



**Statement of
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Director**

Opportunities to Increase Efficiency in Health Care

**at the Health Reform Summit of the
Committee on Finance
United States Senate**

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The single most important factor influencing the federal government's long-term fiscal balance is the rate of growth in health care costs. The Congressional Budget Office (CBO) projects that, without any changes in federal law, total spending on health care will rise from 16 percent of the gross domestic product (GDP) in 2007 to 25 percent in 2025 and 49 percent in 2082, and net federal spending on Medicare and Medicaid will rise from 4 percent of GDP to almost 20 percent over the same period.¹ Many of the other factors that will play a key role in determining future fiscal conditions—including the actuarial deficit in Social Security and a decision about extending the 2001 and 2003 tax legislation past its scheduled expiration in 2010—pale by comparison over the long term with the impact and challenges of containing growth in the cost of federal health insurance programs.

Both demographic changes and rising health care costs per beneficiary contribute significantly to our future fiscal challenges, but it seems clear that the latter is more important over the long term. To be sure, among adults, health care spending generally increases with age. As the number of elderly people increases over time, health spending naturally will grow. Yet the dominance of cost growth in health care over the effect of demographic changes can be seen by comparing the trajectory of cost growth in Social Security with that in Medicare and Medicaid over time (see Figure 1).

Given the nature of the programs, a demographic shift will have similar effects on the costs of Social Security and of Medicare and Medicaid. In the next 10 to 20 years, the projected growth of spending in those programs differs but perhaps not all that dramatically, which suggests that demographics account for a relatively large share of the increase during that period. Beyond that point, however, Social Security spending levels off as a share of GDP, while spending on Medicare and Medicaid is projected to grow much more rapidly. Some have interpreted that relative dominance of cost growth per beneficiary in influencing our fiscal future as an excuse for not addressing the higher costs associated with an aging population. That reasoning makes little sense to me; it is a non sequitur. To say that problem A is bigger than problem B is not to say that problem B does not exist or should not be addressed.

My statement briefly explores evidence of the potentially substantial inefficiencies in health care and then discusses a few pathways to reducing them.

Evidence of Inefficiency

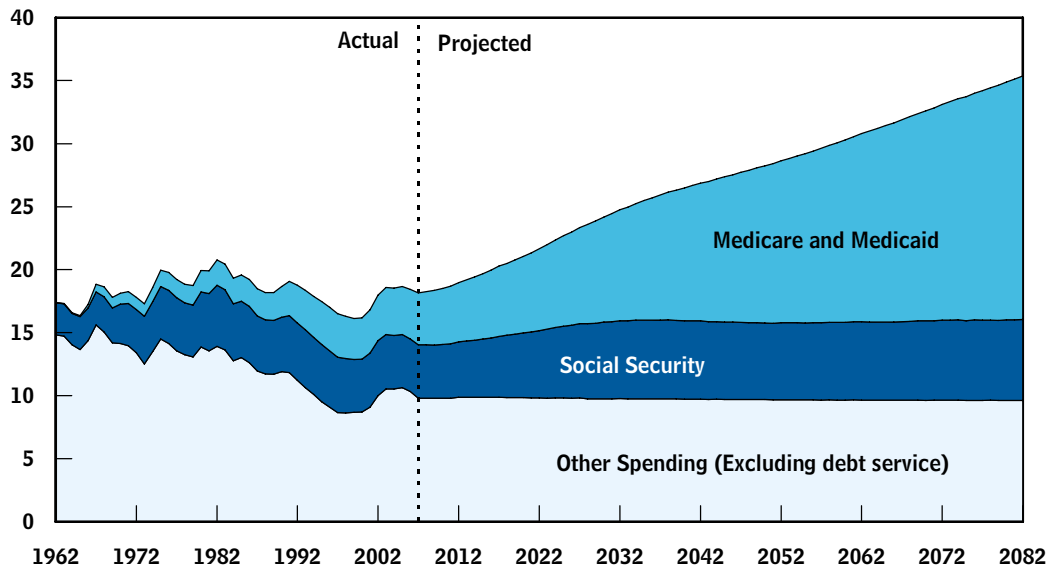
Embedded in the nation's long-term fiscal challenge is a substantial opportunity: to reduce health care costs without adversely affecting health outcomes. Perhaps the most compelling evidence suggesting that opportunity is that per capita health care spending varies widely across the United States (see Figure 2), and yet the very substantial variation in cost per beneficiary is not correlated with overall health outcomes. For example, a comparison of composite quality scores for medical centers, on the one

1. Congressional Budget Office, *The Long-Term Outlook for Health Care Spending* (November 2007).

Figure 1.

Federal Spending Under CBO's Alternative Fiscal Scenario

(Percentage of gross domestic product)



Source: Congressional Budget Office.

hand, and average spending per beneficiary, on the other, shows that facilities in states with high average costs are no more likely to provide recommended care for some common health problems than are facilities in states with lower costs (see Figure 3); if anything, it would appear that the opposite might be true.

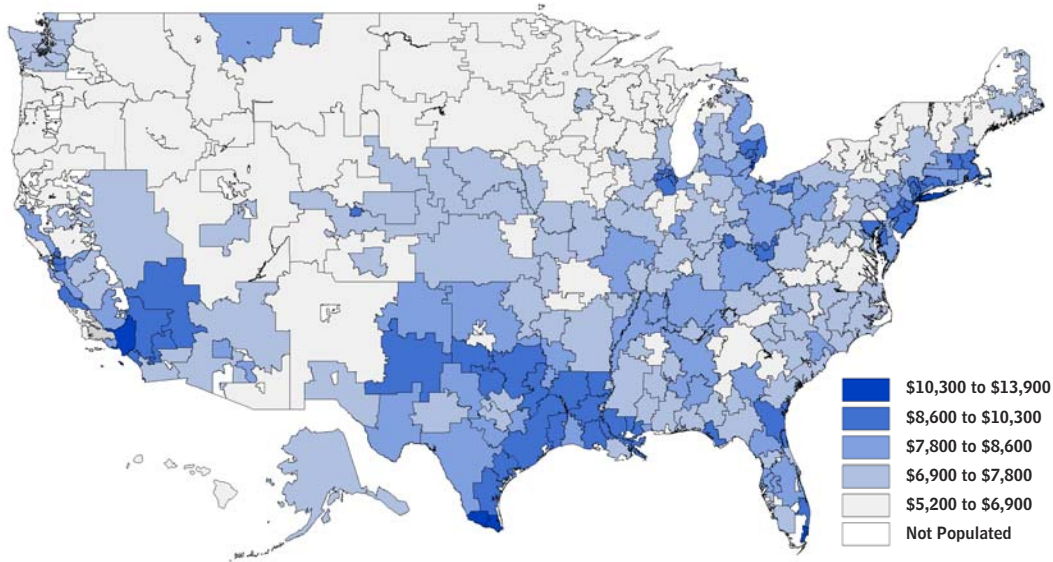
Variations in health care are often most dramatic when there is uncertainty about what kind of treatment to administer. For example, it is clear that aspirin should almost always be provided to a patient upon admission to the hospital for a heart attack, and there is very little variation in that practice. However, there is significant geographic variation in the use of imaging and diagnostic tests, and it is often unclear when those services generate useful information or how frequently they should be provided.

Similarly, admission to the hospital for a hip fracture is always indicated, and admission rates for people with that injury show little variation; but much less of a consensus exists about back surgery, and the related admission rates vary much more widely. Overuse of supply-sensitive services and differences in social norms among local physicians seem to drive regional approaches in the use of innovations and treatments. Some regions appear more prone to adopt low-cost, highly effective patterns of care, whereas others are more prone to adopt high-cost patterns of care and to deliver treatments that provide little benefit or are even harmful.

One might note that some of the highest-cost areas are concentrated around the top U.S. medical centers and assume that it is the work of those centers that drives the

Figure 2.

Medicare Spending per Beneficiary in the United States, by Hospital Referral Region, 2005



Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

Note: The data are for Medicare spending per beneficiary in the fee-for-service program, adjusted for age, sex, and race. The geographic unit is the hospital referral region, as defined by the Dartmouth Atlas of Health Care. Areas labeled "Not Populated" include places such as national parks, forests, lakes, and islands.

cost differences across the nation. However, even among elite medical centers, there is significant variation in cost. Among the UCLA (University of California, Los Angeles) Medical Center, Massachusetts General Hospital, and the Mayo Clinic (St. Mary's Hospital), for example, composite quality scores are very similar (81.5, 85.9, and 90.4, respectively). Although the Mayo Clinic scores above the other two, its cost per beneficiary for Medicare clients in the last six months of life (\$26,330) is nearly half that at the UCLA Medical Center (\$50,522) and significantly lower than the cost at Massachusetts General Hospital (\$40,181). Uwe Reinhardt, renowned professor of economics at Princeton University, asks, "How can it be that 'the best medical care in the world' costs twice as much as the best medical care in the world?"²

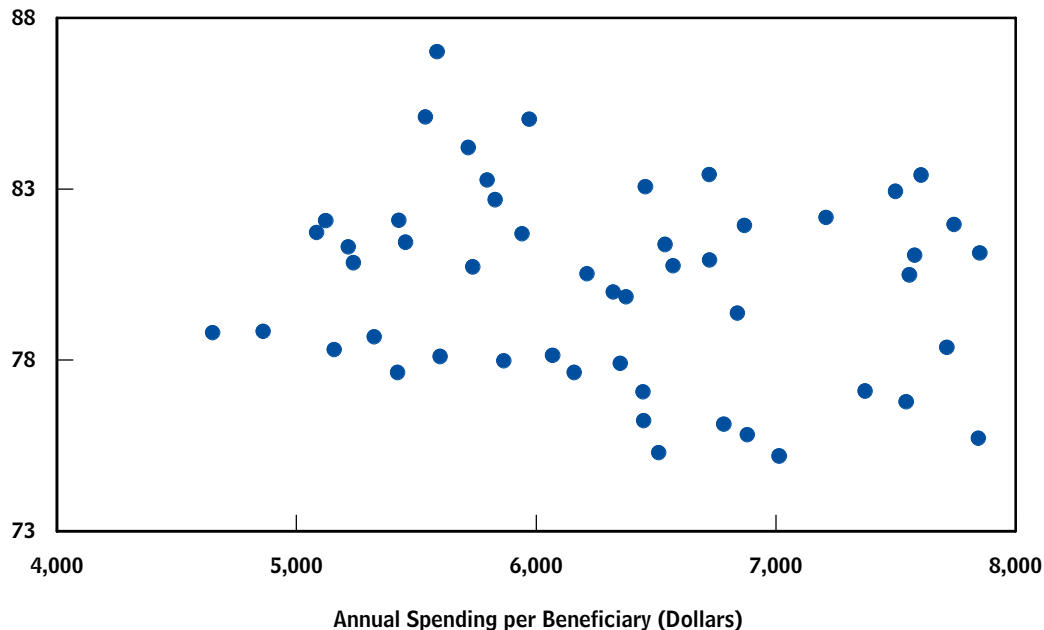
So how much could all this amount to? Researchers have estimated that nearly 30 percent of Medicare's costs could be saved without negatively affecting health outcomes if spending in high- and medium-cost areas could be reduced to the level in low-cost

2. As quoted in Gina Kolata, "Sharp Regional Incongruity Found in Medical Costs and Treatments," *Women's Health*, January 30, 1996, available at www.nytimes.com/specials/women/warchive/960130_1576.html.

Figure 3.

The Relationship Between Medicare Spending and Quality of Care, by State, 2004

(Composite measure of quality of care)



Source: Congressional Budget Office based on data from Department of Health and Human Services, Agency for Healthcare Research and Quality, *National Healthcare Quality Report, 2005* (December 2005), Data Tables Appendix, available at www.ahrq.gov/qual/nhqr05/index.html, and data from the Centers for Medicare and Medicaid Services' Continuous Medicare History Sample.

Notes: The composite measure of the quality of care, based on Medicare beneficiaries in the fee-for-service program who were hospitalized in 2004, conveys the percentage who received recommended care for myocardial infarction, heart failure, or pneumonia.

Spending figures convey average amounts by state.

areas—and those estimates could probably be extrapolated to the health care system as a whole.³ With health care spending currently representing 16 percent of GDP, that estimate would suggest that nearly 5 percent of GDP—or roughly \$700 billion each year—goes to health care spending that cannot be shown to improve health outcomes. Of course, figuring out how to reduce spending only for inappropriate and unnecessary care is a not a trivial exercise. Nevertheless, there do not appear to be other examples that credible analysts can identify that offer a potential efficiency gain of that magnitude for the U.S. economy.

3. John E. Wennberg and others, "Geography and the Debate Over Medicare Reform," *Health Affairs*, Web Exclusive (February 13, 2002), pp. W96–W114; and Elliott Fisher, "More Care Is Not Better Care," *Expert Voices*, Issue 7 (National Institute for Health Care Management, January 2005).

The idea that there could be such a potentially large inefficiency—valued at \$700 billion per year—in the health care system is striking. Also striking is the relatively small investment in research focused on the mechanics of restructuring the delivery of and payments for health care to reduce inefficiency.

Behavioral Economics and Efficiency in the Health Sector

One factor helping to perpetuate inefficiencies in health care is a lack of clarity regarding what insurance costs and who bears those costs, especially for employment-based health insurance. Employers' payments for employment-based health insurance and nearly all payments by employees for that insurance are excluded from individual income and payroll taxes. Although both theory and evidence suggest that workers ultimately finance their employment-based insurance through lower take-home pay, the costs are not evident to many workers.

We know from other settings that salience matters—and indeed that it often matters much more than the underlying financial incentives, at least when relatively small sums are involved. When consumers go into a store, for example, they see pretax prices on the items. One might assume—or at least the Econ 101 rational optimizing model would assume—that consumers are generally aware of which items are taxable and what the tax rate is. But studies in the growing field of behavioral economics question those assumptions. For example, when researchers went into a grocery store and posted after-tax prices on some items, sales of those goods fell by about 8 percent.⁴ They found similar effects when examining the effects of sales taxes and excise taxes (which are included in posted prices) on alcohol sales. Another study looked at a related question: When highway tolls are automated, does the reduced salience induce higher prices?⁵ The answer is that it does. The author found that toll rates were 20 percent to 40 percent higher than they would have been without electronic toll collection.

I suspect, on the basis of similar logic, that workers demand less efficiency from the health system than they would if they knew the full cost that they pay via forgone wages for coverage. I suspect also that making the underlying costs associated with employment-based insurance more transparent might prove to be quite important in containing health care costs. For workers and dependents with employment-based insurance, deductibles and copayments account for only about a fifth of their health care spending. The remainder comes from insurance premiums, only a quarter of which is paid directly by workers. As transparency increases and workers see how much their income is being reduced for employers' contributions and what those con-

4. Raj Chetty, Adam Looney, and Kory Kroft, *Salience and Taxation: Theory and Evidence*, Working Paper No. 13330 (Cambridge, Mass.: National Bureau of Economic Research, August 2007).

5. Amy Finkelstein, *E-ZTax: Tax Salience and Tax Rates*, Working Paper No. 12924 (Cambridge, Mass.: National Bureau of Economic Research, January 2007).

tributions are paying for, there might be a broader change in cost-consciousness that shifts demand.

Pathways to Improving Efficiency

What could be done to improve the efficiency with which health care is delivered—and specifically to reduce the delivery of services with little or no value? In health care, the vast majority of decisions are heavily influenced by doctors and other medical professionals. Restraining cost growth will therefore primarily require changing their choices. Cost constraints could be implemented by refusing to pay for certain services; I suspect, however, that more subtle actions may be more sustainable.

Like other people, doctors tend to follow professional norms of behavior. There are a number of reasons for that behavior, among them that following professional norms is simple and that it may help defend against charges of malpractice. The problem is that the professional norms in different parts of the nation do not always follow evidence-based standards of best practice. Indeed, the regional pattern of health care delivery (apparent in Figure 2) probably reflects, at least in part, differences in norms of practice among doctors. Professional norms may differ by locality because local colleagues may have a disproportionate influence and because bias favoring the status quo may make norms slow to change in the face of new evidence.

How can norms be shifted? Two potentially complementary approaches to reducing total health care spending involve generating more information about the relative effectiveness of medical treatments and changing the incentives for providers and consumers of health care. More information on the “comparative effectiveness” of alternative medical treatments could offer a basis for ensuring that future technologies and existing costly services are used only in cases in which they confer clinical benefits that are superior to those of other, cheaper services. Analysis of comparative effectiveness is simply a comparison of the impact of different options that are available for treating a given medical condition in a particular set of patients.

Anesthesiology provides one example of a great success story in putting evidence-based standards into practice. In the mid-1980s, after analyzing the most common sources of errors, the American Society of Anesthesiologists promulgated standards of optimal practice (both in procedures and equipment).⁶ Providers had an incentive to follow the standards because deviations from them made the imposition of malpractice liability more likely. After the standards were adopted, mortality rates fell to about 5 per million encounters, as compared with averages above 100 per million during

6. See Jeffrey B. Cooper, “Getting Into Patient Safety: A Personal Story,” *AHRQ WebM&M: Morbidity and Mortality Rounds on the Web* (Agency for Healthcare Research and Quality, August 2006), available at www.webmm.ahrq.gov/perspective.aspx?perspectiveID=29.

earlier periods.⁷ Thus, aggressively promulgated standards backed by some incentives can alter a long-standing and suboptimal status quo.

Research suggests, however, that the merely providing information to physicians results in an “exceedingly modest behavioral response.”⁸ The current financial incentives for both providers and patients tend to encourage or at least facilitate the adoption of expensive treatments and procedures, even if evidence about their effectiveness relative to existing therapies is limited. Costly services that are known to be highly effective for some patients are sometimes provided to others for whom the clinical benefits have not been rigorously demonstrated. Therefore, to alter providers’ behavior, it is probably necessary to combine comparative effectiveness research with aggressive promulgation of standards and changes in financial and other incentives.⁹

Inefficiency and Price Transparency for Specific Medical Services

Let me also address the effect of transparency with regard to specific medical services. Some observers believe that if people know the prices of health care services, they are more likely to seek out less expensive providers or treatments and to question how effective the care they are purchasing is likely to be. But several factors may limit the effectiveness of that type of transparency in cutting health care expenditures.

On the consumer side, more than 80 percent of the population is covered by some form of health insurance, which insulates people from the full price of their health care, limiting their incentive to compare prices. Doctors and other health professionals often direct the decisions about what services to buy from whom, as patients may have little information on the care they need or the quality or value of that care. Moreover, for insured and uninsured people alike, awareness of prices will make little difference in emergencies or in the relatively small number of cases that account for a disproportionate share of overall health care spending.

On the provider side, more transparency would make information about the prices that hospitals, physicians, and drug companies charge insurers more visible, but whether such disclosure would lead to higher or lower prices for consumers on average is unclear and depends on the nature of competition in the relevant market. The markets for some health care services are highly concentrated, so increasing transparency in such markets could lead to higher, rather than lower, prices because higher prices are easier to maintain when the prices charged by each provider involved can be

7. See David Hyman and Charles Silver, “You Get What You Pay For: Result-Based Compensation for Health Care,” *Washington and Lee Law Review* (Fall 2001).

8. David E. Kanouse, Joel Kallich, and James P. Kahan. “Dissemination of Effectiveness and Outcomes Research,” *Health Policy*, vol. 34, no. 3 (1995), pp. 167–192.

9. See Congressional Budget Office, *Research on the Comparative Effectiveness of Medical Treatments: Issues and Options for an Expanded Federal Role* (December 2007).

observed by all of the others. However, aggregated information or information on average prices would make it more difficult for providers to coordinate higher prices because individual providers' prices would not be obvious. Whatever the effect on average prices, more transparent prices would probably reduce the range of prices.¹⁰

CBO's Activities

Because future health care spending is the single most important factor determining the nation's long-term fiscal condition, CBO is devoting increasing resources to assessing options for reducing such spending in the future. The agency has expanded the number of full-time-equivalent staff analyzing health care issues from 30 at roughly this time last year to 44 now, with 6 more coming on board within the next four months. Last year, CBO established a panel of health advisers (consisting of experts from academia, industry, and independent research organizations), which meets periodically to examine frontier research in health policy and to advise the agency on its analyses of health care issues. As part of its work generally, CBO continually reviews research conducted both in and outside of government. Late this year, the agency plans to release two reports on health policy: One will present budget estimates for numerous specific policy options, and the other will address critical topics related to proposals to make major changes in the health care system. CBO hopes that those efforts will be of significant value to the Congress in assessing ways to address these critical policy issues.

10. See Congressional Budget Office, *Increasing Transparency in the Pricing of Health Care Services and Pharmaceuticals* (June 5, 2008).