Why Is US Healthcare so Expensive?

Derek Thompson in *The Atlantic*: The average routine office visit in the U.S. costs 3 times more than in Canada. The average CT scan costs 5 times more than in Canada. In the U.S. health care system, everything costs more. Being in a hospital cost more. Our drugs cost more (prescription drug prices can be 10X the rate in the UK or Germany). And our doctors cost more (a US family physician makes three times her German counterpart—the cost of a German physician's education is nearly free).

In *The Healing of America*, T. D. Reid explored why American medicine falls behind other countries in quality while it races far ahead in cost of care. Reid identifies two big reasons why U.S. health care is so expensive: (1) Unlike other countries, the U.S. government doesn't manage prices; and (2) the complication created by our for-profit system adds tremendous costs.

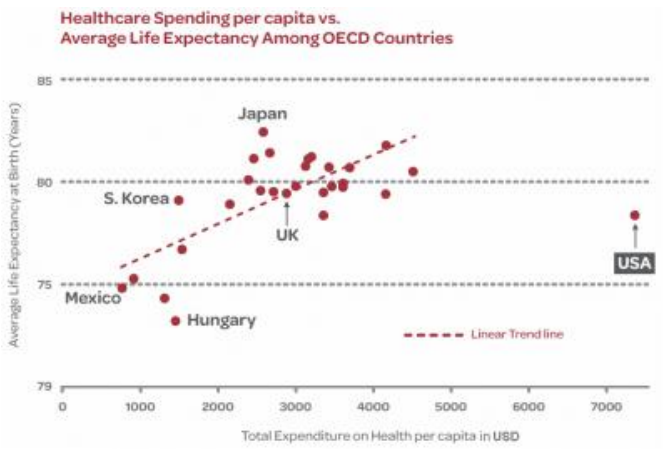
While some developed countries have one health care insurance plan for everybody—where the government either sets prices or oversees price negotiations—the U.S. is unique in our reliance on for-profit insurance companies to pay for both essential and elective care. Twenty cents from every $1 goes, not to health care, but to "marketing, underwriting, administration, and profit." In a system where government doesn't negotiate prices down, prices will be higher. In a system where for-profit companies need profit margins and advertising, prices will be higher.

Second, the complexity of U.S. health care creates its own costs. There is a separate health care system for seniors, veterans, military personnel, Native Americans, end-stage renal failure, under 16 in a poor family, over 16 in a poor family, and working for the federal government—that's on top of hundreds of private plans.

All these systems have another inefficiency—middlemen who compile the bills doctors submit and shuttle them thru the payment system. The US GAO concluded that if we could get administrative costs of our medical system down to the Canadian level, the money saved would be enough to pay for health care for all the Americans who are uninsured.

It's not like all this money buys us *nothing*. Complexity creates jobs, for high- and low-skilled workers alike. American health care is the world's envy in some categories, especially in cancer care, wait times, and access to new technologies for affluent and insured families. We have the highest share of adults (90 percent) who report being in good health. The OECD average is 69 percent. But in terms of coverage and cost, we rank embarrassingly low among developed countries. It would be nice to say this is a bug of the American medical system. But it's a feature. It's a choice we've made. In some countries, government sets a lower price and doesn't charge patients for marketing and margins. To this model, we've essentially said: No, thanks.

Todd Hixon in *Forbes*: The U.S. spent about $7,000 per capita in 2008 on health care. Peer countries, like Japan and the U.K., spend about half that amount and achieve equally good results, as measured, for example, by life expectancy at birth. That comparison is captured in the famous Mary Meeker graph, Chart 1. It shows that the gap is about $3,500 per person in the U.S. ($1.1 trillion for the 305 million U.S. residents).



U.S. spending on physicians per capita is about 5 times higher than peer countries: $1,600 versus $310 in peer countries, a difference of $1,290 per capita or $390 billion nationally, 37% of the health care spending gap. These conclusions come from an analysis co-authored by Miriam Laugesen of the Columbia University School of Public Health and Sherry Gleid, an Assistant Secretary in the U.S. Department of Health and Human Services.

The biggest driver of the gap is spending on specialist doctors, which is 3-6 times higher in the US. This difference is mainly due to much higher prices in the U.S., which are driven by both higher per-procedure rates paid by both public and private payers, and larger proportion of higher-paying private payers in the U.S. By comparison, public per visit rates for US primary care doctors are at the high end of the range and private rates are slightly above the range, and primary care doctor incomes are higher, but less than half of the incomes of U.S. specialists. Primary care doctor utilization is comparatively low in the U.S., which keeps overall spending on primary care down. This is not good for overall health care or health costs, however.

The physician-spending gap exists mainly because Medicare and Medicaid pay much more for specialist services relative to primary care services than government authorities in peer countries and private insurers have done a poor job of negotiating rates with specialists. In addition, The high level of per capita income in the U.S. is a major factor driving U.S. health care spending. The U.S. has higher per capita income than any other large country, and higher income is closely associated with

higher health care spending. This is an explanation, but not a good justification, because, as the Meeker analyses show, the U.S. appears not to receive value for the higher spending, as measured by medical outcomes.

Dartmouth University has analyzed differences in health care costs between US regions, comparing the highest-cost regions to the lowest-cost. The research shows a spending variation of $2,300 per capita after taking account of differences in health status, income, and ethnicity. But health outcomes are no better in the high spending regions than in the low spending regions. Dartmouth attributes the gap to regional differences in discretionary medical decisions driving higher patient referral rates for high-cost advanced care (specialists, hospitalization, CAT and MRI scans, etc.). If the entire country were brought to the spending level of the lowest 20%, the savings would be about $750 per capita.

Ewe Reinhardt, a leading expert on the economics of healthcare, cites several other factors contributing to higher health care costs: pharmaceutical pricing, higher administrative costs for medical payments relative to single-payer models, and the highly-developed U.S. tort system and resulting defensive medicine.

But the data I found says the dominant problem with U.S. health care costs is a labor problem with medical professionals. Wages and work rules (i.e., referral decisions leading to over-utilization, staffing levels in hospitals) have driven costs to a level that is now unbearable.

David Cutler on *The PBS Newshour*: The first reason healthcare in America costs so much is because the administrative costs of running our health care system are astronomical. About one quarter of health care cost is associated with administration, which is far higher than in any other country. Just to give you one example, Duke University Hospital has 900 hospital beds and 1,300 billing clerks. The typical Canadian hospital has a handful of billing clerks. Single-payer systems have fewer administrative needs. What a lot of those people are doing in America is figuring out how to bill different insurers for different systems, figuring out how to collect money from people.

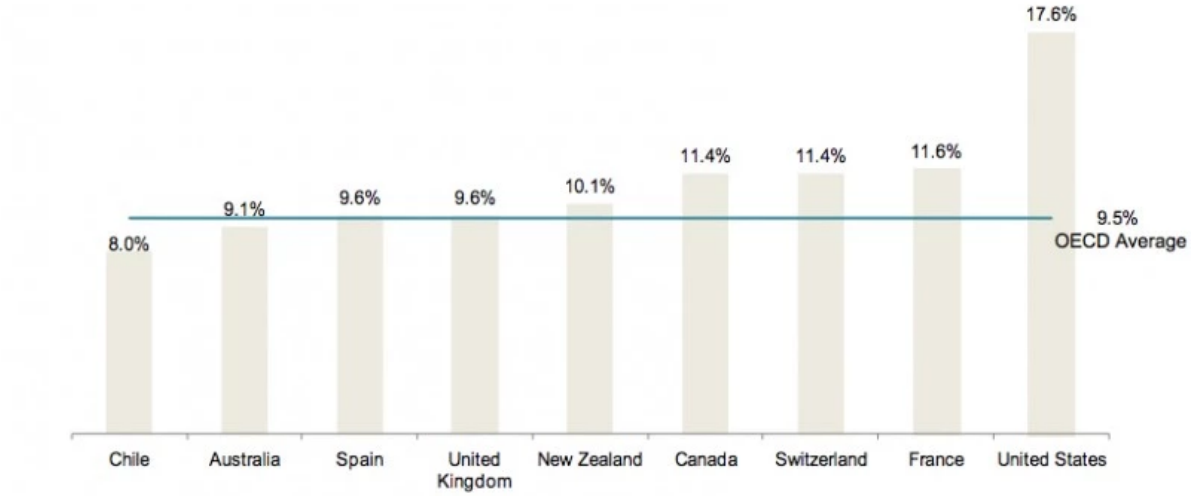
The second reason health care costs so much in the US is that we spend more than other countries on many of the same things. Drugs are the most commonly noted item, where a branded drug costs much more in the U.S. than in other countries. But, for example, doctors also earn more for doing the same thing in the US that doctors do in other countries, and a lot of suppliers charge more for things like durable medical equipment in the US than in other countries. The lowest prices for pharmaceuticals, and a variety of other medical devices and payments to physicians, are in government plans. So Medicaid gets the best prices on pharmaceuticals. In terms of physician payments, Medicaid payments are the lowest. Medicare payments are above that and private payments are above that. The more leverage the buyer has, the lower the price they get. That's true in every industry. In health care, the United States doesn't utilize that leverage as much as other countries do.

The third reason is Americans receive more medical care than people do in other countries, not so much in terms of doctor visits, but if a person has a heart attack in the United States, they're much more likely to get open-heart surgery than they are in most other countries. Go back to Canada. In all of Ontario there are 11 hospitals that can do open heart surgery. Pennsylvania has roughly the population of Ontario and it has a bit over 60 hospitals that can do open heart surgery. So there's no way you can operate on as many people in Ontario as you can in Pennsylvania even if you operated around the clock. Sometimes people wait longer. However, there's a large gray area where it's not clear if you need open-heart surgery or not. In the US, people will get it and in Canada, they might not. The interesting thing about it is that life expectancy or one-year mortality after a heart attack is the same in the two countries.

Technology is an underlying driver of costs and there will always be some of that, which is why health care may not be like other industries in terms of always going down in price. On the other hand, there's so much waste in the system—the best guess is that about a third of medical spending is not associated with improved outcomes—that for the next 15 to 20 years people believe that costs could be stable or falling as a share of the economy without cutting into necessary services—just by eliminating the things that are not necessary.

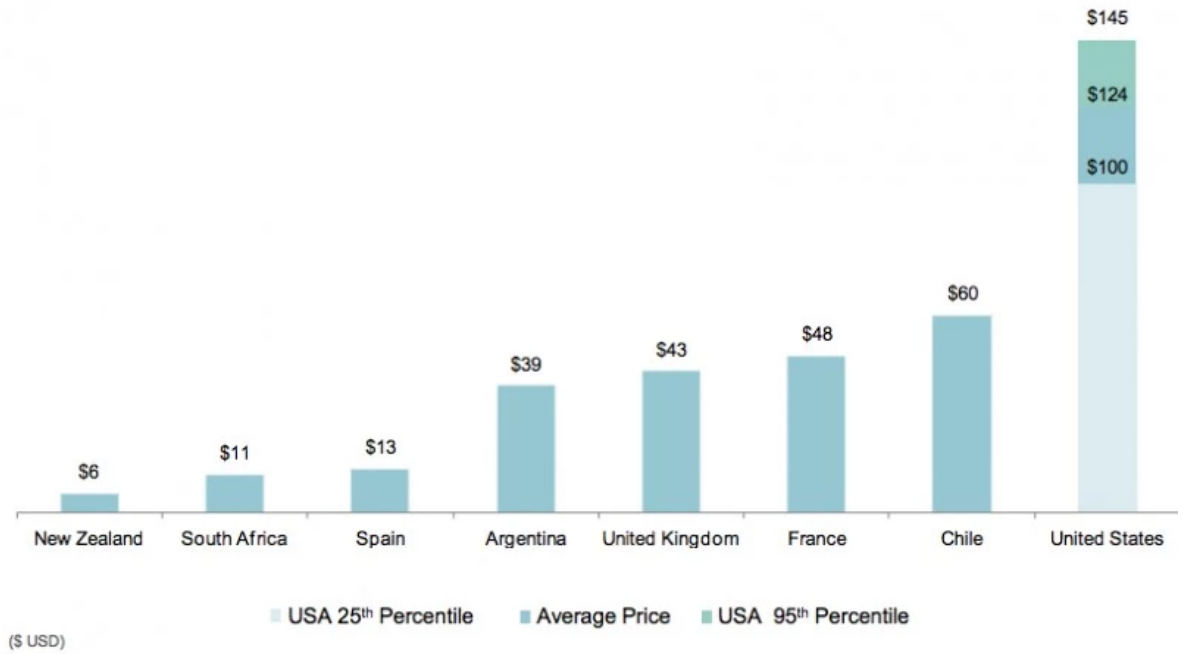
We can also use higher co-pays. We know that people respond to co-payments and they like cheaper care. So the hope is to steer people to less expensive alternatives. Another approach is to make insurance payments to doctors and hospitals and other care providers not be based on volume (so-called "fee for service"), but instead be value-based payments. So say, here's a person with coronary artery disease. Pay a fixed amount for that person and let the medical professionals figure out how to treat that person, not with the incentive to do more and earn more, but with the incentive to figure out how to do what will maximize the health outcome. Couple that with a very aggressive approach to measuring quality. This does two things: one is on the demand side trying to make people smarter consumers, and the second is on the provider side, eliminating the monetary incentives to do more testing and procedures. Instead, let's move to a system that says, "Do what's appropriate, make the patients better and you'll get rewarded for it."

2010 Health Spending as Percent of GDP



2012 Drugs: Lipitor

Lipitor is commonly prescribed for high cholesterol.



($ USD)