

**Institute for Alternative Futures
Foresight Seminars on Health and Innovation**

SUMMARY

FORESIGHT SEMINAR ON COST CONTAINMENT
AND BIOMEDICAL RESEARCH
NOVEMBER 10, 1983

ABSTRACT

The discussion of health care cost containment can be framed according to: 1) where reductions should be made -- should they affect consumers of medical services or providers of services; 2) how these reductions should be made; and 3) how the federal government should encourage use of the most effective cost-cutting measures. Almost without exception, however, these proposals entail some sacrifice and risk. The central question becomes how much risk and what sacrifices will be tolerated.

Among the proposals are strategies to improve efficiency, provide less costly treatment choices or forego treatment altogether. Some say there is more opportunity for savings among the strategies aimed at providers, those to improve efficiency, than there is in the other options, which are aimed at patients.

And many argue that changes made in the name of cost containment may lead patients to defer treatment, especially lower-cost preventive services. In the long run, this may mean increased use of more costly emergency treatment. There are also the risks that providers will bypass uninsured and poor patients, or that innovation, especially if it requires higher expenses, will be discouraged.

An important element of cost containment is its effect on biomedical research. The state of medical technology affects health care costs. At the same time, according to one theory, medical costs affect technology. This effect is based on a series of links among costs, insurance, research and development, and, finally, technology.

Some experts believe the use of diagnostic related groups (DRGs) and prospective payments for hospitals will provide incentives for those hospitals to develop more efficient technologies and so certain types of innovation will be encouraged. Others, however, argue that DRGs will institutionalize the status quo, including some ineffective procedures or, that only cost-saving techniques will be developed while more expensive technologies - - even those that may save money over the long-run--will be discouraged. There is also the question ~‘ whether technological breakthroughs, if they are allowed to develop, can bring about significant cost savings by providing cheap disease prevention or cures.

The November 10 Foresight Seminar on health care cost containment and biomedical research raised the procedural questions of where and how to cut costs, and then examined the risks posed by the various cost-cutting options. Paul B. Ginsburg, Ph.D., Deputy Assistant Director for Income Security and Health at the Congressional Budget

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Office, presented a framework of policy questions and alternatives for addressing cost containment. Helen L. Smits, M.D., Associate Professor of Medicine and Public Health at Yale School of Medicine, outlined the major risks associated with the various cost-containment strategies. Burton A. Weisbrod, Ph.D., Professor of Economics at the University of Wisconsin, discussed the relationship between research and development and cost containment.

PAUL B. GINSBURG

The question of how far society is willing to go in order to control health care costs becomes important in examining cost-control strategies because most of these strategies entail some sacrifice. Society, for example, may soon reach the point of abandoning services with low or uncertain medical value.

This is one of the underlying issues in the effort to control health care costs. The more direct questions raised in this effort are: 1) where to reduce costs; 2) what mechanisms should be used to reduce costs; and 3) what can the federal government do to increase the use of the selected mechanisms.

Among the options available to answer the first question -- where to reduce costs the best opportunity for savings lies with mechanisms that affect the provider, such as improved efficiency in provision of specific services. This may include slowing the growth rate in physician fees or other wages, more aggressive purchasing policies or application of industrial measures, such as time-motion studies, to ensure optimum use of resources. There is even more opportunity for saving in other strategies: improved efficiency in use of services for a given treatment, such as the judicious use of ancillary procedures; lower cost treatments, substituting medical for surgical treatments, for example; and foregoing treatment. Knee surgery is an example of an expensive treatment that could be avoided in certain cases.

Answers to the second question -- what mechanisms should be used to control costs -- include: incentives to patients, such as cost-sharing and Preferred Provider Organizations (PPOs); incentives to providers, such as HMOs, primary care networks and prospective payments; use of market power by large payers, such as prospective payments as a means to Lower prices; and direct controls by government or payers, such as utilization review, designation of certain providers for expensive procedures, health planning or exclusion of coverage for expensive procedures with uncertain medical value.

Answers to the third question -- what can the federal government do to increase use of the best mechanisms -- include policy tools affecting both publicly and privately financed health care. In the public realm of Medicare and Medicaid, the government can restructure benefits, reduce physician fees or institute systems of vouchers, DRGs or peer review. In the private sphere, government can employ tax caps, extend prospective payments to all payers or pursue anti-trust policies.

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But it may turn out that government actions may have the most influence through unintended effects on the private sector. Medicare DRGs, for example, may be one of the most significant steps the government has taken to stimulate such private sector developments as the growth of PPOs and other alternative delivery systems.

HELEN L. SMITS

Cost Containment poses the risk that innovation, especially if it requires higher expenditures, will be discouraged. Also, there are the risks that patients will defer important treatment or that the wealthiest and best insured patients will be favored.

Cost-containment mechanisms that affect direct medical intervention, such as Professional Standard Review Organizations (PSROs), are based on the status quo -- a 'snapshot' of existing data -- and hence discourage innovation. Incentives for providers to cut costs present the risk of discouraging behavior that increases costs, even if it is effective in treating disease. Under DRGs, for example, longer patient life is more costly, and so increased survival is, in theory, discouraged. Also, this category of incentives could lead providers to favor the wealthiest and best-insured patients. Existing payment schemes have already led providers to sort out the poor and uninsured. Finally, incentives to encourage cost-conscious behavior among patients, through heavy cost-sharing, for example, pose the risk that patients will defer preventive and other treatment that doesn't offer immediate, perceptible benefit. This risk suggests that cost-sharing systems might be developed to be similar to many dental insurance plans, where preventive work is provided for.

The results of medical care, which cover the spectrum from decreased mortality to increased comfort, contain, for the most part, some element of luxury. In addition to decreasing mortality, health care has lowered disability, increased rates of recovery and slowed rates of debilitation. It has reduced symptoms, especially pain, and increased mental and physical comfort, particularly through the reassurance which often accompanies a diagnosis. Health care has been measured largely by its effect on mortality. While these other benefits are important, they are not measured by standard economic criteria. Accordingly, there is a tendency to ignore benefits other than reduced mortality when cost containment is considered. All outcomes, with the exception of decreased mortality or marked decrease in disability, incorporate at least some element of luxury. While no one should be forced to remain in great pain, there is a large element of luxury at the end of the spectrum where medical care may only remove some uncertainty or provide minor cosmetic change. Cost containment efforts could reduce coverage for medical services at the luxury end of the spectrum, or make them available for private purchase only. But cost-containment strategies should protect central care, through which mortality and disability are decreased.

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BURTON A. WEISBROD

It is vital to interject the element of medical technology into any discussion of cost containment because technology both affects, and is affected by, health care expenditures. The effect of technology on costs may correspond to a cycle: when a disease such as polio first appears, there is no technology to treat it, so expenses are low. Spending increases as partially effective "halfway" technologies, such as the iron lung, are discovered. But costs decrease again when high technology produces an effective prevention or cure -- the polio vaccine. The recent rapid increase in health care costs may be attributable to the fact that most technologies are still approaching the expensive "halfway" point, after which costs may drop. This model implies that profound cost increases may be only a short-term problem because breakthrough technologies will eventually reduce costs.

The converse theory, that medical expenditures affect the state of technology, is based on a series of links among health care costs, insurance, medical research and development, and medical technologies. Rising health care costs caused a growing demand for insurance, and this insurance itself caused costs to rise as incentives to save declined with the shift from individual to third-party payment. Insurance arrangements guaranteed virtually unlimited demand for effective technologies, regardless of cost, and so high-cost technologies were implicitly encouraged. Without insurance, economic considerations would have encouraged scientists to develop lower-cost, even if less effective technologies. But insurance removed the consideration of direct expense to the consumer, which would have affected demand, thereby encouraging the development of higher-cost technologies. This effect on medical R & D in turn affected the state of medical technology.

Cost-containment efforts are really directed at expenditures, not costs. Expenditures have risen for several reasons, which should be viewed distinctly: quantity of services has risen; prices of standard commodities have risen; and quality of care has risen.

Cost containment is not by itself an appropriate public policy goal because with it must be reconciled the objectives of improved health. If cost control was the sole objective, it would be appropriate to take extreme steps, cutting off funding for R & D, for example. The extreme example is that death should be encouraged because it is cheaper than health care. This conclusion is unacceptable, of course, but it illustrates that controlling costs is appropriate only if the alternatives are acceptable. Moreover, a short-run control of expenditures -- curbing R & D, for example -- may mean increased expenditures over the long run. The appropriate goal should be expenditure "Optimization," not expenditure reduction.

QUESTION AND DISCUSSION

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In response to a question on whether DRGs will institutionalize ineffective care, Ginsburg said the system will slow technologies that increase costs. But because hospitals are at risk, there are incentives to eliminate ineffective technologies. As hospitals save money, the DRGs will be adjusted to incorporate the improved efficiency. But there will be problems when DRGs must be adjusted to reflect more expensive technologies, and so these developments will be discouraged.

Weisbrod agreed that the fixed-fee system will provide incentives for development of cost-reducing technologies. He predicted a response in R & D--innovation to shorten hospital stays, for example -- because of the large potential for savings.

Smits said the system is more promising than others proposed in the past, but cautioned that medical practices may be frozen at a 1980 level because DRGs are based on 1980 data. This is a problem particularly because of the lack of good measures to assess the medical outcomes of given procedures, making evaluation of a cost-enhancing advance difficult unless some clear-cut outcome, such as death is altered.

On the other expected effects of prospective payments, Ginsburg predicted the system will have a significant effect by placing pressure on hospitals to improve efficiency. But there are problems with the system: physician fees are not addressed and there are no controls to overcome some inadvertent incentives to put more patients in the hospital. He said changes in medical protocol may hold the biggest potential for cost savings, but there may be problems funding this type of research.

Weisbrod warned that hospitals may find ways to shift costs by substituting services. For example, more patients may be treated in institutions other than hospitals to avoid the controls. He also said that while expenditures depend on prices, quantity, and quality of services, DRGs address only prices. Quality controls are left to the hospital and there may be pressure to adjust the quantity of services provided. Patients could be released prematurely, for example.

Smits said the new system will raise questions about the uninsured patient and the cost of teaching and research. Hospitals, which have been absorbing the costs of non-paying patients, may no longer be able to afford this under the new controls. Another potential effect, she said, is illustrated by the New Jersey experience, where hospitals are rejecting physicians because their past practices have been too expensive. As yet, we do not link the cost of practice patterns to medical outcomes produced by the physician.

When questioned about how to return the health care system to a normal market, Smits said this goal may be impossible to achieve. If the goal is only to control outlays, the British National Health System provides a good model. Although it is experiencing problems, the system has distinguished essential care from luxury care, but at the cost of capital starvation. Weisbrod said maximum access to health care has been taken for

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granted in the United States. But revisions that make certain services available only at private expense will create serious social tensions.

Market effects may lead the government to implement catastrophic coverage instead of first-dollar coverage. While first-dollar coverage, which was instituted in the interest of providers, has stimulated R & D, catastrophic coverage may be more equitable.

In response to a question on whether cost containment will affect breakthrough technology, Weisbrod said the present system, which encourages high-cost technology, could be altered by cost-containment policies. The existing National institutes of Health criteria for awarding research funds, for example, is based only on scientific merit, without consideration of cost. The system could include potential savings as a criterion for funding. Also, a move to catastrophic insurance may weaken incentives for development of high-cost technology by removing the unlimited demand for technologies regardless of cost guaranteed by first-dollar coverage.

Smits said catastrophic insurance could be modeled on casualty insurance, where short-run costs may be higher, and the patient is directed to designated providers, but decisions are driven by the clear medical outcome of rehabilitation.

In response to a question on why our current health care costs are unacceptable, Weisbrod raised the concern that the system operates inefficiently. Also, physician income is much higher relative to the average income in this country than it is in other countries, and there has been little effort to control these prices.