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SPOTLIGHT ON FIXING HEALTH CARE

What Drives High Health Care Costs— and How to Fight Back

by Jeff Levin-Scherz

Reprint [R1004E](#)

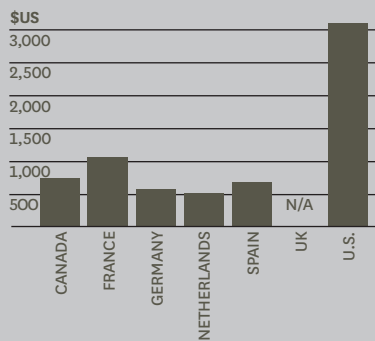
What Drives High Health Care Costs—and How to Fight Back

Managing U.S. health care costs and improving quality will require many simultaneous interventions. Because every dollar of those costs is someone's revenue, resistance from physicians, hospitals, drug and device companies, insurers, and others must be overcome. by Jeff Levin-Scherz

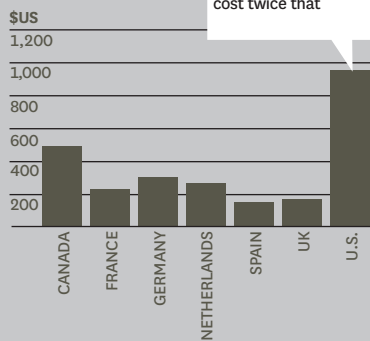
1. OUT-OF-CONTROL PRICING

Health services across the board, from hospital stays to CT scans, cost dramatically more per unit in the U.S. than in other developed countries, where prices are often regulated.

ONE DAY IN THE HOSPITAL



A HEAD CT SCAN

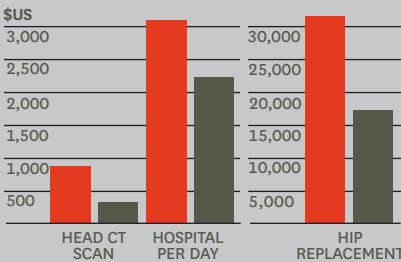


SOURCE INTERNATIONAL FEDERATION OF HEALTH PLANS, 2009

WHAT TO DO CUT PRICES AND COMPETE

Though it would be difficult to mandate prices for nongovernmental players, Medicare and Medicaid successfully limit payments, reimbursing far less than other insurers.

CAPPING PAYMENTS



SOURCE INTERNATIONAL FEDERATION OF HEALTH PLANS, 2009

COMPETING ON PRICE

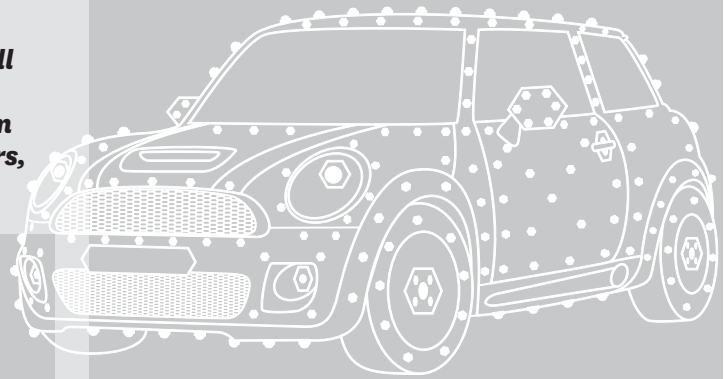


SOURCE MARKET SCOPE

Competition among providers and transparent pricing help contain costs. Giving consumers responsibility for spending also lowers easily comparable prices for elective services such as laser eye surgery.

2. PAYMENT SCHEMES THAT REWARD EXCESS

If automakers were paid by the bolt, cars would be brimming with unnecessary bolts. The U.S. fee-for-service system in effect pays for “bolts”—units of service—rather than for results, rewarding volume over value and encouraging extra visits, procedures, and tests.

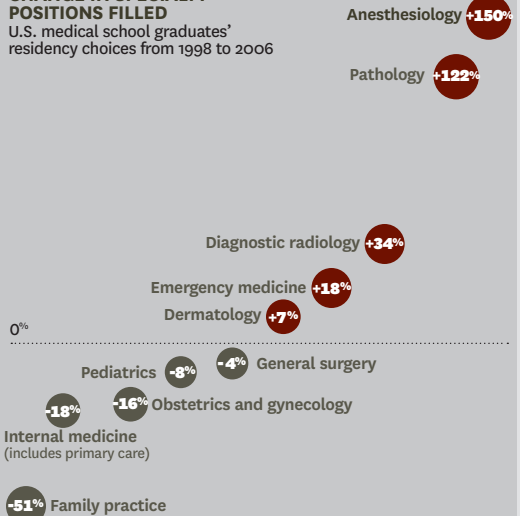


3. TOO MANY SPECIALISTS

Increasing specialist-to-primary-care ratios raises medical costs in a community without necessarily improving quality. Yet U.S. doctors-in-training are flocking to higher-status, more lucrative specialties.

CHANGE IN SPECIALTY POSITIONS FILLED

U.S. medical school graduates' residency choices from 1998 to 2006



SOURCE NATIONAL RESIDENT MATCHING PROGRAM

WHAT TO DO SHIFT FUNDS

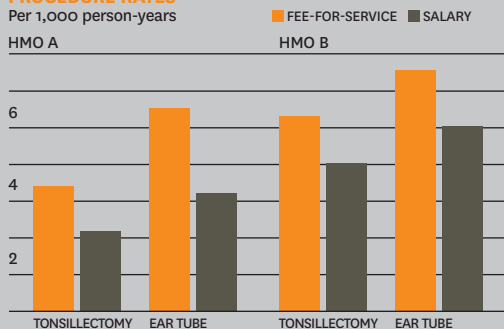
Family practitioners' median annual compensation is about \$180,000, according to the Medical Group Management Association, whereas orthopedic surgeons make \$476,000. Increase compensation and redirect government training dollars to attract doctors to general medicine.

WHAT TO DO STOP PAYING “BY THE BOLT”

A study of HMOs found that salaried physicians performed fewer procedures than those paid by fee-for-service.

PROCEDURE RATES

Per 1,000 person-years



SOURCE SAVER, ET AL., AM. J. MANAG. CARE, 2004

Capitation arrangements, which pay a set rate per patient regardless of services provided, can rein in costs. In one large ophthalmology network, converting from fee-for-service to capitation led to a

51%

decline in cataract surgeries in one year.

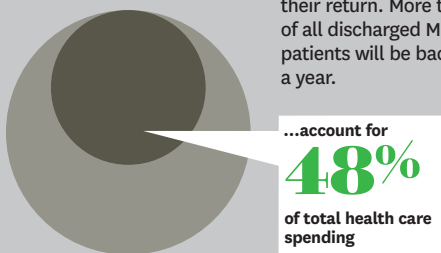
SOURCE SHRANK ET AL., ARCH. OPHTHALMOL., 2005

4. A FEW PEOPLE COST A LOT

A relatively small number of patients—often older or chronically ill people—account for a large portion of all medical costs.

These include frequent hospital readmissions and managing the consequences of obesity and uncontrolled diabetes.

One in five Medicare patients discharged from the hospital will return within a month; half won't have seen a doctor before their return. More than 50% of all discharged Medicare patients will be back within a year.



SOURCE HENRY J. KAISER FAMILY FOUNDATION

WHAT TO DO COORDINATE AND FOLLOW UP

Patients with complicated illnesses should receive care in “centers of excellence” with disease-specific expertise. They should have follow-up appointments after hospital discharge to prevent readmission. Well-coordinated care should be rewarded.

PAY FOR PERFORMANCE

The Physician Group Practice Demonstration, a Medicare pilot program, rewards groups for coordinating patient care, improving quality, and reducing costs. In the first three years, the groups increased average quality scores by this many percentage points:

10 on 10 diabetes measures

11 on 10 congestive heart failure measures

6 on seven coronary artery disease measures

10 on two cancer screening measures

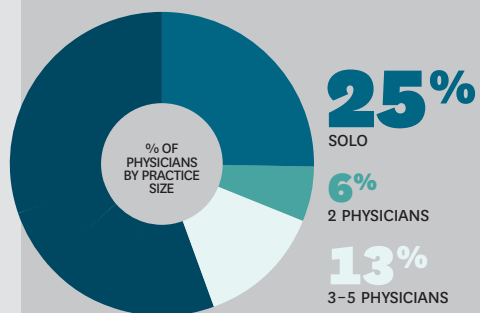
\$32.3M

SAVINGS GENERATED BY THE REWARD SCHEME

SOURCE CENTERS FOR MEDICARE & MEDICAID SERVICES

5. SMALL PRACTICES, FRACTURED CARE

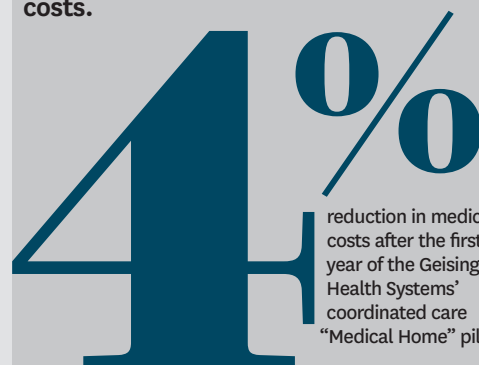
Patients are often cared for by doctors and facilities that communicate poorly. Nearly half of all U.S. physicians work on their own or in groups of five or fewer. Such small practices can find it difficult to invest in improvements in communication, quality, and cost-effectiveness.



SOURCE AMA; MEDICAL GROUP MANAGEMENT ASSOCIATION

WHAT TO DO INTEGRATE AND COMMUNICATE

Integration into large multispecialty groups or delivery systems can improve communication and accountability. Such organizations are more likely to have salaried physicians, which can reduce costs.



They typically have better IT infrastructure, including electronic medical records, and use more non-physicians in a team approach.

Large, integrated groups also have the leverage to demand higher prices, so mechanisms to encourage price competition among them are important.

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