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U.S. Health Care's Technology Cost Crisis

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Booz & Company

03/31/2004

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U.S. Health Care's Technology Cost Crisis

Spiraling drug prices aren't the only challenge facing the U.S. health-care system. Medical technology costs must be controlled, without sacrificing innovation.

by Charles Beever, Heather Burns, and Melanie Karbe

In the ongoing national debate in the United States about the spiraling price tag for health care, drug costs have received the lion's share of attention. But there's another culprit lurking that will soon attract government and business scrutiny as pressure builds to control spending: the cost of medical technology.

If manufacturers and health-care providers want to play a pivotal role in the coming debate over technology spending, it is time for them to act together to develop a better process for assessing the value of medical technologies and balancing costs against outcomes. At the least, they need to brace themselves for future pressure to reduce spending.

Although the benefits of innovative medical technologies are undeniable (for example, advances have cut the death rate from cardiovascular disease by 25 percent over the last 20 years), innovation comes with a price. Overall health-care costs have outpaced GNP growth by more than four percentage points, on average, in the last five years and now total $1.5 trillion per year. Spending on medical technology has accounted for about 20 percent of that growth, and now exceeds $200 billion per year. This spending surge presents a challenge to the U.S. economy and society: How can we control cost increases without sacrificing the benefits of innovation?

Three Cost Drivers

There is substantial evidence that overutilization and misuse of technology leads to spending that exceeds its value for patients. In the diagnostic imaging technology category — which has grown to nearly a $100 billion business — spending increases are driven to a large extent by the growth in the number of machines installed in hospitals, as well as in doctors' offices and at imaging centers. This has led in turn to overcapacity in many areas and has created incentives for doctors to prescribe unnecessary procedures. Duplication of procedures (i.e., a patient receives an MRI, then a PET scan, even though doing both procedures does

not help doctors get closer to a diagnosis) and overuse of high-end procedures in situations where they add little value has also driven up technology spending unnecessarily.

We have identified three important reasons medical technology is not being used cost-effectively. First, patients do not pay directly for the health care they receive, so they sometimes make unreasonable demands on physicians for diagnosis and treatment. Second, a new technology may be adopted because of its clinical superiority to existing technologies, but there is no market mechanism to ensure that it will be used where it is clinically most appropriate or where it offers highest value for a patient compared with other treatments. Third, because there is no market mechanism for determining the value of medical technology, there is currently no generally accepted screening process to assess its value; cost-effectiveness is not a criterion for regulatory approval of procedures, and manufacturers do not consistently perform studies of the economic benefits of new procedures.

Options for Change

Private medical insurers and companies that pay for health-care plans have started to realize the significant impact of medical technology on health-care costs, and are likely to look for ways to reduce costs without hindering innovation. In principle, given continued third-party payment for health care, there are two options: One is to force a national debate about ways to introduce consistent and generally accepted value calculations into the evaluation of new technologies; the other is to look for targeted strategies that reduce costs in specific areas of the health-care system.

The most important question in establishing a value paradigm is the level at which value assessments would be made. One possibility is to use a federal agency, such as the Food and Drug Administration,

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akin to the national authorities that evaluate new technologies in Canada, France, the United Kingdom, and other countries. Another possibility would be to create a public/private partnership between existing government entities and private health-care groups. Both options have advantages and disadvantages; it seems more likely in the short term, however, that the U.S. will opt for a smaller-scale approach (versus creating a national body), for example, contracting the work to several small private entities, similar to the privately run centers that currently perform technology assessments.

A wide range of cost-management possibilities exists at the level of individual health-care plans. Differing levels of co-payments can be introduced, as they have been in some plans, for various diagnostic imaging techniques. Another potential strategy is to align the incentives of payers and providers to reduce overutilization of technology.

All players, especially technology manufacturers and health-care providers, need to prepare for, or even step in to shape, the almost certain changes in the way medical technologies are paid for and deployed. Manufacturers should be thinking about ways to more thoroughly document the value of their technology, to better understand what changes in product positioning and pricing may be required, and to critically review product-development portfolios. Health-care providers may want to consider more extensive patient and provider education programs, supported by incentives that better align desired outcomes. Both sets of players should get involved in determining the best way to perform value reviews with other health-care constituencies and in creating joint forums for discussion.

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Resources

"What's Driving Prescription Drug Costs?" by Heather Burns, Charles Beever, and Robert Hutchens, *s+b enews*, 09/29/03. www.strategy-business.com/enewsarticle/enews092903

"Patient Safety: A Data-Driven Prescription," by Heather Burns and Charles Beever, *s+b enews*, 02/13/03. www.strategy-business.com/enewsarticle/22314

"Health Care's New Electronic Marketplace," by J. Philip Lathrop, Gary Ahlquist, and David G. Knott, *s+b*, 2Q 2000. www.strategy-business.com/article/16821

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is published by Booz & Company Inc.
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Originally published as "U.S. Health Care's Technology Cost Crisis" by
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