Where Are the Health Care Cost Savings?

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As of July 2010, the United States spent $2.6 trillion per year on health care. It is not just the level of spending that is of concern but the rate of growth over time. During the last 30 years, the growth in US health care spending has been 2.1% more per year than growth in gross domestic product (GDP). This is why the percentage of GDP attributable to health has nearly doubled in 30 years. At this rate, projections suggest that by 2040 1 of every 3 dollars will be spent on health care and by 2080, it will be nearly 1 of every 2 dollars. In 2010, the entire GDP of France was $2.58 trillion, the world’s fifth-largest economy. That means US health care spending is equivalent to the world’s fifth-largest economy.

False Cost Control

Physicians often gravitate to cost control proposals that do not involve their own role and changing their practices, whereas policymakers may propose solutions that will not significantly reduce costs. In assessing cost control proposals, 2 criteria are fundamental. One criterion is that 2% growth in health care costs over growth in GDP amounts to $52 billion a year; serious proposals are aimed at reducing the growth in health care costs to 1% over GDP growth. Consequently, anything short of $26 billion in savings is not credible. A second criterion is that cost control proposals should transform the delivery of care and lead to improved quality as well as patient and physician satisfaction.

Malpractice Costs. Physicians frequently cite malpractice premiums and the cost of defensive medicine as drivers of high costs. A recent Congressional Budget Office (CBO) analysis estimated that a package of reforms consisting of a $250 000 cap on noneconomic damages, a $500 000 cap on punitive damages, reducing the statute of limitations (1 year for adults and 3 years for children), and implementing fair-share liability could reduce malpractice premiums by 10% ($3.5 billion per year) and reduce defensive medicine for the entire health care system by 0.3% ($7 billion), for a total savings of approximately $11 billion or 0.5% of national health care spending per year. No reliable data indicate that other malpractice reforms would generate cost savings.

Importantly, more than 30 states have instituted similar caps and limits. If these measures have reduced costs, they are insufficient to counter other factors increasing costs. In addition, physicians in those states, such as California, do not seem to indicate that the practice environment is better. There is little research on the effects of malpractice caps on quality, although 1 study cited by the CBO suggested that caps lowered the quality of care. This suggests that limits on malpractice liability would not likely both reduce costs and improve quality.

Insurance Company Profits. Another proposed cost control mechanism focuses on the profits of insurance companies. In 2010, the combined profits of the 5 largest insurers—Wellpoint, United, Aetna, Humana, and Cigna—increased substantially, reaching $11.7 billion. It may be worthy to reduce these profits, but in the scheme of $2.6 trillion in national health care spending, this amount constitutes just 0.5% of total spending.

Drug Costs. In 2010, the United States spent $262 billion on prescription drugs, 10% of total health care spending. There is a worrisome trend that new drugs and biologics costing tens of thousands of dollars per year do not provide cures, but achieve only modest disease benefit. One approach to cost savings is drug reimportation, which would allow brand-name drugs sold at lower prices in Canada or other countries to be imported into the United States. Assuming the logistical and supply problems were solved, the CBO estimated that reimportation could save approximately 1% of drug costs, an insignificant $2.6 billion.

Another approach might be to substitute generic drugs for brand-name drugs. Between 2004 and 2009, use of generic drugs increased substantially from 57% to 75% of all prescriptions. Despite this change, costs for health care and for prescription drugs have both increased by approximately 25% during those years. By increasing generic prescription levels to 100%—an unrealistic level—CBO estimated that an additional $900 million could be saved for Medicare Part D in 2009. Of the $502 billion spent on Medicare in 2009, this would amount to a savings of less than 0.2%. The US Department of Health and Human Services recently concluded that increased savings from expanding generic use “are likely to be small relative to total spending on drugs”—not to mention total health care costs.

“The Million Dollar Baby.” Many physicians believe the US health care system expends excessive amounts on so-called “million dollar babies”—patients who spend long periods in intensive care units and require tracheostomies, gastrostomy tubes, and myriad other interventions. However, an analysis of nearly 20 million commercially insured patients revealed that only 255 patients had consumed more than $1 million each on health care expenditures in 2010. Extrapolating to the entire health care system suggests these patients use 0.5% of all health care costs. Even if all costs attributed to care of these “million dollar babies” could be eliminated, there are not enough of such patients to significantly reduce health care spending. Expanding this group to patients who consume more than $250 000

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in health care expenditures each per year would translate into 6.5% of health care costs. But how can these high-cost patients be identified before they get treatment? Furthermore, it would not seem possible to curtail the health care services such patients receive without raising the charge of “death panels.”

Some may suggest that even if each of these individual cost control measures does not save much money, all together the savings might begin to approach $15 or $20 billion. Maybe. However, there are no specific policies that would enable saving money on the care of “million dollar babies” and the probability of policies that would foster adoption in other areas is remote. More importantly, none of these cost control approaches would transform the delivery of care and generate higher-quality care more efficiently. Malpractice reform based on caps to damages has the suggestion of lowering quality, reimportation of drugs and reducing insurers’ profits lower prices but do not affect the delivery of care or quality, and money saved on the “million dollar babies” cannot be anticipated.

**Where Are the Cost Savings?**

Where is the money in health care? Approximately 10% of the population consumes about 64% of health care expenditures. Who are these patients? “Chronic conditions were closely linked to high expenditure levels: more than 75% of high-cost beneficiaries . . . had one or more of seven major chronic conditions . . . 42% had coronary artery disease, 30% had congestive heart failure, and 30% had diabetes.”

Another reason to focus on these patients is to improve quality—they use the majority of health care services.

There are 2 important aspects about their health care spending and quality of care. First, one estimate suggested that as much as 22% of all health care expenditures is related to potentially avoidable complications such as hospital admissions for patients with diabetes with ketoacidosis or amputation of gangrenous limbs or of patients with congestive heart failure for shortness of breath due to fluid overload. Thus, reducing avoidable complications by 10% could save more than $40 billion per year.

Second, reducing unnecessary medical care for chronically ill patients is about improving tertiary prevention. While some efforts to improve tertiary prevention have failed, others have succeeded. Development and dissemination of additional approaches are needed. Successful efforts seem to entail instituting at least 4 common changes: (1) installing electronic health records and using them to track patients’ health status and physician performance, as well as using decision supports to increase adherence to treatment pathways; (2) using the information for more intensive interactions between patients, caregivers, and clinic staff, including use of care coordinators, 24/7 access, interventions to increase medication adherence, specialized clinic services for recurrent problems of patients with chronic disease such as anticoagulation clinics; (3) reducing use of specialists, and when specialists are involved using those who are more efficient; and (4) providing services not traditionally covered by fee-for-service reimbursement, such as e-mail, wireless monitoring to increase medication adherence, home evaluations to minimize falls, lifestyle interventions to improve nutrition and exercise, and transportation services for office visits. Cumulatively, the savings appear to occur through fewer hospitalizations, emergency department visits, and lower use of specialist services.

**The Role of Physicians**

For physicians to know “where the money is” and the availability of some successful models for reducing costs has 3 implications. First, physicians must be the leaders and must stop looking to drug companies, insurers, or someone else to initiate and achieve cost savings.

Second, physicians have the responsibility to redesign care delivery to emphasize more tertiary prevention and avoid unnecessary complications. Although this will be hard work, only effective physician leadership can ensure successful redesign.

Third, physicians know well that such care redesign cannot occur without payment reform. Rather than complain about the payment system and reimbursement rates, and the problems of accountable care organization regulations or bundled payment regulations, physicians need to take the initiative. They need to develop and propose bundled payments or suggest revisions to the new regulations on accountable care organizations that will facilitate the redesign of care and tertiary prevention.

Deficit pressures are making cost control inevitable. It will only be successful if physicians stop looking to others to find solutions and focus on approaches that improve the care for patients with chronic illnesses.

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**Online-Only Material:** The Author Interview is available at http://www.jama.com.

**REFERENCES**


