Health Care Cost Containment: Action Alternatives

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The cost of health care in America rose some 380% between 1970 and 1982, going from 5.3% to nearly 10% of the Gross National Product. Among the factors contributing to rising health care costs are: general inflation, the aging of the population, rising incomes, increased insurance coverage, and technological advances.

EVERYONE PAYS . . .

Whether young or old, healthy or sick, insured or not, everyone feels the pressure of rising health care costs. Whether you have ever utilized your health insurance coverage or not, your premiums rise as other clients are covered for increasingly expensive services. Even if you pay no insurance premiums, your taxes may rise to pay for the growing Medicare, Medicaid, and local health services budgets.

If your employer pays your health insurance premiums, it is at a cost to you of foregone wages your employer might otherwise have paid. You pay part of the health care bill of employees of other firms as well. For example, Ford Motor Company estimates that its employee health care costs add $338 to the price of each Ford produced. (This figure is up from $130 in 1978.) At Chrysler Corporation, the figure is $600, up from $75 per car in 1970.

. . . BUT NO ONE PAYS

Whether we are ever sick or not, we are all pinched by medical cost increases. Although we may bruise, do we really feel the pinch? The nature of the health care economy suggests "no."

Economic analysis rests on the assumption that the quantity demanded of any good or service is responsive to changes in its price. As the price rises, the quantity demanded falls. But in the health care economy, the links between price and quantity consumed are in great measure broken. "Consumers" of health care services—that is, those in whose tests and procedures are actually performed—are often not directly influenced by price in their decisions to consume. This is true, at least, for all consumers who are insured by private, state, or federal insurance. They don't feel the full "pinch" of health care costs, because they are not paying the full bill.

Another break in the price-quantity link is the doctor. It can be argued, in fact, that it is the doctor, rather than the patient, who is the de facto consumer of health care services. It is, after all, the physician who orders tests, prescribes medications, recommends procedures, refers to specialists, determines choice of hospital, controls length of stay, supervises recuperation and rehabilitation, and carries out followup procedures. The patients themselves, whether through incapacity, ignorance, unwillingness, or fear, may have little say in these matters. Furthermore, physicians are often not aware of the price of tests and procedures they order. In such cases, price would not be a factor influencing the consumption decisions taken by physicians on behalf of their patients. Only recently has federal legislation been introduced which may cause the link between price and physicians' consumption decisions to be strengthened. This will be discussed in a later section.

CHANGING THE SYSTEM

The staggering increases in health care costs in recent years have prompted a new interest in adjusting the health care system to limit these cost increases. There are basically five groups in society which directly influence facets of the system. They are:

- consumers
- providers
- employers
- insurers
- government

Each group has different interests, and their interests may conflict with those of other groups. But there are actions which can be taken by members of each group to restructure the system, strengthen the weakened links between price and quantity demanded, and control costs to individuals, corporations, and society.

The purpose of this paper is to review in brief the many approaches which have been suggested by economists for ameliorating rising health care costs. The alternative actions are broken down into those affecting the demand for health care services, and those affecting the supply. None of these actions is without complicated effects, and the taking of certain actions in combination might tend to neutralize the effect each might have alone. Other combinations, however, might result in a multiplication of benefits.

None of these suggested actions is necessarily advocated by the authors. The present paper is designed to familiarize the reader with the range of options being discussed by people working in the field, and to provide a springboard to further investigation and application.
LOWERING DEMAND
Reducing Overall Demand

Much of the rise in health care costs in the last twenty years can be attributed to a rapid increase in quantity demanded. The institution of Medicare, increases in availability of employer-paid insurance plans, the development of new medical tests and techniques, and rising real incomes all have greatly increased the use of the medical system.

One approach, then, might be to decrease pressure on prices caused by burgeoning demand. There is evidence from research suggesting that many people see the doctor for common, temporary illnesses (head colds, upset stomach) for which a doctor can offer no medical solution. Education as to which symptoms suggest a visit to the doctor and which do not could save individuals money and cut demand for physicians' time. Further evidence suggests that much illness may be brought on by unhealthy lifestyles. Educating people as to how their health is affected by what they eat and drink and how they live could result in an overall decline in the demand for medical services. Some of the demand pressure on the system as a whole would then be relieved.

Demand for medical services has grown over the last twenty years in large part because of the increase in the percentage of the population covered by health insurance. About 84% of the people in this country are covered through their employer or through a private insurance company. Employers, especially, are feeling the pressure put on their companies' resources due to rising health care costs. These firms are in a unique position to negotiate with insurance companies to create incentives for employees to reduce use of the health care system. This, in turn, reduces the outlay required by employers to cover their employees' health care needs by reducing insurance companies' outlays and premiums.

It is not only consumers who put what is considered by some to be undue demand on the health care system. Physicians may do this as well, when in their role as demanders of health care services, they order tests and procedures which are not medically necessary, but will help protect the physician from the threat of malpractice suits. This behavior has been labeled "defensive medicine" in the literature, it is not clear to what extent defensive medicine is practiced, nor has its cost to consumers been determined. Nonetheless, any justified decrease in defensive medicine would be to the advantage of the health care system as a whole. Until further evidence is available indicating the extent of the practice of defensive medicine, the issue of malpractice insurance costs is more appropriately considered on the cost, rather than the demand side, of health care. A further discussion of malpractice costs is included in a following section.

The following outline brings together suggestions that have been made by economists for reducing demand for health care. They are actions which can be taken by consumers, employers, or insurance companies.

GOAL I: REDUCE EXPENDITURES BY REDUCING OVERALL DEMAND FOR HEALTH CARE SERVICES.

APPROACH A. CONSUMERS can reduce their medical care needs by improving their personal health status.

ACTION 1. Improve nutrition
ACTION 2. Reduce health risks
  Step a. Stop smoking
  Step b. Fasten seat belts
  Step c. Control alcohol intake
  Step d. Exercise properly
  Step e. Control weight

ACTION 3. Increase medical self-help knowledge

APPROACH B. EMPLOYERS can provide incentives for their employees to reduce use of the health care system.

ACTION 1. Offer rebates to employees who use less than their dollar allocation for health care in a given year.
ACTION 2. Offer pay raises or bonuses to employees who quit smoking, deal with alcoholism, reduce weight, etc.
ACTION 3. Provide health education, wellness programs, and physical fitness opportunities and facilities to employees.
APPROACH C. INSURANCE COMPANIES can provide incentives for their clients to economize on use of health care services.

ACTION 1. Offer lower premiums to non-smokers, joggers, and others who are at lower health risk than the average.

ACTION 2. Increase co-payments and deductibles.17

ACTION 3. Set specific, pre-announced levels for reimbursement for non-emergency services to encourage "shopping around" for best price.

Shifting Demand
A second money-saving technique on the demand side is to shift demand from high-cost services to equally effective but lower-cost ones. There are many such lower-cost options which consumers would make use of if given proper incentives.18 Among these options are "Preferred Provider Organizations," or PPO's, which are groups of physicians and/or hospitals which agree to provide medical services to a company's employees at a discounted price. Health Maintenance Organizations, or HMO's, are companies which provide unlimited medical and hospital care for a set, pre-paid charge per enrollee. There is evidence that HMO's have lower rates of hospitalization than the national average and therefore may be a lower-cost alternative to traditional insurance plans which in their very nature may encourage high hospitalization rates.

GOAL II: REDUCE MEDICAL EXPENDITURES BY SHIFTING DEMAND FROM HIGHER-COST TO LOWER-COST MEDICAL SERVICES.

APPROACH A. INSURANCE COMPANIES and EMPLOYERS can design health benefit packages that create incentives to utilize lower-cost services.

ACTION 1. Cover certain procedures only if performed as an outpatient.

ACTION 2. Require a significant deductible before covering use of emergency room facilities for non-emergencies.

ACTION 3. Require and cover a second opinion before paying full costs of non-emergency surgery.19

ACTION 4. Negotiate with physicians and hospitals to provide discounts for employees and cover fully only services supplied by these "Preferred Providers."20

ACTION 5. Establish a company clinic.

ACTION 6. Provide services by means of a Health Maintenance Organization option where available.21

CONTROLLING COST-PUSH

The other side of "demand-pull" effects which cause price rises are "cost-push" or supply side factors. Doctors' fees, personnel salaries and productivity, technology costs, percentage of charity cases, construction costs, interest rates, government regulations, and other factors increase the costs of providing care. These increases are then passed on as increased prices to employers, insurers, taxpayers, and individual consumers.

New legislation limiting the reimbursement to hospitals for Medicare patients has made cost control a top priority.22 The new Diagnosis-Related Grouping (DRG) reimbursement program sets a flat rate at which hospitals will be reimbursed for the services rendered to each Medicare patient, depending on their diagnosis. This system stands in economic opposition to the former Medicare system, in which hospitals were reimbursed for any and all "reasonable" costs incurred on behalf of a patient. Under the new system, then, hospitals must seek treatments which can be accomplished within the budget set for the patient's particular diagnosis. If the hospital spends less than the set reimbursement, it keeps the difference. If it spends more, it must cover the gap out of its own funds, as the hospitals are not allowed to charge the patient more than the DRG reimbursement figure. The actual amount set for each diagnosis depends on what part of the country the hospital is in and whether it is classified by the federal government as a rural or an urban hospital. The DRG program, which went into partial effect in October 1983, will be fully phased in over four years, increasing the need for hospitals to cut costs.

As was mentioned earlier in this paper, malpractice fees are a factor adding to the cost of providing care. The number of malpractice claims filed is growing, awards are increasing, and malpractice insurance premiums are rising.23 The following table shows the levels and growth rates of
malpractice premiums across the U.S. for different physician categories:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Median Premiums In 1974</th>
<th>Median Premiums In 1983</th>
<th>Percent Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP's</td>
<td>$1,000</td>
<td>$2,630</td>
<td>163</td>
</tr>
<tr>
<td>FP's</td>
<td>1,000</td>
<td>2,510</td>
<td>151</td>
</tr>
<tr>
<td>Internists</td>
<td>700</td>
<td>2,430</td>
<td>247</td>
</tr>
<tr>
<td>Gen. Surgeons</td>
<td>2,600</td>
<td>8,500</td>
<td>227</td>
</tr>
<tr>
<td>OBG's</td>
<td>3,300</td>
<td>11,840</td>
<td>259</td>
</tr>
<tr>
<td>Pediatricians</td>
<td>600</td>
<td>2,030</td>
<td>238</td>
</tr>
</tbody>
</table>


In spite of these colossal rises in premiums, the percentage of gross practice income represented by malpractice premiums has risen only 5% since 1975 (3.0% of income in 1975, 3.5% in 1983). Thus it is clear that virtually all of these malpractice expenses have been passed on to consumers.

In Indiana, the Medical Malpractice Act sets a $500,000 limit on malpractice claims awards against licensed health care providers whose insurance carriers meet certain conditions set out by the State Insurance Department. If the conditions are met, the insurance company's maximum liability per case is $100,000, and the Insurance Department will cover an additional $400,000. Only if a health care provider chooses to insure himself independently does he risk unlimited claims awards. The Indiana system thus gives health care providers and insurance carriers an effective malpractice cost containment option.

A final aspect of cost containment involves businesses and insurance companies, which also have a role to play in the supply of medical services. Because they are often major users and/or payers of health care services in a given area, they may be able to exert influence over local hospitals and doctors. Businesses can form coalitions to negotiate with health care providers on issues of cost reduction. “Broad-based” coalitions, representing business, hospitals, doctors, insurers, government, labor, and individual consumers can open up discussion and education in an attempt to alleviate problems of health care cost increases.

Finally, any interested and knowledgeable citizen can influence legislation, hospital board decision-making, etc., through his or her legislative representatives at the local, state, or national level. The following outline reviews various supply-oriented approaches to cost containment:

GOAL III: CONTROL COSTS ON THE SUPPLY SIDE

APPROACH A. HOSPITALS and CLINICS can adopt cost control techniques.

ACTION 1. Share the cost and use of expensive equipment.

ACTION 2. Specialize in particular health problems to gain efficiency.

ACTION 3. Improve data collection and analysis to increase cost effectiveness.

ACTION 4. Cooperate with voluntary rate review programs and abide by suggested budgets.

ACTION 5. Provide economic incentives for physicians to adopt cost-efficient practices.

APPROACH B. INSURANCE COMPANIES can promote programs that lessen malpractice risks to doctors.

ACTION 1. Sponsor seminars and instructional programs on how physicians can reduce their malpractice risks.

ACTION 2. Monitor physicians' and hospitals' practice with the aim of reducing malpractice risks.

APPROACH C. HOSPITALS can reduce their malpractice liability.


ACTION 2. Careful and immediate investigation of all hospital incidents that might lead to malpractice suits.

APPROACH D. LEGISLATORS and VOTERS can work for the passage of laws that limit malpractice costs to providers.

ACTION 1. Bar plaintiffs in malpractice suits from claiming costs already paid by their health insurance.

ACTION 2. Set limits on non-economic damage awards ("pain and suffering").
ACTION 3. Allow for periodic payments and structured settlements rather than lump-sum payments.
ACTION 4. Limit attorney’s contingency fee.
ACTION 5. License physicians more strictly.

APPROACH E. BUSINESSES, INSURANCE COMPANIES, and CONSUMERS can become involved in health care decision-making.

ACTION 1. Form business coalitions to negotiate for improved efficiency in health care delivery.
ACTION 2. Form “broad-based” coalitions as a public forum for the issue.
ACTION 3. Influence legislators to vote for cost-effective legislation in health care.

SUMMARY
The actions outlined can be undertaken by each of the groups who have a stake in health care costs. The system is in a state of flux, and both users and providers are strongly interested in developing new ways to control cost. The job can be tackled from the level of the individual, family, community, county, state, or nation. Some of the benefits which may accrue are better health, lower insurance premiums, better use of tax monies, more cost-effective health coverage, and greater cooperation between health care users and providers. The issue is open to anyone with knowledge and enthusiasm to aid in restructuring the health care system.

NOTES


[13] The issue of “defensive medicine” is briefly discussed in Sam M. Cordes, A Description and Analysis of Rising Health Care Expenditures, The Pennsylvania State University Extension Studies 77, University Park, PA, December 1977, p. 59; Rice, p. 804. For a more thorough analysis of the topic, see Hershey.


[17] For an example of cost-benefit analysis of a company fitness program, see Chenoweth, Blue Cross/Blue Shield of Indiana sponsors a Health Promotion program for its corporate clients, discussed in Dean A. Grove et al., “A Health Promotion Program in a Corporate Setting,” The Journal of Family Practice, Vol. 9, No. 1, 1979, pp. 83-88; For a comprehensive study of how corporations can develop health promotion programs, see Keith W. Sehnert and John K. Tillotson, How Business Can Promote Good Health for Employees and Their Families, Interstudy, for the National Chamber Foundation, 1978.


[19] Wolfe discusses many of these options, including PPO’s and HMO’s.


[27] This action and the preceding one are discussed in Cordes, pp. 47-48.


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