

Ends and Means in Budgeting for Health Care

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Topics for this Talk

The Goals of Budgeting

and the challenge of health expenditure

What Politicians and the Public Want

and the distinctive demand for health expenditure

A Framework to Analyze Expenditure Control Policies

the means of budgeting, and why they succeed or fail

Implications for System Design

bureau vs. entitlement, dedicated vs. general revenue, “competition” vs. “regulation”

Budgetary Ends

Economy

to limit spending

Balancing Conflicting Policy Goals

especially: to reconcile preferences about the details with preferences about the totals

Efficiency or “Value for Money”

to maximize ratio of output to input

Equity

budgetary (“fair shares”) or ideas about the socialization of risk

The Goal of Economy

The “Guardian Role” – vs. “Claimants”

But Guarding What?

not exactly government budgets...

Mandated but Off-Budget “Public Spending”

affects ability to raise other revenue

effects on employment (?)

Is the Goal to Limit Spending or to Fit It in an Envelope?

might lead to different views of dedicated funding

Balance Rightly Understood

Does Not Mean No Deficit

Does Mean **Reconciling Preferences About Details to Preferences About Totals**

can adjust details *or* totals - spending more on health care could be good budgeting.

Borrowing Is Acceptable if That's the Best Way to Balance Values

Budget Responsibility Means Knowing and Choosing Consequences on all Dimensions

control = spend what you mean to spend

comprehensiveness = consider all consequences

Meanings of Efficiency

Value for Money

More output for same spending; same output for less spending

But Compared to What?

Other workplans for same program – traditional budget analysis

Spending on other programs – the dream of “budgeting for performance”

And What is the Output?

Health or Health Care?

What Analysts Want or the Public Wants?

Health Care and Efficiency

Economy is Normally Sold as Efficiency

which does not mean it is true

Efficiency Sounds Good to the Voters

not so good to providers. **C = E !**

Endless Comparative Efficiency Claims:

“Spend on This to Save on That”

especially about hospitals – beware!

And Especially “Spend on Health Not Care”

There May Be Too Many Ideas

Equity

Typical Budget Definition: Incrementalism and
“Fair Shares”

easier to apply to agencies than entitlements

Health Expenditure Redistributes Large
Amounts of Money

it **must** involve politics of relative social burdens

Health Could Be in the Market, and Some Is

public/private border must be a major issue

and effects are complex due to demand for...

Equitable Access to Rescue

like a fire department

Political Demand for Spending

Especially Salient and Important to Voters

Consumption Good, Necessity of Life

There may be no other government program for which spending restraint potentially affects voters so directly

education not as expensive, voters aren't the consumers

pensions closest, but spending varies more; recently has grown more slowly

main driver is age; for health, main driver is costs per person

which brings us to...

Expanding Notions of “Need”

Suppliers ALWAYS try to create demand. For any program. That’s called “advocacy.”

Health is different because advocacy not just through political process

medicalization of conditions

redefinition of risks as illnesses

“prevention” as reason to do more

“Technology” only partial explanation

does not implement itself (variations!)

service growth is not only “high-tech” services

Coping with Demand: Avoiding Blame

Focus on spending, not services

so prices or overhead, not volume.

Reduce Industry's ability to induce demand.

the reason for bundling, capitation...

Get patients to “choose” to do without

the logic for cost-sharing, some versions of “markets”

Maximize the distance between the decision to restrain and the experience of restraint

limit capacity, hand budgets to organizations

Experts and Their Advocacy

Everybody is selling something

experts are “faith-based” too

believers do not attend to evidence, but budgeters should (believe CBO, not Peter Orszag)

Lots of “New,” “Innovative” ideas

often relabeling ideas that failed before

Disagreements Among Expert Groups, e.g.

“excess” insurance

do lower prices increase efficiency?

Ideas persist if they fit expert world-views

not because they work!

Why Policies Succeed or Fail

They should be direct, with few steps

Easier to implement, more certain results

Require **knowledge**, or technical capacity

does anybody, anywhere, know how to do this?

easier to control prices than manage care

Require **power**, or institutional capacity

is my government able to do this?

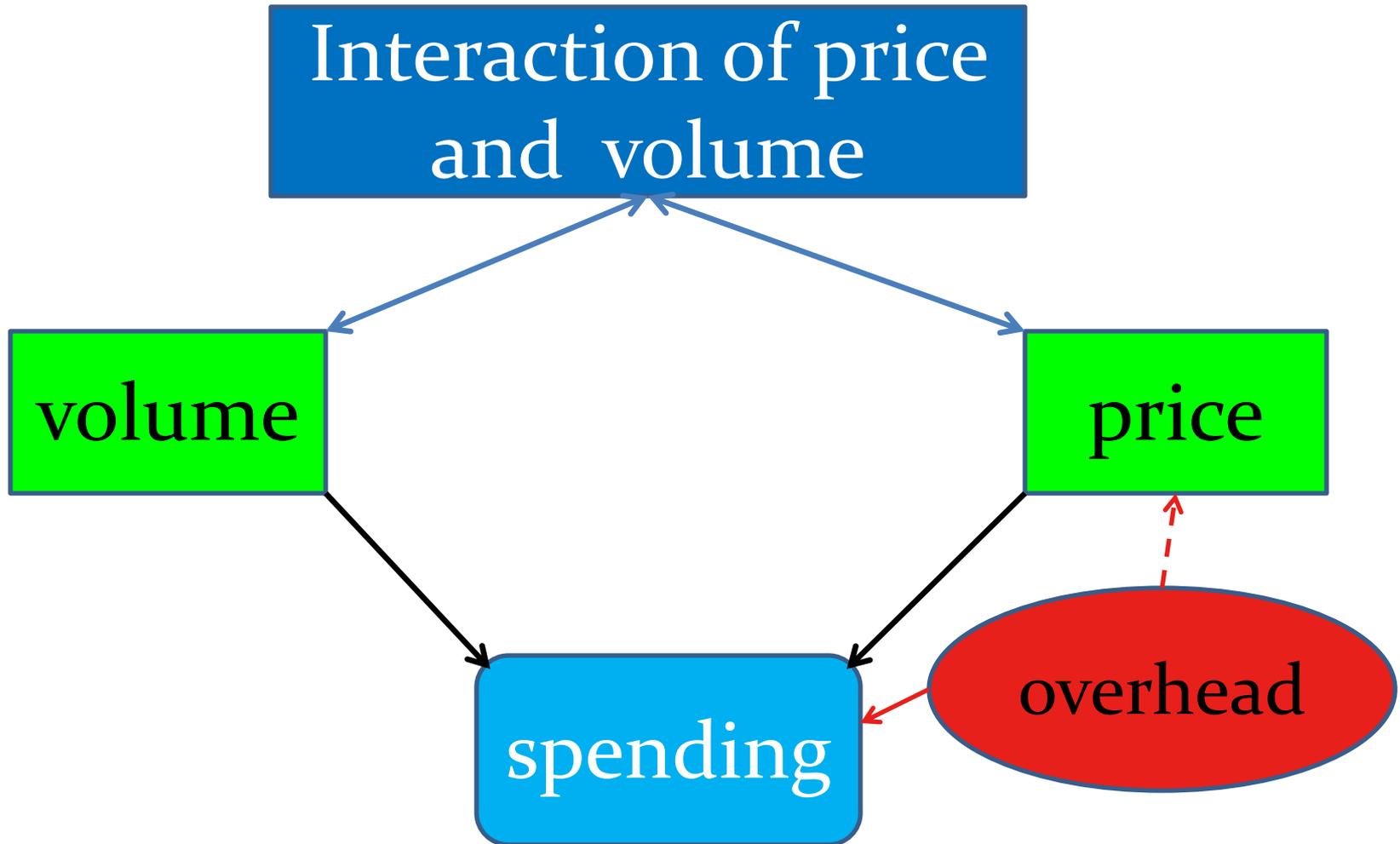
easier to oversee investment than treatments

Require **will**, or political capacity

can we agree to do this?

easier to cut investment than current services

Direct influences on Spending



Prices and Volume (Separately)

Prices are Primary

if you can't control prices, you are in deep trouble
except in extreme cases, more popular
policy-makers know how (but need to focus more
on relative prices than most do!)

Volume is harder

limiting fraud is a start (doesn't get enough respect)
ethicists propose explicit rationing...
direct volume caps exist in some systems
defining boundaries of "health care"

Prices and Volume (Together)

To prevent volume response to price restraint
(or price to volume if price limits weak – U.S. market)

Bundling – pay for more services at once

often explained as changing “incentives”

not clear why payer should care about that

but there are reasons for patients to worry

Volume-adjusted fee schedules

Very different effects on service levels!

Improve Organization’s Productivity

Only possible if payer controls management

Influences on overhead costs

Rules for collecting funds or distributing subsidies

Simpler is better

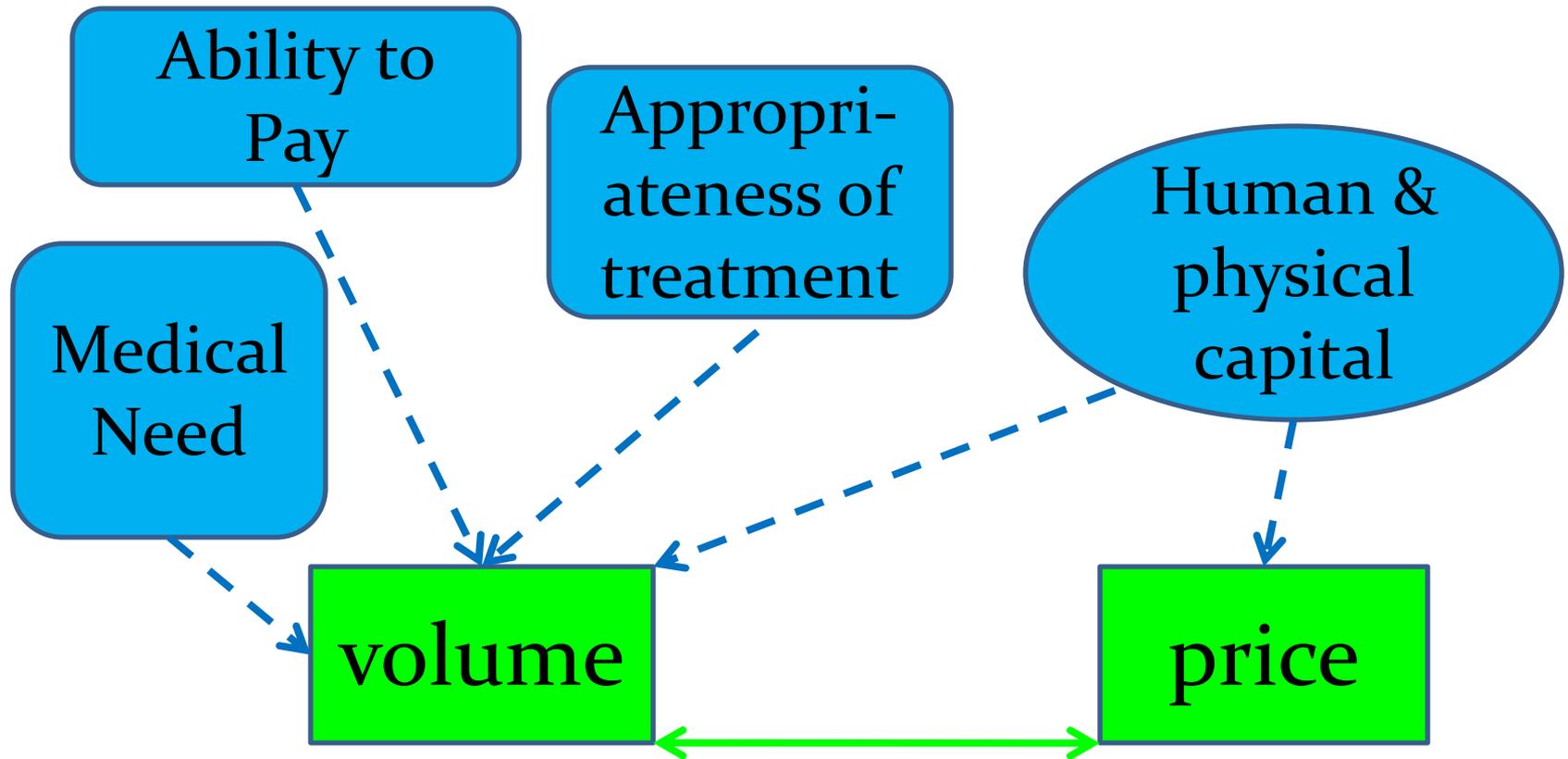
Insurance company discretion to choose whom and what they cover at what price

Less is better

Variety of contracts to pay providers

Standardization is better

Less Direct Influences on Spending



Limiting Capacity

Major method (except in U.S.)

Very controversial. But standard budgeting

Indirect because depends on price policies

Can lower prices and volume

- spreading costs over more uses;

- less reason to offer services;

- or just can't offer services – shortages

Can constrain services too much

- though people will disagree about “too much”

- effects depend on incentives for physicians

Effects on Demand (with their policies and professions)

Medical Need

Improve population health

The public health profession's view

Economic Demand

Increase individuals' cost consciousness

Promoted by economists

Appropriateness of Care

“Manage” to make more “Evidence-based”

(or something like that)

Health Services Research view

Obstacles to the Demand Policies

Public Health:

prevention is not normally cheaper than cure
changing behavior is very hard
changing society is harder

Cost Consciousness

Voters don't like it

May not help efficiency; very dubious for equity

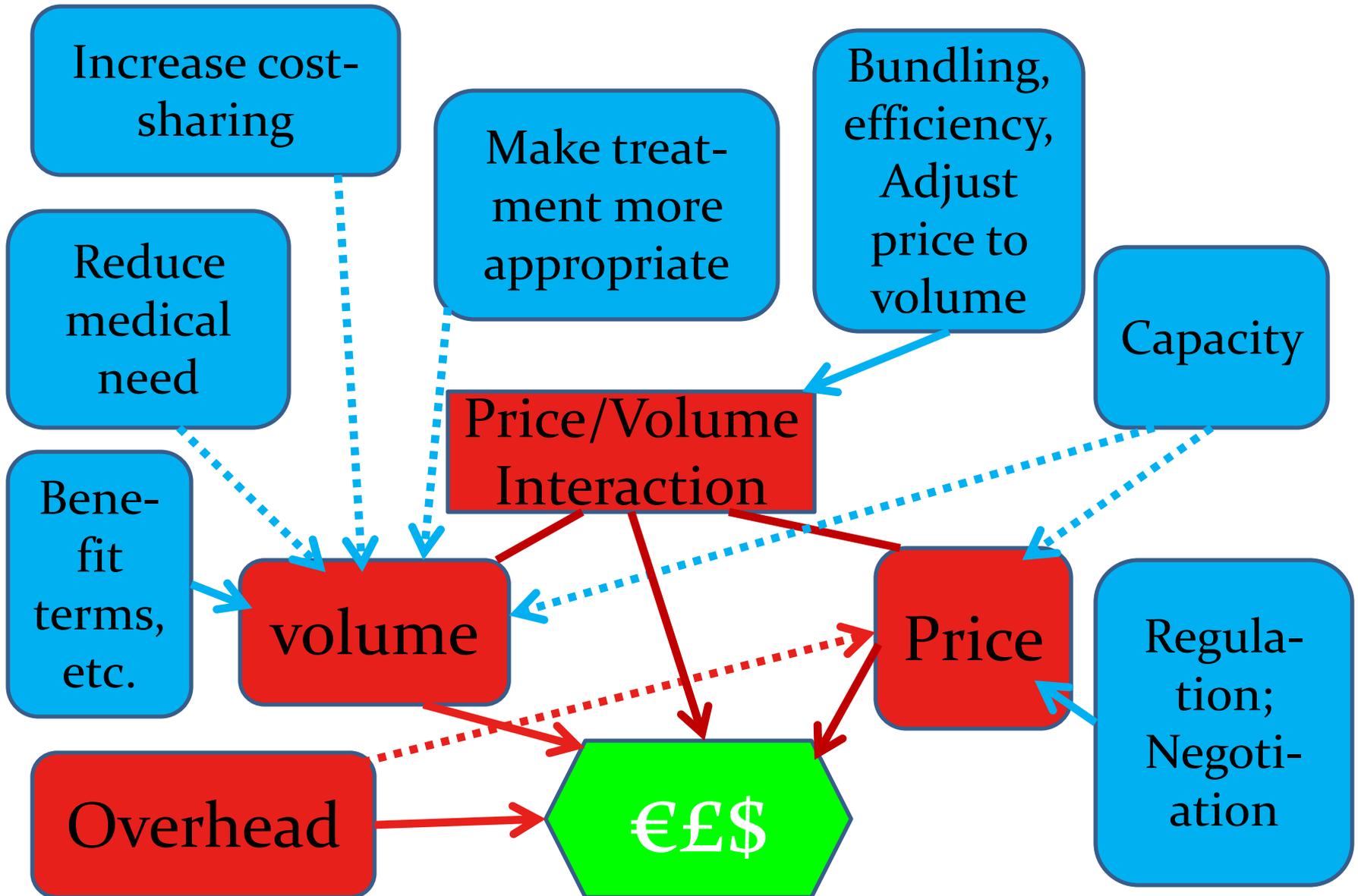
A Goldilocks problem with no clear solution

Making Care More Appropriate

Don't know how.

Would not be trusted to implement if did.

(almost) everything in one slide



Summary Points

Prices are Primary

Standardizing Insurance and Billing is Helpful

So Beware of Giving Up These Advantages!

Capacity Regulation is Important

but other policies shape effects, and be careful

Look at ALL price/volume combination options

Indirect Demand Policies Fail for Good Reasons

knowledge, power, or will usually insufficient

but that will not inhibit advocacy!

in a few cases, power might be greater outside U.S.

Bureaus vs. Entitlements

Blame Avoidance

Budgeters can blame managers of bureaus

Bundling is a way to make entitlements more like bureaus on this dimension. And maybe better.

Managing for Efficiency

More likely with a bureau program.

More tools and forms of influence, e.g. to enforce guidelines.

Contracting is promoted as more powerful and flexible. Seems unlikely.

General vs. Dedicated Revenue

Distinction is diminishing

Standard public finance favors general revenue to force tradeoffs

I'm not sure how well this applies in this case.

Dedicated Revenue may encourage more honest budgeting

Effect of dedicated funding on spending might be asymmetrical

may make it slightly harder to cut or increase

Is ideal combination bureau and dedicated?

“Competition” vs. “Regulation”

Or **Selective** vs. **Collective** Contracting

Collective Contracting/Coordinated Payment

has large advantages on price and overhead

“Competition” and blame avoidance?

Enthoven capacity argument.

Displace blame to insurance companies?

“Competition” and rationalization?

Did not work in the U.S.

“Market forces” may not reward delivery efficiency

Incentives do not create organizations

If I Only Had a Minute...

Economy is not the only goal. Except when it is!

The health policy community has many experts carrying “solutions” to improve efficiency. Be skeptical budgeters!

Beware: Do Not Abandon What Works

Performance budgeting is barely more plausible here than in other applications

Government health programs provide a uniquely sensitive and salient service

The subject is health care, not health.