Will We Ever Bend the Cost Curve in Healthcare?

By Ehsan U. Syed, MD
Associate Professor of Psychiatry, Penn State University College of Medicine, and Medical Director, Child and Adolescent Service Line, Pennsylvania Psychiatric Institute, Hershey, PA

Healthcare in America remains one of the most expensive systems in the world. Among industrialized nations, the United States spends the highest per-capita on healthcare, but is mediocre in terms of indices such as life expectancy, healthcare coverage, and infant and maternal mortality.1 During the decade between 2016 and 2025, the national health expenditure is projected to grow at an average of 5.6% and outpace the gross domestic product by more than 1%.2 As a result, the proportion of the US economy that will be attributed to healthcare is projected to climb from approximately 18% in 2015 to almost 20% in 2015.2

According to data from the Centers for Medicare & Medicaid Services, starting from 2018, spending in Medicare and Medicaid is projected to grow faster than spending in private health insurance plans.2 Among the many reasons cited for the increase in personal healthcare, the most significant is the aging of the US population, as more baby boomers become eligible for Medicare. As people get older, their healthcare needs often increase tremendously. Among the baby boomer age-group, the highest expenses are projected to be in home healthcare, with a growth of approximately 8%, and prescription drug expenditures, at more than 6% annually.3 A large portion of prescription drug spending is on new specialty drugs for the treatment of chronic, difficult-to-treat conditions, such as rheumatoid arthritis, psoriasis, and cancer, conditions that are associated with older age.2

Healthcare spending is now the biggest driver of the federal budget deficit and outstanding public debt, and is projected to reach a staggering $24 trillion in 2025.1 Growing interest payments on this national debt affects all other federal spending and economic programs, including spending on education, social welfare, and infrastructure improvement and maintenance. This debt is projected to burden the future generation and slow down economic growth, leading to chronic recession.3 Medicare, Medicaid, state Children’s Health Insurance Program, and insurance subsidies that were provided through federal and state insurance exchanges account for most of this spending, which will reach 27% of the federal budget in 2025 and cost approximately $1.9 trillion.5

To understand how we got here, we need to understand the US healthcare system and compare it with systems in other countries that are members of the Organisation for Economic Co-operation and Development (OECD) to get a better perspective. Our system is unique among the OECD countries, because we do not have a single-payer National Health Service like the United Kingdom or a multipayer universal healthcare system like Germany; instead, we have a hybrid healthcare system. In 2017, approximately 91% of our population was covered by private health insurance or by public insurance (ie, Medicare, Medicaid, or military coverage), with the latter covering approximately 38% of the total insured pool.4 In 2014, almost 33 million Americans had no health insurance coverage, and that number has shrunk considerably since the introduction of the Affordable Care Act.5

In 2016, the United States spent more than $9800 per-capita on healthcare, which is more than double the average of all 35 OECD members, and our public sector spending was one of the highest among OECD countries.6 The next 2 countries with the highest spending on healthcare were Switzerland and Luxembourg, although their total per-capita dollar amounts were only approximately 25% of our costs.6 Experts point out 3 major contributors to this cost discrepancy between the United States and the OECD countries.1 The highest driver is the cost of pharmaceuticals and similar nondurable medical care.6,7

In 2015, the United States spent an average of $1162 per-capita compared with an average of $553 per-capita for other OECD countries.6 When comparing the difference in total per-capita healthcare spending between the United States and other OECD countries, drugs account for 18.4% of the per-capita difference versus Germany, 23.2% versus The Netherlands, and 33.8% versus Sweden. Pharmaceuticals exceed every other category of spending in terms of cost difference.7 The other 2 major factors that increase cost are chronic disease management, and the astounding high administrative costs, which stand at $752 per-capita—more than 3 times that of Germany ($232) and The Netherlands ($208).1,7 Physician salaries contribute only 4% to the difference in per-capita cost compared with other industrialized countries.7

The rising cost of healthcare translates into cost opportunity, meaning that by curbing costs, the money that...
would be spent on healthcare could instead be spent on other programs that are equally or more important. As the National Association of State Budget Officers explains, “Medicaid has risen as a percentage of total state spending, growing from 20.5 percent in fiscal 2008 to an estimated 29.0 percent in fiscal 2017. At the same time, elementary and secondary education has gone from representing 22.0 percent of total state spending in fiscal 2008 to an estimated 19.4 percent in fiscal 2017.”

The healthcare cost curve needs to be bent, and a serious effort has to be made looking into this matter. I am focusing mainly on pharmaceutical prices and suggest some measures to control the ever-increasing rates of prescription drugs. Lee and colleagues reviewed more than 250 studies to examine different ways to reduce or regulate drug prices, and they have grouped these measures into the following 3 broad categories.

The first category is consumer- or patient-related, and includes deductibles, coinsurance, or any other prescription charges—essentially cost-sharing. This is the most common method of price regulation used in the United States. In the United States, coinsurance is tiered, namely, it goes up and down according to the price of the drug. Cost-sharing methods have a downside in that they also reduce the utilization of essential and less expensive drugs, more so for the latter. This reduces overall spending on pharmaceuticals, with the caveat that people may neglect their health by not filling their prescription because of cost.

The second category of drug-related cost reduction is physician- and prescriber-focused. There are different ways to approach this, one of which is educational intervention or adherence to guidelines. Examples of this from Europe are the National Institute for Health and Care Excellence (NICE) guidelines, which are universally accepted in the United Kingdom by all specialties, and Prescribing Analysis and Cost data from the National Health Service and utilization review, which allow physicians to access patients’ medication history and prescribing recommendations. Evidence from the study by Lee and colleagues suggests that educational interventions can lower prescribing based on evidence and cost-effectiveness.

Such interventions are likely to succeed, and information in different guidelines, such as those from NICE, is offered to physicians as evidence-based, with objective data on the specific intervention’s cost-effectiveness. In the United States, reimbursement restrictions and prior authorization for expensive drugs are predominantly used by public payers, such as Medicaid, and often are used to control drug utilization. Another initiative used in the United States and some European countries is provider incentives for prescribing practices such as Dutch physicians received a bonus for prescribing generics. In the Dutch study, the use of provider incentives did not lead to any major reduction in overall cost, and this initiative can be subject to misuse by prescribers.

Finally, the most controversial policy for the United States is price control. As a free market, any idea that includes externally fixing prices, especially by a government regulatory body, can meet stiff resistance from all stakeholders. Germany has been using a reference pricing system, in which the patient pays a price that is the difference between the cost of the particular drug and the reference price. The reference price could be the average price of that drug category, as in Germany, or the lowest price for that drug class, as in Canada. Lee and colleagues indicate that reference drug pricing has a modest effect on overall cost curtailment, although it can also increase the use of the reference drug and reduce the utilization of nonreference drugs, without any scientific reason.

All 3 measures of pharmaceutical price control can have a significant effect on health expenditures by reducing unnecessary prescribing of expensive drugs, cost-sharing by patients, and some price regulation using reference drug pricing. Controlling costs to contain expenditures requires the regulation of drug prices and the volume of prescribed medications. Having uniform guidelines such as the NICE guidelines can also modify prescribing practices based on evidence and cost-effectiveness.

References