VIEWPOINT

Appropriately Framing Child Health Care Spending
A Prerequisite for Value Improvement

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In 2015, children aged 0 to 18 years accounted for an estimated 8% of total US health spending but represented approximately 24% of the population.[1] This relatively small proportion of total spending raises the question of whether child health should be important to physician leaders, administrators, payers, and other groups that focus on improving the value of health care. The answer to this question, in part, may depend on the manner in which the magnitude of child health care spending is framed. When framed relative to adult spending, spending for children may seem so small that it could be perceived as an unimportant "rounding error" in the health care system.[2]

However, even small percentages of total health care spending represent large expenditures given the sheer scale of the US system. For instance, in absolute terms, child health care spending totaled $277 billion in 2012, according to the National Health Expenditure Accounts.[3] To put this amount in perspective, $277 billion represented 1.7% of US gross domestic product in 2012[3] and was more than the amount any other industrialized country spent on health care for its entire population in 2012, except for Germany and Japan.[4] If child health care spending increased 3.4% per year between 2012 and 2017, as it did between 2010 and 2012,[3] then child health care spending in 2017 would be approximately $327 billion—more than half the US defense budget in fiscal year 2017.[5]

> The resulting misperception that child health care spending is small may impede efforts to provide high-quality, value-based care to children.

Whether child health care spending is framed using relative or absolute language is not mere semantics. As research in linguistics and psychology demonstrates, the manner in which information is framed can have powerful and potentially distortionary effects on perception. For example, the pharmaceutical industry has attempted to deter cost-control efforts by arguing that despite recent increases, retail prescription drug spending still represents just 10% of total US health care spending.[6] Similarly, relative rather than absolute characterizations may promote the tendency to conceptualize child health care spending in terms of its smallness compared with adult spending, thus masking how large this spending is in absolute terms.

The resulting misperception that child health care spending is small may impede efforts to provide high-quality, value-based care to children. First, policy makers may have limited enthusiasm for implementing interventions to decrease unnecessary and potentially harmful care for children, even though emerging evidence suggests that potential savings could be substantial. For example, the use of just 20 low-value pediatric services has been estimated to result in $227 million in unnecessary annual spending among commercially insured children alone.[7] In addition, evidence of large variations in care for common high-cost pediatric conditions, such as prematurity, suggests that cost savings are possible.[8] These findings suggest that ongoing efforts to improve value in the health care system, including payment and delivery reforms to reduce low-value care, should span the entire age spectrum.

Second, if child health care spending is misperceived as small, clinicians caring for children may fail to appreciate the effect that their therapeutic decisions can have on the financial health of families. Out-of-pocket spending on health care averaged $384 per child in 2012.[3] Since then, cost-sharing requirements in commercial plans have become even more burdensome, especially for the increasing number of US families enrolled in high-deductible health plans. Furthermore, many states have begun to raise cost-sharing requirements for Medicaid beneficiaries, suggesting that the risk of financial harm from pediatric care is increasing for families of both publicly and privately insured children. As evidence of this risk, due in part to Mylan Pharmaceuticals' aggressive price hikes for the EpiPen and incomplete protection from these increases in insurance benefit design, annual out-of-pocket spending for this lifesaving medicine between 2007 and 2014 more than doubled to $92 for families of commercially insured children with serious allergies.[9] Approximately 10% of these families paid at least $250 out of pocket in 2014. Even with the recent release of a $300 generic EpiPen and the entry of lower-cost competitors, out-of-pocket spending for epinephrine autoinjectors may still be substantial, particularly for families subjected to deductibles or co-insurance for drugs.

Third, without an appreciation of the absolute magnitude of child health care spending, clinicians providing care for children may fail to recognize the opportunity cost of their therapeutic decisions for society. Almost 4 in 10 children are covered by Medicaid, a program that represents an increasing portion of state annual budgets. Because most states are legally required to balance their budgets, every additional dollar spent by states on a child covered by

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Medicaid is a dollar that cannot be used to fund investments in early childhood education and good housing—social programs with high rates of return on child health and human capital development. In commercial insurance, high spending on pediatric beneficiaries can also force difficult tradeoffs, such as whether to pay for expensive treatments such as chimeric antigen receptor T-cell therapy for life-threatening pediatric diseases. Thus, even seemingly trivial ordering decisions for children can in aggregate detract from other potentially worthwhile investments.

As a consequence, policy makers, researchers, payers, health care professionals, and health care organizations both inside and outside of pediatrics should reject language that frames child health care spending as small compared with adult spending. They should instead use language that appropriately frames child health care spending as a substantial burden to families and society. To be clear, appropriate framing alone is not sufficient to spark interest in optimizing the enormous amount of dollars spent on the health care of children. However, it is a necessary first step. If child health care spending is misperceived as small, it will be difficult to promote the judicious management of limited pediatric health care resources as a central clinical, ethical, and policy goal.

ARTICLE INFORMATION

Published Online: February 26, 2018. doi:10.1001/jama.2018.0014

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

Additional Contributions: We thank Elbert Huang, MD, MPH (Department of Medicine, Division of General Internal Medicine, University of Chicago, Chicago, Illinois), and Mona Sharifi, MD, MPH (Yale School of Medicine, New Haven, Connecticut), for their helpful feedback on this manuscript. They did not receive compensation for their contributions.

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