PERSPECTIVE

ELECTION 2004

Controlling Health Care Costs

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Every year, without fail, spending for services covered by private health insurance increases. Sometimes health care spending grows slowly, as it did in the mid-1990s during the managed-care boom. But more often, it increases rapidly, as it is doing now — in part because of the managed-care bust. Presidential candidates do not want to venture beyond platitudes concerning costs because they risk being accused of taking things away from people. Both President George W. Bush and Senator John F. Kerry have served up proposals designed to ease voters' angst about the affordability of health care, but neither proposal, as it has been elaborated through September, gets at the core issues involved in controlling the growth of health care costs.

Between 1999 and 2003, the per capita spending for services covered by private health insurance increased by 39 percent.[1] Given that the average hourly earnings of U.S. workers increased by only 14 percent during that period (see Figure), affordability is an acute and growing concern.[2] Unlike increased spending for most other goods and services, which often inspires a celebration of our economy's ability to shift resources rapidly to new products and services that consumers want, rapidly increasing health care spending is often viewed negatively — almost as a force of nature that lies outside consumers' control. The simple explanation for rapidly increasing health care costs is that people are getting more care, much of which is associated with new medical technologies. But many experts have doubts about the value of some of this care in relation to its cost. And when health care costs increase at a much faster rate than incomes, many people — especially those with low incomes — can no longer afford insurance coverage.

Over the long term, new medical technology has been the dominant driver of increases in health care costs and insurance premiums. "New technology" includes not only new diagnostic procedures and treatments that are more costly than older ones, but also some that cost less per unit but are more effective or cause less discomfort to patients — qualities that stimulate much higher rates of use. Additional applications of established technologies (for example, magnetic resonance imaging) may be even more important to cost increases than technologies that are being applied to medical care for the first time. Some new technologies — many vaccines, for example — do result in lower spending, but research has shown that, on balance, changing technology in medicine results in increased spending and accounts for one half to two thirds of the increase in health care spending in excess of general inflation.[3] Perhaps the result would be different if these technologies were used more judiciously, with greater guidance from research on medical effectiveness.

Both presidential candidates have proposed ways of expanding health care coverage and keeping health insurance affordable. The Kerry proposal focuses more on cost containment than the Bush plan does. However, much of the improved affordability in both plans would result from increased government subsidies rather than from any reduction in the rate of growth of underlying costs. For example, Kerry proposes reimbursing employer-sponsored health plans for 75 percent of catastrophic costs of more than $30,000 per person as long as employers pass on the savings to employees by reducing their share of premiums. This proposal for reinsurance would increase affordability not by slowing cost trends but by substituting government payments for employee payments. Bush also emphasizes affordability rather than cost containment in his proposal for a tax credit for the purchase of individual insurance.

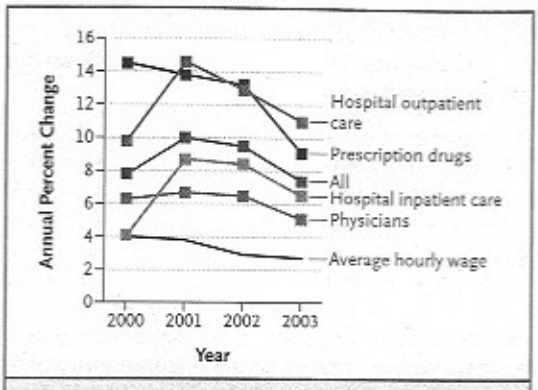

Figure. Annual Percent Changes per Capita in Health Care Expenditures and in Average Hourly Wages for Workers in All Industries, 2000 through 2003.

Data are from Strunk and Ginsburg.[3]

In reality, there are four basic options for slowing the trends in health care spending: one can increase the efficiency of health care delivery; increase the financial incentives for patients to limit their use of medical services; increase the administrative controls on the use of these services; or limit the resources available to the health care system. Health care systems throughout the world are pursuing variations on all four options, and the success of their efforts depends in part on how vigorously cost-containment tools are applied. But success does not come easily. For one thing, all health care spending represents someone else's income, and those who are facing a loss of income will work to block efforts to contain costs. In addition, each of these options, with the possible exception of the first, requires some people to get less medical care than they would like. For the most part, our leaders have been unwilling to acknowledge the inherent trade-offs between health care costs and people's access to care.

Government may be able to contribute to the efficiency of the health care system by supporting the development and installation of information technology to improve the coordination of patient care; both candidates have proposed subsidies for this purpose, although neither acknowledges the uncertainty over whether cost reductions would be achieved. Greater adherence to the practice of evidence-based medicine, additional research on the effectiveness of medical treatments, and greater assessment of technology before it is used outside research settings may all lead to gains in efficiency, but neither candidate devotes much attention to these issues. Current efforts to improve system efficiency give priority to improving the quality of care and have an uncertain effect on costs. For example, efforts to increase the rate of conformity to practice guidelines may increase rather than decrease the use of services.[4] Many health policy experts have offered vague assurances that increased quality would result in a reduction of costs, seemingly in an effort to avoid acknowledging that there may be a trade-off.

Reform in the realm of professional liability could increase efficiency by reducing incentives to practice defensive medicine and allowing a higher proportion of liability premiums to be used for the compensation of injured patients. The Bush and Kerry plans both seek to limit frivolous suits and the punitive damages that could be awarded, but only Bush favors caps on awards for all noneconomic damages.

Kerry's proposal to set up an insurance purchasing pool that resembles the Federal Employees Health Benefits Program could, if successful, increase the proportion of insurance dollars that goes to benefits by reducing selling costs and creating a more competitive market for health insurance.

In recent years, employers have taken such steps as increasing deductibles in order to shift more costs to employees, giving them a financial incentive to use fewer services. Innovation is under way in this area: new benefit structures have been developed, including consumer-directed health plans, which typically have employer-funded spending accounts tied to insurance policies with a large annual deductible that exceeds the annual contribution to the account. Moreover, attempts are being made to support consumers by supplying better information on provider quality and prices. Having patients share more costs can benefit consumers when it leads them to forgo care that has very limited benefits. But when the tools are used bluntly — as when they are applied equally to care that is deemed essential and care that is considered to be more discretionary — they can pose a barrier to important care or cause financial hardship for patients with low incomes or substantial medical needs. These tools must be refined if substantial cost containment is to be attained through this approach.

Only the Bush plan endorses the increased use of financial incentives for patients, extolling the virtues of high-deductible health plans and proposing tax deductibility for plans that meet the qualifications for health savings accounts. However, Bush

describes this proposal as a way of expanding coverage rather than as a cost-containment measure. The use of health savings accounts is likely to decrease spending for services that are typically covered by insurance but to increase spending on other services that qualify for the medical-expense deduction, such as dental care and optical services.

An approach stressing administrative controls, relying on tools such as restrictive provider networks, prior authorization for services, and payment of providers on a capitated or episode basis, was used extensively by managed-care plans but proved highly unpopular. Many restrictions were later relaxed in response to a backlash against managed care. Neither candidate has called for increased administrative controls. Indeed, both have called for a "patients' bill of rights," which would, presumably, make these tools even more difficult to use.

Restricting the resources that go into the medical care system and the prices paid to providers is an approach that has been used extensively in Canada and Western Europe but has never gained much of a foothold in the United States. Attempts to regulate facility expansion and hospital rates were common in the United States during the 1970s but declined with the expansion of managed care and increased competition in medical care. Neither candidate is advocating this approach.

That neither Bush nor Kerry is aggressive about containing costs is not surprising. Presidential campaigns are focused on promising to do things for voters — not on taking things away. We can only hope that whoever is elected president will move beyond campaign-trail rhetoric and provide the leadership needed for a candid national discussion about health care costs. If not, we will find ourselves on a downward spiral, as more and more resources are used to pay for the health care of fewer and fewer Americans — a potentially intolerable situation.

From the Center for Studying Health System Change, Washington, D.C.

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Problems with Drug-Eluting Coronary Stents — The FDA Perspective

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The introduction of drug-eluting coronary stents in the United States has rapidly and profoundly affected the field of interventional cardiology. Met with widespread anticipation by the clinical community, drug-eluting stents are now used in a majority of intracoronary stenting procedures, justifying their characterization as a "transforming technology." However, both such stents that are currently approved by the Food and Drug Administration (FDA), the Cordis Cypher sirolimus-eluting stent and the Boston Scientific Taxus Express[2] paclitaxel-eluting stent, have also been associated with highly publicized adverse events after they were approved for marketing, leading some to question their safety. As a by-product of this concern, there has been considerable interest in how these stents are regulated by the FDA. Questions have been raised about the agency's evaluation of their safety and effectiveness before marketing and about its actions after the adverse events became known.

The difficulties in interpreting data on reports of adverse events during the postmarketing period were recently highlighted by our decision to issue public health notifications regarding the Cypher stent. The first drug-eluting stent, Cypher was approved by the FDA in April 2003.[1] Soon afterward, we saw an influx and clustering of reports of subacute thrombosis associated with the stent, and Cordis, in conjunction with the FDA, issued a letter in July 2003 notifying physicians of these initial re-