Rate of Health Spending Growth Slowed in 2008

BY MARY ELLEN SCHNEIDER

Health care spending in the United States grew less than 5% in 2008, the slowest rate of growth since the federal government officially began measuring it in 1960, according to a new report from the Centers for Medicare and Medicaid Services.

But the figures show that even though the rate of increase is slower than in previous years, health care spending is still outpacing the gross domestic product (GDP). In 2008, health care spending rose 4.4% to $2.3 trillion, compared with only a 2.8% increase in the GDP. And health spending continues to consume a larger portion of the overall GDP: 16.2% in 2008, compared with 15.9% in 2007 (Health Affairs 2010;29:147-55).

The overall slowdown in health spending growth is reflected in slower rates of increase in hospital spending, physician services spending, retail prescription drug spending, and spending for nursing home and home health services.

For example, spending on physician and clinical services increased 5% in 2008, down from 5.8% in 2007. The deceleration in physician services was driven by a decrease in patient volume, even as the intensity of services picked up in 2008.

While spending rates slowed in many areas, the federal government's share of health spending soared in 2008, rising from 28% in 2007 to nearly 36%, according to CMS. The increase is due in part to the Recovery Act, which retroactively shifted $7 billion in federal funds to Medicaid to assist budget-challenged states at the end of 2008. ■

Government Releases Health Plan for Disaster Situations

BY MARY ELLEN SCHNEIDER

The U.S. government has released its plan to deal with the health consequences associated with major national emergencies such as disease outbreaks, natural disasters, and terrorist attacks.

The National Health Security Strategy, available at www.hhs.gov/disasters, is the federal government's first attempt to put together a comprehensive strategy focused specifically on protecting people's health during an emergency, according to the Health and Human Services department.

The plan outlines several objectives including fostering integrated, scalable health care delivery systems; incorporating postincident health recovery into planning and response; maintaining a workforce necessary to respond to health emergencies; and preventing or minimizing emerging threats to health. HHS will update the plan every 2 years to reflect advances in medicine and public health.

Although the National Health Security Strategy was prepared by the federal government, HHS Secretary Kathleen Sebelius said that for the plan to be effective, it requires participation from everyone in the nation.

"As we've learned in the response to the 2009 H1N1 pandemic, responsibility for improving our nation's ability to address existing and emergency health threats must be broadly shared by everyone—governments, communities, families, and individuals," Ms. Sebelius said in a statement. "The National Health Security Strategy is a call to action for each of us so that every community becomes fully prepared and ready to recover quickly after an emergency."

The new national plan provides a framework for physicians, in particular, to begin planning for their response to an emergency, Dr. Georges C. Benjamin, executive director of the American Public Health Association, said in an interview. Looking back at the challenges that physicians faced during the aftermath of Hurricane Katrina, Dr. Benjamin said that many of those obstacles could have been addressed in a systemic way if a strategy like this one had existed at the time.

This year, HHS officials, with the help of government and external partners, plan to analyze health care workforce levels, seeking to identify any areas where there is a shortage when it come to health security readiness. For example, shortages have already been identified in the number of public health nurses, epidemiologists, and laboratory personnel, according to HHS.

Dr. Benjamin said that workforce is a major issue. While part of the solution will likely involve recruiting more people to the health care field, it will also involve asking clinicians to expand their traditional scope of practice. For example, there is a range of emergency skills that practicing internists are trained in, but don't use in daily practice. As part of emergency planning, they may need to refresh those skills, he said.

Emergency skills also must be taught so that health care providers are ready for the long term, Dr. Benjamin said. That means reexamining graduate medical education to ensure that the full range of practitioners—physicians, nurses, physician assistants, and nurse practitioners—are able, he said. "We've never done that in a comprehensive way in our country."

"Good planning for those kinds of emergencies, for your own needs as well as your family's and your patients' needs, is probably a good thing to do," Dr. Benjamin said. ■

POLICY & PRACTICE

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Tobacco Act Gets Singed

A federal district court has struck down parts of the Family Smoking Prevention and Tobacco Control Act of 2009, saying that some of the landmark law violates tobacco makers' free speech rights. The U.S. District Court for the Western District of Kentucky ruled it unconstitutional for government to ban color and images in tobacco advertising. However, the court upheld provisions of the law requiring large, strongly worded warnings on tobacco packaging, prohibiting companies from making health claims about tobacco products without Food and Drug Administration review, and banning tobacco-branded events and merchandise, such as T-shirts. American Thoracic Society president J.R. Curtis said in a statement that the society is still "confident that the FDA will exercise its new authority to reduce tobacco use in the U.S. by stopping the efforts of big tobacco to market its dangerous products to minors, and by giving current smokers more motivation to stop smoking."

New York Limits Its Salt

The New York City Health Department said it will ask restaurants and producers of packaged food to voluntarily reduce sodium in their meals and products by 25% over 5 years in an effort to curb high blood pressure and heart disease. The department acted as leader of the National Salt Reduction Initiative, a partnership of cities, states, and health organizations. The New York agency said that only 11% of the sodium in Americans' diets comes from salt added at home, while nearly 80% is added to foods before they are sold. After a year of consultation with food industry leaders, the coalition has developed targets for salt reductions in various foods. In a statement following the New York announcement, Centers for Disease Control and Prevention director Thomas Frieden endorsed such efforts and said, "The majority of Americans are consuming about twice the recommended limit of sodium each day, and not by choice. Achieving substantial reductions in sodium levels by incremental decreases in sodium content across the food supply can save many lives while maintaining good taste."

Adverse Event Reports Are Limited

Little information is made public about adverse events in hospitals, even though public disclosure can help practitioners improve patient safety, according to a government report. The Department of Health and Human Services Inspector General reviewed eight federally approved patient safety organizations and 17 systems that collect adverse event information for states. It found that only seven state systems passed along to providers adverse event analyses that led to changes in practice. The other states passed along reports without any analysis. A nationwide database of adverse events collected by the patient safety organizations won't be operational until at least 2011, the report said.

Few Drug-Safety Data Are Online

Safety and efficacy information collected as part of the federal drug approval process is not available online for 9 of the top 25 prescribed brand-name drugs in the United States, according to the Sunlight Foundation, a group that advocates for transparency in government. The foundation's report found that the FDA makes background documents available online only for drugs approved since 1997. Information for drugs approved earlier is online only if someone made a formal request for it. Safety and efficacy information for Lipitor (atorvastatin), Plavix (clopidogrel), and Synthroid (levothroxine) is not available online, according to the foundation. In addition, the information that is online is in a format that's difficult for researchers and the public to use, the report claimed.

FDA Okayed 26 New Meds in 2009

The FDA approved 19 new chemical entities and 7 new biologics in 2009, according to Washington Analysis, a Washington–based investment adviser. Among the new biologics were Medicis's injectable wrinkle fighter Dysport. In the report, Washington Analysis's Ira Loss said that he expected more approvals last year because the agency claimed it wouldn't let statutory approval dates be overridden and it received more money for reviews. In 2008, the FDA approved 21 new chemical entities and 4 new biologics, according to the report.

CMS Launches Provider Survey

The Centers for Medicare and Medicaid Services kicked off its fifth annual survey to determine provider satisfaction with Medicare fee-for-service contractors. The contractors process and pay more than $370 billion in Medicare claims each year. The Medicare Contractor Provider Satisfaction Survey offers physicians and other providers a chance to say how well their contractor handles inquiries, outreach, education, claims processing, appeals, reviews, and audits. The CMS said it is sending the 2010 survey to approximately 30,000 randomly selected providers, including practitioners, suppliers, and institutions. Participants can submit their responses confidentially online or via mail, fax, or telephone, the CMS said.

—Jane Anderson