

INTERNATIONAL TRENDS IN HEALTH CARE AND IN HEALTH POLICY

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Presented to the

Emerging Industrial Technology & Strategy Review Board Meeting 2003

Science & Technology Advisory Group of the Executive Yuan

Taipei, Taiwan

August 25-29, 2003

INTERNATIONAL TRENDS IN HEALTH CARE AND HEALTH POLICY

I. INTERNATIONAL TRENDS IN HEALTH SPENDING

II. COMMON MISPERCEPTIONS ABOUT HEALTH CARE



III. COMMON CONCERNS ABROAD ABOUT HEALTH CARE

IV. EXPERIENCE ABROAD WITH MANAGED COMPETITION

V. THE NEXT NEW (REALLY OLD) THING IN HEALTH CARE: MSAs

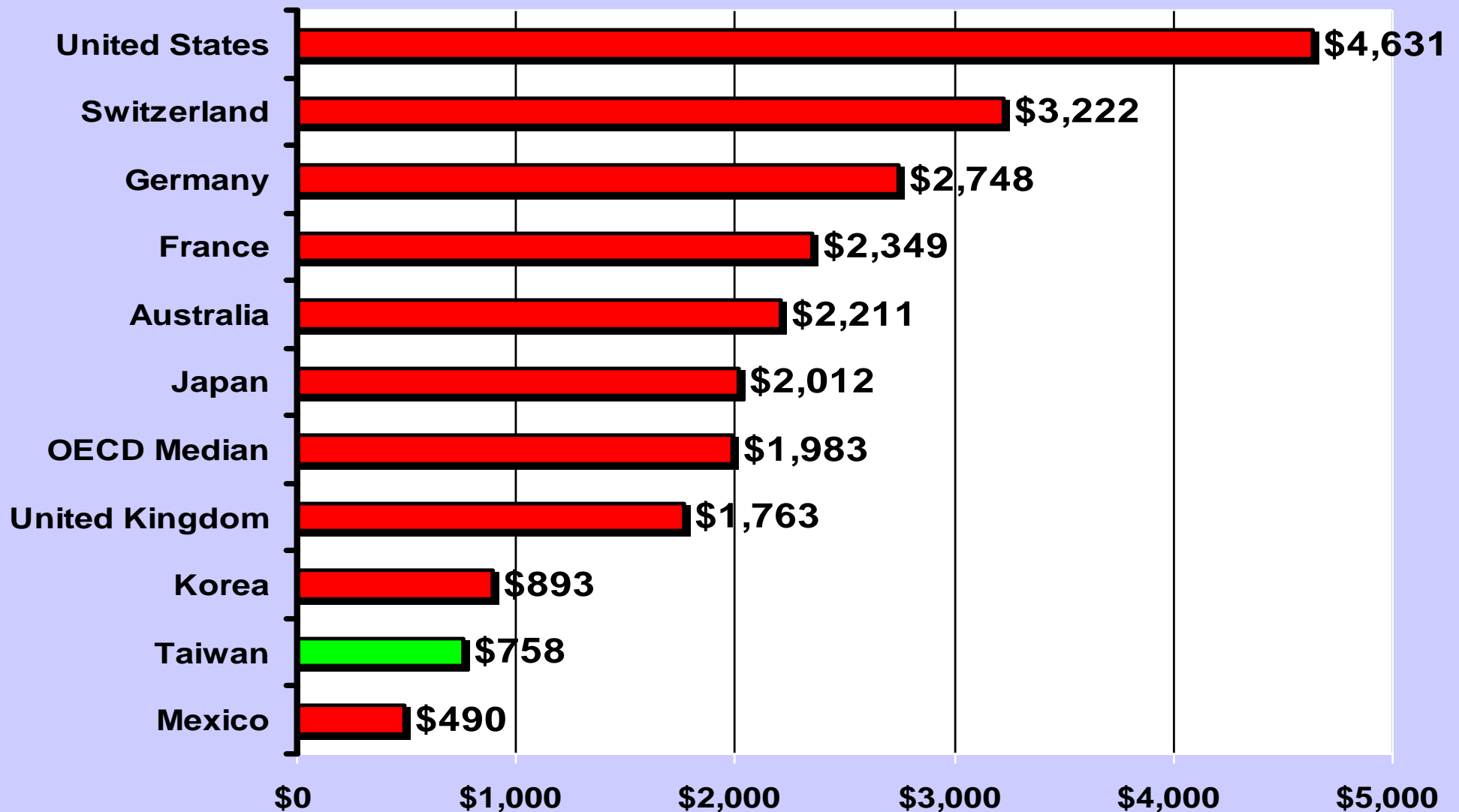
INTERNATIONAL TRENDS IN HEALTH CARE AND HEALTH POLICY

I. INTERNATIONAL TRENDS IN HEALTH SPENDING



PER CAPITA HEALTH SPENDING IN SELECTED OECD NATIONS AND TAIWAN, 2000

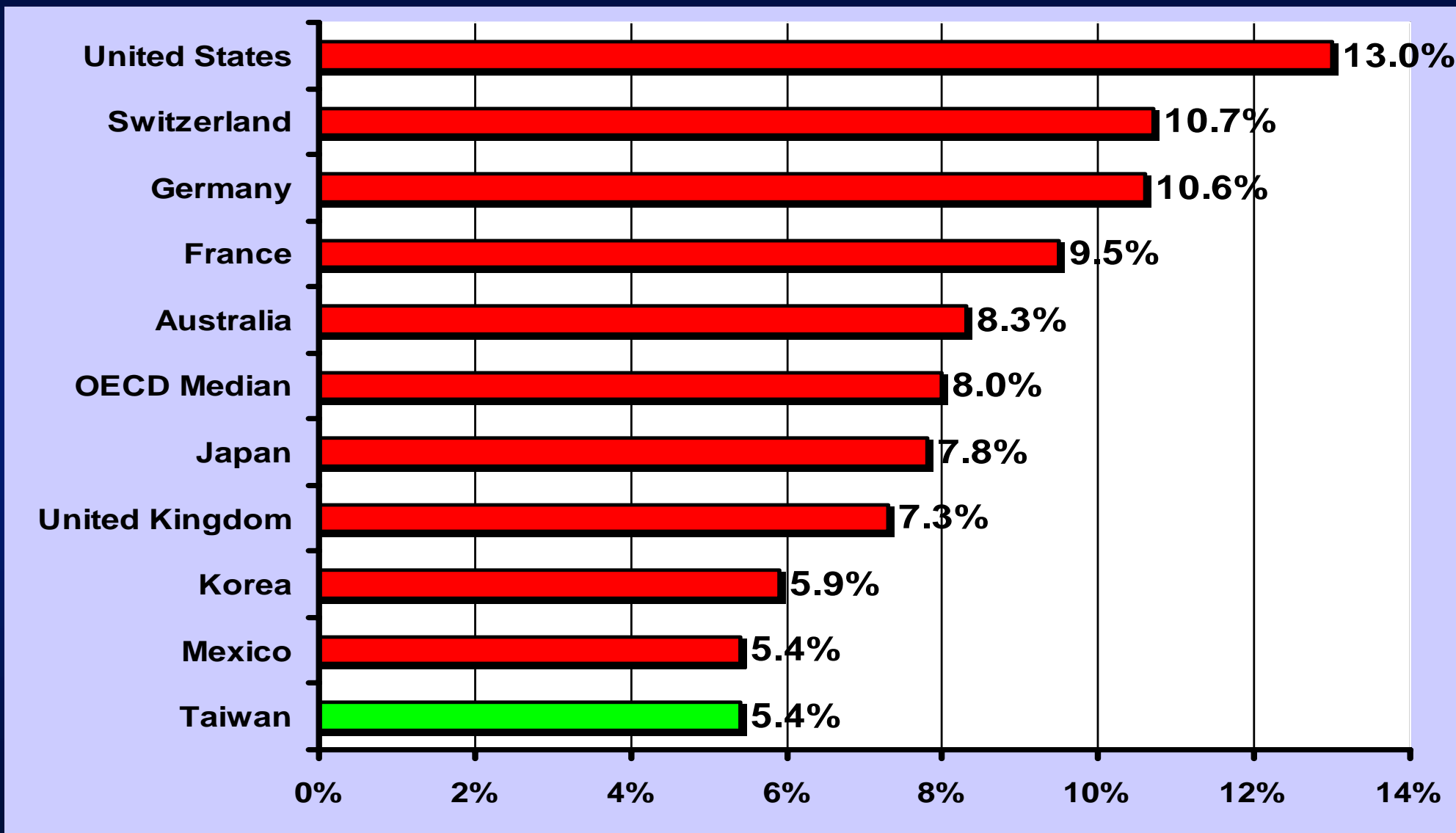
In purchasing-power parity adjusted equivalent U.S. Dollars (except for Taiwan)



SOURCE: OECD Data, 2002; DoH, ROC, 2001 Health Statistical Trends.

HEALTH SPENDING AS % OF GDP IN SELECTED OECD NATIONS AND TAIWAN, 2000

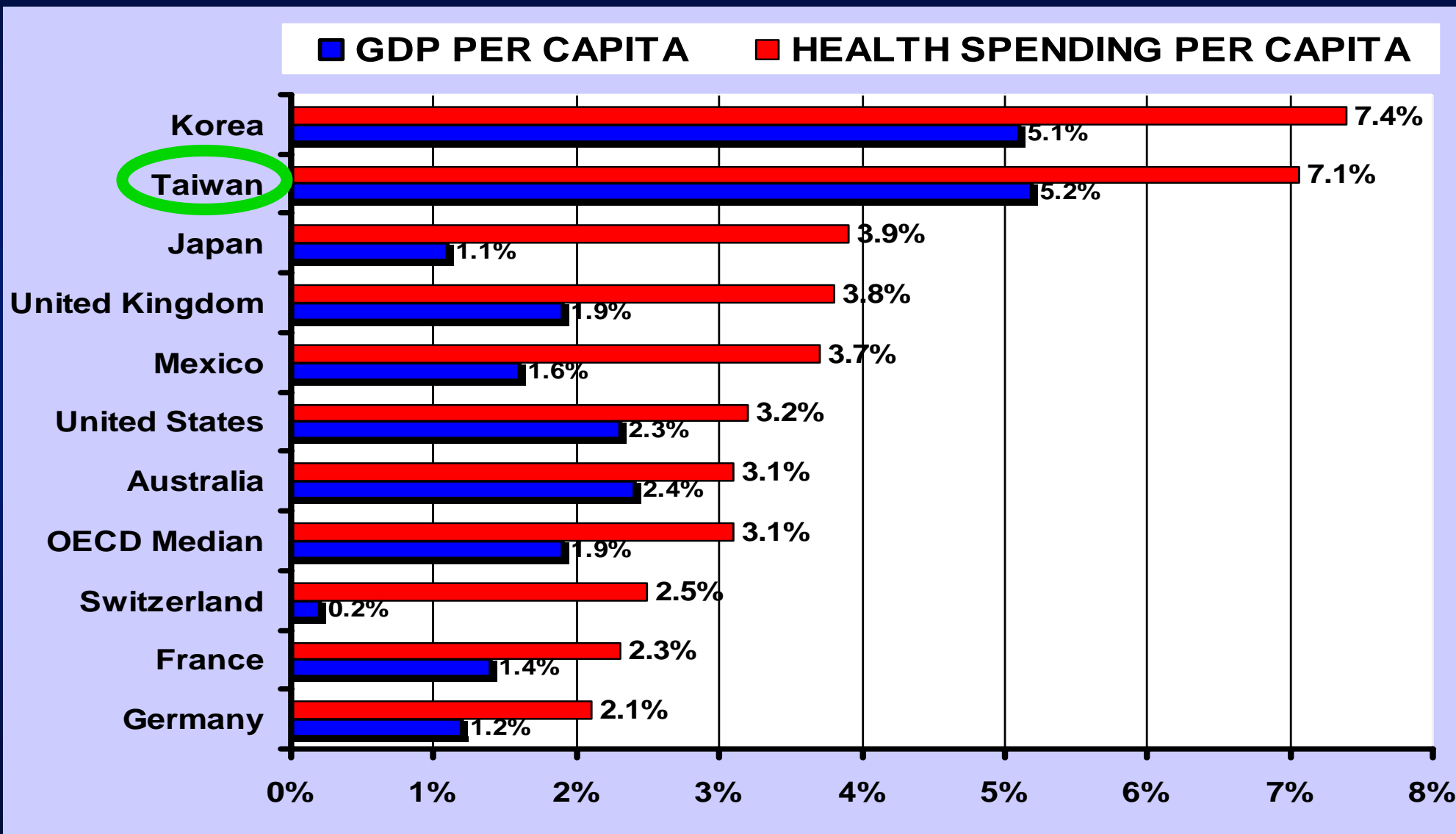
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SOURCE: OECD Data, 2002; DoH, ROC, 2001 Health Statistical Trends.

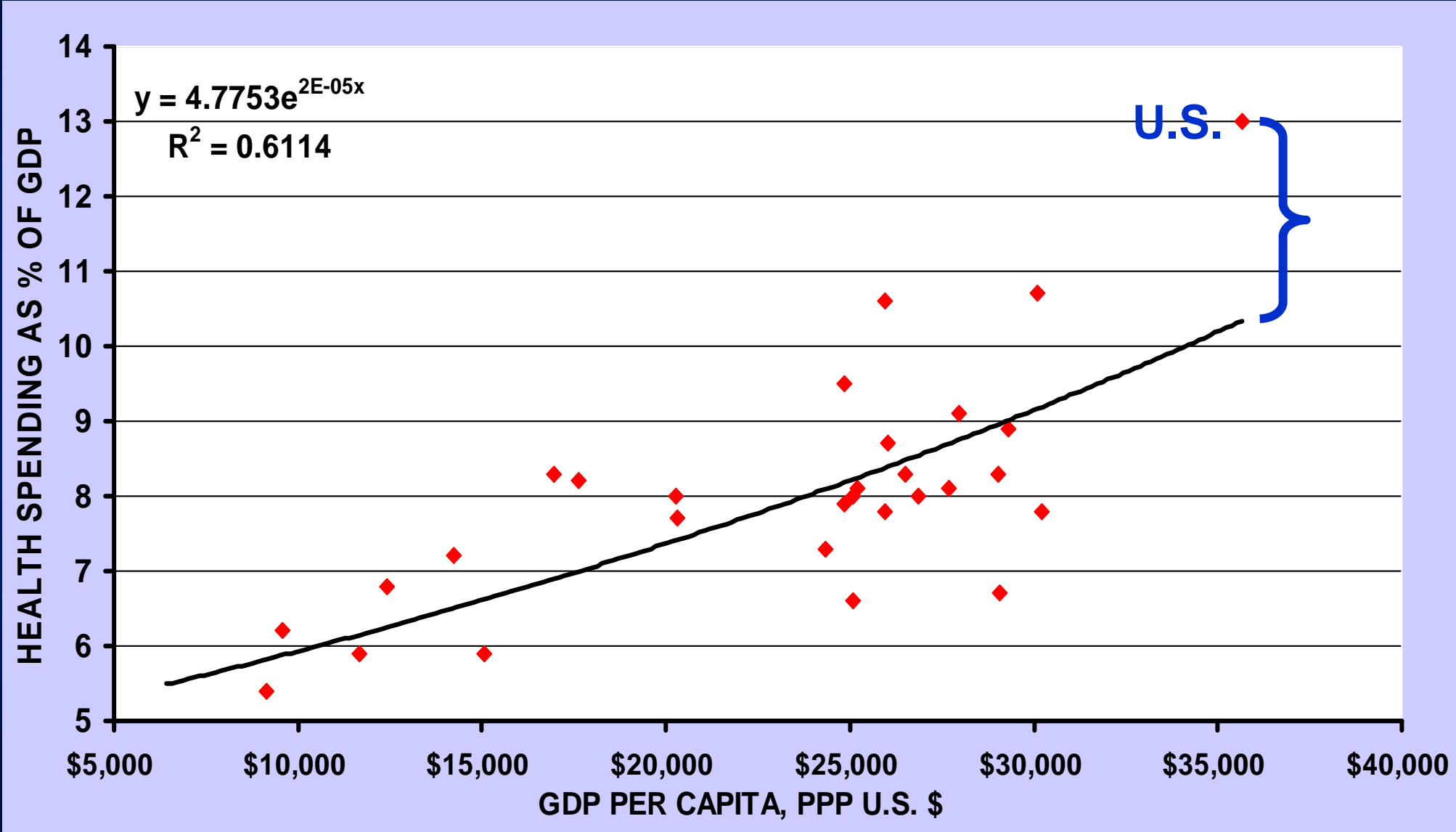
AVERAGE ANNUAL GROWTH IN GDP AND HEALTH SPENDING PER CAPITA, 1990-2000

In purchasing-power parity adjusted equivalent U.S. Dollars (except for Taiwan)



SOURCE: OECD Data, 2002; DoH, ROC, 2001 Health Statistical Trends.

HEALTH SPENDING AS % OF GDP PLOTTED ON GDP PER CAPITA, 2000 FOR 32 COUNTRIES IN THE OECD



SOURCE: OECD DATA 2002

TAKE-AWAY MESSAGE

In most countries, health spending per capita tends to grow faster than GDP per capita. It is a natural economic phenomenon.

■
Consequently, policy makers should expect the percentage of GDP going to health care to rise over time.

A policy to keep that percentage constant over time is likely to produce high public dissatisfaction with the health system.

INTERNATIONAL TRENDS IN HEALTH CARE AND HEALTH POLICY

I. INTERNATIONAL TRENDS IN HEALTH SPENDING

II. COMMON MISPERCEPTIONS ABOUT HEALTH CARE

A. Health spending displaces capital investments



OUR COMMENT:

First, much of health spending is in itself an investment in the nation's human capital, through better health.

Second, that part of health spending that is more in the nature of consumption may displace either investment or other forms of consumption.

In any event, if we worry that health spending displaces capital investment, then why not worry that other forms of consumption (e.g., entertainment, fashion, beer, etc.) does so as well?

INTERNATIONAL TRENDS IN HEALTH CARE AND HEALTH POLICY

I. INTERNATIONAL TRENDS IN HEALTH SPENDING

II. COMMON MISPERCEPTIONS ABOUT HEALTH CARE

A. Health spending displaces capital investments

B. Health spending hurt international competitiveness

OUR COMMENT:

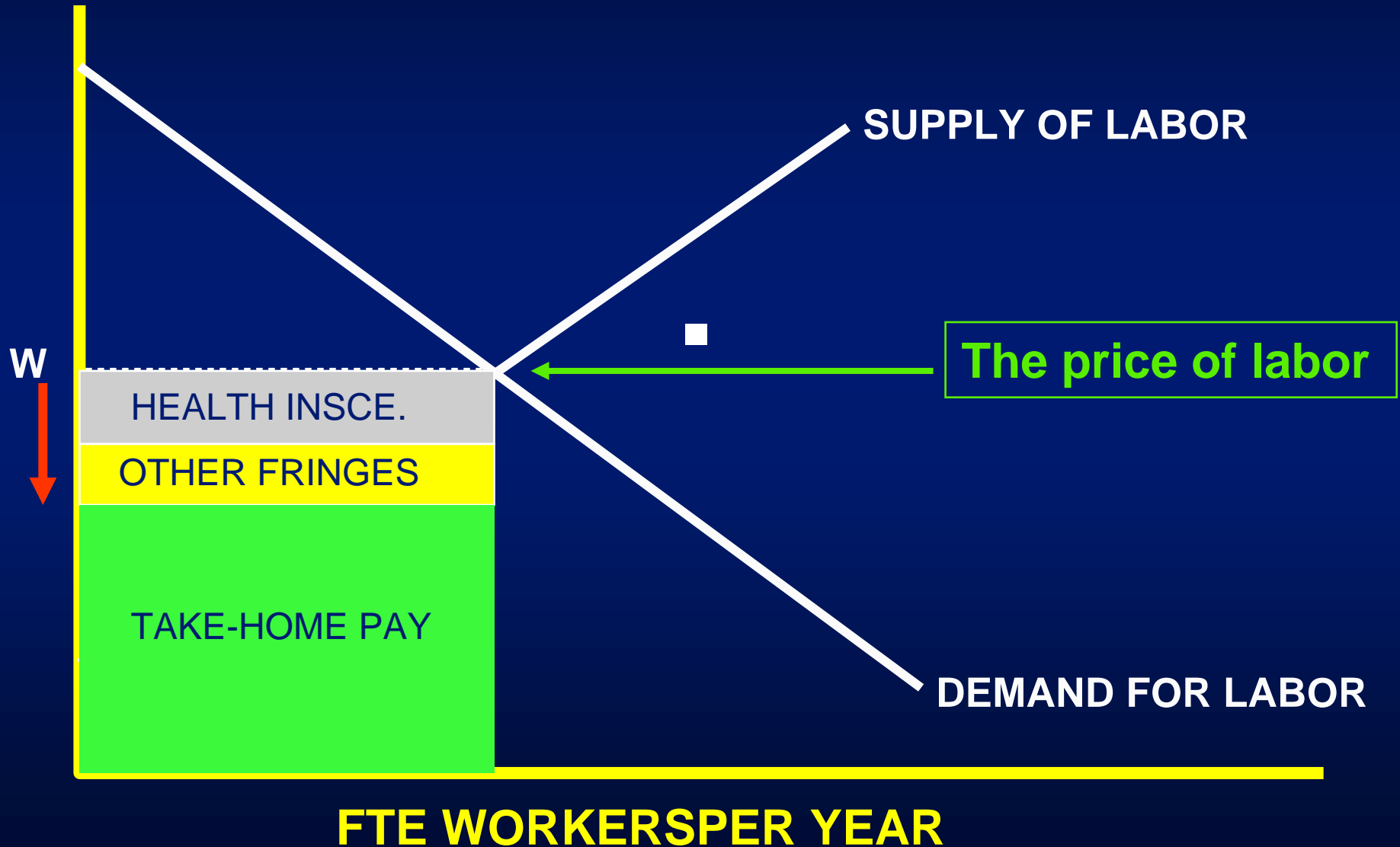
A nation's health spending does not impair its international competitiveness.

If that were so, why would not other forms of spending impair a nation's competitiveness—e.g. transportation (much of which is wasteful)?

For the most part, payroll taxes and fringe benefits paid by business are shifted back to employees in the form of lower take-home pay. They need not be passed on to the prices of products.

ALL FRINGE BENEFITS ULTIMATELY COME OUT OF TOTAL COMPENSATION

TOTAL COMPENSATION PER YEAR (THE PRICE OF LABOR)



INTERNATIONAL TRENDS IN HEALTH CARE AND HEALTH POLICY

I. INTERNATIONAL TRENDS IN HEALTH SPENDING

II. COMMON MISPERCEPTIONS ABOUT HEALTH CARE

A. Health spending displaces capital investments

B. Health spending hurt international competitiveness

C. Further growth in health spending is not “sustainable”

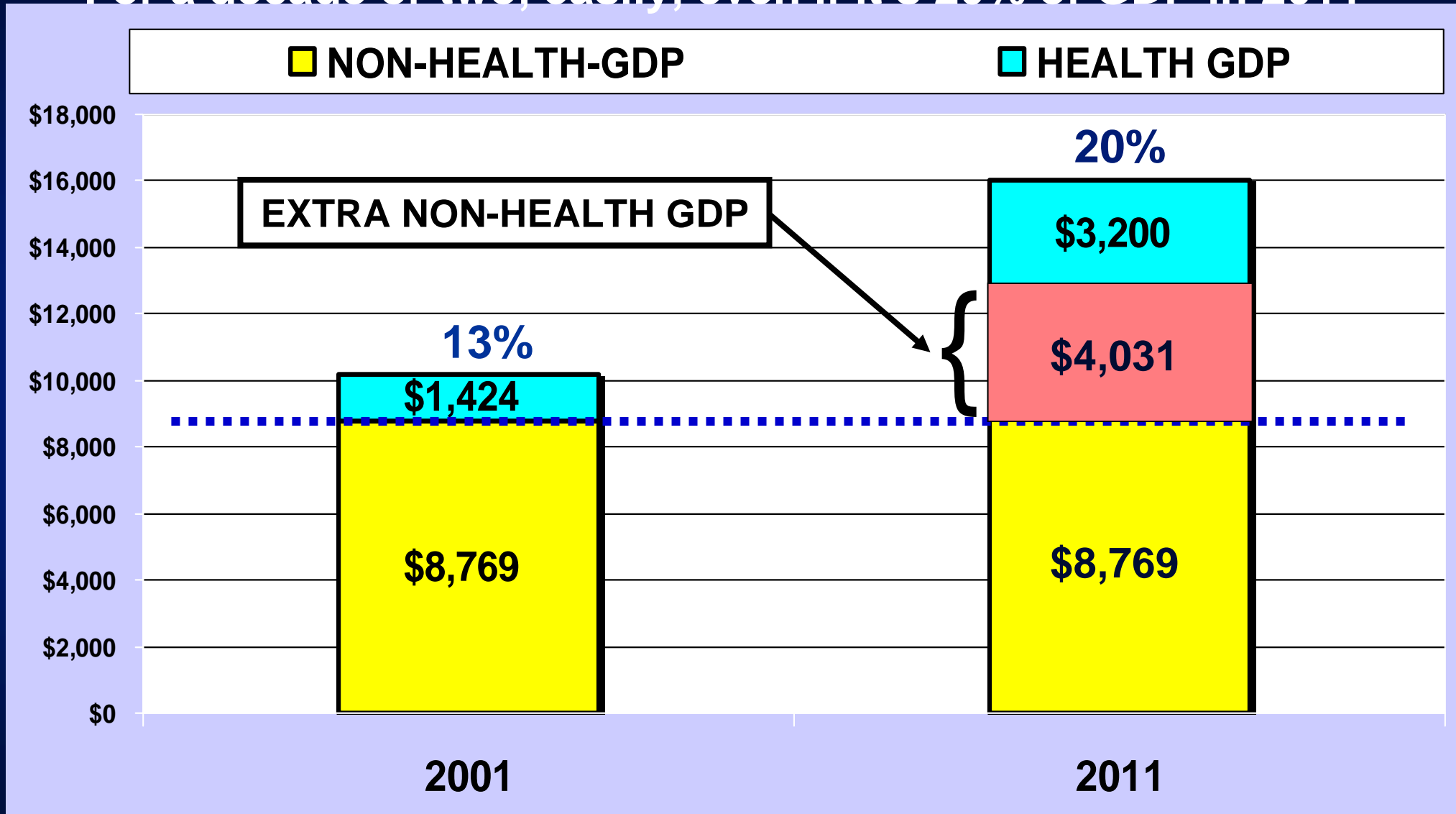
OUR COMMENT:

From a purely macro-economic perspective, the current annual growth in health spending certainly is affordable, and the projected future growth is affordable as well, that is, it is “sustainable.” ■

This is true even for the extreme example—the U.S.—which currently spends 15% of its GDP on health and might well spend 20% in 2011.

CAN AMERICA AFFORD THIS SPENDING?

For a decade or two, easily, even if it's 20% of GDP in 2011



SOURCE: Hefler et al., *Health Affairs*, March/April 2002, p. 207

OUR COMMENT: (continued)

The crucial issue in health care is not “sustainability”,
but:

1. Is the total economic burden of health care shared in what the public considers a “fair” way?
2. Are we getting our dollar’s worth in health care, that is, do we get the quality we should be getting, and are all services delivered to patients actually necessary?

The 2nd question has become a major issue in most industrialized nations—also in Taiwan.

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I. INTERNATIONAL TRENDS IN HEALTH SPENDING

II. COMMON MISPERCEPTIONS ABOUT HEALTH CARE

A. Health spending displaces capital investments

B. Health spending hurt international competitiveness

C. Future growth in health spending is not “sustainable”

D. The aging of the population drives health spending

OUR COMMENT:

Research in several countries has shown that, by itself, the aging of the population is so gradual a process over time—even in Taiwan--that it can explain less than 1 percentage point of the annual growth in health spending.

The chief driver of annual spending growth appears to be new technology that drives up the volume and cost of health care per capita for all age groups.

INTERNATIONAL TRENDS IN HEALTH CARE AND HEALTH POLICY

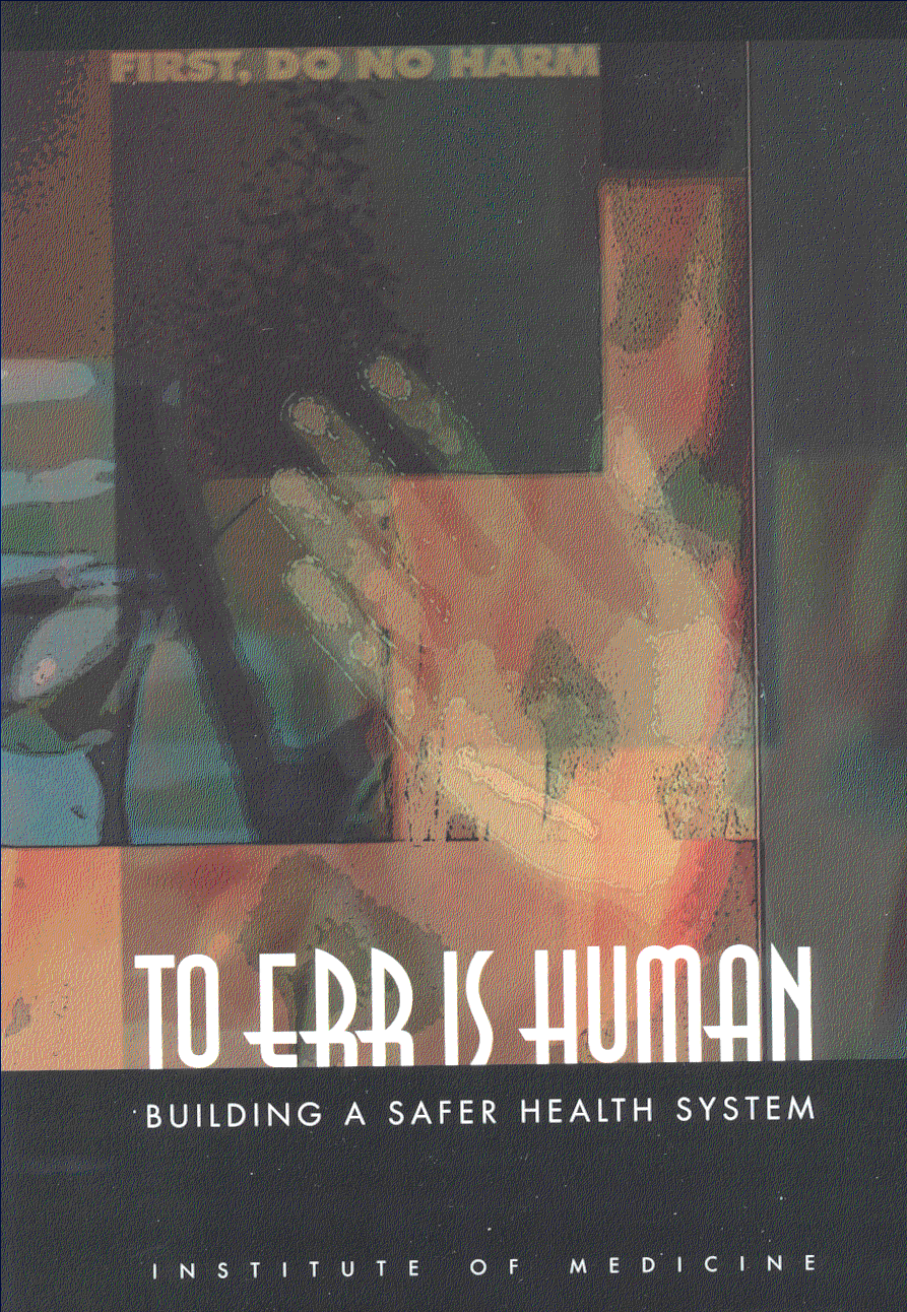
I. INTERNATIONAL TRENDS IN HEALTH SPENDING

II. COMMON MISPERCEPTIONS ABOUT HEALTH CARE

III. **COMMON CONCERNS ABROAD ABOUT HEALTH CARE**

A. The quality of health care: ■

- the problem of medical errors



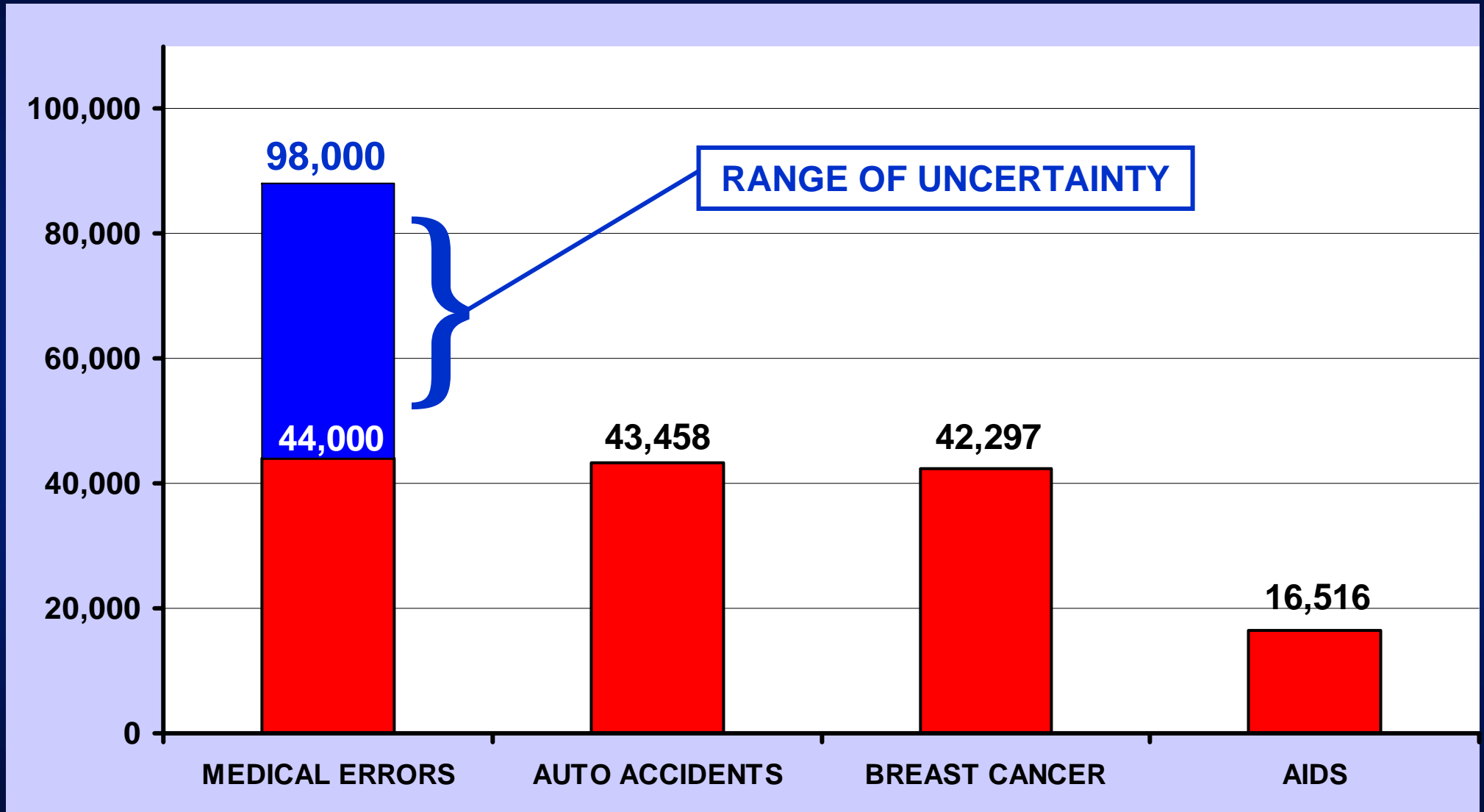
FIRST, DO NO HARM

TO ERR IS HUMAN

BUILDING A SAFER HEALTH SYSTEM

INSTITUTE OF MEDICINE

SELECTED CAUSES OF DEATH, UNITED STATES, 1997



SOURCE: Institute of Medicine, *To Err is Human: Building a Safer Health System*, November, 1999..

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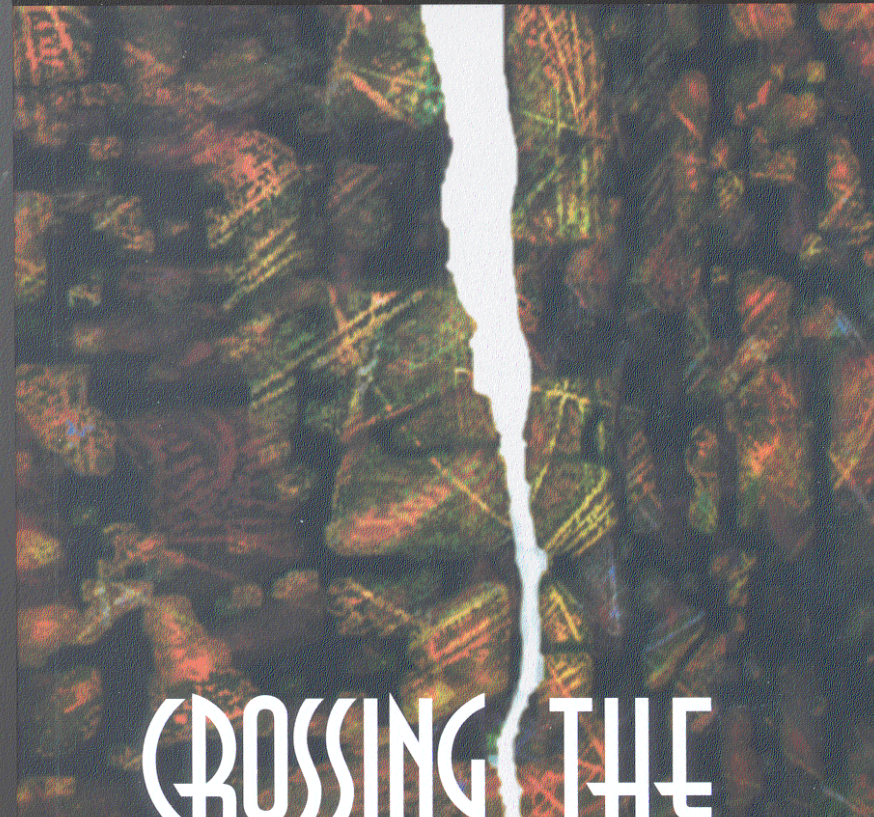
A. **The quality of health care:** ■

- the problem of medical errors

- **overuse, underuse and misuse of health care**

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I N S T I T U T E O F M E D I C I N E



CROSSING THE QUALITY CHASM

A New Health System for the 21st Century

Overuse of services--especially of prescription drugs—
but also underuse and misuse of health care is thought
to be a major problem in Taiwan as well.

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A. The quality of health care: ■

- the problem of medical errors

- overuse, underuse and misuse of health care

- outcomes research and cost effectiveness

In “cost effectiveness” analyses, we seek to relate the cost of health care to a meaningful measure of outcome.



A frequently used measure for this purpose is added “quality-adjusted life years” (QALYs) yielded by the treatment

**THEN WE CAN THINK OF “COST EFFECTIVENESS” OF
A MEDICAL TREATMENT AS:**

$$\text{COST EFFECTIVENESS} = \frac{\text{TOTAL “COST” OF TREATMENT}}{\text{QALYs ADDED BY TREATMENT}}$$

Ideally, scarce health care resources should be allocated in terms of their COST EFFECTIVENESS.

WHY COST EFFECTIVENESS ANALYSIS?

Extensive research has shown that there are huge geographic variations in per-capita health spending that cannot be explained by demographic factors, the cost of practice or even morbidity. ■

Furthermore, very recent research has shown that there is no correlation between these spending variations and (a) the quality of health care processes or (b) outcomes.

TAKE-AWAY MESSAGE:

A number of international collaborations on the problem of the quality of health care have emerged.

Taiwan policy makers and analysts will find it productive to work closely with the U.S. *Agency for Health Care Research and Quality (AHRQ)*. Their information-rich website is AHRQ.gov.

Taiwan might consider establishing such an agency itself and to invite scholars from abroad to work in it for periods of time.

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A. The quality of health care: ■

B. More effective use of information technology (IT)

TAKE-AWAY MESSAGE:

The health systems of most nations—most notably of the U.S.—have been slow to harvest the benefits of modern IT.

A sensible IT infrastructure for health care cannot be built without:

- 1. more heavy government funding of IT
- 2. smart government coordination of the IT infrastructure.

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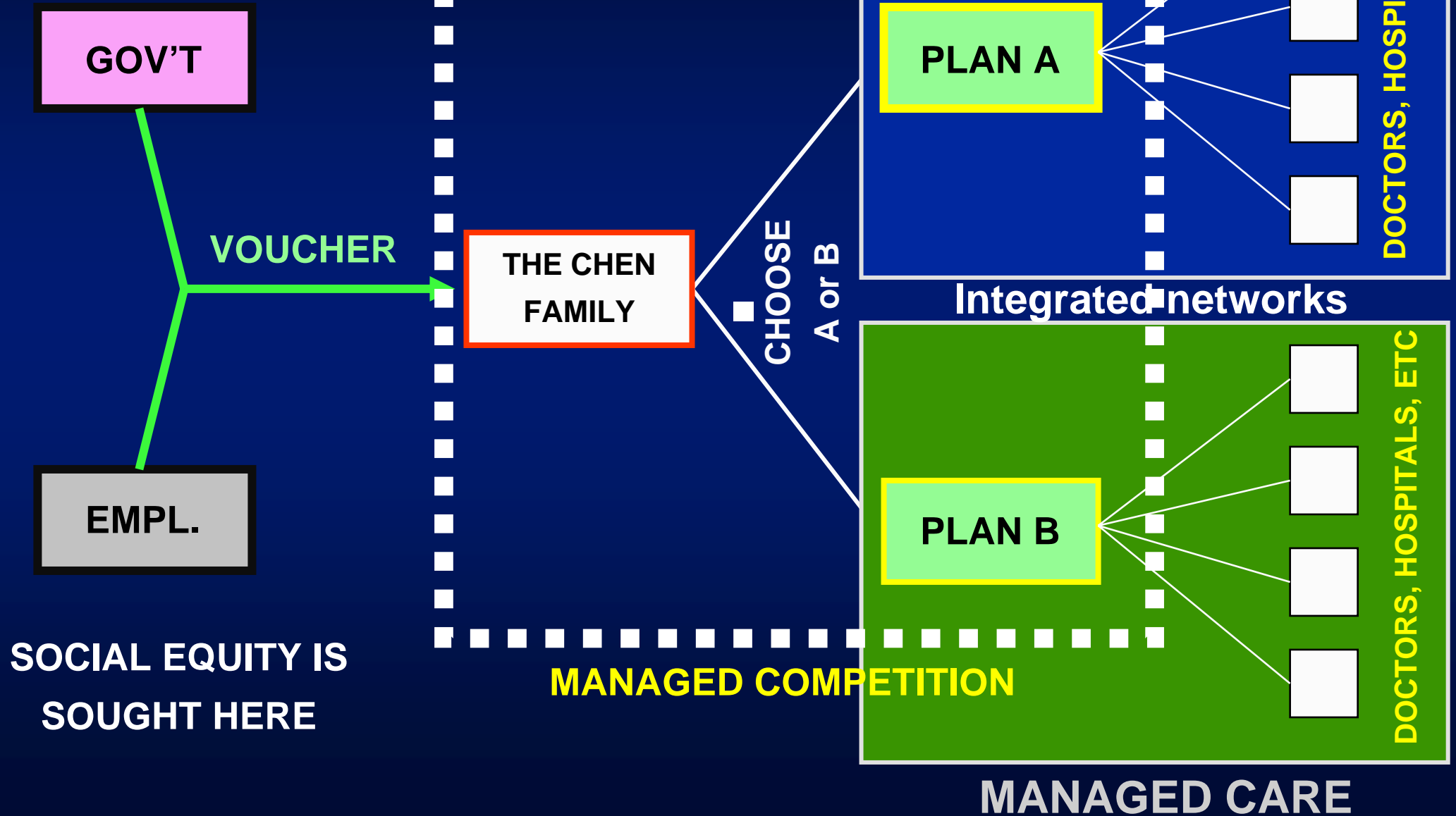
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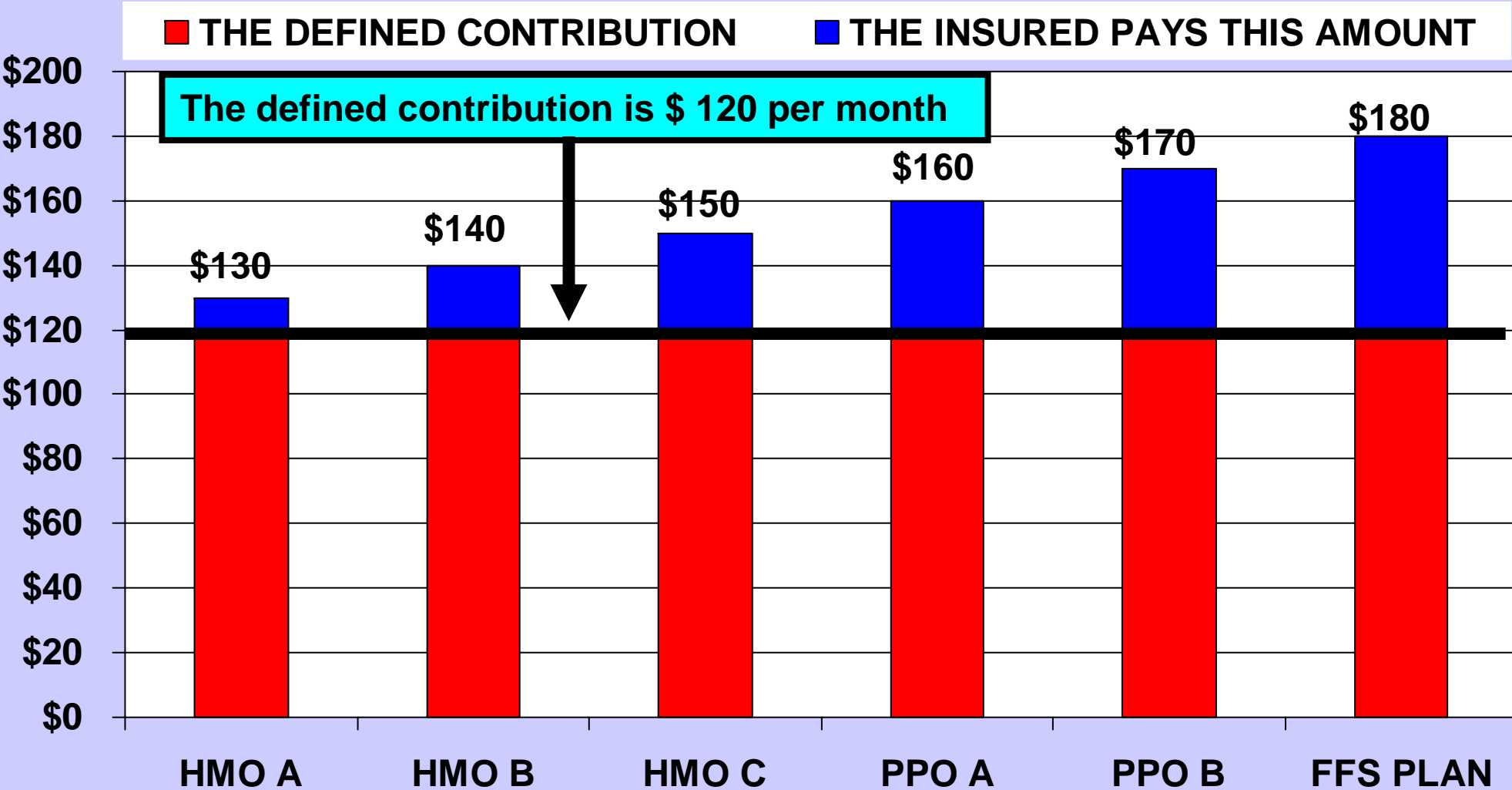
IV. EXPERIENCE ABROAD WITH MANAGED COMPETITION

A. The theory of “managed competition” and “managed care”

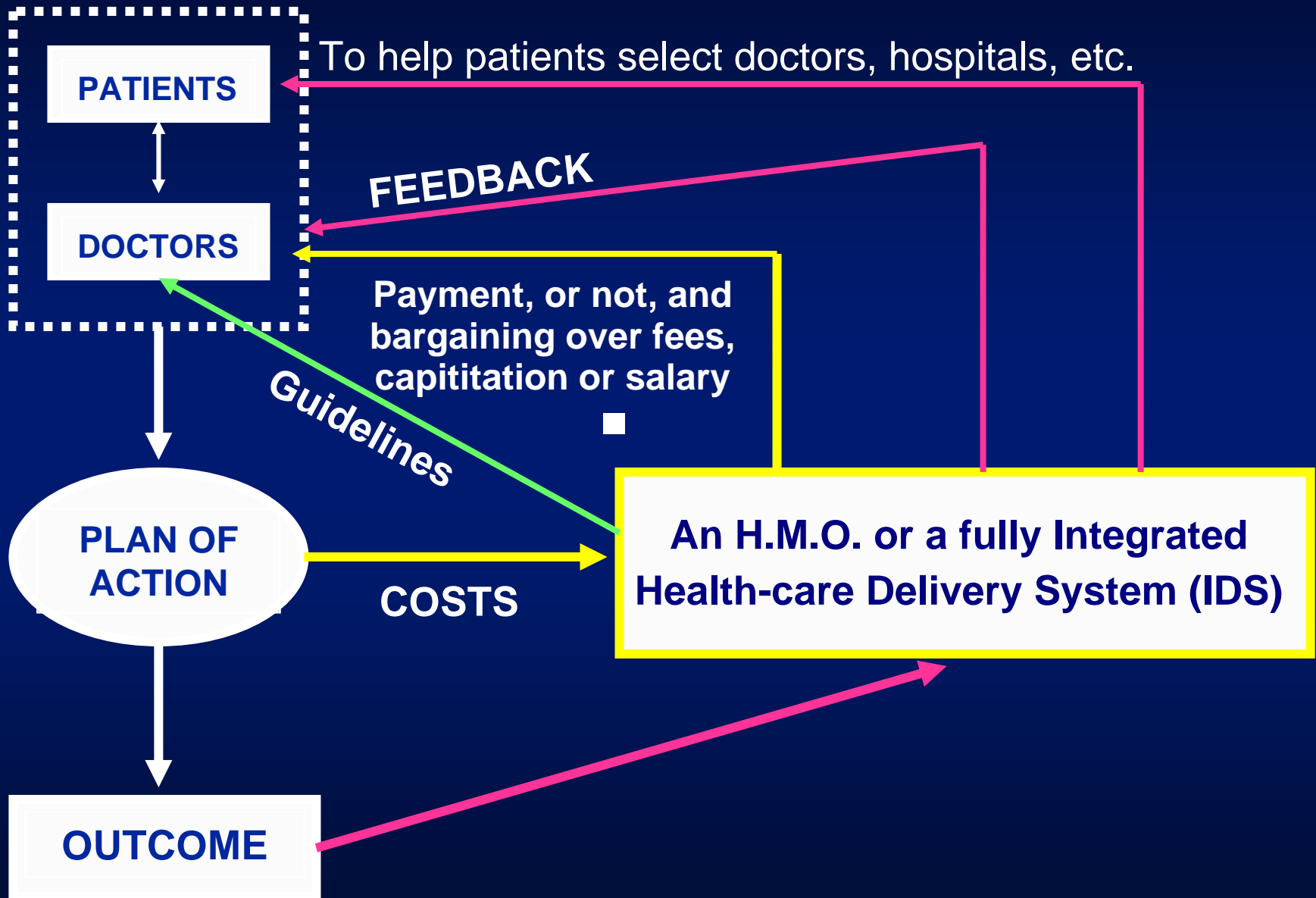
THE MARKET STRUCTURE FOR MANAGED CARE AND -COMPETITION



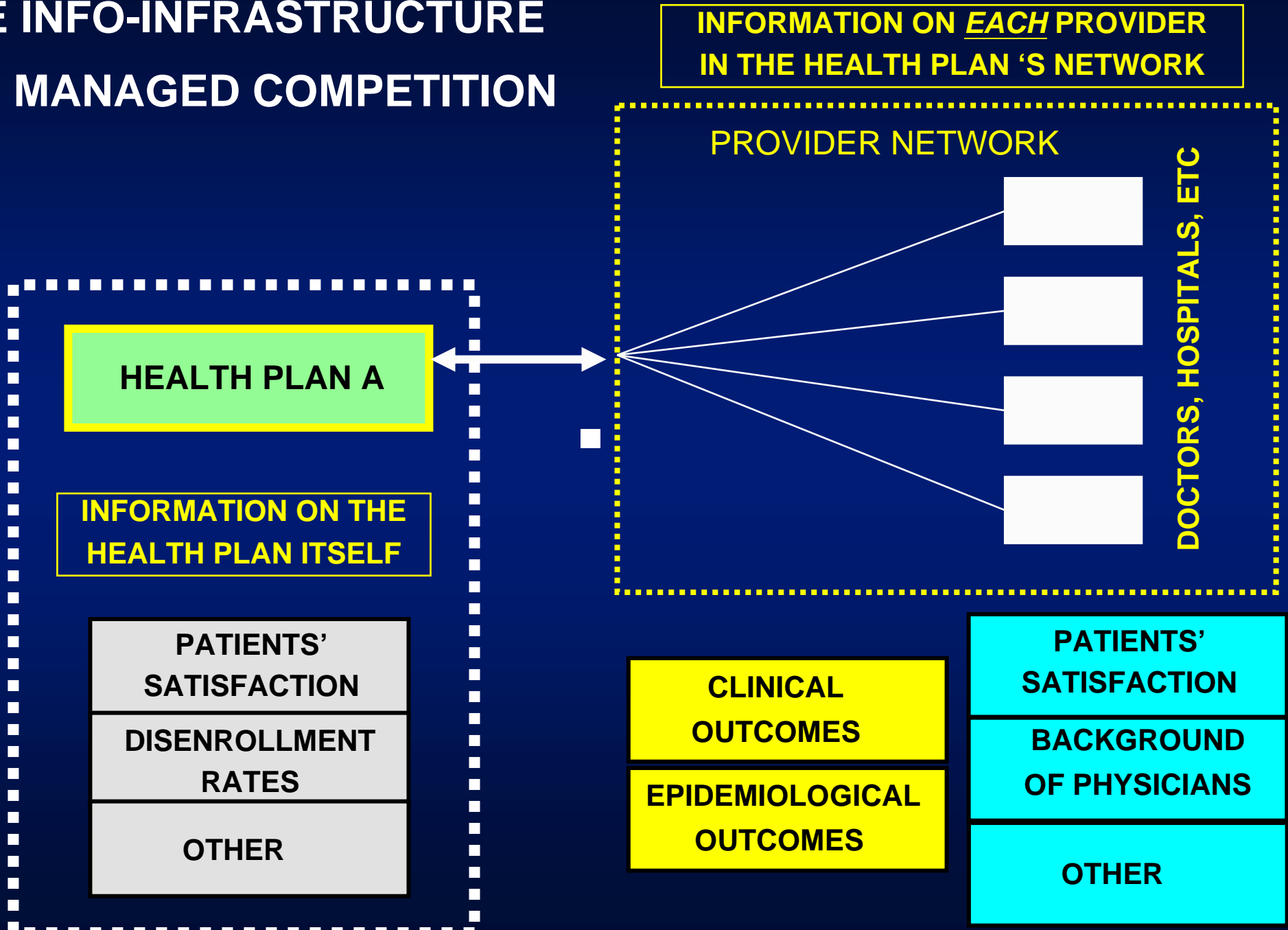
EMPLOYER (OR GOVERNMENT) MAKES A “DEFINED CONTRIBUTION” OF, SAY, \$120 A MONTH; THE INSURED INDIVIDUAL PAYS THE REST OF THE PREMIUM



CARE WOULD BE MANAGED WITH OUTCOMES DATA AND GUIDELINES



THE INFO-INFRASTRUCTURE FOR MANAGED COMPETITION



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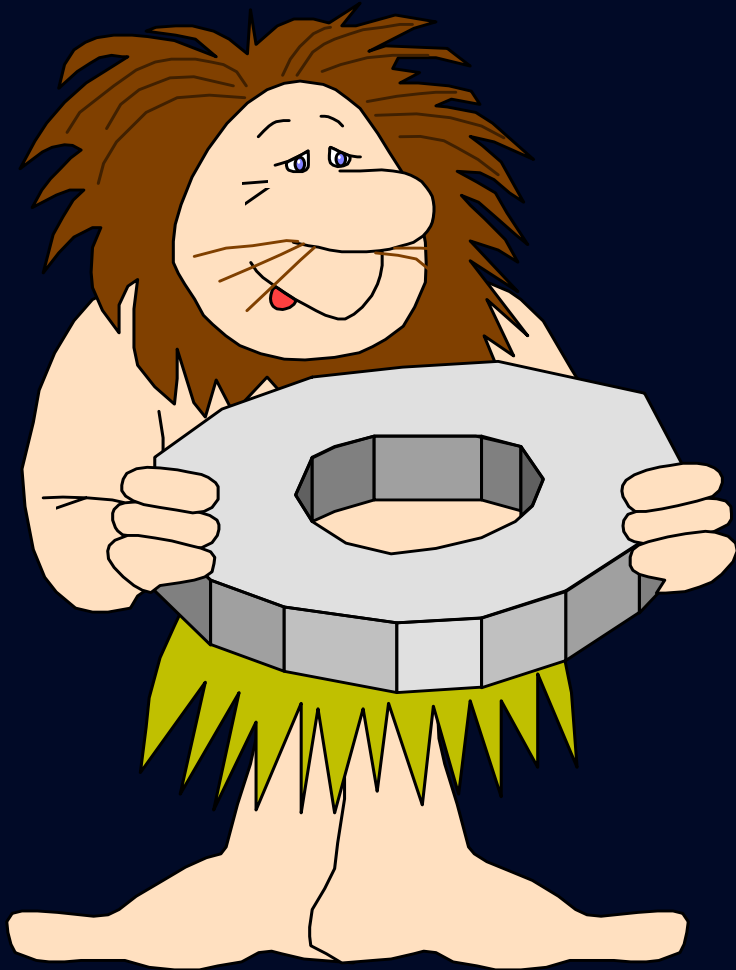
III. COMMON CONCERNS ABROAD ABOUT HEALTH CARE

IV. EXPERIENCE ABROAD WITH MANAGED COMPETITION

A. The theory of “managed competition” and “managed care”

B. Managed-competition in practice

**THERE IS A WORLD OF DIFFERENCE BETWEEN
POLICY BLUEBRINTS and POLICY IN PRACTICE**

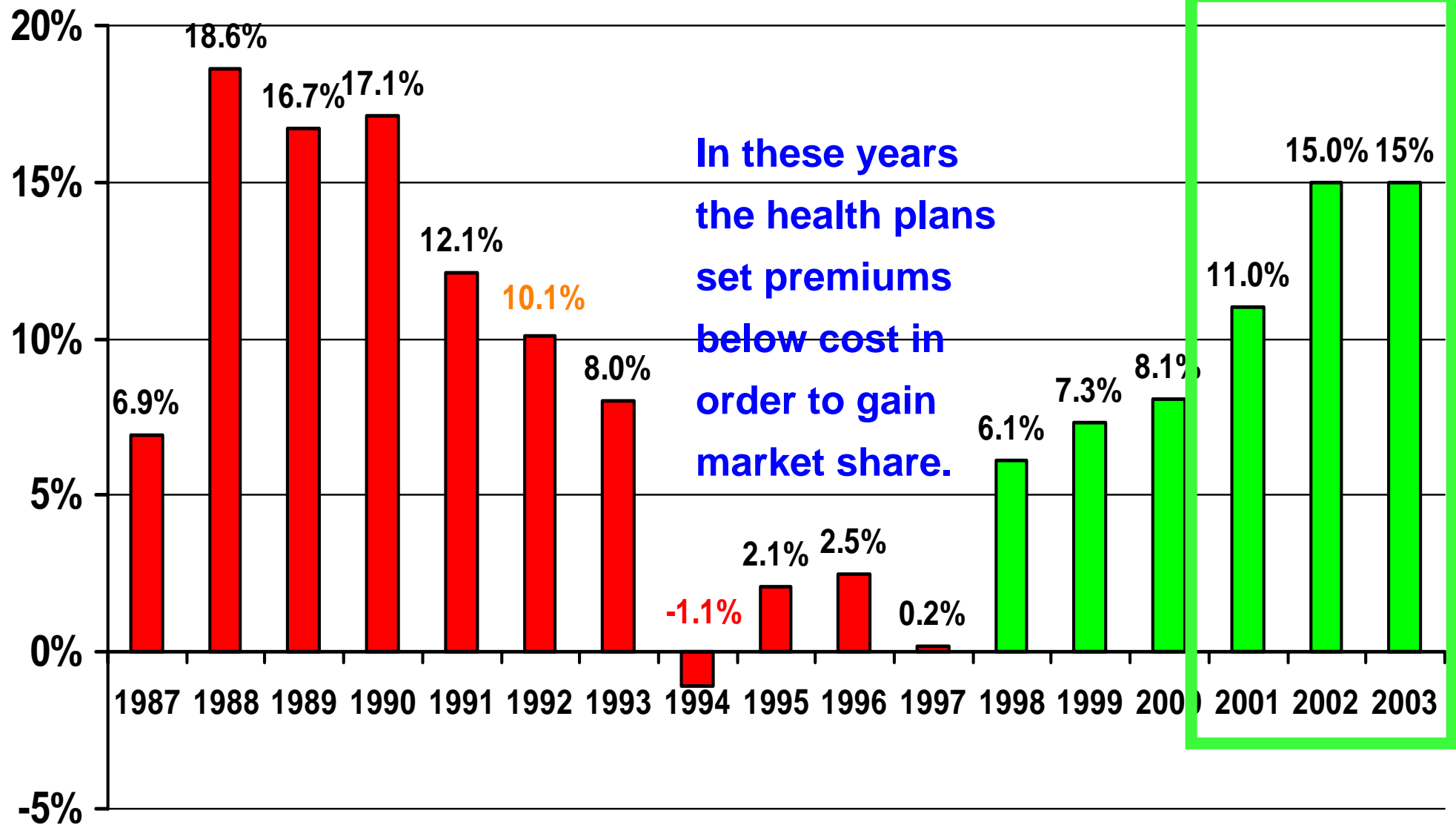


For example, the person who invented the wheel was smart.

But the the person who invented the other three was the true genius!

**GENIUS OFTEN FAILS – OR GETS SABOTAGED – IN
THE IMPLEMENTATION OF HEALTH POLICY**

AND THIS IS WHAT HAPPENED TO HMO PREMIUMS



Newsweek

November 8, 1999 : \$3.50

www.newsweek.com

PUFFY'S ORBIT
'SUPERMODEL EGG' HYPE



The War
Over
Patients'
Rights

HMO HELL

Fixing
Managed Care:
Is There a
Better Way?

Ranking the
Biggest HMOs



BCMDG## CAR-RT SORT ## R-002
00538221100194000 NY-R
EINHARDT 001192M
BROOKS BEND P06080
MCCETON NJ 08540-7530

Nov. 8, 1999

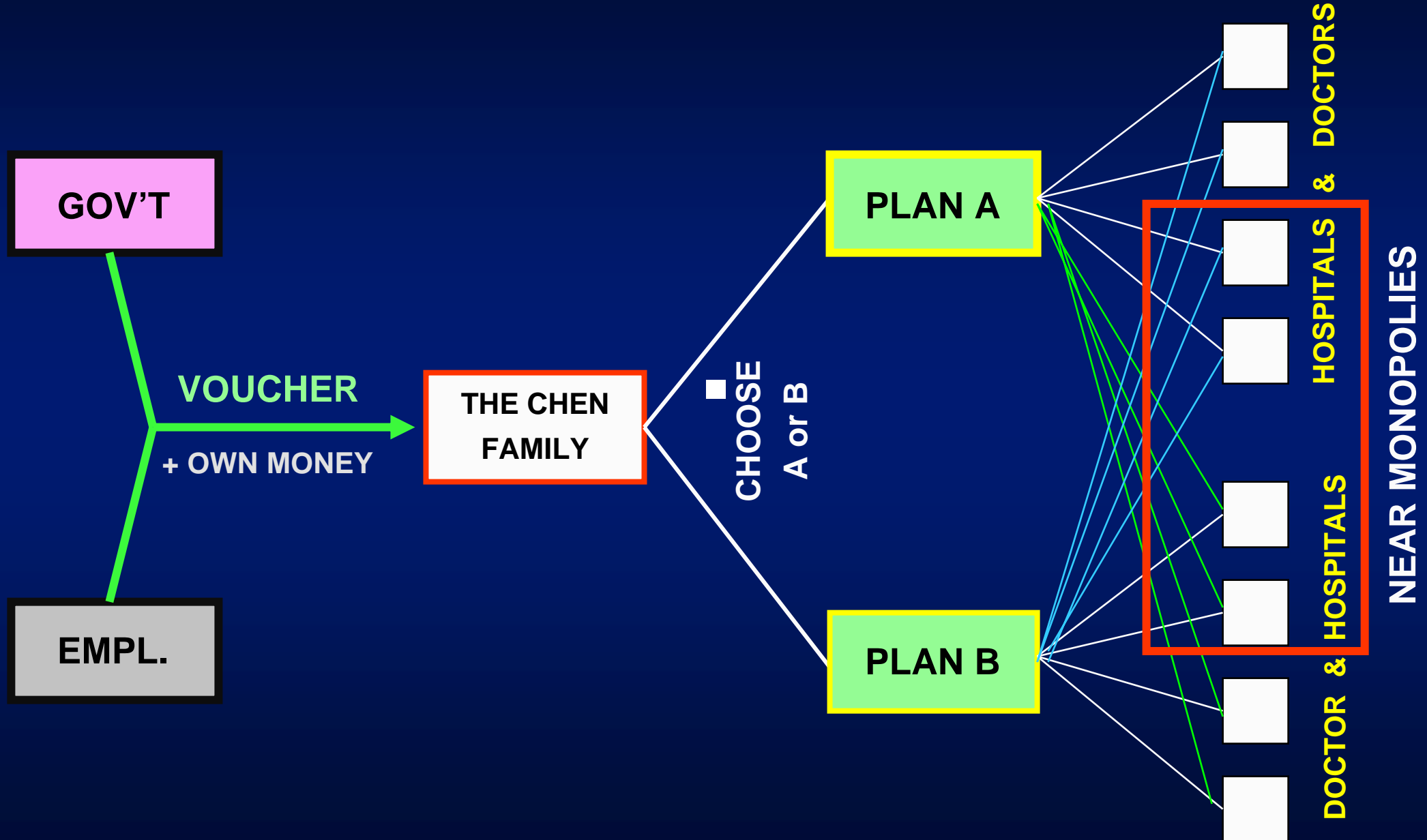
Commentary:
“Efficiency and Civility in Maternity Care”
or “How Much Jello Can a Mother Eat?”

Uwe E. Reinhardt
Princeton University

Overarching this nation's long and torturous debate over health policy has been the question which algorithm—“government regulation” or “the market”—is best suited to do society's bidding in allocating the nation's health.

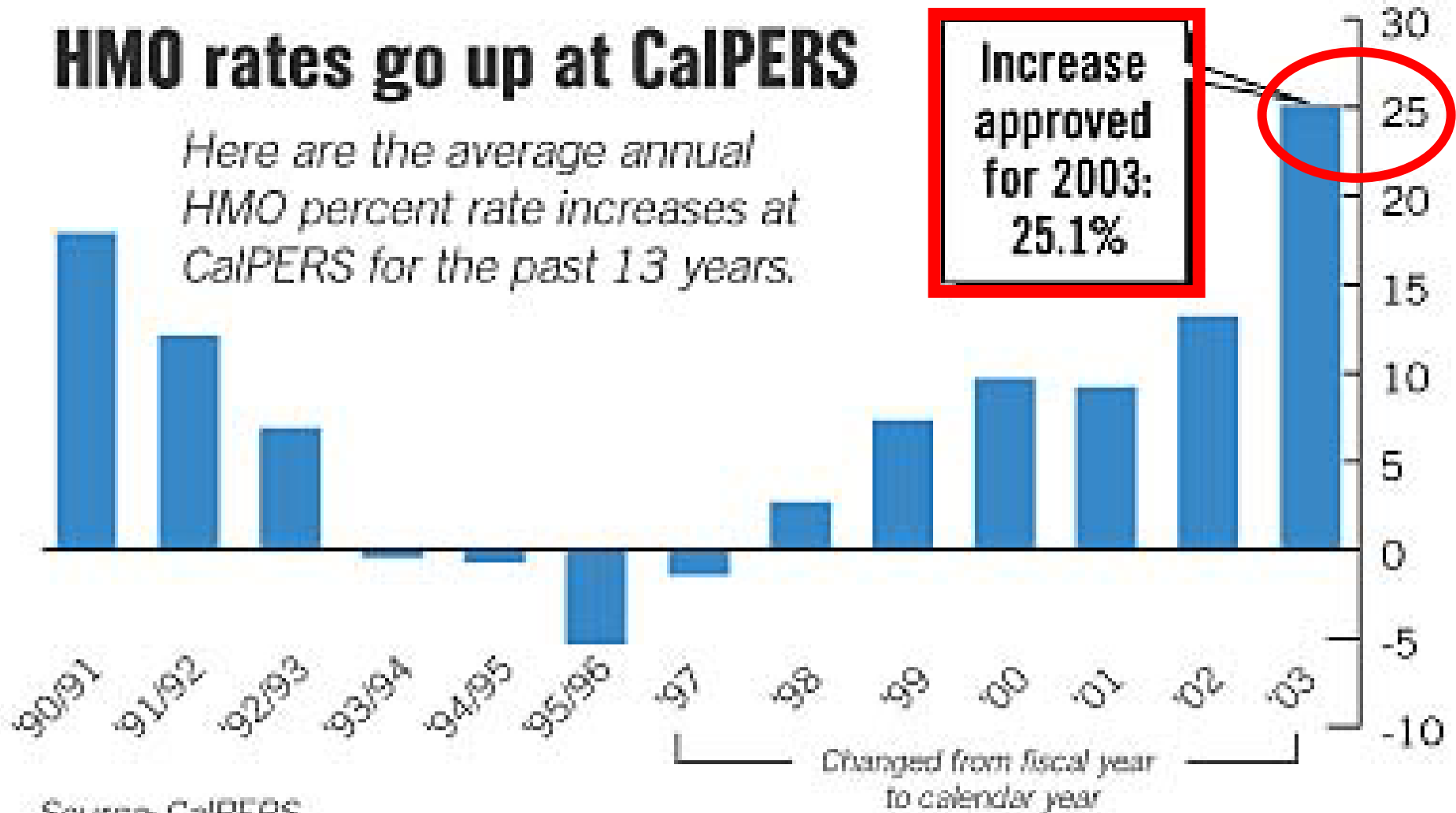
SOURCE: *Medical Research and Review*, March, 1999; pp. 47-54.

WHAT ACTUALLY HAPPENED: NO INTEGRATED NETWORKS DEVELOPED



HMO rates go up at CalPERS

Here are the average annual HMO percent rate increases at CalPERS for the past 13 years.



Source: CalPERS

Chronicle Graphic

SOURCE: San Francisco Chronicle, April 18, 2002.

OUR CONCLUSIONS:

- 1. On paper, the theory of managed competition among private health insurance plans is intuitively very seductive.**
- 2. Unfortunately, they have not worked in practice as advertised. In the U.S., private health insurance premiums currently are rising at 15% or so even for large employers, and in many instances at even higher rates.**
- 3. At the moment, there is no end in sight for these large annual premiums increases.**

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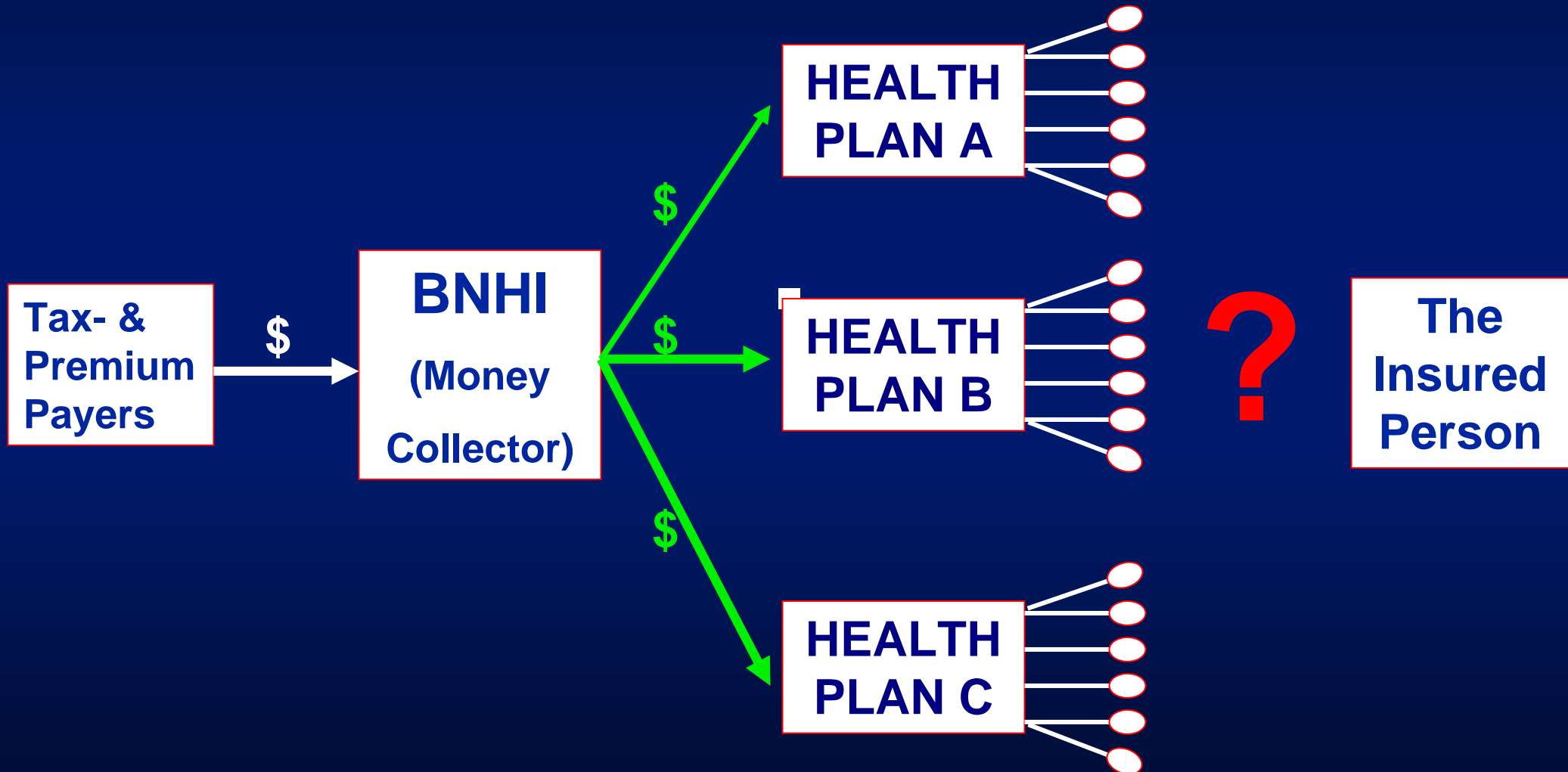
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A. The theory of “managed competition” and “managed care”

B. Managed-competition in practice

C. Managed-competition for Taiwan?

IF TAIWAN DECIDED TO PRIVATIZE HEALTH INSURANCE BY SPLITTING THE BNHI INTO TWO COMPONENTS:



POSSIBLE POSITIVE EFFECTS

- 1. The insured have a choice of insurer and can tell their current insurer to “go to hell” if they are not pleased. They cannot do that now with the BNHI.**
- 2. The competing health plans may experiment with different ways to control cost and quality. (The “Let hundred flowers bloom” theory of management.)**
- 3. The health plans might possibly offer health care of better quality, although that is just a theory, not a proven fact.**

POSSIBLE NEGATIVE EFFECTS

- 1. A much larger percentage of total health spending will be eaten up by administration and marketing (8 to 10% vs 2%).**
- 2. The prices and fees paid the providers of health care will go up, because the demand side is now weaker.**
■
- 3. Unless the health plans can substantially reduce the volume of services, total health spending in Taiwan will increase substantially.**
- 4. The insured may well turn out less satisfied than they are now, because they will lose freedom of choice and may resent the volume controls used by the health plans.**

OUR RECOMMENDATION:

CAVEAT EMPTOR!

(Let the buyer [of this policy proposal] beware!)

Do at most a demonstration experiment in one city to see if you could make such a thing work.

It would not work only in rural areas.

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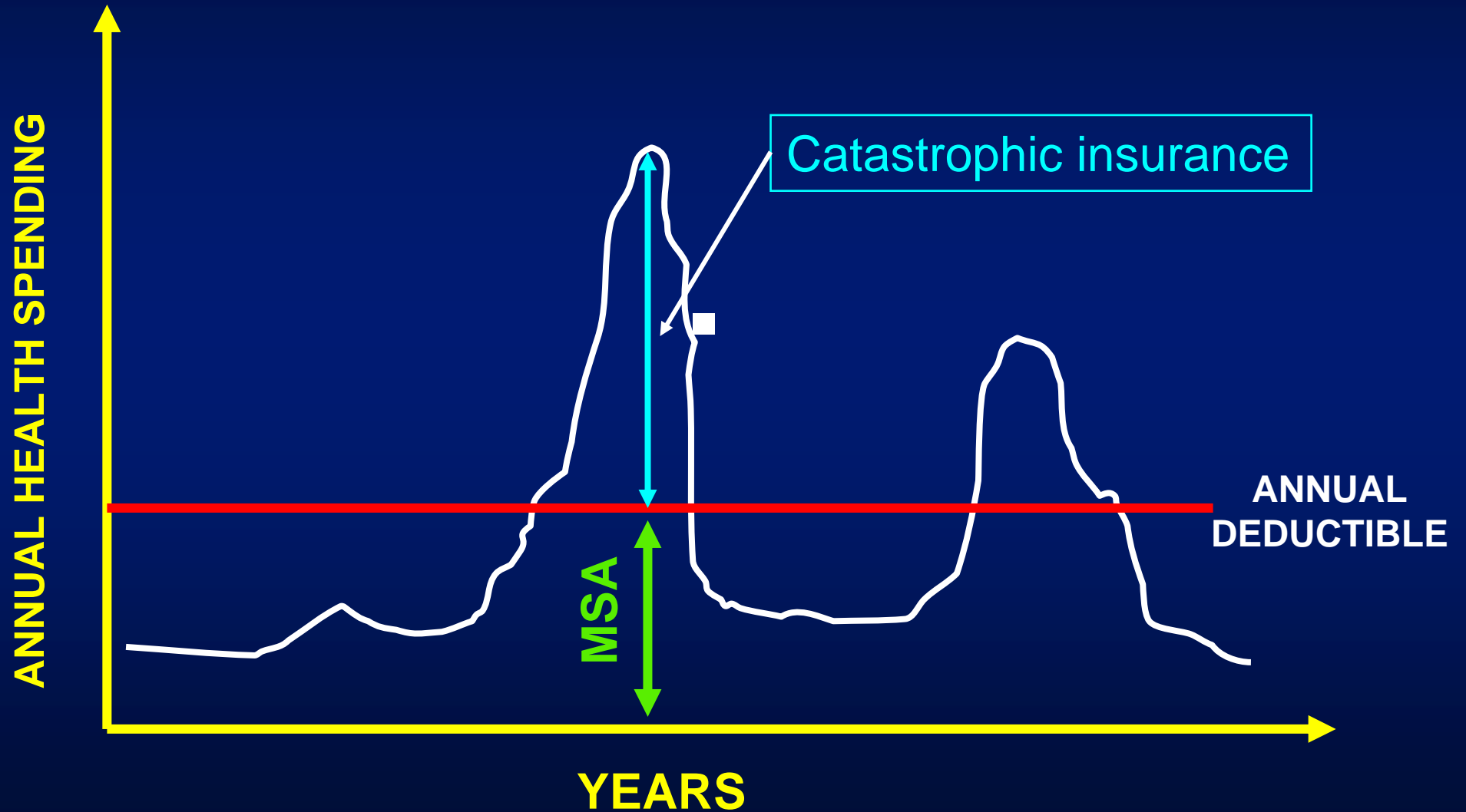
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THE GENERAL IDEA OF MEDICAL SAVINGS ACCOUNTS



THE NEWEST NEW THING IN U.S. HEALTH INSURANCE :

Medical Savings Accounts with Defined Contributions and Catastrophic Insurance

Catastrophic health insurance pays costs above \$4,000, probably under a managed-care insurance product

Patient pays next \$2,500 out of family's budget

Employer contributes \$1,500

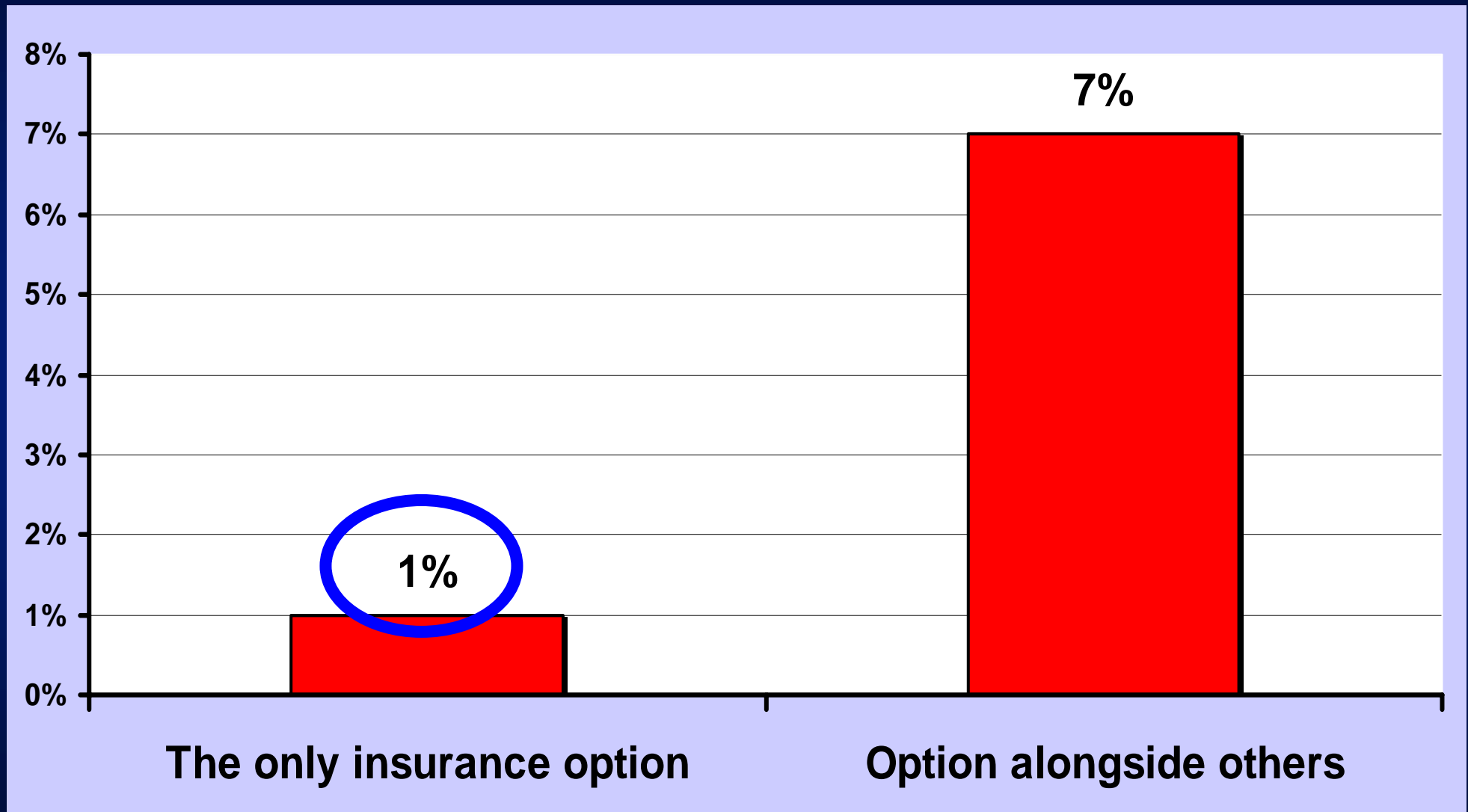
PATIENT'S TOTAL HEALTH BILL FOR THE YEAR

These plans have been around for a while. In the U.S., they have not been popular so far.



Very few employers offer these plans to their employees, because they tend to shift the financial burden of health care from healthy to chronically sick people.

EMPLOYERS ADOPTING “CONSUMER-DRIVEN” HEALTH PLANS IN 2003



SOURCE: Towers Perrin, cited in *Modern Healthcare* March 10, 2003; p. 31.

There is also the famous 20-80 rule in health care, according to which 15% to 20% of the population accounts for 80% of all health spending in any given year.



In other words, much health spending in any given year will still be paid for by catastrophic insurance.

SHIEH · SHIEH