Health Care Spending Paper

"From a giant of health care policy, an engaging and enlightening account of why American health care is so expensive -- and why it doesn't have to be. Uwe Reinhardt was a towering figure and moral conscience of health care policy in the United States and beyond. Famously bipartisan, he advised presidents and Congress on health reform and originated central features of the Affordable

Care Act. In Priced Out, Reinhardt offers an engaging and enlightening account of today's U.S. health care system, explaining why it costs so much more and delivers so much less than the systems of every other advanced country, why this situation is morally indefensible, and how we might improve it. The problem, Reinhardt says, is not one of economics but of social ethics. There is no American political consensus on a fundamental question other countries settled long ago: to what

extent should we be our brothers' and sisters' keepers when it comes to health care? Drawing on the best evidence, he guides readers through the chaotic, secretive, and inefficient way America finances health care, and he offers a penetrating ethical analysis of recent reform proposals. At this point, he argues, the United States appears to have three stark choices: the government can make the rich help pay for the health care of the poor, ration care by income, or control costs. Reinhardt proposes an

alternative path: that by age 26 all Americans must choose either to join an insurance arrangement with community-rated premiums, or take a chance on being uninsured or relying on a health insurance market that charges premiums based on health status. An incisive look at the American health care system, Priced Out dispels the confusion, ignorance, myths, and misinformation that hinder effective reform." --

The United States has the highest per capita spending on health care of any

industrialized nation but continually lags behind other nations in health care outcomes including life expectancy and infant mortality. National health expenditures are projected to exceed $2.5 trillion in 2009. Given healthcare's direct impact on the economy, there is a critical need to control health care spending. According to The Health Imperative: Lowering Costs and Improving Outcomes, the costs of health care have strained the federal budget, and negatively affected state

governments, the private sector and individuals. Healthcare expenditures have restricted the ability of state and local governments to fund other priorities and have contributed to slowing growth in wages and jobs in the private sector. Moreover, the number of uninsured has risen from 45.7 million in 2007 to 46.3 million in 2008. The Health Imperative: Lowering Costs and Improving Outcomes identifies a number of factors driving expenditure growth including scientific uncertainty, perverse

economic and practice incentives, system fragmentation, lack of patient involvement, and under-investment in population health. Experts discussed key levers for catalyzing transformation of the delivery system. A few included streamlined health insurance regulation, administrative simplification and clarification and quality and consistency in treatment. The book is an excellent guide for policymakers at all levels of government, as well as private sector healthcare

workers.

This paper proposes a new set of public health and long-term care expenditure projections till 2060, following up on the previous set of projections published in 2006. It disentangles health from longterm care expenditure as well as the demographic from the non-demographic drivers, and refines the previous methodology, in particular by better identifying the underlying determinants of health and long-term care spending and by extending the country coverage to

include BRIICS countries. A costcontainment and a cost-pressure scenario are provided together with sensitivity analysis. On average across OECD countries, total health and long-term care expenditure is projected to increase by 3.3 and 7.7 percentage points of GDP between 2010 and 2060 in the cost-containment and the cost-pressure scenarios respectively. For the BRIICS over the same period, it is projected to increase by 2.8 and 7.3 percentage points of GDP in the cost-containment

and the cost-pressure scenarios respectively.
For-Profit Enterprise in Health Care
Essays on the Economics of Health Insurance
An Issues Paper
Why Spending More is Getting Us Less
Priced Out
Ensuring Value for Money in Health Care

This book explores trends in health care outcomes and spending; ways of assessing efficiency; new indicators of health care policies and institutions; and the characteristics and performance of health care systems.

Over the past twenty years, many low- and middle-income countries have experimented with health insurance options. While their plans have varied widely in scale and ambition, their goals are the same: to make health services more affordable through the use of public subsidies while also moving care providers partially or fully into competitive markets. Colombia embarked in 1993 on a fifteen-year effort to cover its entire population with insurance, in combination with greater freedom to choose among providers. A decade later Mexico followed suit with a program tailored to its federal system. Several African nations have introduced new programs in the

past decade, and many are testing options for reform. For the past twenty years, Eastern Europe has been shifting from government-run care to insurance-based competitive systems, and both China and India have experimental programs to expand coverage. These nations are betting that insurance-based health care financing can increase the accessibility of services, increase providers' productivity, and change the population's health care use patterns, mirroring the development of health systems in most OECD countries. Until now, however, we have known little about the actual effects of these dramatic policy changes. Understanding the impact

of health insurance–based care is key to the public policy debate of whether to extend insurance to low-income populations—and if so, how to do it—or to serve them through other means. Using recent household data, this book presents evidence of the impact of insurance programs in China, Colombia, Costa Rica, Ghana, Indonesia, Namibia, and Peru. The contributors also discuss potential design improvements that could increase impact. They provide innovative insights on improving the evaluation of health insurance reforms and on building a robust knowledge base to guide policy as other countries tackle the health insurance challenge.

This report addresses the concepts and controversy surrounding health technology assessment in Europe, with a particular focus on selected Member States including Sweden, the Netherlands, Finland, France, Germany and the United Kingdom. It is intended to identify and address current considerations regarding HTA methodological and process issues related to the prioritization and financing of modern health care. In particular, it describes the processes and challenges for identifying and prioritizing assessments; assesses and compares current assessment methods and procedures; and highlights the barriers to effective implementation. The report also

ascertains the roles and terms of engagement of key stakeholders, and captures the opportunities and challenges for the use of HTA guidance in general priority-setting, decision-making and health-care provision.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Health Care Reform Controlling Spending and Increasing Efficiency

The U.S. Health Care Industry

Measuring and Modeling Health Care Costs

Recognizing the Limits of Existing Forecasts

Health Care Spending, Fiscal Sustainability, and Public Investment

U.S. physicians are increasingly joining multispecialty group practices. In this paper, we analyze how a primary care physician's practice type -- single (SSP) versus multispecialty practice (MSP) -- affects health care spending and use. Focusing on Medicare beneficiaries who change their primary care physician due to a geographic move, we compare changes in practice patterns before and after the move between patients who switch practice types and those who do not. We use instrumental variables to address potential selection by patients into practice types after the move. We find that

changing from a single to a multi-specialty primary care group practice decreases annual Medicare-financed per capita expenditures by about $1,600 - a 28% reduction. The effect is driven primarily by changes in hospital expenditures and is concentrated among patients with two or more chronic conditions, suggesting that MSP improves care delivery by reducing hospitalizations among relatively sick patients. The results imply that, while research has shown the potential for physician consolidation to increase prices in some settings, large multispecialty groups also have the potential to lower

costs.

Abstract: Public technology assessments in general and Comparative Effectiveness Research (CER) in particular have been justified by offsetting benefits of improving patient health and reducing health care spending. However, little conceptual and empirical understanding exists concerning the quantitative impact of public technology assessments such as CER. This is needed to assess whether CER has benefits that outweighs its investment costs. This paper provides a systematic framework to analyze the impact of CER on health outcomes and medical

care spending. We interpret CER to infuse evidence on product quality into the market place declaring product winners and losers. This shifts demand by patients and doctors as well as coverage by third party payers towards the winners of CER studies and away from losers. We trace out the spending and health implications of such responses to evidence on product quality in privately and publicly financed health care markets. We simulate these effects for antipsychotics that are among the largest drug classes of the US Medicaid program and for which CER has been

conducted by means of the CATIE trial in 1999. Our main conclusion, from both the conceptual and empirical analysis, is that investments into CER may not always have the intended benefits of lowering spending and improving health outcomes. Because CER may result in higher spending and worse health, it is important to have methods to evaluate quantitatively the impacts of CER investments

There is little empirical evidence to support the claim that public spending improves education and health indicators. This paper uses cross-sectional data for 50 developing and transition

countries to show that expenditure allocations within the two social sectors improve both access to and attainment in schools and reduce mortality rates for infants and children. The size and efficiency of these allocations are important for promoting equity and furthering second-generation reforms.
Cracking Health Costs

Moral Hazard in Health Insurance
The Impact of Health Insurance in Low- and Middle-Income Countries
The Economic Consequences of Health Shocks
Lowering Costs and Improving Outcomes: Workshop Series

Summary

This paper describes how economic behavior in the market for health care in the United States is influenced by a range of impediments to the functioning of the price mechanism which impart an upward bias to health care costs and imply efficiency losses. The paper also considers how to reform the health care sector, with particular emphasis on finding a way of resolving the dilemma posed by the tradeoff between the risk spreading afforded by insurance and

establishing appropriate incentives to restrain expenditures.

Measuring and Modeling Health Care CostsUniversity of Chicago Press

Foreword by Harvey V. Fineberg, President of the Institute of Medicine For decades, experts have puzzled over why the US spends more on health care but suffers poorer outcomes than other industrialized nations. Now Elizabeth H. Bradley and Lauren A. Taylor marshal extensive research, including a

comparative study of health care data from thirty countries, and get to the root of this paradox: We've left out of our tally the most impactful expenditures countries make to improve the health of their populations-investments in social services. In The American Health Care Paradox, Bradley and Taylor illuminate how narrow definitions of "health care," archaic divisions in the distribution of health and social services, and our allergy to government

programs combine to create needless suffering in individual lives, even as health care spending continues to soar. They show us how and why the US health care "system" developed as it did; examine the constraints on, and possibilities for, reform; and profile inspiring new initiatives from around the world. Offering a unique and clarifying perspective on the problems the Affordable Care Act won't solve, this book also points a new way forward. The American Health Care

Paradox
Public Spending on Health and Long-term Care
Service Annual Survey
The Effects of Multispecialty Group Practice on Health Care Spending and Use
A Resource Book
Health Care Systems Efficiency and Policy Settings

This manual provides a set of comprehensive, consistent and flexible accounts to meet the needs of government and private-sector analysts and policy-makers. These accounts constitute a common framework for enhancing the comparability of data over time and

across countries.

In Miami, average inpatient Medicare spending on people in their last six months of life was about double Medicare spending in Minneapolis; average ICU days were nearly four times higher. What are the implications of such differences for the efficiency of health care? In this paper, we used Medicare claims data to document the extent of these variations across 306 hospital referral regions in the U.S. We did not find strong evidence that the spending differences were due to underlying variation in health levels across regions. Nor did we find evidence of any benefits from higher spending levels; regional survival rates following acute conditions like AMI

(heart attacks), stroke, and gastrointestinal bleeding were not correlated with more intensive health care spending. Finally, a number of recent studies suggest that people prefer less, rather than more intensive treatment. In sum, our results suggest that (i) regions providing more intensive care are not gaining net health benefits over regions providing less care, and (ii) allocative inefficiency may be present, in that patients are not necessarily matched with the treatment they prefer.

A recent dramatic slowdown in the rate at which private-sector spending for health insurance increases each year has raised many questions about the meaning of the trend and its implications for the future. According

to the federal government's national health accounts (NHA), the annual growth rate of private health insurance expenditures tumbled from around 14 percent in 1990 to less than 3 percent in 1994 and 1995. Understanding the factors that contribute to that reduction is of particular concern to policymakers who are seeking ways to slow the growth of Medicare spending. At the same time that fundamental changes are occurring in the market for private health insurance, Medicare spending has continued to rise virtually unabated, growing by almost 12 percent in 1995-more than four times the rate for private-sector spending.

The Economics of Public Health Care

Reform in Advanced and Emerging Economies
Performance and Issues
A System of Health Accounts
Canadian Tax Paper
Trends in Health Care Spending by the Private Sector
A New Set of Projections

Three major aspects of the debate over health care spending and its fiscal implications in Canada may be identified: (a) the concept and measurement of sustainability, (b) health care and fiscal federalism, and (c) health spending as consumption or investment. This paper addresses the above issues.

"This resource book discusses the economic arguments that could (and could not) be put forth to support the case for investing in the social determinants of health on average and in the reduction in socially determined health inequalities. It provides an overview and introduction into how economists would approach the assessment of the economic motivation to invest in the social determinants of health and socially determined health inequities, including what the major challenges are in

this assessment. It illustrates the extent to which an economic argument can be made in favour of investment in 3 major social determinants of health areas: education, social protection, and urban development and infrastructure. It describes whether education policy, social protection, and urban development, housing and transport policy can act as health policy"--

"Total health care expenditure in the EU countries accounts for between 4 and 11% of GDP, out of which between 3 and

9% of GDP is financed from public sources. As it accounts for between 10 and 18 % of total government spending, health care is therefore among the most significant items of social public expenditure. In addition, public expenditure on health care has been growing over most of the second half of the 20th century, not only in absolute terms, but also in relation to the national income. The paper analyses past developments of health care expenditure in EU Member States. The

methodology used expands the set of standard explanatory variables, such as demographic structure, income and health status of the population, by a variable characterising the effect of the technological progress on health care spending. Subsequently the paper provides a projection of the long-term development of health care expenditure, with the methodology based on the EC-EPC model extended by the impact of technological development."--Publication information page.

Measuring Economic

Sustainability and Progress
The Impact of Comparative Effectiveness Research on Health and Health Care Spending
How Useful Are Benefit Incidence Analyses of Public Education and Health Spending
How Much is Enough?
The Role of Health Technology Assessment in the European Union
The Future of the Public's Health in the 21st Century

Since the Great Depression, researchers and statisticians have recognized the need for more extensive methods for

measuring economic growth and sustainability. The recent recession renewed commitments to closing long-standing gaps in economic measurement, including those related to sustainability and well-being. The latest in the NBER's influential Studies in Income and Wealth series, which has played a key role in the development of national account statistics in the United States and other nations, this volume explores collaborative solutions between academics, policy

researchers, and official statisticians to some of today's most important economic measurement challenges. Contributors to this volume extend past research on the integration and extension of national accounts to establish an even more comprehensive understanding of the distribution of economic growth and its impact on well-being, including health, human capital, and the environment. The research contributions assess, among other topics, specific

conceptual and empirical proposals for extending national accounts.
The anthrax incidents following the 9/11 terrorist attacks put the spotlight on the nation's public health agencies, placing it under an unprecedented scrutiny that added new dimensions to the complex issues considered in this report. The Future of the Public's Health in the 21st Century reaffirms the vision of Healthy People 2010, and outlines a systems approach to assuring the nation's health in

practice, research, and policy. This approach focuses on joining the unique resources and perspectives of diverse sectors and entities and challenges these groups to work in a concerted, strategic way to promote and protect the public's health. Focusing on diverse partnerships as the framework for public health, the book discusses: The need for a shift from an individual to a population-based approach in practice, research, policy, and community engagement. The

status of the governmental public health infrastructure and what needs to be improved, including its interface with the health care delivery system. The roles nongovernment actors, such as academia, business, local communities and the media can play in creating a healthy nation. Providing an accessible analysis, this book will be important to public health policy-makers and practitioners, business and community leaders, health advocates, educators and journalists.

"[This book is] the most authoritative assessment of the advantages and disadvantages of recent trends toward the commercialization of health care," says Robert Pear of The New York Times. This major study by the Institute of Medicine examines virtually all aspects of for-profit health care in the United States, including the quality and availability of health care, the cost of medical care, access to financial capital, implications for education and research, and the

fiduciary role of the physician. In addition to the report, the book contains 15 papers by experts in the field of for-profit health care covering a broad range of topics--from trends in the growth of major investor-owned hospital companies to the ethical issues in for-profit health care. "The report makes a lasting contribution to the health policy literature."--Journal of Health Politics, Policy and Law.

Efficiency and Medicare Spending in the Last Six

Months of Life
Competition and Health Planning
Efficiency and Policy Settings
National Commission on the Cost of Medical Care, 1976-1977: Collected papers
Medical and Dental Expenses
Presidential Address and Papers

The paper reviews trends in health-care expenditure and assesses the main forces underlying the increase since 1960. It then describes and evaluates

various health-care reforms. The report argues that top-down budget controls appear to have had some success in reducing the growth in health-care spending but, to be sustainable, they need to be supported by microeconomic reforms. Significant improvements in micro-efficiency and effectiveness can be obtained by improving incentives facing health-care providers. Policy developments in a few leading countries

suggest that a system where funders/insurers act as purchasers, contracting with competing health-care providers, is a promising model for reform. A statistical annex assesses whether differences in institutional arrangements for funding and providing health care explain international differences in health expenditure ...
Health care reform will be a key fiscal policy

challenge in both advanced and emerging economies in coming years. In the advanced economies, the health sector has been one of the main drivers of government expenditure, accounting for about half of the rise in total spending over the past forty years. These spending pressures are expected to intensify over the next two decades, reflecting the aging of the population, income growth, and continued technological

innovations in health care. These spending increases will come at a time when countries need to undertake fiscal consolidation to reduce public debt ratios in the wake of the global financial crisis. In the emerging economies, health care reform is also a key issue, given substantial lags in health indicators and limited fiscal resources. For these economies, the challenge will be to expand public coverage without

undermining fiscal sustainability. This book provides new insights into these challenges and potential policy responses, with cross-country analysis and case studies. Health care costs represent a nearly 18% of U.S. gross domestic product and 20% of government spending. While there is detailed information on where these health care dollars are spent, there is much less evidence on how this spending

affects health. The research in Measuring and Modeling Health Care Costs seeks to connect our knowledge of expenditures with what we are able to measure of results, probing questions of methodology, changes in the pharmaceutical industry, and the shifting landscape of physician practice. The research in this volume investigates, for example, obesity's effect on health care spending, the effect of

generic pharmaceutical releases on the market, and the disparity between disease-based and population-based spending measures. This vast and varied volume applies a range of economic tools to the analysis of health care and health outcomes. Practical and descriptive, this new volume in the Studies in Income and Wealth series is full of insights relevant to health policy students and specialists alike.

A Briefing Paper
Occupational Outlook Handbook
Health Care Cost Containment
Health Care Spending Projections and Policy Changes
Price Setting and Price Regulation in Health Care
The Healthcare Imperative

The objectives of this study are to describe experiences in price setting and how pricing has been used to attain better coverage, quality, financial

protection, and health outcomes. It builds on newly commissioned case studies and lessons learned in calculating prices, negotiating with providers, and monitoring changes. Recognising that no single model is applicable to all settings, the study aimed to generate best practices and identify areas for future research, particularly in low- and middle-income settings. The report and the case studies were jointly developed by the OECD and the WHO Centre for Health Development in Kobe

(Japan).
Cracking Health Costs reveals the best ways for companiesand small businesses to fight back, right now, against risinghealth care costs. This book proposes multiple, practical stepsthat you can take to control costs and increase the effectivenessof the health benefit. The book is all about rolling back health care costs to savecompanies and employees money. Working hand-in-hand with theiremployees, businesses need to ensure that,

whenever feasible,employees with the most expensive diagnoses get optimal treatmentat hospitals not practicing "volume-driven" medicinefor higher profits. Less than 10% of employees incur 80% of costs.About 20% of patients have been completely misdiagnosed, while manyothers are simply the victims of surgeons who are either practicingbad medicine or overtreating for profit. For example, some companies, such as Walmart and Lowe's,are turning to the

"Centers of Excellence" approachauthor Tom Emerick helped to pioneer while running benefits forWalmart. By determining which hospitals are adopting the higheststandards of care, benefits managers can reduce the number ofunnecessary high-cost surgeries and improve employees'overall health. The solution-based approach offered by the book isunique, because it can be implemented by businesses today. Addressing the challenge of covering heath care

expenses—while minimizing economic risks. Moral hazard—the tendency to change behavior when the cost of that behavior will be borne by others—is a particularly tricky question when considering health care. Kenneth J. Arrow's seminal 1963 paper on this topic (included in this volume) was one of the first to explore the implication of moral hazard for health care, and Amy Finkelstein—recognized as one of the world's foremost experts on the topic—here examines this issue in the context of contemporary

American health care policy. Drawing on research from both the original RAND Health Insurance Experiment and her own research, including a 2008 Health Insurance Experiment in Oregon, Finkelstein presents compelling evidence that health insurance does indeed affect medical spending and encourages policy solutions that acknowledge and account for this. The volume also features commentaries and insights from other renowned economists, including an introduction

by Joseph P. Newhouse that provides context for the discussion, a commentary from Jonathan Gruber that considers provider-side moral hazard, and reflections from Joseph E. Stiglitz and Kenneth J. Arrow. "Reads like a fireside chat among a group of distinguished, articulate health economists." —Choice

How to Cut Your Company's Health Costs and Provide Employees Better Care

The Economics of Health Care and Nursing

Does Higher Government Spending Buy Better

Results in Education and Health Care?
The Economics of Social Determinants of Health and Health Inequalities
Health Care Reform in the United States
The Role of Technology in Health Care Expenditure in the EU

This thesis brings together three essays on issues in the economics of health insurance. The first study considers the effects of average per-patient caps on Medicare reimbursement for home health care, which took effect in October 1997. I use regional variation in the restrictiveness of per-patient caps to identify the short-run effects of this reimbursement change on

home health agency behavior, beneficiary health care utilization, and health status. The empirical evidence suggests that agencies responded to the caps by shifting the composition of their caseload towards healthier beneficiaries. In addition, I find that decreases in home care utilization were associated with an increase in outpatient care, and had little adverse impact on the health status of beneficiaries. In the second paper, I examine the impact of Medicare balance billing restrictions on physician behavior and on beneficiary spending. My findings include a significant decline in out-of-pocket expenditures for medical care by elderly households, but no impact on the quantity of care received or

in the duration of office visits. The third paper (written with Jonathan Gruber) explores the causes of the dramatic rise in employee contributions to employer-provided health insurance over the past 20 years. We find that there was a large impact of falling tax rates, rising eligibility for insurance through the Medicaid system and through spouses, and deteriorating economic conditions (in the late 1980s and early 1990s). We also find more modest impacts of increased managed care penetration and rising health care costs. Overall, this set of factors can explain about one-quarter of the rise in employee contributions over the 1982-1996 period.

This paper provides a primer on benefit incidence analysis (BIA) for

macroeconomists and a new data set on the benefit incidence of education and health spending covering 56 countries over 1960-2000, representing a significant improvement in quality and coverage over existing compilations. The paper demonstrates the usefulness of BIA in two dimensions. First, the paper finds, among other things, that overall education and health spending are poorly targeted; benefits from primary education and primary health care go disproportionately to the middle class, particularly in sub-Saharan Africa, HIPCs and transition economies; but targeting has improved in the 1990s. Second, simple measures of association show that countries with a more

propoor incidence of education and health spending tend to have better education and health outcomes, good governance, high per capita income, and wider accessibility to information. The paper explores policy implications of these findings.