
Commentary

Health Care Cost Containment: What Is Too Much?

by Samuel A. Mitchell and John R. Virts

With lower general inflation and intensified cost management, health care spending growth in the 1980s clearly has slowed. Initiatives such as Medicare's prospective payment system (PPS), utilization review, greater patient cost sharing, and greater use of health maintenance organizations (HMOs) have accelerated the trends of declining hospital admissions and decreased lengths-of-stay. Specifically, providers have improved the efficiency of their procedures (provider efficiency) and, where possible, have shifted care to lower-cost sites such as outpatient facilities (site efficiency).

In 1984, the unusually rapid rise in the gross national product (GNP) of nearly 11 percent over 1983, coupled with reduced growth in health care spending of 9.1 percent, caused the proportion of GNP devoted to health care spending to fall for the first time in many years—from 10.5 percent in 1983 to 10.3 percent in 1984. In 1985, health care spending growth was further reduced to 8.9 percent from 1984. However, sluggish GNP growth of less than 6 percent resulted in a 10.7 percent ratio of health care spending to GNP.

Our analysis indicates that year-to-year increases in price-deflated per capita total consumption of health care goods and services were about the same in 1984 and 1985 as in recent history. The most significant factor slowing health care spending growth since 1981 has been the decline in general inflation. In effect, much of the price-deflated savings from fewer hospital admissions and decreased length of patient stay in hospitals has been consumed by spending for other forms of health services. We do not know, of course, but we suspect that current patterns of cost containment, cost shifting, and perhaps some rationing (or even reduction in quality by some definitions) will fairly rapidly achieve their maximum potential in reducing the growth in the share of the GNP absorbed by health care.

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The Fluff Hypothesis

Some believe that as much as 25 percent of health care spending is sheer waste. They expect that health care spending as a percent of GNP will decline if government and the private sector will only shave the fluff off. It is important for consumers, employers, insurers, and policymakers to know whether this “fluff hypothesis” is correct. If it is mainly right, then private and public payers can continue to be aggressive in making further cuts. If it is wrong and expenditures are cut too much, medically appropriate services will not be provided.

The fluff hypothesis rests on a few key assumptions: (1) There is a significant amount of controllable health-specific inflation in excess of general inflation; (2) There is a large amount of unnecessary use of services, especially hospitalization; and (3) The coming dominance of HMOs with their built-in cost-containment incentives will squeeze out the price and utilization excesses.

Before explaining why we think these assumptions are a dangerous guide to policy making or expectations about future health care costs, one thing must be made perfectly clear. There, of course, has been some excess inflation and some pure waste, that is, health costs with no associated medical benefits. The new competitive environment has already had substantial impact on both prices and utilization. Our contention is that this pure waste is but a fraction of the 20–30 percent of total estimated by some. If this is correct, then private and public sector cuts soon will run into quality and access problems.

Cost saving or cost shifting? A good bit of the cost savings now being reported by individual payers may turn out to be cost shifting. Initial support for this alternative hypothesis comes from econometric studies. One study found that greater age-adjusted per capita utilization of personal health care goods and services accounted for only about 22 percent of the total increase in health care spending from 1965 to 1981.¹ Thus, unless the potential saving can be found in the prices of goods and services, it will have to be found in the increased spending on new technology and the increased access to care stimulated by public and private policies. In any event, it is unlikely to be near the magnitude of 25 percent of total spending.

Expenditures for health care goods and services, of course, are not the only economic costs of illness to individuals, employers, and the economy. Loss of productive time, whether in employment or homemaking, and loss of productive life due to premature death are also costs of illness. Rice, Hodgson, and Kopstein recently published estimates of the magnitude and trends in the total U.S. economic costs of illness broken down into direct cost and the indirect economic costs of morbidity and mortality.² As population, productivity, prices, incomes, and many other fac-

tors have grown over time, each of these measures of costs of illness have also grown. The relative trends of growth of direct and indirect costs can be assessed by relating each of the costs and their total to GNP for the same year (see Exhibit 1).

Exhibit 1
Economic Costs Of Illness As Percent Of GNP

	1963	1972	1980
Direct costs	3.7%	6.2%	7.7%
Indirect costs ^a			
Morbidity	3.5	3.5	2.5
Mortality	8.2	5.9	5.0
Total	15.4	15.6	15.2

Source: Calculated from Table 12, p. 76 of Dorothy P. Rice, Thomas A. Hodgson, and Andrea N. Kopstein, "The Economic Costs of Illness: A Replication and Update," *Health Care Financing Review* 7 (Fall 1985).

^aIt should be noted that much of the indirect costs (for example, the economic value of home labor or the present value of expected compensation due to delayed death) are not included in GNP. Therefore the levels of those ratios for any one year are difficult to interpret. Since, however, the data content is constant for each year's measure, the trends are useful information.

These data indicate that rapidly rising health expenditures relative to GNP have been accompanied by declines in the economic costs of morbidity and mortality relative to GNP. Whether or not the improved access to care, utilization of care, and new technology were the principal causes of the decline in the indirect costs of morbidity and mortality relative to GNP cannot be determined from these data. But this possibility cannot be neglected by policymakers. The matter deserves continuing research and study. As a society we have perhaps been substituting direct for indirect economic costs of illness. Any net gains in quality of life (including less pain, less suffering, and longer life for the elderly, particularly) are in addition to these economic measures.

Virtually everyone believes, of course, that our improvements over the past twenty years in care itself, payment methods, access, and utilization management could have resulted in even more efficiency—lowering the total cost of illness relative to GNP by not having raised direct costs so much, for example. Thus, initiatives to improve efficiency are clearly in order. However, care must be exercised not to jeopardize the declining trend in the indirect economic costs of illness.

The Reasons For Health Inflation

Empirical work has shown that the amount of health-specific price inflation is surprisingly small. Because of a failure to note the relatively high labor intensity of health care, many analyses have not adequately assessed the impact of general inflation on health care prices. Since the introduction of Medicare and Medicaid in 1965, economywide price

inflation after adjustment for relative labor intensity caused about 58 percent of the increase in spending for health care through 1981. However, health-specific inflation accounted for less than 6 percent of the increase in health expenditures.³ Hospital-specific inflation was higher, accounting for about 10 percent of the increase in hospital costs during the 1970s and very early 1980s. There were three main reasons for this: labor cost per unit increases were above the economywide average, malpractice insurance premiums rose four times faster than the rate of increase in the GNP deflator, and food and utility price increases outpaced the deflator increase by 29 percent and 66 percent, respectively.

The key point about the causes of health-specific inflation in excess of general inflation is that they were essentially beyond the control of providers. Monopoly power thus has not been a problem in health care price inflation. While not evident for years, supply problems eventually will be the result if price controls are employed when potential monopoly power over pricing is absent. Significant savings will have to come from lower utilization of health services after maximum provider and site efficiencies have been reached.

Utilization: How Much Is Unnecessary?

Health policy experts disagree often, but at least on one issue there is unanimity: all studies show that health care spending is highly concentrated. About 9 percent of Medicare enrollees in 1982 accounted for over 82 percent of Medicare Part A reimbursements, and 28 percent of Medicare spending is on beneficiaries in the last year of life.⁴ The Congressional Budget Office found that 5 percent of federal employees and their families covered by Blue Cross plans incurred 50 percent of total spending in 1978.⁵ Similarly, one private employer has found that 10 percent of its employees accounted for two-thirds of total health spending.⁶

What does concentration have to do with the utilization issue? Significant savings will have to come from treatments for people who are really sick. For example, a 25 percent cut in the health spending of that 90 percent of the population incurring only 33 percent of total costs would reduce health care costs by only 8 percent.

Dilemmas in cutting costs. Recent studies suggest that it will not be easy to reduce high utilization-related costs without having to make some painful choices. One study—based on data from the records of patients hospitalized in 1972, 1977, and 1982—found that “‘little ticket’ procedures, such as laboratory tests, did not contribute to rising costs, and new imaging techniques were commonly substituted for older, more invasive procedures. The primary causes of rising costs were the provision of surgery to patients admitted for acute myocardial infarction, delivery or respiratory distress syndrome of the newborn, and provision

of other intensive treatments for the critically ill.”⁷ There was no improvement in inhospital survival. Whether this outcome justifies cutting spending on the very ill is a difficult question if for no other reason than because physicians do not always know in advance who might be helped.

A study on trends in Medicare-financed surgery poses less of a medical dilemma but an even greater economic dilemma. In 1981, Medicare patients accounted for 22 percent of total hospital admissions with surgery, up from 15 percent in 1972. For high growth procedures—cataract surgery with lens implant, coronary bypass, and hip replacement—Medicare patients accounted for 66 percent of the total, versus 35 percent in 1972.⁸ These three procedures alone cost Medicare \$2.6 billion in 1981 (over 7 percent of total Medicare spending).

Inhospital mortality rates declined, as did length-of-stay, even though the patients hospitalized for surgery in 1981 generally were more severely ill than patients with a like diagnosis hospitalized in 1972. Analysis of the causes of the increase in surgery showed that demand rather than supply factors were primarily responsible for the growth.⁹ Advances in technology have made various surgeries safer, and Medicare beneficiaries have sought them to improve their quality of life.

Cutting utilization of services for people who are very sick and for Medicare beneficiaries can create serious ethical dilemmas. From the standpoint of society, it might make strict economic sense to cut care for the catastrophically ill and the elderly. The savings would probably be much greater than the lost productivity and output. Put another way, the benefits to society from a much more stringent utilization review program might be large relative to the cost, and aggregate mortality and morbidity statistics might be largely unaffected. The British experience seems to prove this point. But the waste that is being eliminated is not waste to those who are being denied. The issues thus are ethical.

Many respected health policy researchers disagree with some or all of our points. Some of these researchers contend that further cost containment is necessary and feasible; they point to wide geographic variations in medical and surgical procedure rates and the experience of HMOs.

HMOs: A Welcome Addition But Not A Panacea

The literature on health maintenance organizations seems to demonstrate conclusively that they take care of their enrollees with fewer hospital days per enrollee per year than conventional insurance plans.¹⁰ One major study that controls for age and sex showed not only fewer hospital days per thousand but also lower total costs per enrollee relative to fee-for-service patients with no cost sharing.¹¹ Interestingly, the same study also showed that per capita costs of people enrolled in the fee-for-service plan with high coinsurance up to a \$1,000 per family limit (1977

dollars) were about the same as the per capita costs of HMO enrollees.¹² (Note that it is exactly in the direction of such greater deductibles and copayments that most employment-based insurance has been moving.)

Despite the findings of some controlled studies of HMO performance relative to free care, it is far too early to conclude that proliferation of HMOs or other forms of prepaid plans will continue to save the public large sums at no loss of services that patients or their families would like to have. HMO percent savings have been based on a comparison to health plans where all health care was free. Consequently, the savings probably are somewhat overstated since the vast majority of health plans in the future, if not now, will have some form of cost sharing. Also, only HMOs with closed staffs of salaried physicians have been studied in depth. Yet the fastest growing form of HMO is the independent practice association (IPA), where fee-for-service physicians agree to receive a fixed fee per capita for a specified population. IPAs do show lower hospital days per thousand enrollees than do conventional insurance plans, but we do not yet know whether IPAs save money on a per capita basis after adjustment for age, sex, health status, and so on. In fact, some benefits managers are reporting that after adjustment for demographic factors, IPA premiums often are higher than comparable indemnity payment plans with utilization management.

The growth of HMO enrollment and the competitive responses it evokes from the fee-for-service sector may well reduce health care spending relative to GNP from what it otherwise would have been. But there is no evidence whatever that the rate of increase in health care spending is lower for HMOs. In fact, it has been shown that the rates of increase of HMO and fee-for-service sector costs are essentially identical.¹³ If the rate of increase in health spending continues to be driven by the aging of the population and the public's demand for clinically effective new technology, health spending over the long run probably will continue to absorb at least as much, if not more, of our national economic output as it does currently.

Fewer Variations, Continued Quality

Some health experts, optimistic about opportunities for hospital cost reduction without sacrificing quality, point to population-based differences in rates of surgery and medical treatment. Specifically, John Wennberg and colleagues show that variations in care received by the populations in adjacent areas are widely different with no apparent differences in outcome. Wennberg, for example, notes that "in Maine, by the time women reach seventy years of age in one hospital market, the likelihood they have undergone a hysterectomy is 20 percent while in another market it is 70 percent. In Iowa, the chances that male residents

who reach age eighty-five have undergone prostatectomy range from a low of 15 percent to a high of more than 60 percent in different hospital markets."¹⁴

Some infer from these studies that if the practice patterns of all physicians could conform with the practice styles of the most conservative physicians, savings would be achieved at little or no loss of quality. However, others cite problems with this conclusion.¹⁵ Francis D. Moore asserts that: (1) The prevalence of disease and the level of complaint for any given problem and therefore demand for treatment is not constant from one population to another; (2) The availability of treatment options, which also affects demand for services, is not uniform from one area to another; and (3) Variability is not necessarily bad; constancy is not necessarily good. Variation is to be expected. Patient preferences differ as does the rate at which new knowledge diffuses. Trying to develop uniform treatments for the same diagnoses is desirable only in those cases where there is no uncertainty as to what the proper course of treatment should be.

Continued growth and development of utilization and peer review by payers and providers should reduce such variability. If conducted in an environment that includes competition in price, cost, and quality, variability will remain—but not at inefficient levels.

The Bottom Line: No Escaping Painful Choices

If we read the trends correctly, we may be about halfway through the eye of the storm caused by the public and private program changes of the past few years. Fraud, abuse, and procedures that clearly are not medically necessary are being found and eliminated. Clearly this will result in savings—but not necessarily a reduction in the long-term rate of growth in health care spending. We will reach the point where consumers, payers, and providers will have to choose between rising health expenditures relative to GNP and procedures that are medically appropriate but not economically appropriate by some standard. The cost-containment problem then becomes ethical and political.

If the health care cost issue eventually turns mainly on ethical and political considerations, then two questions become paramount. First, what principles should guide the giving or withholding of care? And above all, who should make these choices? Thus, the issue of health care cost containment ultimately is about the distribution of power.

There are two basic strategies for distributing the power to control health care costs: centralization and pluralism. The pluralism strategy, anchored in a bedrock of competition and much better utilization information, offers compelling advantages: (1) There is faster learning about what technologies have the higher payoffs. The more experimen-

tation, the greater the chance is of finding the right balance among costs, risks, and benefits. Innovation flourishes best in the fluid, uncertain world of competition. (2) Mistakes are corrected faster. The protection afforded by the sovereign power of government insulates a bureaucracy from its mistakes. In a pluralistic system, where there is competition among insurers and among providers, the consequences of bureaucracy are much more difficult to hide. (3) There is a close fit between those with the information needed to make good decisions and those with the authority. A pluralistic system puts control where knowledge is, namely with patients, payers, physicians, and local communities.

Policy implications of the pluralism strategy. First, Medicare eventually should get out of the business of paying providers directly and instead give beneficiaries a fixed amount of money per year and let them buy health plan coverage on their own. We are already in the early stages of what could become part of the essential phase-in of such a strategy. Second, there should be tax bases (federal, state, and local) and/or private insurance pools dedicated to assuring that the uninsured poor have access to decent care. The pluralism strategy will improve the health care value the great majority receives for each dollar spent, but a minority could be significantly worse off. Competing health plans will want to look good to payers in economic terms; hence, there will be a great reluctance to take on bad risks unless there is a societally financed subsidy with a broad, preferably progressive, revenue base. Third, employees, employers, insurers, and providers will have to give much greater thought to both the ethical and the economic bases of their decisions. Specifically, they will have to balance the desire for higher quality, extensive care for today's workers and retirees against possible future costs in terms of employers' profits, economic growth, and even employment opportunities. In addition, they will have to judge the impact of every program of financing care on productivity and output to determine its true costs.

In sum, tremendous gains in cost containment—many of them driven by private employers and insurers—should not deceive politicians or analysts into the notion that unlimited spending cuts can be made without jeopardizing quality.

NOTES

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3. John R. Virts and George W. Wilson, "Inflation and Health Care Prices," *Health Affairs* (Spring 1984): 95-97.
4. Daniel Waldo and Helen C. Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977-1984," *Health Care Financing Review* 6 (September 1984): 19; and James Lubitz and Ronald Prihoda, "The Use and Costs of Medicare Services in the Last Two Years of Life," *Health Care Financing Review* (March 1984): 117.
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15. Francis D. Moore, "Small Area Variations Studies: Illuminating or Misleading?" *Health Affairs* (Spring 1985): 96.

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