OPPORTUNITY 08
Independent Ideas For Our Next President

Slowing the Growth of Health Spending

We Need Mixed Strategies, and We Need to Start Now

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Summary

Americans are deeply concerned about paying their mounting bills for health care. This is true whether they have private insurance or public (Medicare or Medicaid)—and certainly for the 46 million with no insurance at all. The federal government's health spending, primarily for Medicare and Medicaid, is clearly unsustainable. If current commitments are kept, other government services will have to be slashed or taxes increased drastically just to pay for these two programs. But the problem of rising health care costs is not confined to the federal budget; private health spending is rising just as quickly. Conventional strategies to slow federal health spending—like cutting Medicare and Medicaid benefits or restricting eligibility—will merely shift the financial burden of health care to other payers and swell the ranks of the uninsured. These efforts will not significantly slow the growth of total health spending.

Despite the recognized successes of U.S. health care, there are abundant opportunities for increasing efficiency and spending health care dollars more wisely. The federal government—and the new President—might take advantage of these opportunities, using federal programs to provide leadership that would slow the growth of total health spending and move the whole health care system toward greater efficiency and effectiveness.

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Specifically, the new President should adopt a broad agenda of reform, drawing from policies that:

- Support incremental advances using both market and regulatory reforms
- Continue to use Medicare and Medicaid to promote system-wide improvements through, for example, adoption of clinical practice guidelines and disease management for costly chronic conditions
- Use their marketplace clout to improve price-setting through carefully applied pay-for-performance strategies, competitive bidding, and direct price negotiations
- Encourage better system management through deployment of health information technology
- Promote consumerism in health care, to make individuals more aware and responsible for costly health coverage and care choices and
- Adjust the open-ended entitlement provided by Medicare and Medicaid in ways that could shrink costs without sacrificing beneficiary health or shifting costs elsewhere.

Context

The Basic Problem: Third-Party Payment

When people spend increasing amounts on video games or espresso drinks, no one suggests second-guessing them to slow spending down. Society relies on market prices to keep supply and demand in balance and ensure reasonably efficient production. But health care is different. Society doesn't accept the notion that people should be denied needed care just because they cannot pay. Moreover, illness often comes in costly, unpredictable episodes, like a sudden heart attack. People want to be protected from sudden, involuntary bills that could bankrupt them.

These characteristics have led to third-party payment for most health services almost everywhere. Many countries have universal health coverage paid out of tax revenues. The United States has a complex system involving employer-based insurance subsidized through the income tax, other private insurance, and state and federal government programs covering seniors, the disabled, and many of the poor. In other

words, most health bills for most people are paid by someone else, although about 16 percent of Americans are without health insurance .

When a third party—whether the government or a private insurer—is paying most of the cost, patients have little incentive to consider the cost of services or to find the most efficient provider. Providers, who typically are paid for each individual service rendered and who realize that their patients are not paying the bill, have little reason to economize. Thus, third-party payment results in higher spending for health care than would have occurred if patients paid the full cost directly.

The effects of third-party payment on spending can be diminished by requiring that patients pay more of the cost of their care out of their own pockets. However, such payments may cause hardship, especially for the less affluent and for people on fixed incomes. They may keep people from seeking care when a condition is at an early stage, when it is less costly to treat.

Health plans sometimes try to limit direct access to services, usually by requiring patients to obtain a referral from a “gate-keeper” (usually primary care) physician before obtaining costly specialist services. These limits help control spending, but they are unpopular with both patients and providers.

Public programs provide health coverage to millions of people and improve the health status of seniors and the poor, but like private insurance, they also contribute substantially to the rapid growth of health spending. Subsidizing private insurance through the tax system (mostly because employers’ premium contributions are excluded from employees’ taxable income) has enabled millions of Americans to have health insurance. It also encourages the purchase of more generous insurance plans (with lower out-of-pocket costs paid by consumers), which blunts the consumer’s sensitivity to health care prices and encourages greater use of services.

Despite its downsides, eliminating third-party payment is not a realistic or desirable option. The challenge is to mitigate its perverse incentives without doing more harm than good.

Do We Get Our Money's Worth?

Analyzing variations in medical practice and outcomes can yield clues about the effectiveness and efficiency of care. Dr. Jack Wennberg and colleagues at the Center for Evaluative Clinical Sciences at the Dartmouth Medical School have long studied Medicare data to uncover variations across regions, states, and providers in the resources used to treat the same diagnoses, as well as the outcomes achieved.

This research yields three robust results. First, variations in resource use are huge. Medicare spending for the average patient in Miami is about two and a half times what it is in Minneapolis. This is true even after controlling for health and demographic differences between the two populations. In the last two years of life, when costs tend to be relatively high, these enormous differences persist. For example, in New Jersey in recent years, Medicare spent an average of $40,000 on patients in the last 24 months of life, but only $25,000 in Ohio.

Second, resource use is sensitive to supply. In areas with more hospital beds per person, Medicare patients were more likely to be hospitalized, and in areas with more cardiologists per person, Medicare patients with heart disease had more cardiologist visits.

Third, and most important, more aggressive treatment and higher spending do not result in better patient outcomes. One study that followed Medicare patients with three specific diagnoses found that greater care intensity (more services and costs) was associated with *increased* mortality rates. Moreover, both high- and low-cost areas underutilize effective preventive services, such as mammography or vaccination for pneumonia. These findings indicate that making the practices of the least efficient providers more like the most efficient would save significant resources, both in Medicare and in the rest of the health system. For example, a recent five-year study

of large California hospitals found that Medicare spending per patient in the last two years of life ranged from $24,722 to $106,254—again, with no demonstrable difference in health status, quality of health care, or longevity. During the study period, Medicare could have saved $1.7 billion in the Los Angeles area alone, if the resource-intense hospital care there had matched the type of care provided in lower-cost areas of the state.

The challenge is moving from documenting inefficiency to actually reducing it. At present, providers often have inadequate information on what works best and for whom, or fail to use the information available. Payment systems encourage greater resource use and reward excessive treatment, even when it results in preventable medical errors. If a patient acquires an infection in a hospital and has to be readmitted, Medicare will pay the costs of that second hospital stay.

Efforts are under way to design incentives for providers to collect and share information on effective treatments. Medicare, for example, now pays for certain treatments (such as implantable cardiac defibrillators) only provisionally, contingent on learning more about the success of this treatment among Medicare patients.

Despite the lack of clear evidence for much of what is done in medicine, the wealth of information on treatment options can be overwhelming, even for well-trained physicians trying to keep up with medical progress. Methods of helping physicians manage information overload include:

- Practice guidelines based on evidence
- Disease management and patient management methods that rely on evidence-based protocols and improved coordination among providers;
- Improved Internet access to the latest scientific studies; and
- Computer-based decision support tools.

Unfortunately, many physicians do not make the best use of such information tools for both cultural and business reasons. Computers are not always accessible—for example in examining rooms—and can interfere with face-to-face interaction between physician

and patient. Hand-held devices may reduce this problem, but the many older physicians are uncomfortable with the technology. Conventional practice often lags behind the latest evidence unless new findings are brought to the physician's attention.

Adhering to evidence-based standards also may be bad for business. Fee-for-service payment combined with low negotiated reimbursement rates from insurers reward the use (and overuse) of health services. The patient, who is not paying much of the bill and is typically not knowledgeable about the options, is unlikely to recognize or object to treatment that does not meet evidence standards.

To improve the efficiency and effectiveness of health care, the knowledge base necessary for sound medical decision-making must be built and that knowledge must be made accessible and usable to patients, physicians, and payers. The financial incentives must be redirected toward more prudent use of care while also finding mechanisms that assure that patients seek and receive the care they truly need.

Two Impediments to Addressing Health Spending Growth

A first impediment to slowing the rapid growth of health spending is the notion, espoused by many policy analysts, that the United States cannot control the growth of health spending until it undertakes comprehensive reform of its complex and fragmented health system. We believe the opposite is more likely true. Comprehensive reform will take time and require major institutional and cultural changes. The nation cannot wait for comprehensive reform to address the problem of rising spending. Indeed, squeezing waste and inefficiency out of the system and designing mechanisms to make health spending more effective can set the stage for more fundamental reform.

A second impediment is the unrealistic hope that there is some simple remedy that will provide better health care at lower cost for everyone. Some believe that accelerating the adoption of information technology can greatly increase productivity in the health sector. Some pin their hopes on prevention and healthier life styles. Others argue that capping awards in medical malpractice cases could substantially reduce the cost of

health care. Still others voice enthusiasm for "evidence-based medicine" and "pay-for-performance" and believe that aligning provider reimbursement to patient outcomes can result in higher quality at lower cost.

All of these prescriptions have merit—and we discuss them further below—but none is a silver bullet. Slowing the growth of health spending will require multiple policy interventions and persistent effort. Everyone—patient, provider, employer, taxpayer—will ultimately be involved in the difficult decisions necessary to slow the growth of spending to a sustainable rate.

Reform Strategies: The Options

Perhaps the greatest impediment to realistic reform is the belief that a clear-cut choice must be made between two competing strategies for restraining health spending: market strategies and regulatory strategies. On the contrary, we believe that a blend of the two strategies is necessary to effective reform.

Market Strategies

Proponents of market strategies believe that if individuals had more direct responsibility for the cost of their care, they would weigh these costs and the value they receive more carefully. Providers would be forced to compete for consumer dollars on the basis of price, quality, and customer service. This heightened competition would cause health care providers to adopt more efficient practice styles. Prices for services would be established in the market, reflecting both supply and demand and providing incentives for continued medical innovation.

A modest step toward a market strategy involves giving consumers choices among competing health plans at different prices. For example, some analysts have suggested including other groups in the Federal Employees Health Benefits Program (FEHBP), which offers federal employees and retirees a wide choice of health plans. This approach may make consumers more cost-conscious when they choose plans, but it still leaves a third party (the plan) paying most of the bills.

A more aggressive approach would require consumers to pay out-of-pocket for most health expenditures, with insurance protecting them only from the catastrophic losses that could accompany a major illness or accident. Such consumer-driven health plans typically offer insurance with a high deductible plus a savings account, intended to help people set aside funds to cover out-of-pocket costs. Congress embraced this concept in 2003 when it enacted health savings accounts (HSAs)—tax-favored accounts available to people with catastrophic coverage.

Health spending is concentrated—10 percent of the U.S. population accounts for 69 percent of the nation's health spending. Much of the spending for high-cost patients is above the deductible amount for a typical consumer-driven health plan and therefore unaffected by financial incentives. Other methods, such as care management for high-cost cases, may be more effective in limiting inappropriate spending in this group.

Market strategies, in theory, rely on decisions by informed consumers. At present, the information people need to make sound health care decisions—reliable information on the cost, quality, and appropriateness of services—is largely unavailable. It is almost impossible to find out in advance the cost of a full episode of care, since services of multiple providers (physicians, hospitals, imaging and laboratory services, and so on) are typically billed separately. Mortality rates, hospital readmission rates, and other commonly available quality indicators are inadequate assessments of provider quality. Data comparing the effectiveness of alternative treatments are not readily available, and the typical consumer would need substantial medical knowledge or the advice of a disinterested, knowledgeable physician to interpret the studies that do exist. Insurers, providers, and government agencies are beginning to develop better information for consumers, but the average person is still poorly equipped to interpret complex price and quality information.

In short, market strategies hold promise, but the steps necessary to create a functioning health market are daunting.

Regulatory Strategies

Advocates of regulatory strategies argue that the nation has a social responsibility to ensure that everyone has access to good quality care, delivered as efficiently as possible. We cannot rely upon private companies to provide that care without regulation, they say, since experience shows that insurers try to avoid enrolling people with serious health conditions and that drug companies charge substantially more than their costs of production. They believe that government programs' considerable market power should be exercised on behalf of consumers and taxpayers.

There are risks to setting lower prices for health services than would have prevailed in an unregulated market, since health providers may try to make up for lower prices by increasing the volume of services. Moreover, if prices are held too low, too long, health providers and suppliers exit the market and innovation is stifled. For example, Medicaid's low reimbursement rates have made many providers unwilling to serve Medicaid-covered low-income people, and some providers limit the number of Medicare patients in their practices.

Proponents of regulation argue that just because regulation has sometimes been done badly does not mean it cannot be done well. They envision a system in which the government uses its power to ensure that health services are effective and delivered efficiently. This could involve analyzing data to establish best practices, promulgating practice guidelines, and refusing to pay for care that does not conform to those guidelines, as well as imposing caps on total health spending and devising rules for enforcing those caps. However, undertaking any of these steps requires considerable technical and political effort.

The More Feasible Option: A Blended Strategy

America's health system already is a hodgepodge of market and regulatory elements. Moving the current system toward greater efficiency as well as equity will take a blend of market-oriented and regulatory reforms. For example, aggressive implementation of pay-for-performance by both public and private payers could involve elements of both strategies. Better information and stronger financial incentives could be established, in

order to encourage consumers to seek out providers who offer the best value in terms of price, quality, and customer service. But reform must recognize that the largest decisions about what and where to buy are made by third-party payers and that regulations, as well as incentives, may be needed to guide those decisions.

Regulation and markets are facts of life in the health system. Reforms may nudge the system toward greater regulation or more competitive markets, but a wholesale shift in either direction is both unlikely and undesirable.

Opportunities for Federal Leadership

Because of the size and impact of federal health policies and programs, well-designed reforms in Washington can catalyze improvements in the whole health system. Of course, poorly conceived federal policy can make matters worse for everyone, so it is important to get the reforms right.

Medicare is the largest single purchaser of health care, and its policies directly affect virtually every health care provider. Medicare's record-keeping, coding, and billing practices are the industry norm. When Medicare introduces innovations in payment methods, such as prospective payment, they are widely adopted by private insurers, too. For example, the Medicare prescription drug benefit has prompted health plans and providers to alter the way they manage both their Medicare and private business.

Innovative approaches are being tested by states seeking to improve the operation of their Medicaid programs—including Maine, Massachusetts, West Virginia, and California. Efforts to make other federal health programs more efficient—including the State Children's Health Insurance Program (SCHIP), the Veterans Health Administration (VHA), and the Defense Department's TRICARE program—could reduce the growth in federal outlays. The lessons learned from such initiatives could be applied more broadly. For example, more efficient practices in the VHA already are influencing other systems.

Altering federal tax subsidies could have a major impact on employment-based private health insurance. Restructuring the tax preference by capping the amount that may be excluded from taxable income and providing a refundable tax credit for health insurance, could better target those in need and minimize the adverse incentives that promote inefficiency in the health system.

Regulatory agencies—the Federal Trade Commission (FTC) and the Food and Drug Administration (FDA)—can shape competition in the health sector and determine how quickly new drugs and devices enter the market. Research agencies, such as the National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ), contribute to the development of medical innovation and improvements in clinical practice and the delivery of health care. However, despite the large potential payoff of health systems research, including analysis to compare effectiveness of treatments, this field currently receives relatively little funding.

Federal action could play an important role in health reform in several key areas, including information development, price-setting, improving care delivery, and encouraging competition. The policy options listed below represent a starting point, not an exhaustive survey of possible reforms.

Develop Information

All approaches to improving the efficiency of the health system and the quality of care depend on making reliable information readily available to providers, administrators, and consumers. Federal action can improve the knowledge base for clinical decision-making by developing comprehensive data on patient care and by sponsoring research on outcomes and effectiveness of care. It can make these data easier to collect, analyze, and disseminate by promoting health information technology.

Accelerate development and use of health information technology (HIT)

The health care sector lags behind many other segments of the U.S. economy in developing and deploying information technologies to serve the needs of clinicians,

administrators, and patients. A great many national initiatives are already under way, and among their first priorities are the following:

- ***Develop standards for interoperable HIT.*** The development of information-exchange networks and adoption of standards for interoperable technology will enable data to be shared among physicians, hospitals, and patients, eventually eliminating less-efficient paper records and making patient information immediately available to those who need it, when they need it.
- ***Provide incentives and financing for HIT adoption.*** The costs of implementing HIT, or transforming an existing system to comply with standards, can be significant—especially for solo or small physician practices. The federal government could promote wider adoption through grants, tax incentives, or reducing legal barriers to private subsidies from insurers and hospital systems for physician purchase of HIT.
- ***Build on HIT activities already under way.*** Use existing exemplary systems as a testing ground for improvements in HIT, including development of fully interoperable systems accessible across sites of care, new hardware and software, and changes in work methods.

Promote Research on Outcomes and Effectiveness

- ***Develop tools to analyze patient-level data across health plans.*** Ideally, a fully wired health system could gather and analyze information on patients and their treatment, drawn from many sources. Until such a system develops, existing Medicare data can provide a rich source of patient information on which to base assessments of clinical outcomes and quality of care. Other insurers—including Medicaid, VHA, FEHBP, and private plans—could also contribute information for such analyses.
- ***Promote research and disseminate results widely.*** The federal government should increase its support for effectiveness research through additional funding and by making data available to private researchers, health plans, and insurers for their own analyses. Additional research on cost-effectiveness and comparative effectiveness of various treatments could improve

clinical decision-making and influence insurers' decisions on what services to cover.

Improve Health Care Delivery

Beyond developing better information on health services' effectiveness and quality of care, additional steps can be taken to improve health care delivery.

Develop and Disseminate Practice Guidelines

- ***Create evidence-based practice guidelines.*** Clinical guidelines can promote appropriate, high quality care by helping physicians incorporate the latest evidence into their treatment decisions. The federal government can use its data development activities to generate more comprehensive clinical guidelines.
- ***Encourage use of guidelines in assessing provider performance.*** Medicare and Medicaid could examine provider-specific patterns of service to identify outliers from local or national norms. Scorecards benchmarking providers' performance against average performance in their market could include incentives to improve performance. Giving providers information to compare their performance against their peers can be effective in improving adherence to guidelines.

Promote Care Management and Coordination

- ***Support the development of effective care management models.*** Better patient management—especially for costly chronic disease like diabetes—offers the promise of more effective treatment and possibly lower costs, but evidence on what works best is lacking. Medicare has several demonstration projects under way to test disease management for patients with chronic conditions and complex health needs.
- ***Increase incentives for enrollment in managed care and disease management programs.*** Medicaid has continued to use managed care methods to discourage unnecessary spending while maintaining reasonable access to care. Many states also use disease management programs. Such programs provide patients with education on managing their disease, actively

monitor the patient's condition, and coordinate care and facilitate information-sharing across providers.

- ***Improve coordination of patient care.*** Providers often do not have an easy way to share information that could reduce unnecessary or duplicative services and avoid medical errors. Changing financial incentives—such as introducing a case manager or directly rewarding physician and hospital involvement in joint efforts to manage patient care—could promote coordinated care. Another help is, again, use of information technology that electronically delivers patients' complete medical record to each provider caring for them.

Support Other Improvements in Care Delivery

- ***Improve coordination and delivery of end-of-life care.*** Nearly one-quarter of all Medicare and Medicaid outlays is spent on care of patients in their last year of life, though such patients account for only 5 percent of the elderly population. Increasing the use of hospice care may help reduce these costs, as well as improve quality. Greater adherence to evidence-based guidelines could minimize costs from treating severe disease and functional impairment. Better coordination is needed between acute and long-term care providers, as well as between Medicare and Medicaid.
- ***Encourage use of lower-cost delivery settings.*** Visits to hospital emergency departments increased 26 percent over the past decade, with nearly one-third of those visits classified as non-urgent or semi-urgent. Contrary to popular opinion, Medicaid beneficiaries and others with insurance are more likely to use the emergency department than the uninsured. Encouraging federal health program beneficiaries to use lower-cost sites of care—for example, by expanding hours at federally financed clinics—could reduce unnecessary emergency department visits.
- ***Promote healthy behavior and disease prevention.*** The poor health habits of average Americans add significantly to the cost of health care. While disease prevention strategies like immunization programs and environmental strategies like assuring a clean water supply provide unequivocal benefits, it is unclear whether behavior change programs aimed at reducing smoking or obesity or

increasing exercise can yield substantial cost savings. Beyond the difficulty of achieving wide-scale behavior change, even successful health promotion activities—such as smoking cessation programs—may not reduce health care spending in the long term. Government could provide additional support for studies of the cost-effectiveness of prevention and promotion efforts.

Improve Price-Setting

The way in which health care products and services are priced or reimbursed can determine the type of services that are provided, the quality of care, and the cost of that care.

- ***Pay-for-Performance.*** Fee-for-service payments create incentives for providing more services, even if these will likely generate only minimal health improvements. Pay-for-performance (P4P) approaches are being developed to promote more effective care in a fee-for-service setting, although it will be challenging to implement them. Developing specific quality measures to identify differences in provider performance will be necessary to make this approach successful and sustainable. Medicare's size and regulatory authority give it the clout to advance P4P, but it must move carefully to avoid institutionalizing an inadequate payment formula.
- ***Competitive bidding.*** Bidding approaches require all sellers to submit their best offers in advance. This strategy can elicit prices that more accurately reflect local market conditions than a national price formula can. Bidding can reduce program costs, although the bid process must be carefully designed to avoid driving out competition, which ultimately may lead to higher prices.
- ***Direct price negotiation.*** Medicare's decision to use bidding to set payments for Part D (the drug benefit), rather than taking advantage of its aggregate buying power to keep prices low, has been controversial. Outside Medicare—for example, Medicaid "best price" requirements and the VA's Federal Supply Schedule—the federal government uses its market power and legal authority to extract below-market drug prices. This approach may achieve short-term savings, but over the longer term it may cause suppliers to drop out of the market or discourage the entry of new products and services.

Promote Consumerism and Competition

Numerous policy changes are required to introduce effective competition and informed consumer and provider decision-making into the health care market.

- ***Introduce premium support in Medicare.*** Premium support would provide Medicare beneficiaries with a fixed subsidy for a basic set of benefits, while permitting beneficiaries to purchase more expansive insurance coverage if they are willing to pay the additional expense. Such a system operates in the FEHBP, which provides federal employees and retirees with a wide choice of competing health plans. The government pays about three-quarters of the insurance premium, based on the plans' average bid, and enrollees pay the remainder. This arrangement limits the government's financial exposure and fosters competition among the plans that could result in greater efficiency.
- ***Encourage states to test and implement consumer-oriented approaches in Medicaid.*** Both Medicaid and the SCHIP program may provide premium assistance to beneficiaries who enroll in employer-sponsored insurance instead of the government program. Some states have implemented reforms that provide Medicaid beneficiaries with individual budgets for care, giving them more control over how that money is spent. Cash and Counseling programs, which give Medicaid beneficiaries eligible for personal care services a consumer-directed allowance in lieu of agency services, have improved patient satisfaction without increasing program costs. This model is being used in 22 states.
- ***Promote use of high-deductible plans tied to tax-favored health savings accounts (HSAs).*** Increasing insurance plan deductibles makes beneficiaries more aware of the cost of routine care and generally lowers the insurance premium. In shifting to this type of health plan, employers often contribute to the HSA to help employees with their higher out-of-pocket costs. In 2005, FEHBP introduced the option of high-deductible plans with HSAs.[1] Medicare recently announced a new initiative to test account-based coverage. If

[1] Other types of health accounts, including flexible savings accounts (FSAs) and health reimbursement arrangements (HRAs) are available through FEHBP and many private employers. (http://opm.gov/insure/06/guides/70-01).

employers adopt HSAs widely, future generations of seniors may want a similar option when they become eligible for Medicare.

Limit Health Outlays

Directly limiting outlays in Medicare and Medicaid (or limiting tax breaks for private health insurance) would impose fiscal pressure that could promote other health system reforms.

- ***Convert Medicaid to a block grant.*** States receive a federal matching grant that covers at least 50 percent of the cost of their Medicaid programs. This arrangement has enabled states to cover more beneficiaries for more health services, but it has also encouraged rapid spending increases. A block grant could be structured to reward states that achieve better health outcomes and lower-cost treatment. Block grants give the federal government budget predictability and a simple lever for controlling future spending. States would also have stronger incentives to develop ways to save money, as they could keep all the savings.
- ***Modify the entitlement status of Medicare and Medicaid.*** Current law ensures that Medicare and Medicaid will automatically finance all necessary health services covered by the programs without limit. Congress could alter this arrangement by requiring a periodic vote (perhaps every five or ten years) on overall program spending levels and future trends—in essence, a national referendum on the long-term financial promises made by the program.
- ***Limit the tax exclusion for employer-provided health insurance.*** Capping or limiting the tax exclusion for employer-sponsored insurance would encourage the purchase of less expansive coverage with greater cost-sharing requirements, promoting greater cost-consciousness on the part of both consumers and providers. The policy also would yield additional federal revenue that could be used to increase insurance subsidies for low-income Americans.

Other Options

Beyond the major health entitlement programs, other government entities contribute to the legal, institutional, and scientific structure in which public and private health

programs operate. The drug approval process and medical malpractice are examples of areas that could be modified to promote efficiency in the health system.

Change the Drug Approval Process

- ***Streamline the FDA approval process for new drugs and devices.*** The Food and Drug Administration is charged with protecting consumers from unsafe or ineffective drugs without unduly impeding the introduction of innovative products to the market. Increased post-marketing surveillance of new drugs would add to patient safety without imposing unreasonable delays on drug introduction. The FDA's Critical Path Initiative attempts to modernize the process through which basic scientific discoveries translate into new medical treatments, including implementation of standards for clinical trial design and helping companies "fail faster" on drugs that eventually would not be approved.
- ***Speed review of generic drugs.*** The FDA can promote price competition in the drug market by more quickly introducing close substitutes for brand name products. Better funding for the FDA's Office of Generic Drug Approval could help alleviate the growing backlog of applications to bring new generic products to market. Advances in both science and regulation would open the door to "follow-on" biologics—complex molecules that offer great promise for medical treatment—but the benefits of price competition must be balanced against the need to maintain strong incentives for innovation in this emerging pharmaceutical field.
- ***Reform the Malpractice Tort System***

  Public attention periodically focuses on the rising cost of medical liability insurance premiums and concerns about patient safety. Although capping awards and limiting attorneys' fees would lower the cost of malpractice insurance, the impact on overall health costs would be modest. More attention should be placed on preventing medical errors and providing appropriate redress for injured patients. Structured payment rules and use of alternative methods for resolving malpractice claims—such as an administrative compensation system or specialized health courts—would make the system more equitable.

Concluding Observations

The U.S. health care system accounted for 16 percent of GDP in 2005—almost $2 trillion a year and rising. Such a large industry naturally has powerful interests—clinicians, health systems, health plans, drug and device manufacturers, employers, and even consumers themselves. Resistance to change, even in the face of a growing financial crisis, is great. Meanwhile, science moves forward, and what is possible today was unthinkable a dozen years ago. A dozen years hence, many other "disruptive technologies"—that is, those that can fundamentally change a sector—may be in place.

Because the health sector is big, important, and rapidly changing, a single, go-for-broke health reform seems highly unlikely. Instead, we will find ourselves in the position of the man trying to build the bicycle while riding it—fixing one piece here through regulation, another one there through market reforms, and a third one by changing some aspect of the information environment. The trip may be bumpy, but, like it or not, we must get on and ride.

About the Author and the Project

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Additional Resources

For information about the constellation of studies of geographic and inter-institutional differences in costs and outcomes of care, see: Dartmouth Atlas Project, Center for the Evaluative Clinical Sciences, http://www.dartmouthatlas.org.

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