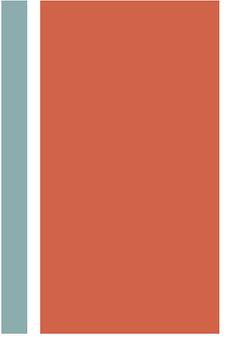


+ Coronary angioplasty



+ Hypothesis #1 Update

- Higher US costs not primarily about providing more care
- We have fewer hospitalizations, doctor visits
- Tests and Procedures a mixed bag:
 - We do a lot more MRIs, TKRs, and PTCAs
 - We do fewer hip replacements
- Bottom line:
 - We're above average on some things
 - We're below average on other things
 - On average, we are pretty average



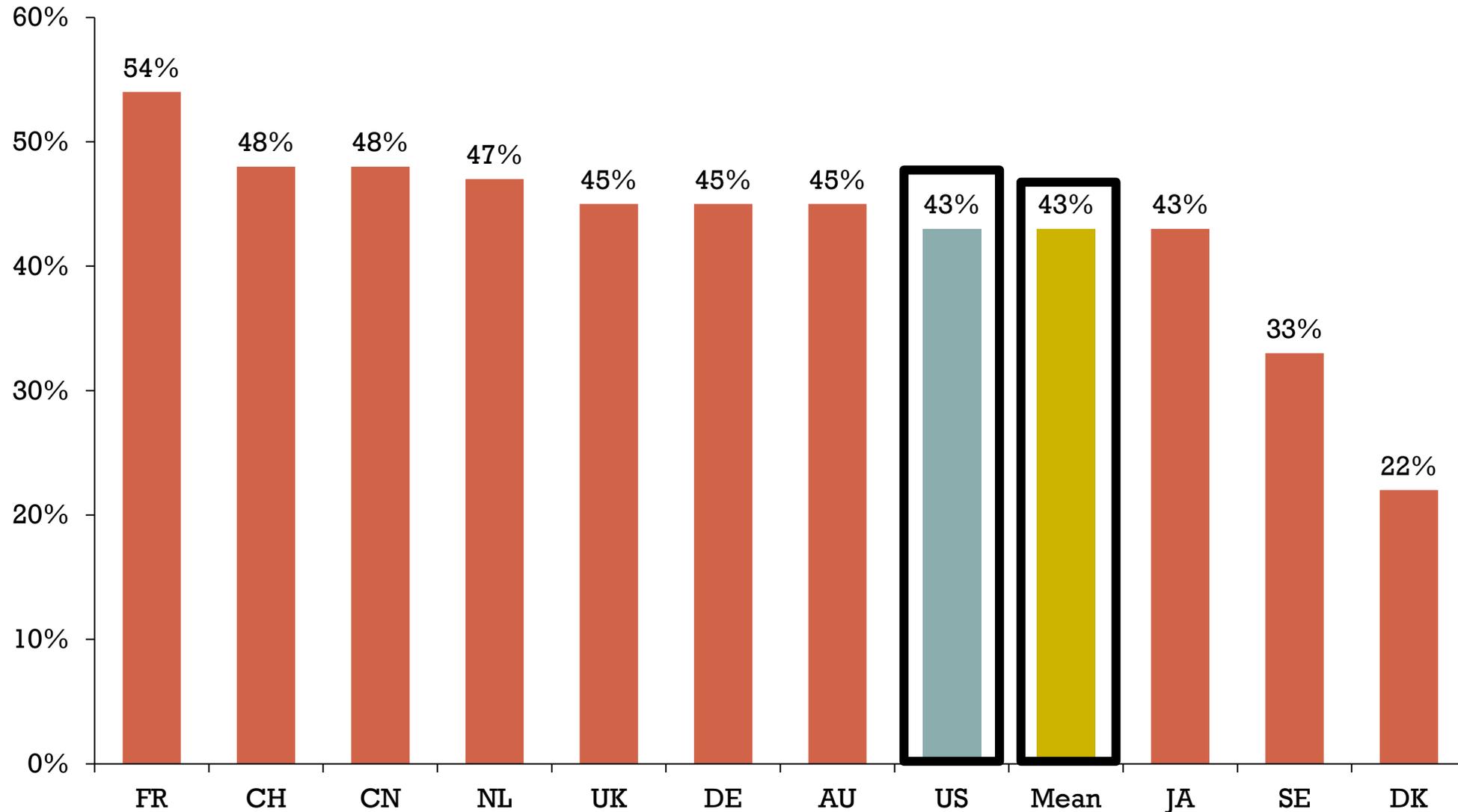
+ Hypothesis #2

+ Specialist driven

Not enough primary care

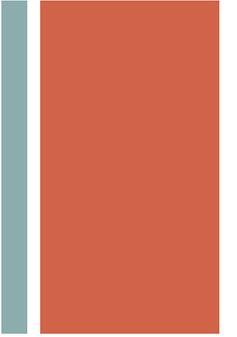


+ Primary care as % of MDs



+ Hypothesis #2 Update

- It's (surprisingly) not about PC vs. specialty mix



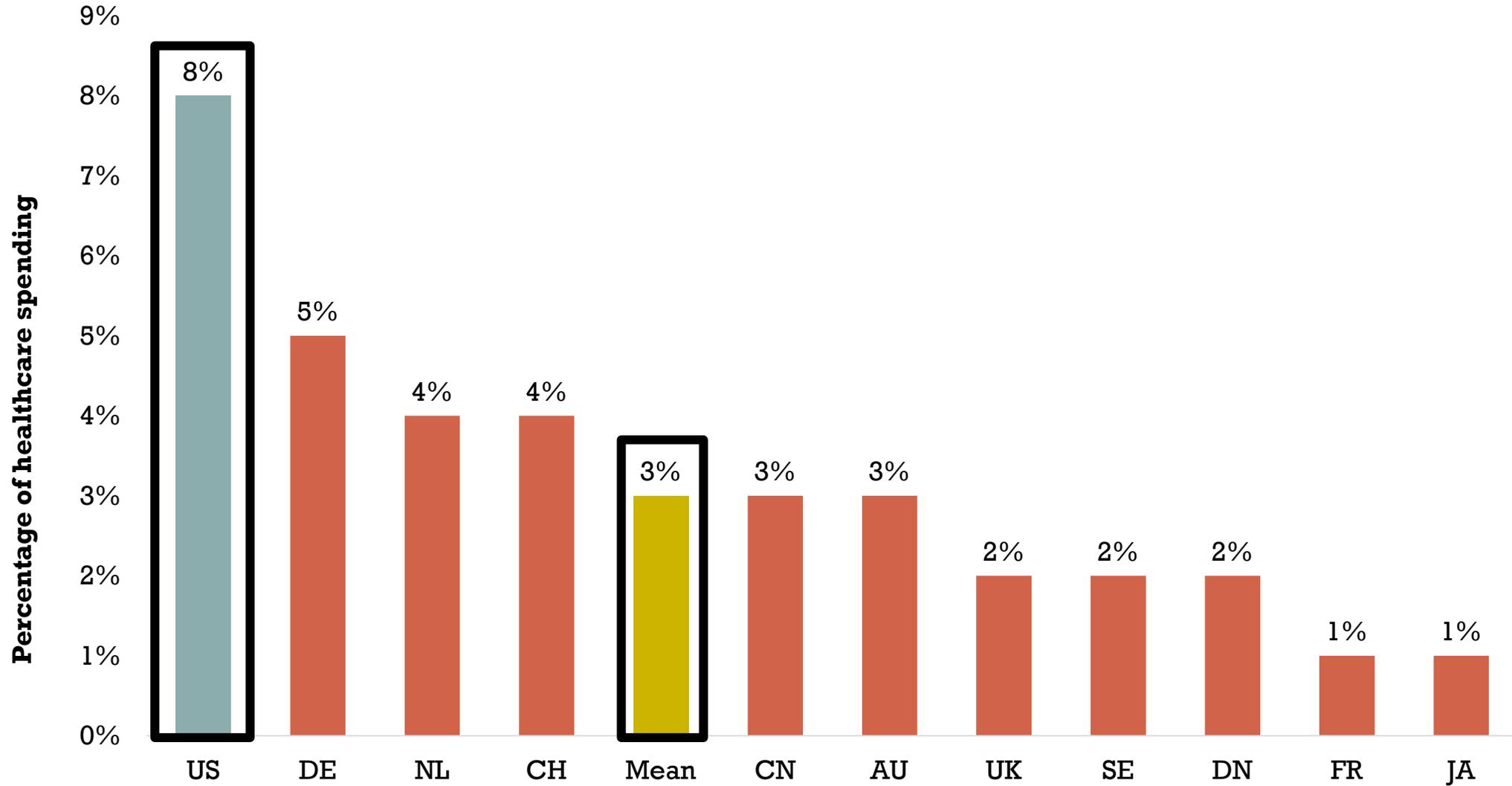
+ OK – so what is it?

+ Why so much *more*?

+ Hypothesis #3

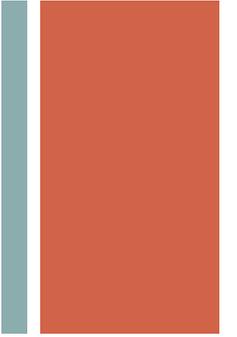
+ Administrative waste

+ Governance, administrative spending



+ Hypothesis #3 Update

- U.S. administrative spending is higher than other countries
- Higher even than countries that have largely private systems
- But that's only part of the story.....





$$\text{Total Spending} = \text{Quantity} \times \text{Price}$$

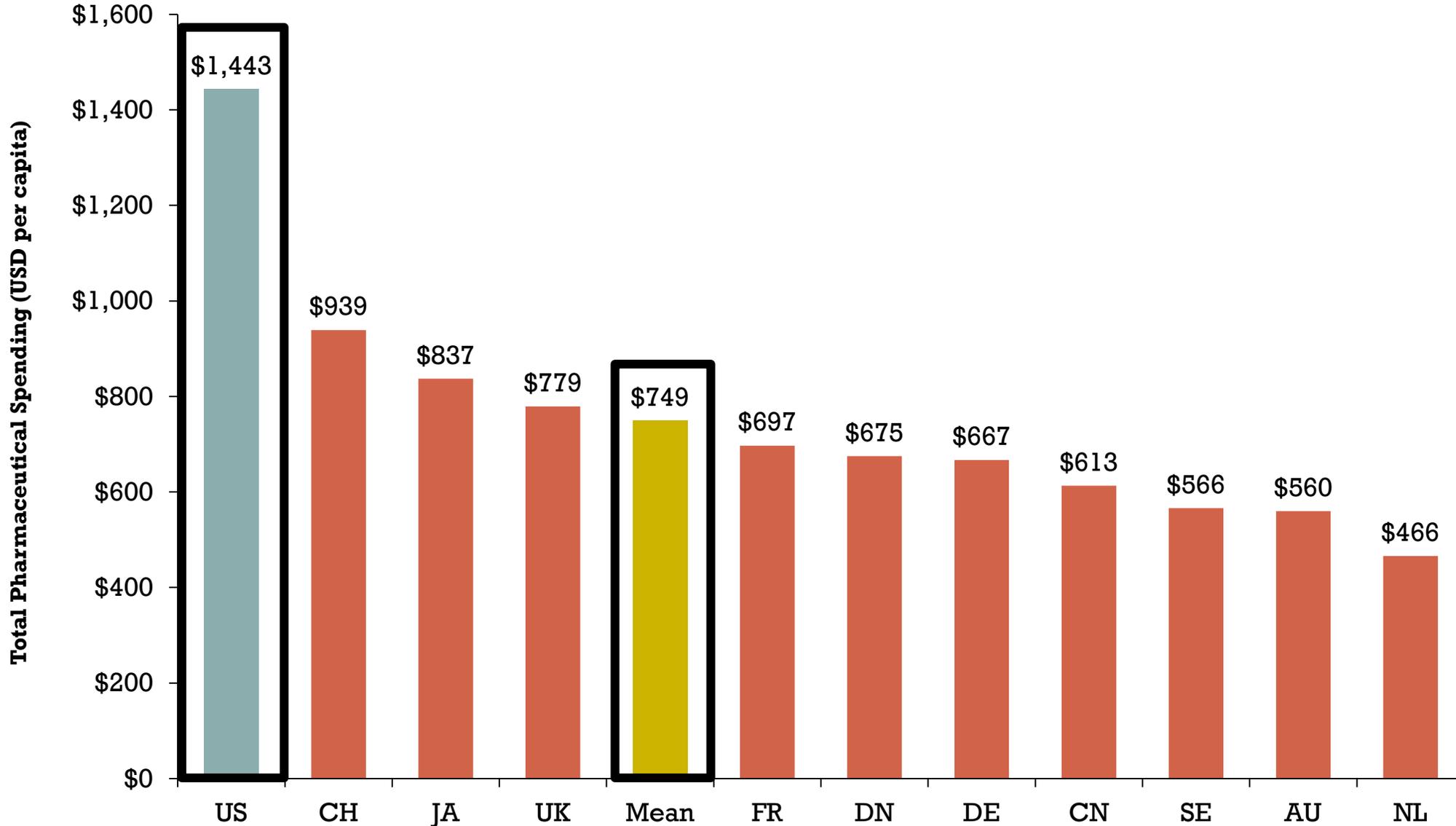
+ Hypothesis #4

+ Prices of what?

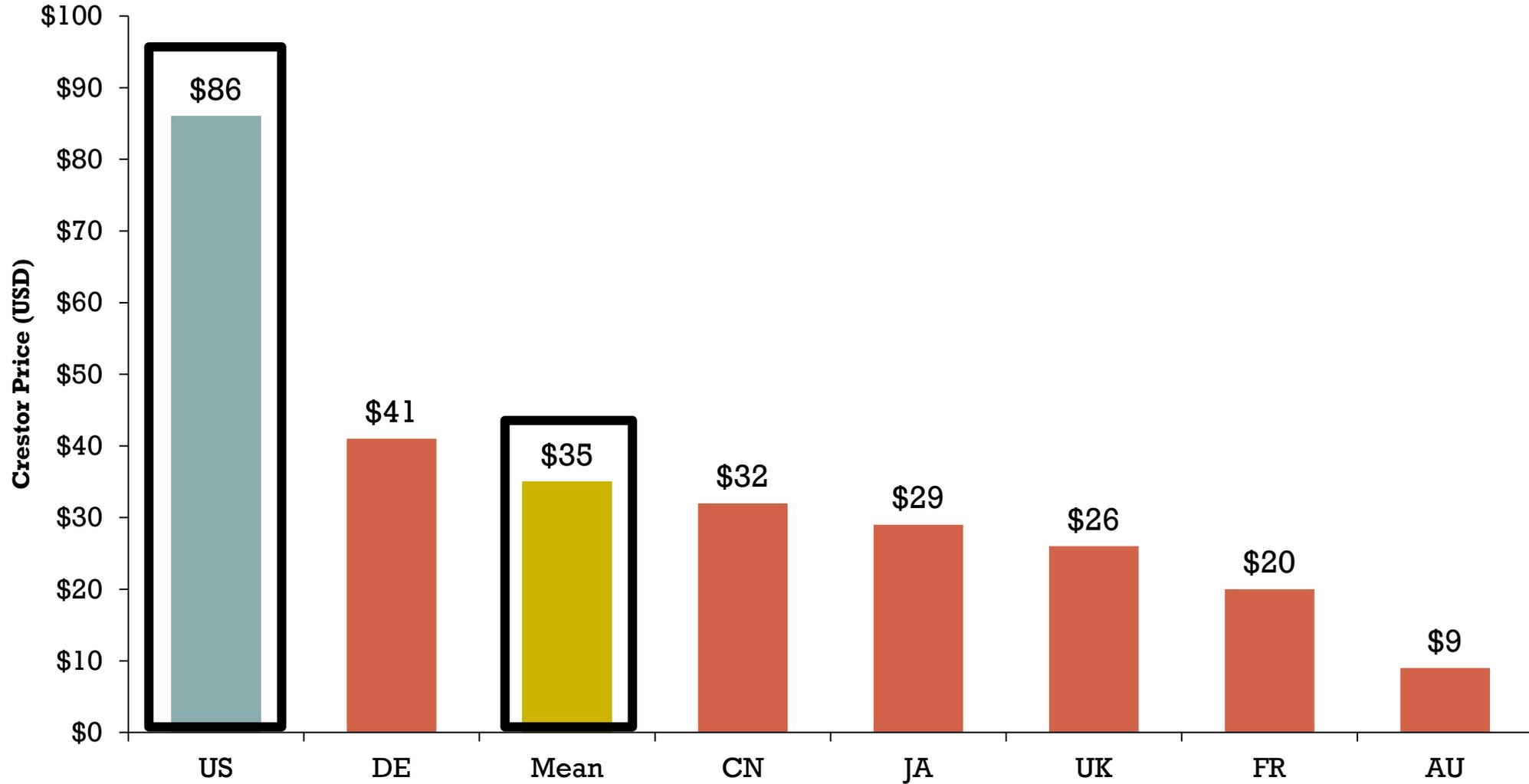
+ Pharmaceuticals!



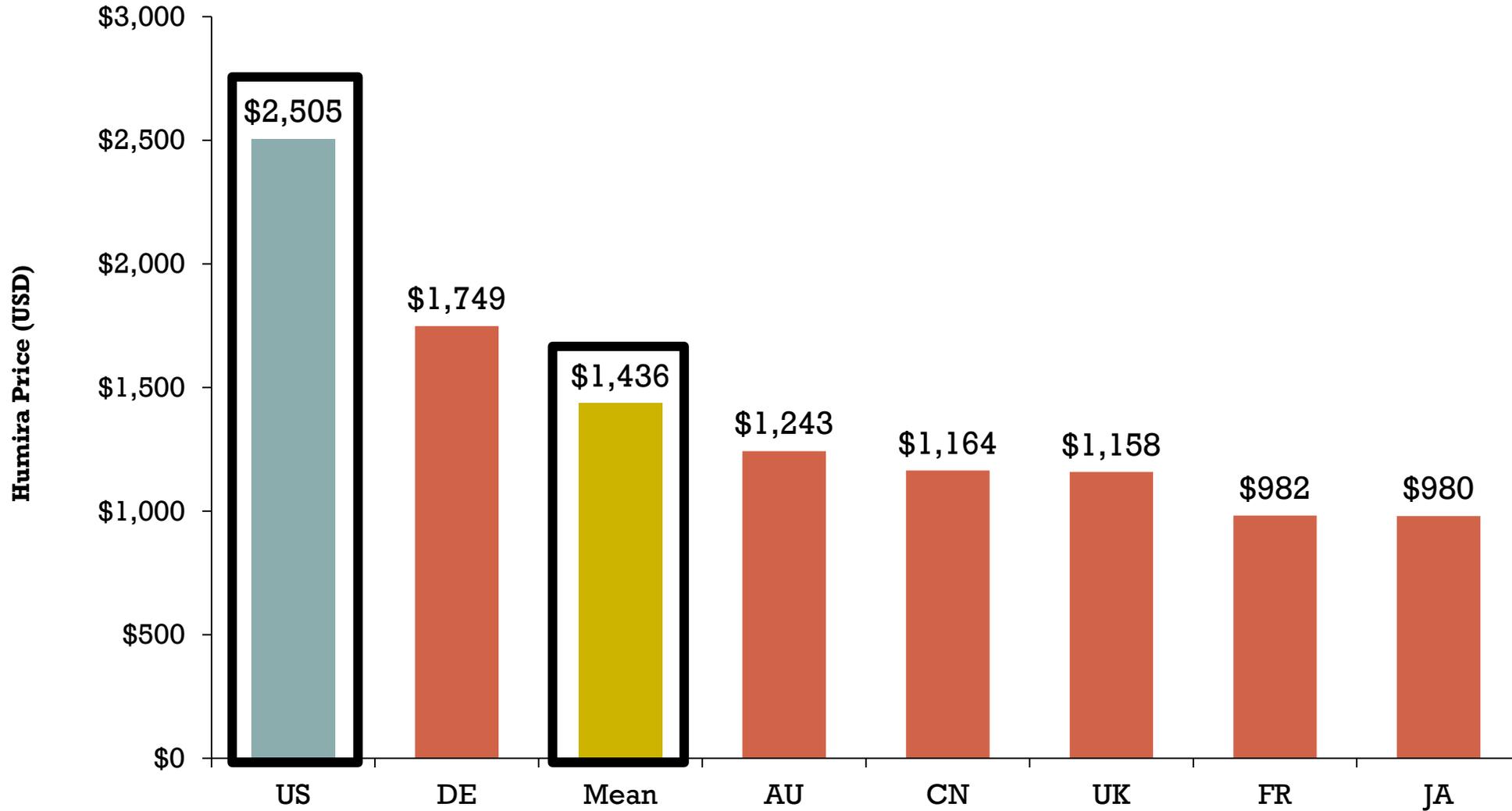
Total Spending (USD Per Capita)



+ Crestor Price



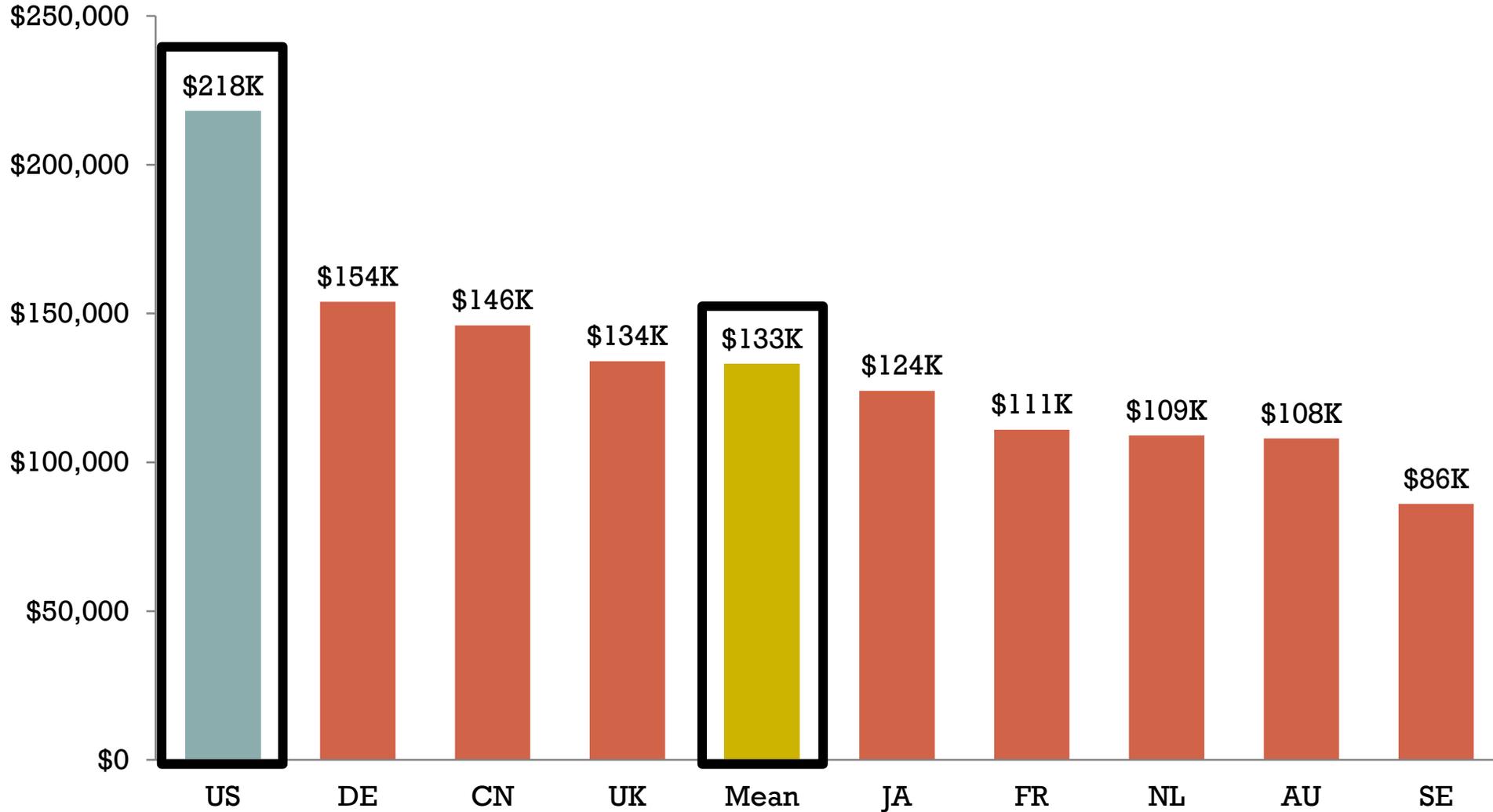
+ Humira Price



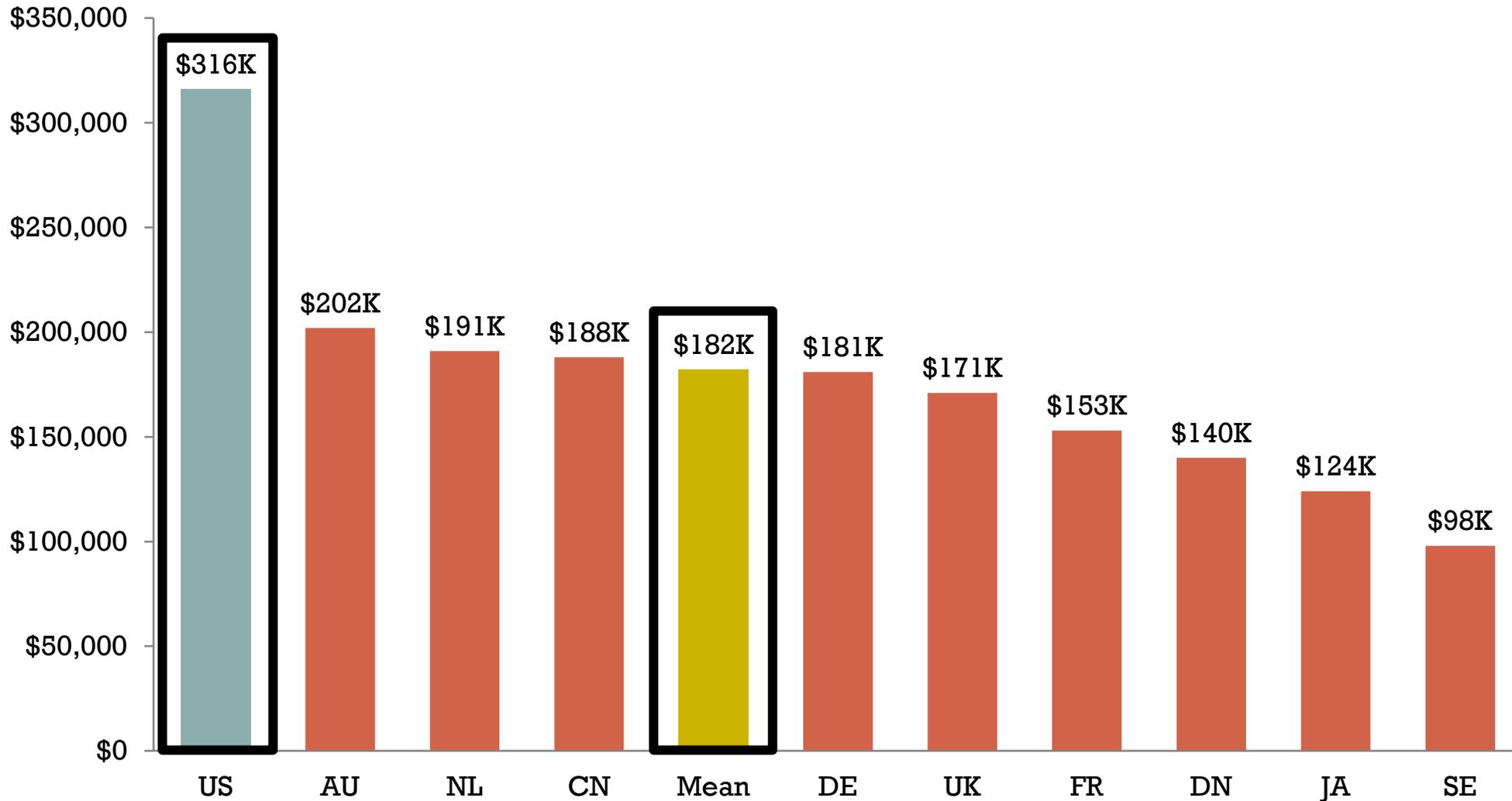
+ Pharma makes up about
15% of all HC spending

+ So that can't be the
whole story

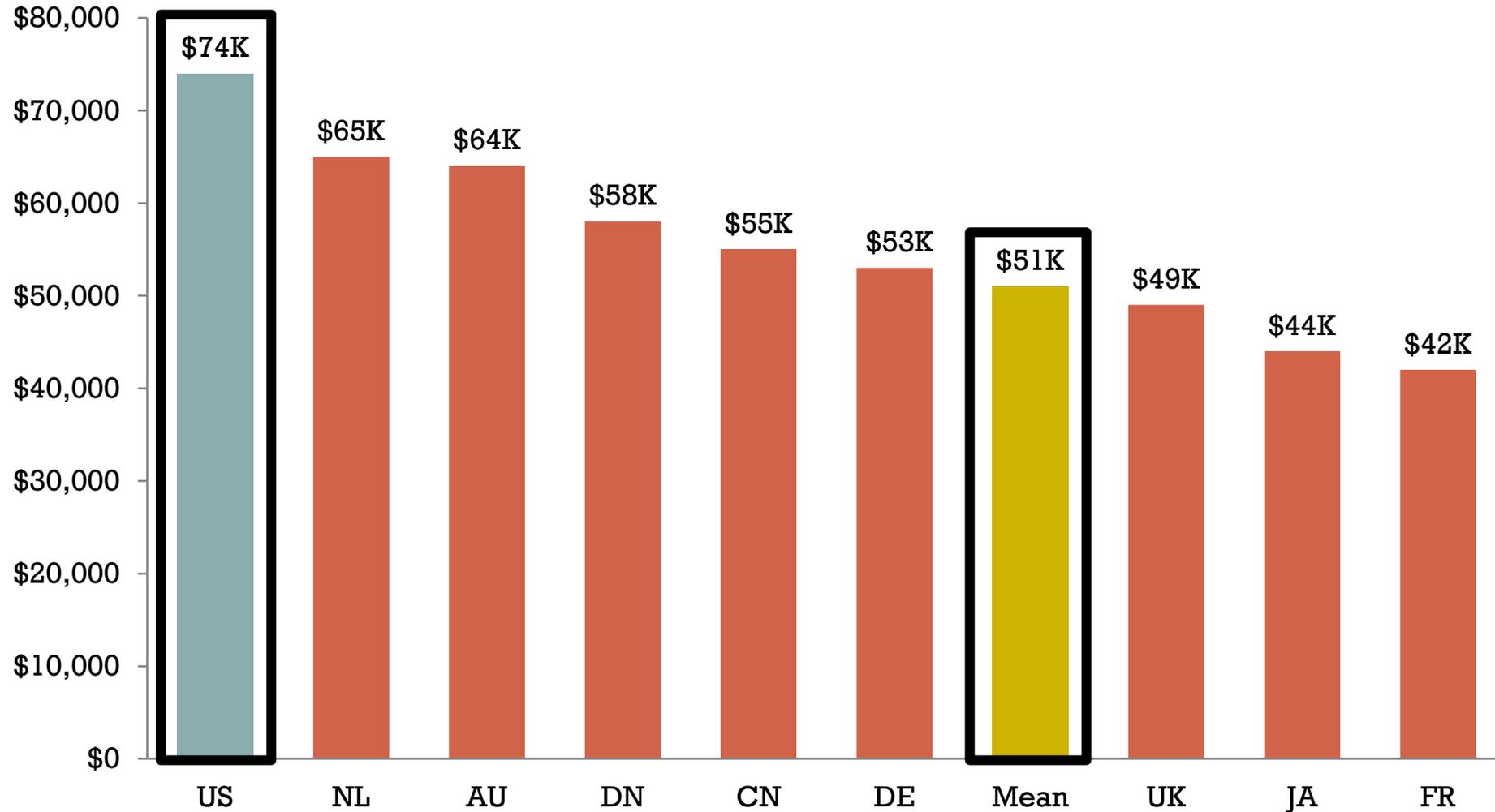
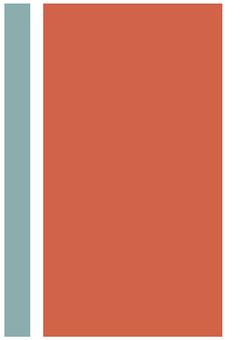
+ Generalist Physician Salaries



+ Specialist Physician Salaries



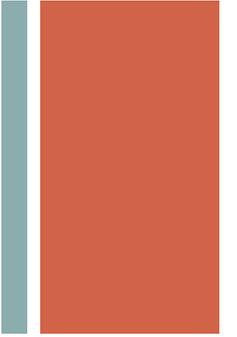
+ Nurse Salaries



+ Salaries are complicated

+ Physician salaries

- Debt
- Length of training
- Opportunity cost in the U.S.



+ What about other stuff?

+ CT Scan Abdomen



+ Appendectomy



+ Knee Replacement

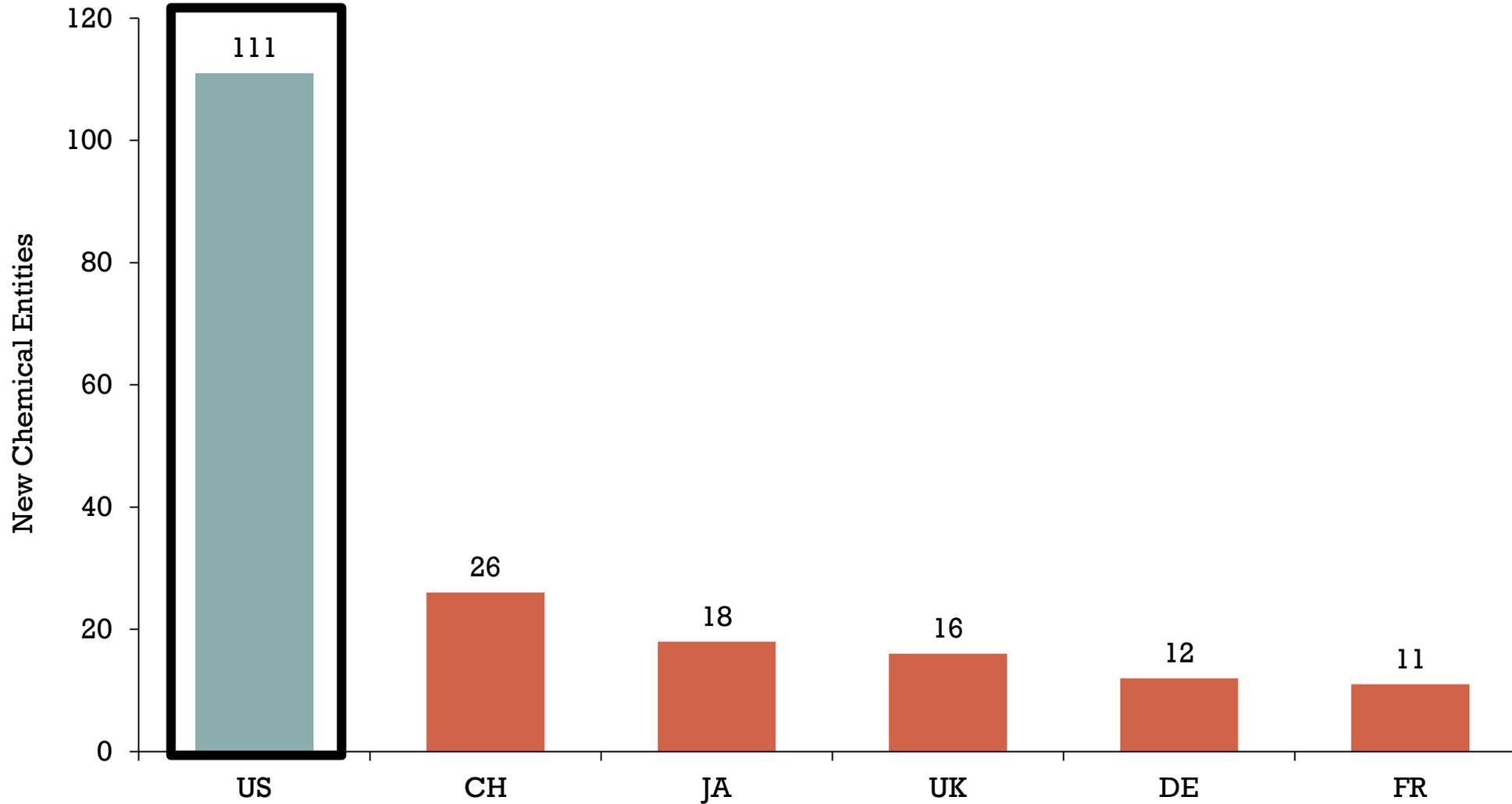


+ Bypass Surgery



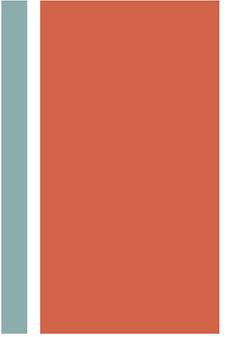
+ High prices have tradeoffs

+ Pharmaceutical Innovation



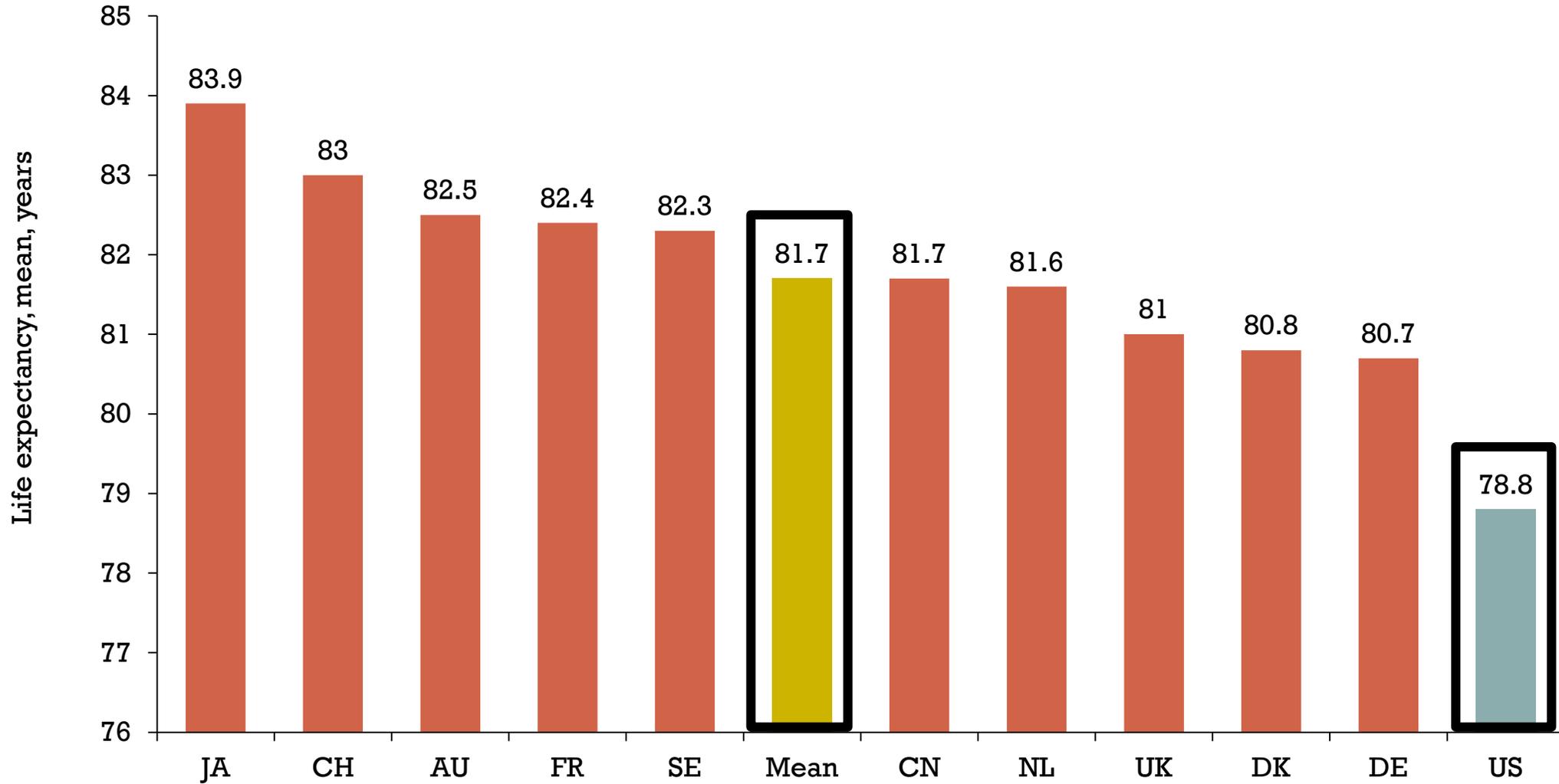
+ Other benefits of higher prices

- High-quality doctors and nurses
- Faster access to diagnostics and procedures
- Nicer amenities and facilities

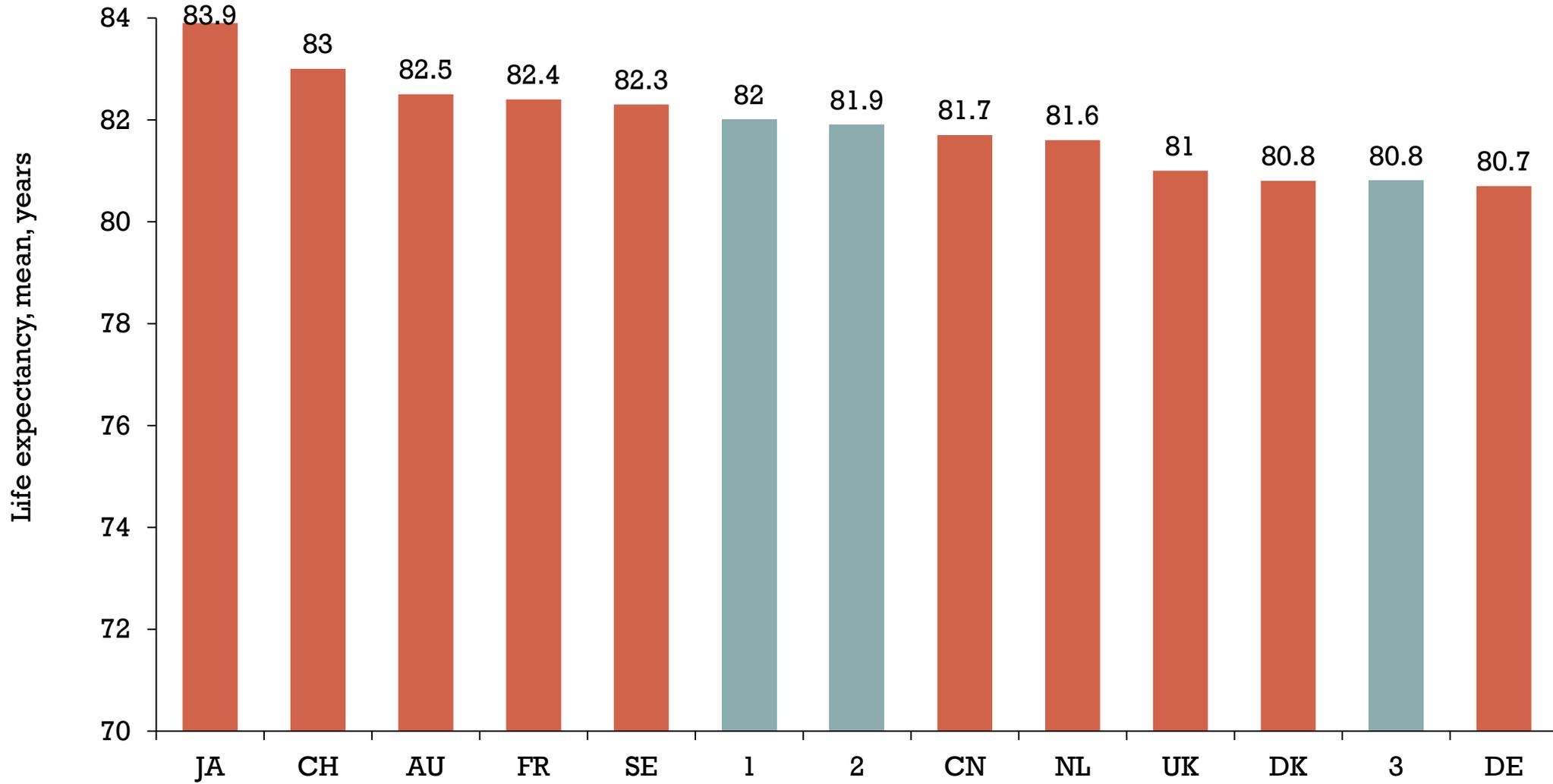


+ What about health outcomes?

+ Life expectancy

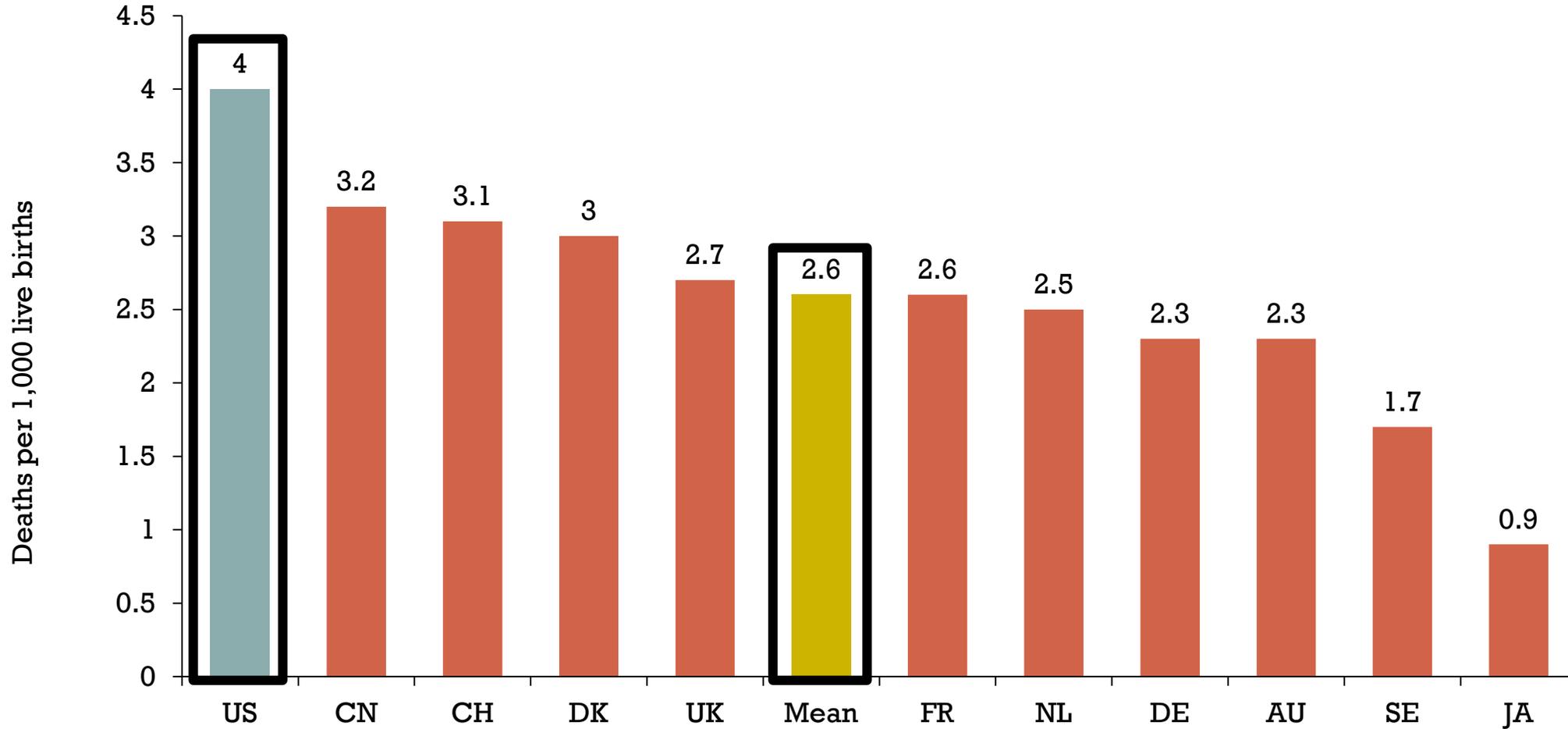
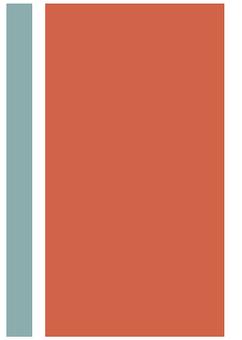


+ Life expectancy

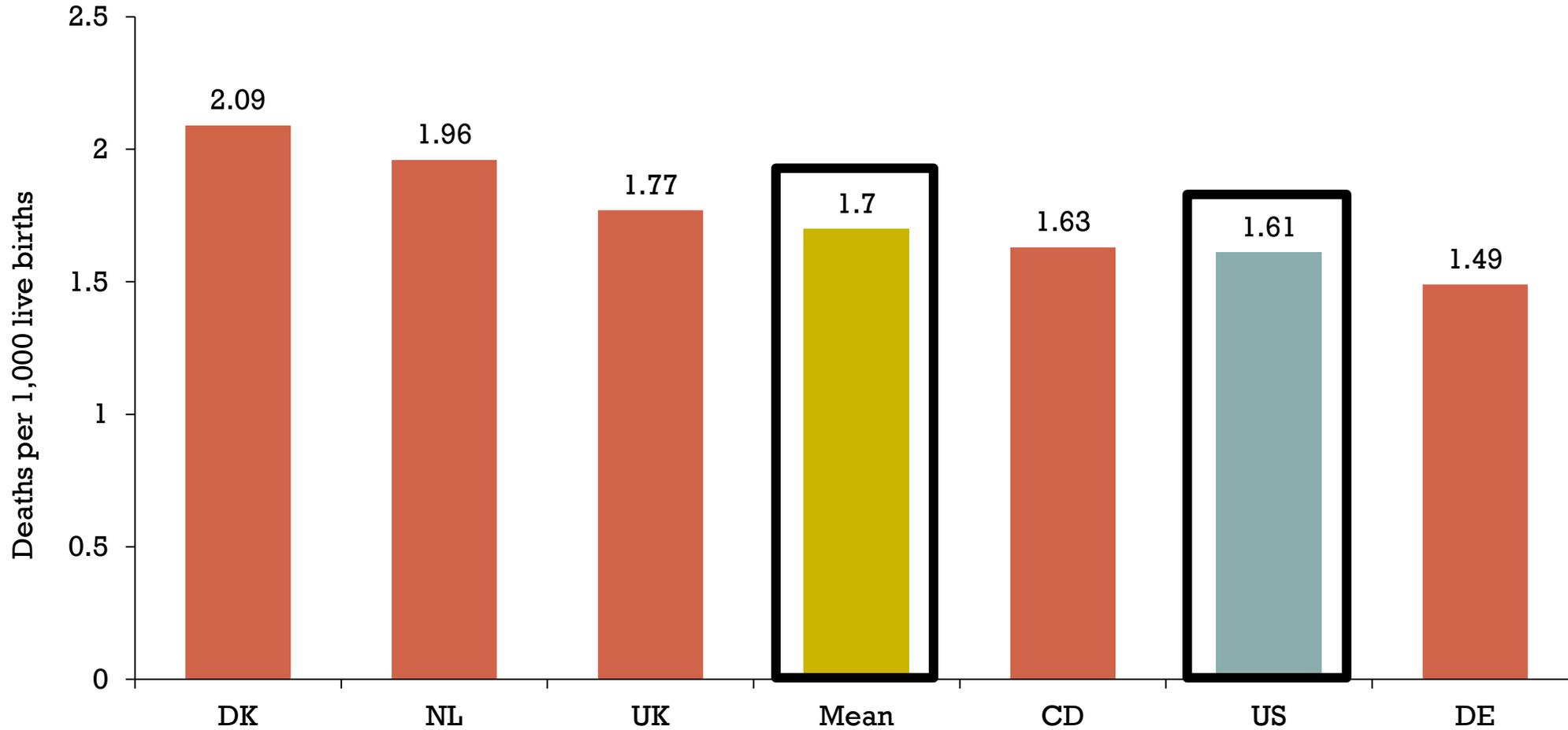




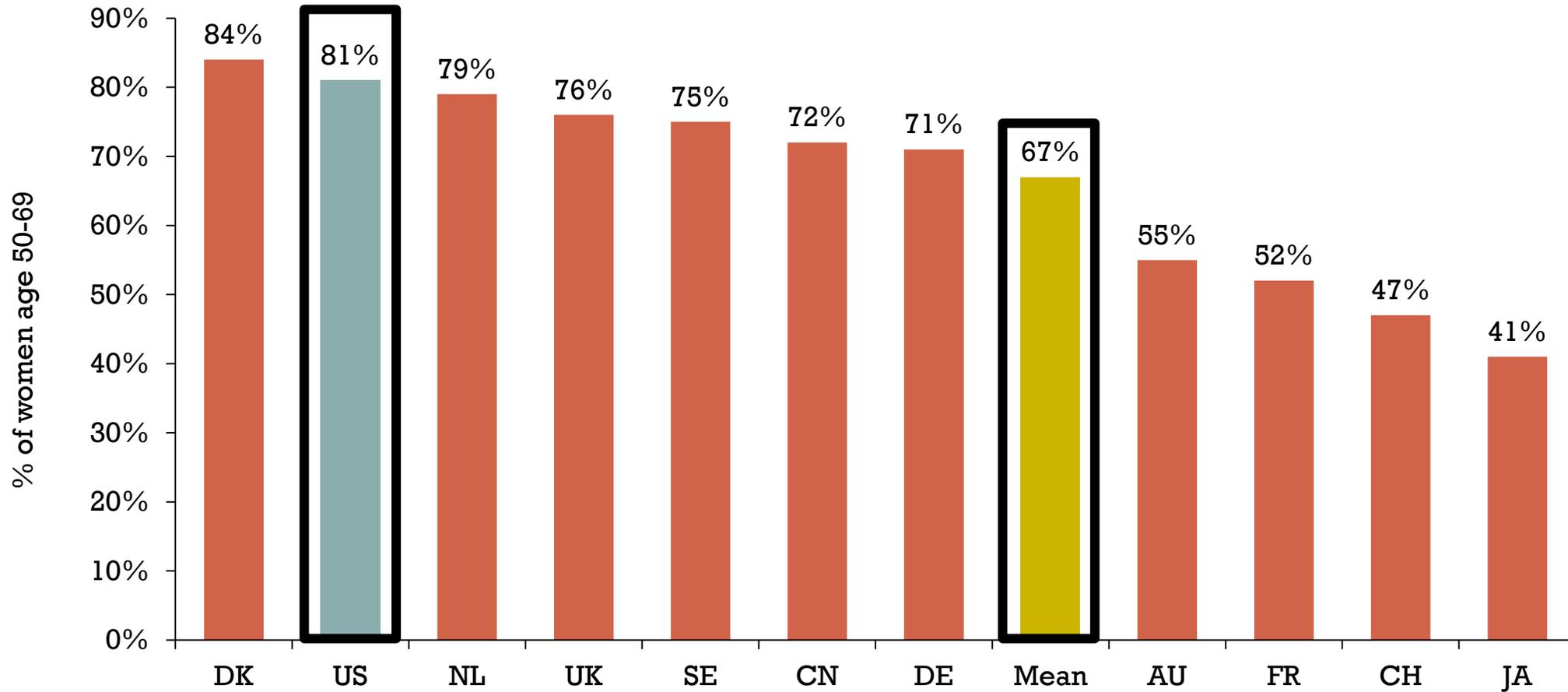
Neonatal mortality



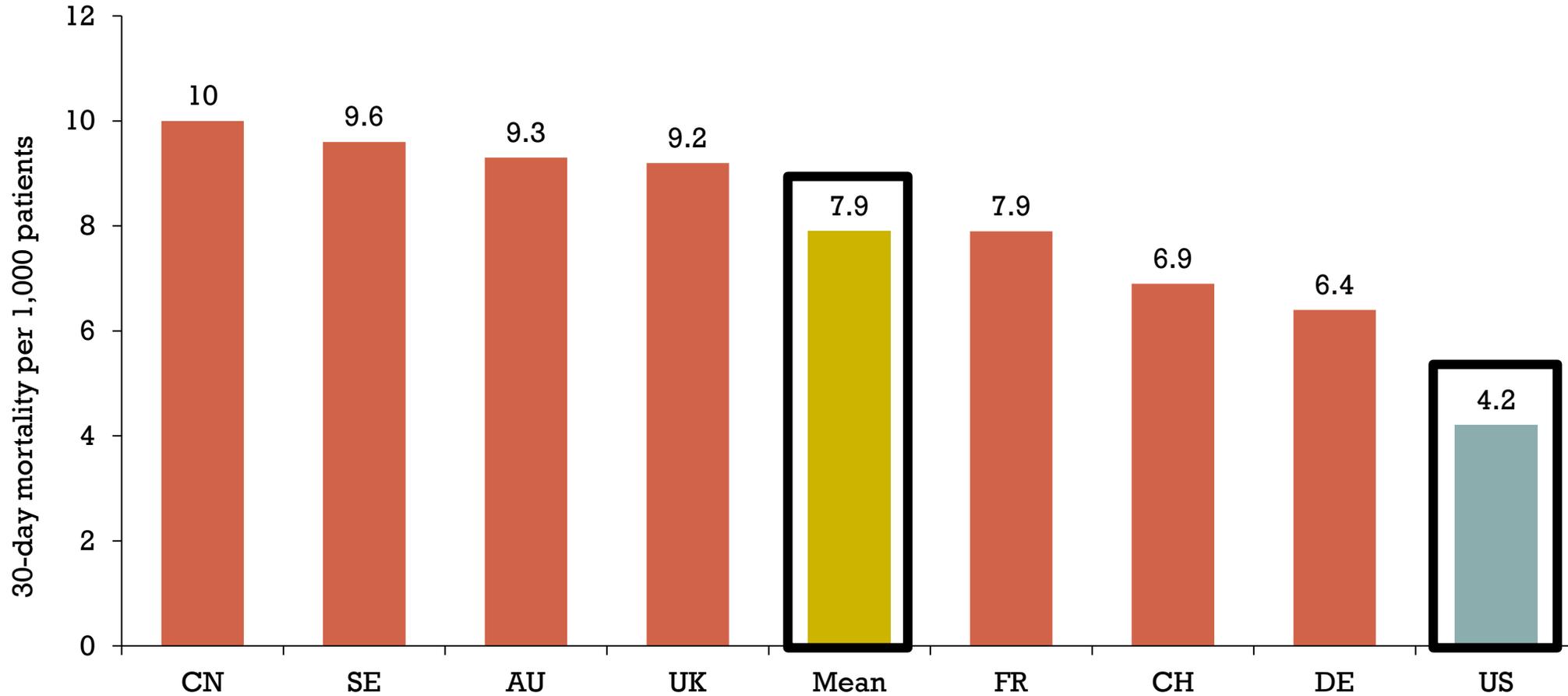
+ Neonatal mortality given LBW



+ Breast cancer screening

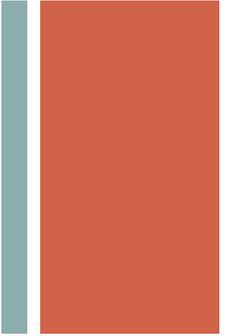


+ 30-day stroke mortality



+ Summary

- High cost healthcare system
 - Driven primarily by administrative costs, prices
- Health outcomes for the population are worse
 - But if you were to get sick, good system to do it

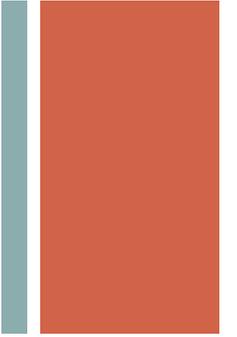


+ National reforms: ACA and Beyond



$$\text{Total Spending} = \text{Quantity} \times \text{Price}$$

+ Based on belief that we do too much



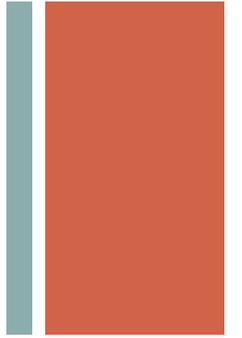
- “Value-based” payments for hospitals (VBP, HRRP, etc.) and docs
 - Largely hasn’t done much
- Accountability and changing the “episode” of payment (ACOs, BP)
 - Bit more reason for optimism (savings of 2-4%)
 - Unclear about its scalability/growth

+ Where is the action going to be?

+ States!



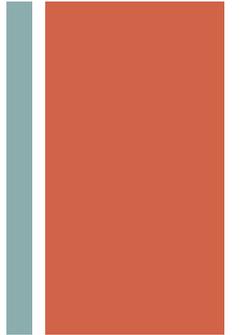
What does state-based reform look like?



- **Maryland's All-Payer Model**
 - Hospitals operate on a global budget
 - Hospital revenue for all payers set in the beginning of the year
 - Created target for per capita hospital revenue growth
- **Massachusetts Health Policy Commission**
 - Created target for healthcare spending growth
 - Encourages movement away from FFS model and toward alternative payment models (ACOs, Medicaid APM)



What does state-based reform look like?



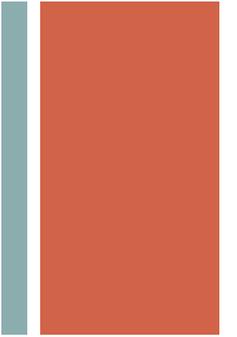
- **Vermont All-Payer Accountable Care Organization Model Agreement**
 - Goal is to attribute 70% of all VT insured residents to an ACO
 - Has set an all-payer growth target and a Medicare growth target

- **Arkansas Health Care Payment Reform Improvement Initiative**
 - Two strategies:
 - 1) Increase number of patients in patient-centered medical homes
 - 2) Episode-based payments for those with multiple encounters with health system

- **Oregon's Alternative Payment and Advanced Care Model**
 - Shift Medicaid reimbursement for Community Health Centers to PMPM
 - Better integrate behavioral health services and increase focus on social determinants



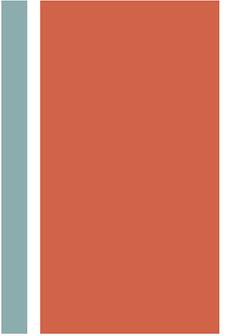
+ What are states doing?



- 40 states were pursuing value-based payment models in 2019
 - 15 of those states have multi-payer initiatives
- 17 states have adopted or are considering adoption of ACOs
- 12 states have adopted or are considering adoption of episodes of care programs
- CMS's State Innovation Models initiatives
- Most states participating in the "Money Follows the Person" program for Medicaid patients to reduce nursing facility stays



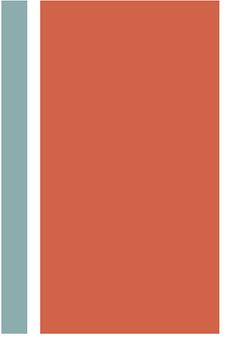
States tiptoeing into price regulation



- California policy on out-of-network provider charges (max 125% of Medicare)
- RI policy: Hospital rate and ACO budget growth caps (commercial)
 - Considering a cost growth target
- Vermont with an all-payer growth target
- West Virginia has a partial rate-setting system for privately insured patients
- Pennsylvania is piloting an all-payer global budget for rural hospitals



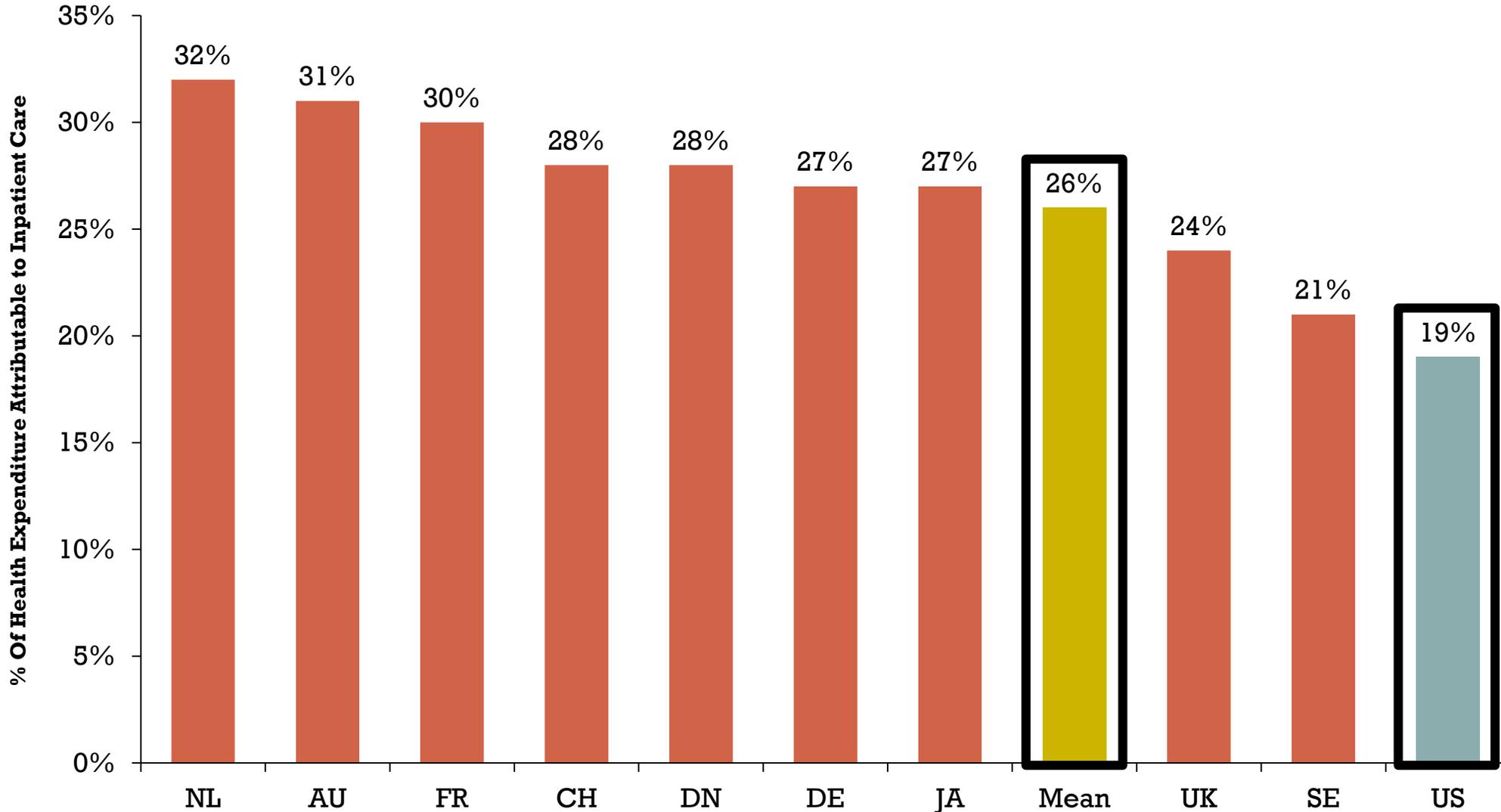
What can we learn from states?



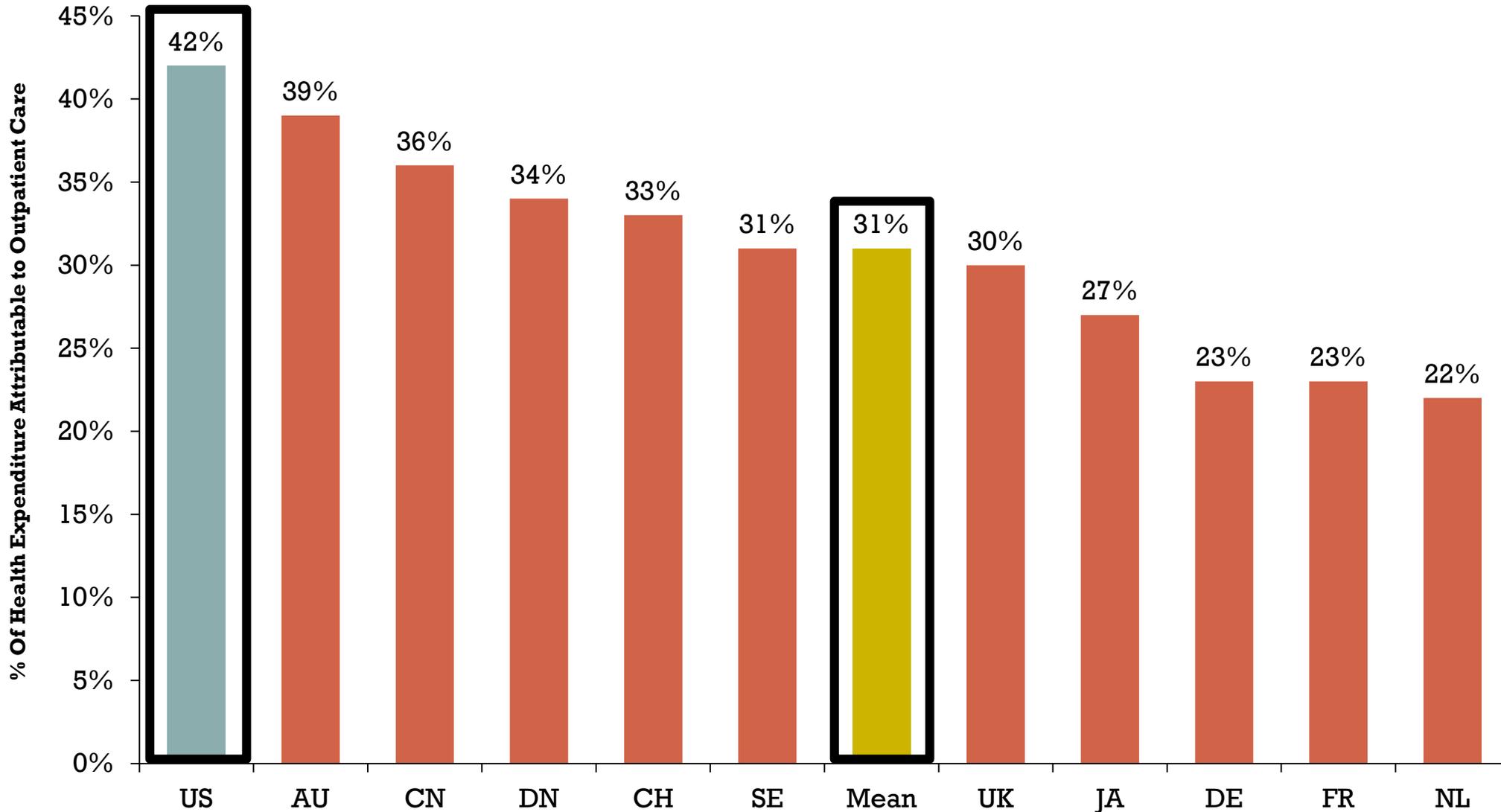
- States are laboratories of innovation
- This is even more true in the era of divided government
- What works for one state may not work for others
- We can create a uniquely American solution
 - States will be leading the way

+ Thank you!

+ % Spending on Inpatient Care

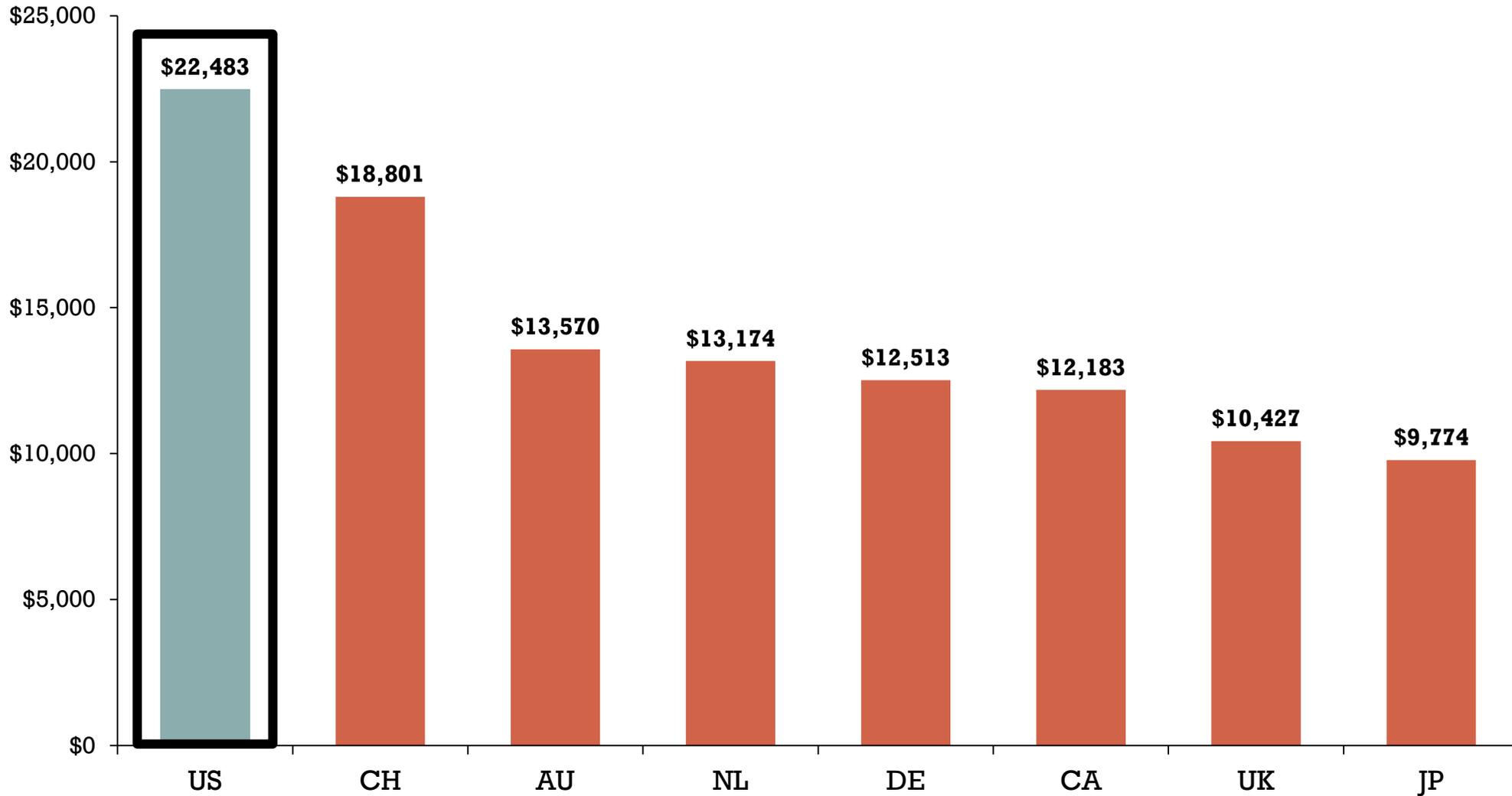
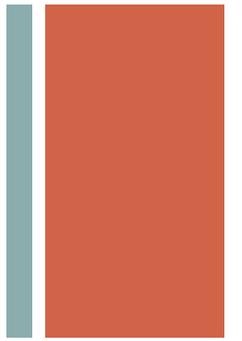


+ % Spending on Outpatient Care





+ Per capita spending for Ages 65+



+ Physicians per 1,000 population

