



## AMERICAN HEALTH CARE: WHY SO COSTLY?

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## EXECUTIVE SUMMARY

Rising health care costs are of concern to policymakers, employers, health care leaders, and insured and uninsured Americans alike. The U.S. has relied on a mixed public–private system of insurance, managed care, and market competition to shape the health care system. Yet, the U.S. has the highest health care spending per capita in the world, and during the 1990s health spending in the U.S. rose faster than in other industrialized nations.

The key to containing costs—as well as getting higher value for what we spend—may well lie in fundamental changes in the supply side of the market. We need to shift our attention to reducing errors, eliminating waste and duplication in clinical care, modernizing and streamlining administration, promoting transparency and accountability for performance, and aligning financial incentives for physicians, hospitals, and other health care providers to reward high-quality and efficient care.

- Health insurance premiums are rising 10 to 15 percent a year. Insurance companies are increasing profits and reserves and recouping losses incurred in the mid-1990s. The underlying rate of increase in health care costs is slower, but nonetheless troubling.
- In 2001, the U.S. spent more than \$1.4 trillion for health care, or 14.1 percent of the gross domestic product (GDP)—a major jump from 13.3 percent of GDP in 2000.
- In 2001, health care costs per capita increased by 8.7 percent—considerably faster than inflation in the economy as a whole. While projected to slow somewhat, the U.S. can expect 7 percent annual increases for the next decade.
- Prescription drugs remain the fastest growing health care item, but acceleration in hospital costs is a troubling development.
- Utilization of health care services, after being relatively flat in the mid-1990s, is rising—more use of hospital outpatient services, more prescription drugs, more physician visits, more emergency room use.
- The rapid increase in specialized physician services under Medicare—specialist consultations, ambulatory surgeries, brain MRIs, pacemaker insertions, heart echography—raise the possibility of “physician-induced” demand.
- Specialist incomes averaged \$219,000 in 1999, compared with \$138,000 for primary care physicians. Both declined in real terms from 1995 to 1999 with constraints on fees from managed care and public programs, perhaps stimulating increased generation of services in the 2000–02 period to recoup lost income.
- Administrative expenses are increasing 11.2 percent a year. Currently at \$111 billion, they are projected to rise to \$223 billion in 2012. Administrative expenses for private insurance are two-and-one-half times as high as for public programs.
- Private insurance health care outlays per enrollee have been rising more rapidly than Medicare outlays per beneficiary in the last 30 years. In 2003, Federal

Employees Health Benefits Plan spending per participant is rising 15 percent, compared with 4.1 percent for Medicare.

- The U.S. spent \$4,631 per capita on health care in 2000, 69 percent more than in Germany, 83 percent more than in Canada, and 134 percent more than the average of all industrialized nations.
- Between 1990 and 2000, health spending in the U.S. adjusted for inflation increased by 3.2 percent a year, compared with the industrialized nation average of 3.1 percent.
- The U.S. has a higher share of private spending (56%) than industrialized nations (average of 26%). Out-of-pocket health care spending per capita was \$707 in the U.S. in 2000, more than twice the industrialized nation average (\$328).
- Americans receive fewer days of hospital care than other industrialized nations, and about the same number of visits to physicians.
- Health care spending in the U.S. is higher because we pay higher prices for the same services, have higher administrative costs, and perform more complex specialized procedures.
- Sick adults in the U.S. report higher rates of medical errors, are more likely to go for duplicate tests, and are less likely to have their medical records available when they go for care compared with similar adults in other major English-speaking countries.
- The U.S. is the only major industrialized nation not to provide health coverage for all.

Achieving a high-performance health care system—high-quality, safe, efficient, and accessible to all—will require a major change in the U.S. system of delivering health services. Steps that could be taken include:

- Public reporting of cost and quality data on physicians, hospitals, nursing homes, other health care providers, and health plans.
- Broad-scale demonstrations of new approaches to health insurance coverage, science-based benefits, use of modern information technology, and high-quality care.
- Investment in health information technology.
- Development and promulgation of clinical guidelines and quality standards.
- Paying for high performance in the delivery of health services under Medicare, Medicaid, and private insurance.
- Investment in research to gain evidence on what works to improve care, eliminate waste and ineffective care, and promote greater efficiency, including use of modern information technology, team work, and improved processes of care.

These steps would take us a long way toward ensuring that the U.S. is a high-performing health system worthy of the 21st century.

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The Commonwealth Fund

Rising health care costs are of concern to policymakers, employers, health care leaders, and insured and uninsured Americans alike. The search for effective cost-containment strategies hinges on understanding recent trends in health care costs. Insight is also provided by contrasting the experience of the U.S. with that of other countries. The U.S. system, with its part-public, part-private system of insurance, managed care, and market competition, is a departure from the stronger government role favored by other industrialized nations in both financing health care and shaping the health care delivery system. Nevertheless, many of the pressures that increase health care outlays affect all nations—from population aging, to shortages of nurses and other skilled personnel, to advances in modern medicine.

What we all want from our health care system is not necessarily cheaper care, but assurances that resources are being invested wisely to buy higher-quality, more patient-responsive care that achieves better outcomes. We should aspire to a high-performance health system—one that is high-quality, efficient, and accessible to all Americans.

In the past, we have focused primarily on the demand side of the market. The key to containing costs, however—and to obtaining greater value for what we spend—may well lie in fundamental changes in the supply side of the market. In other industries, the path to lower costs lies in greater production efficiency, and financial rewards accrue to those firms that succeed in producing a high-quality product more efficiently. But in health care we rarely reward or insist on either greater efficiency or higher quality. In the future, we should shift our attention to reducing errors, eliminating waste and duplication in clinical care, modernizing and streamlining administration, promoting transparency and accountability for performance, and aligning financial incentives for physicians, hospitals, and other health care providers to reward high-quality and efficient care.

## I. Trends in National Health Expenditures

Rising health insurance premiums have drawn the nation's attention to the problem of rising health care costs. After years of relatively modest increases in employer health insurance premiums, Medicare, and Medicaid, double-digits have returned to health care. States are feeling the fiscal squeeze from the economic slowdown and the sudden surge in Medicaid and public employee health benefit expenses. The California CALPERS public employees health benefits program, for example, recently experienced a 26 percent premium increase.<sup>1</sup> In 2003, premiums in the Federal Employee Health Benefits Program are up 15 percent.<sup>2</sup> Some employers are responding to sharp increases in premiums by shifting a portion of the costs to employees; others have stopped paying for health insurance altogether.<sup>3</sup>

Why does the health care system appear to be so costly and why do costs appear to be growing so fast? Like most things in life, the answer is not all that simple. Many factors affect spending and contribute to its growth—insurance underwriting cycles, the price of services, use of services, new technologies, the administrative costs of a fragmented system. Moreover, the relative importance of these factors changes over time.

It is important, though, to distinguish between increases in health insurance premiums and the underlying increase in the cost of providing health care. Premiums are often affected by what is known as the “insurance underwriting cycle.” Benefit payments and premiums do not always move at the same rates. If insurers underestimate what will happen to health care costs and price their premiums too low, it can take several years for insurers to catch up and recoup losses. In addition, in times of tight competitive markets, insurers try to retain or gain market share and keep premiums as low as possible, even taking losses in the short run. As insurance companies consolidate and competition

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<sup>1</sup> CalPERS, *Facts at a Glance: Health*. California Public Employees Retirement System, May 2003.

<sup>2</sup> Mark Merlis, *The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform*. Henry J. Kaiser Family Foundation, May 30, 2003.

<sup>3</sup> Edwards, et al. *The Erosion of Employer-Based Health Coverage and the Threat to Worker's Health Care*. The Commonwealth Fund, August 2002; Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2002 Annual Survey*. Kaiser Family Foundation, Menlo Park, CA and Health Research and Educational Trust, Chicago, IL. 2002.

weakens or reserves become too low, premiums are raised and grow faster than payments for benefits.

That is what we have been seeing over the past few years (Exhibit 1). In 2001, insurance companies raised premiums 10.5 percent, which for the third straight year was faster than the growth in benefits.<sup>4</sup> In 2002, large employers reported a rise in premiums of 12.5 percent.<sup>5</sup> Insurance companies have been building reserves and recouping from their losses in the mid 1990s, when stiff competition among plans led to revenue shortfalls.<sup>6</sup> However, they have probably caught up by now, profits have risen, and premiums may again grow more in line with benefit spending.<sup>7</sup>

The more important question is what is happening to expenditures for health care overall. In 2001, the nation spent more than \$1.4 trillion for health care, or 14.1 percent of the gross domestic product (GDP). This was a major jump from 13.3 percent of GDP in 2000, due to accelerating health care costs as well as relatively weak nominal GDP growth.<sup>8</sup> By 2012, health spending is projected to more than double.

Recent concern about rising health care costs, however, is partly a reflection of their departure from the relatively low growth we experienced in the mid- to late 1990s. From 1993 to 1999, spending rose an average of just 5.4 percent per year<sup>9</sup> (Exhibit 2). The 8.7 percent growth in 2001 is still well below average increases in each of the three decades before 1990, and there are some early signs that things are beginning to slow down again somewhat.<sup>10</sup> Nevertheless, with health care representing a growing share of GDP, and with increasing numbers of uninsured Americans, we need to understand better what our money is buying.

One of the most significant contributors to recent spending growth is health care price inflation. At a time when overall inflation is growing at just 2 percent a year,

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<sup>4</sup> Stephen Heffler et al., "Health Spending Projections for 2002-2012," *Health Affairs* (Web Exclusive February 7, 2003.)

<sup>5</sup> Bradley C. Strunk et al., "Tracking Health Care Costs: Growth Accelerates Again in 2001," *Health Affairs* (Web Exclusive September 25, 2002.)

<sup>6</sup> Cara S. Lesser and Paul B. Ginsburg, *Health Care Cost and Access Problems Intensify*. Center for Studying Health System Change, Issue Brief, No. 63, May 2003.

<sup>7</sup> Heffler et al.

<sup>8</sup> Katharine Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs*, (January/February 2003).

<sup>9</sup> Levit et al.

<sup>10</sup> Heffler et al.

hospital prices have risen 3.2 percent and drug prices have gone up 4.5 percent.<sup>11</sup> When personal health care spending is adjusted for price inflation, the overall picture changes dramatically. Real spending on health care increased by 6.2 percent in 2001, closer to the high rates of 5.5 to 7.7 percent typical of the 1970s and 1980s (Exhibit 3). What is behind these trends? And how realistic are the projections that costs will moderate to about 4 percent real growth by the turn of this decade?

The first insight is gained by looking at trends in different health care services. Because of increasing prices, new drugs coming on the market, and more prescriptions being written, spending on prescription drugs is growing faster than all other services (Exhibit 4). Increased spending on prescription drugs accounted for about one-third of overall spending growth in 1999, and about one-fourth of spending growth in 2002<sup>12</sup> (Exhibit 5). Growth in prescription drugs spending, however, seems to have reached a peak of 15.7 percent in 2001, and every indication is that it is now slowing. Over the next five years, growth is projected to increase at 11.2 percent—still a major expense, but not the powerful cost-driver it was in the past few years.<sup>13</sup>

Perhaps more ominous is that hospital spending, after being virtually flat in the 1994 to 1997 period, increased 8.7 percent in 2001.<sup>14</sup> Hospital care represents one-third of personal health care spending and contributed about half of the total increase in 2001 spending. Most of that increase occurred in the outpatient department.<sup>15</sup> Hospitals are labor-intensive institutions. In tight labor markets, hiring and retaining nurses and other skilled personnel in short supply puts upward pressure on wages. Once the economy recovers, upward pressure on wages could cause an even greater resurgence in hospital costs. Managed care may have succeeded in reducing hospital admissions and shortening lengths of hospital stays in the mid-1990s, but those were one-time savings. Without a new strategy for reducing use of this costly service, the aging population and new technological advances are likely to stimulate greater utilization.

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<sup>11</sup> Levit et al.

<sup>12</sup> Bradley Strunk and Paul Ginsburg, “Tracking Health Care Costs: Trends Stabilize but Remain High in 2002.” *Health Affairs* (Web Exclusive, June 11, 2003.)

<sup>13</sup> Heffler et al.

<sup>14</sup> Strunk et al.

<sup>15</sup> Strunk et al.

## II. Utilization of Health Services

After a number of years of stability, growth in the use of health services is on the rise again (Exhibit 6). We are seeing greater use of the outpatient department, more use of the emergency room, more physician visits, more specialized physician procedures, and more prescriptions written. Use of emergency rooms may be related to the rise in the numbers of uninsured.<sup>16</sup>

Use of hospital services experienced absolute declines from 1994 to 1996, presumably as a result of managed care practices. By 2001, however, the quantity of hospital services increased 8.0 percent and is abating only somewhat to an annual rate of 6.8 percent in the first half of 2002 (Exhibit 7).

Some have suggested that the increasing volume of physician and hospital services is a response to the loosening of managed care.<sup>17</sup> Certainly, the public responded negatively to managed care's constraints on use of specialists and to "drive-through" births, and managed care enrollment has shifted from more tightly managed health maintenance organizations to more loosely managed preferred provider organizations.<sup>18</sup>

The other possible explanation, however, is that physicians and other health care providers are reacting to the reduced prices for their services achieved by managed care, as well as by public programs such as Medicare and Medicaid, by increasing the volume of services provided.<sup>19</sup> This so-called target-income hypothesis suggests that physicians respond to reduced fees by working longer hours, seeing more patients, having patients come back more frequently, and performing more billable procedures.

Average physician net income in 1999 for primary care physicians was \$138,000, down 6.4 percent from 1995 after adjusting for inflation.<sup>20</sup> (Exhibit 8) Specialist

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<sup>16</sup> Schur, C., P. Mohr, and L. Zhao, Emergency Department Use in Maryland: A Profile of Use, Visits, and Ambulance Diversion, Report to the Maryland Health Care Commission, Project HOPE: Bethesda, Md., February 2003.

<sup>17</sup> Cara Lesser and Paul B. Ginsburg, *Health Care Cost and Access Problems Intensify: Initial Findings from HSC's Recent Site Visits*. Center for Studying Health System Change, May 2003.

<sup>18</sup> Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2002 Annual Survey*. Kaiser Family Foundation, Menlo Park, CA and Health Research and Educational Trust, Chicago, IL 2002.

<sup>19</sup> SM Codespote et al., "Estimated Volume and Intensity Response to a Price Change for Physician's Services." Office of the Actuary, Health Care Financing Administration, August 13, 1998.

<sup>20</sup> Marie C. Reed and Paul B. Ginsburg, *Behind the Times: Physician Income, 1995-99*. Center for Studying Health System Change, Data Bulletin 24, March 2003.

physician incomes, on average, were \$219,000 in 1999, down 4 percent from 1995. By contrast, professional and technical workers in the economy as a whole experienced a 3.5 percent increase in income over this four-year period. It is reasonable to hypothesize that after taking such a hit as a result of contraction in fees, physicians began to respond in the 1999–2002 period by increasing the volume of services provided.

Some support for physicians' target-income behavior is suggested by recent data on changes in use of physician services by Medicare beneficiaries. These trends are not influenced by managed care, which has achieved only low penetration in this group of insured. Last year, the number of physician visits to Medicare beneficiaries rose 4.3 percent, nearly twice as fast as in the previous year. Some lab tests grew 22 percent; brain MRIs grew 15 percent; heart echography grew 11 percent; and disturbing to see, emergency room visits were up 6.5 percent (Exhibit 9). Ambulatory surgical procedures also increased significantly from 1997 and 2001 (Exhibit 10).

Why the increase? It is hard to believe that Medicare beneficiaries suddenly demanded 15 percent more brain MRIs in 2001 than in 2000. More plausibly, Medicare payment rates are still sufficiently attractive to induce physicians who provide orthopedic, cardiac, ophthalmology, and X-ray and laboratory procedures to work longer hours and see more patients—all with a view to offsetting the earlier period of fee contraction.

We do not know if these are unnecessary services or if they are now filling an unmet need, or some of both. Physicians also may be providing more and newer technologies—technologies that may be improving life expectancy or quality of life. The fact is that we do not employ a scientific basis in this country for determining the clinical criteria for reimbursable services. The recent decision by the Centers for Medicare and Medicaid Services (CMS) to institute guidelines for coverage of implantable cardiac defibrillators is a beginning step, but it applies to a newly emerging technology, not to existing benefits.<sup>21</sup>

Utilization in the health care system has often been driven by technological advances. New drugs, for example, make it possible to control high cholesterol and other chronic conditions. New advances in cardiac care reduce mortality and yield health and

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<sup>21</sup> Melody Petersen, "U.S. to Back Heart Device in More Cases: Medicare Move is Less Than Industry Wanted," *New York Times*, June 7, 2003, p. C1.

economic gains for society.<sup>22</sup> Clearly, there are many people who would benefit from better access to life-saving drugs, screening tests, and surgical procedures. An informed response to the renewed surge in health care utilization will require far more sophisticated analysis than has yet been undertaken.

Use of prescription drugs has also been on the increase. From 1997 to 2000, nearly one-third of the increase in per-person prescription drug spending came from an increase in the number of prescriptions (Exhibit 11). More people are taking cholesterol-lowering drugs, an aging population is taking more drugs to combat chronic illness, and more people may be taking drugs that are not indicated, or are even contraindicated, given their array of health problems.<sup>23</sup>

### III. **Administrative Costs**

Finally, more attention needs to be given to the rapid increase in administrative costs, up 11.2 percent in 2001 (Exhibit 4). The fragmentation of the U.S. health insurance system—with people moving in and out of coverage and in and out of plans, and changing their usual source of care frequently—all contribute to high administrative costs for insurers and for health care providers.<sup>24</sup> In 2002, the U.S. health system spent \$112 billion on administrative expenses, and expenses are expected to hit \$223 billion in 2012 (Exhibit 12).

Private insurance is the dominant mode of health coverage for the working-age population, while public programs cover elderly and disabled individuals as well as certain low-income populations, especially children and pregnant women. Administrative costs for private insurance include marketing, sales commissions, profits and reserves, as well as the cost of enrolling individuals and paying claims. Government programs, by contrast, do not incur marketing and sales expenses and do not require premiums high enough to generate profits and reserves. Medicare enrollment is stable, typically

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<sup>22</sup> David M. Cutler and Mark McClellan, “Is Technological Change in Medicine Worth It?” *Health Affairs* (September/October 2001): 11–29.

<sup>23</sup> Chunliu Zhan, et al., “Potentially Inappropriate Medication Use in the Community-Dwelling Elderly: Findings From the 1996 Medical Expenditure Panel Survey” *Journal of the American Medical Association*, 2001, 286: 2823–2829.

<sup>24</sup> Karen Davis, “Time For Change: The Hidden Costs of a Fragmented Health Insurance System.” Invited Testimony, Senate Special Committee on Aging, March 10, 2003.

beginning at age 65 and ending at death. Not surprisingly, government programs have much lower administrative costs than private insurance. On average, administrative expenses for private insurers are 11.9 percent of their health care expenditures (Exhibit 13). The costs of administering government programs (including not only Medicare and Medicaid but Veterans Administration, Department of Defense, Indian Health Service, and other direct health services delivery programs) average 4.6 percent of health expenditures—less than half that of private insurance.

#### **IV. Public vs. Private Sector Spending Growth**

Most health care in the U.S. is provided in the private sector; only the Defense Department, Veterans Administration, Indian Health Service, and state and local governments provide care directly in public facilities. However, the government is a major purchaser of care, paying about 45 percent of the national health bill (Exhibit 14). Medicare (18%) and Medicaid (16%) alone purchase more than one-third of all care and therefore constitute a major influence on the use of services, the quality of care provided, and costs of care. Private health insurers purchase more than another third of care (36%) and consumers most of the rest, either directly out-of-pocket (15%) or through philanthropic giving. Consumer out-of-pocket spending is actually an even larger share than reported, because the numbers do not reflect the premiums consumers pay for Medicare and private insurance. It reflects only their deductibles, coinsurance, copays, and payments for services not covered by insurance.<sup>25</sup>

The public sector has been growing faster than the private sector in the last few years (9.4% vs. 8.2% in 2001), but these numbers reflect changes in enrollments as well as use, prices, administrative costs, and other factors. For example, Medicaid rolls grew 8.5 percent in 2001 as a result of the new SCHIP program covering low-income children, Medicaid expansions to some of their parents, and a weakening economy that brought more low-income persons onto the rolls (Exhibit 15). Without this increase in Medicaid enrollment, the numbers of uninsured would have been even greater than what they were. But it meant also that Medicaid spending overall went up 10.8 percent, placing a squeeze on both federal and state budgets.

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<sup>25</sup> Levit et al.

Private health insurance experienced a similar growth in 2001 (10.5%), but enrollment declined sharply rather than increased. Private insurance expenditures rose because of increased use of services and higher provider payments, insurance profits, and administrative costs. Responding to the weakening economy and double-digit premium increases, employers cut back the share of premiums they paid or dropped coverage altogether. Many employees found they could not pay their increased share. Because they lacked insurance, some consumers may have forgone care.

Despite the higher administrative expenses of private insurance and the higher payment rates to providers, the belief that private insurance is more “efficient” is strongly entrenched. However, a recent study comparing the growth in per-enrollee payments for comparable services in Medicare and private insurance found that Medicare outperformed private insurance over the long term<sup>26</sup> (Exhibit 16). Following the implementation of the hospital prospective payment system in 1984, Medicare per enrollee spending has moved slower than employer-based insurance. The physician fee schedule, implemented in 1992, also contributed to lower spending. In 2002, Medicare fees were about 77 to 79 percent of private rates; physician program participation, however, reached about 90 percent of physicians in the same year.<sup>27</sup> The implementation of the newer prospective payment systems for nursing homes, home health care, and the hospital outpatient department are expected to continue to have a dampening effect on spending. A newly released study projects that in 2003, Medicare per-enrollee costs will have risen at about one-third the rate of employer premiums and less than one-third that of the Federal Employee Health Benefit Program (FEHBP) (Exhibit 17). Administrative costs in FEHBP are estimated at nearly three to six times those in Medicare.<sup>28</sup>

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<sup>26</sup> Christina Boccuti and Marilyn Moon, “Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades,” *Health Affairs* (March/April 2003): 230-237.

<sup>27</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*. March 2003.

<sup>28</sup> Mark Merlis, *The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform*. Henry J. Kaiser Family Foundation, May 30, 2003.

## V. **International Comparisons**

The U.S. has by far the most costly health care system in the world, both per-person and as a percent of our nation's total economic resources. In 2000, we spent \$4,631 per person on health care, 69 percent more than in Germany, 83 percent more than in Canada, and 134 percent more than in the average of all members of the Organization of Economic Cooperation and Development (OECD)<sup>29</sup> (Exhibit 18). Higher U.S. costs cannot be attributed to aging; in fact, the U.S. population is "younger" than the populations of most European countries.

Nor is the situation improving. Despite a decade of experimenting with managed care in the U.S., health spending rose faster than in other countries. Between 1990 and 2000, U.S. health spending, adjusted for inflation, increased by 3.2 percent a year, compared with the OECD average of 3.1 percent (Exhibit 19). By contrast, real spending per capita increased by 1.8 percent in Canada and by 2.1 percent in Germany. Moreover, most countries with above-average rates of increase in the 1990s were those that had particularly low spending on health care, such as the U.K. and Japan.

The U.S. is alone among major industrialized nations in other respects. Over half of health care spending is paid for privately, compared with about one-fourth or less in other countries (Exhibit 20). Ironically, because the U.S. is so expensive, the government—while it accounts for only 45 percent of all health care spending—spends as much as a percent of GDP on health care as do other countries with publicly financed health systems. For example, U.S. public spending as a percent of GDP is 5.8 percent, compared with 5.9 percent in the U.K. and 6.5 percent in Canada.<sup>30</sup>

The U.S. is also alone among major industrialized nations in failing to provide universal health coverage. But even when people are insured by private insurance or Medicare, that coverage is less comprehensive than the coverage typically afforded in other countries. As a result, Americans pay more out-of-pocket for health care than do people in other countries—an average of \$707 per person in 2000 versus \$405 in Canada, \$335 in all industrialized countries, and \$171 in the U.K. (Exhibit 21). Yet, some advocate increasing cost-sharing for patients as a way to give patients greater incentives

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<sup>29</sup> Gerard Anderson et al., "It's the Prices, Stupid: Why the United States is So Different from Other Countries," *Health Affairs* (May/June 2003): 89-105.

<sup>30</sup> Anderson et al.

to control utilization of health care services. Clearly, other countries have found effective mechanisms for keeping health care costs to a much lower share of their economic resources without putting financial barriers in the way of patients seeking care.

Our typical assumption is that such countries are rationing effective care, have long waiting lists, and poorer health outcomes. It is true that patients in the U.S. wait shorter times for surgery than any other country. But our waits for a doctor's appointment when sick are actually longer than in other countries, and more Americans rely on emergency rooms for care.<sup>31</sup>

What is not well appreciated is that Americans receive less hospital care, on average, than people in other countries and see the doctor about as frequently. The annual number of physician visits per capita in the U.S. is 5.8 visits, about the same as the OECD nations' average of 5.9 visits and less than the 6.4 average number of visits in Canada (Exhibit 22). Fewer Americans are admitted to the hospital in a given year; when they are admitted, they stay a shorter time than patients in other countries. Consequently, the number of acute care hospital days per capita in the U.S. is 0.7, compared with the OECD's 1.0-day average, and less than the 0.9-day average in the U.K.—a country where long waiting times for hospital care and surgery are a major issue (Exhibit 23).

So if we get the same or less care than people in other countries, why do we spend more? It has led some analysts to conclude, "It's the price, stupid." We do pay our physicians more than other countries. Fees for physician procedures are more than three times as high as in Canada.<sup>32</sup> We pay more for the same drug than other countries—sometimes twice as much for the same drug—even when it is produced by an American company. The U.S. spends \$556 per person on pharmaceuticals, compared with \$385 in Canada and \$262 in other industrialized countries<sup>33</sup> (Exhibit 24).

We also have higher administrative costs than other countries. Canada averages about 1 percent of health care spending on administrative costs.<sup>34</sup> We manage to devote

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<sup>31</sup> Cathy Schoen et al., *Comparison of Health Care System Views and Experiences in Five Nations, 2001*. The Commonwealth Fund, May 2002.

<sup>32</sup> Victor R. Fuchs and J.S. Hahn, "How Does Canada Do It?" *New England Journal of Medicine*, September 27, 1990: 884–890.

<sup>33</sup> Gerard Anderson et al., *Multinational Comparisons of Health Systems Data, 2002*. The Commonwealth Fund, October 2002.

<sup>34</sup> Committee on Ways and Means, U.S. House of Representatives. *Health Care Resource Book*. U.S. Government Printing Office, Washington:1993.

6 percent overall on administrative costs.<sup>35</sup> And that does not count the administrative personnel who work in hospitals or doctors' offices—a much higher number in the U.S.'s fragmented and complex public–private insurance system than in the simpler, unified payment systems of other nations.<sup>36</sup>

But the story is more complicated than just higher prices and higher administrative costs, both of which are powerful explanations of our higher costs. While we have about the same number of physicians per capita as other countries, and fewer visits, a much higher fraction of our doctors are specialists. Not surprisingly, therefore, we greatly exceed other countries in the numbers of specialized procedures performed. For example, U.S. doctors perform 4.8 times as many coronary angioplasties per capita as Canadian doctors, and the U.S. has three times as many MRI units per capita as Canada<sup>37</sup> (Exhibit 25).

Of course, variations across countries in use of procedures does not tell us whether we do too many procedures or they do too few. The U.S. has about the same mortality from heart attacks as the average OECD country (Exhibit 26). But many factors enter into such mortality (France and Japan have rates considerably lower than other countries). On most measures of mortality, the U.S. performs more poorly than other countries, ranking 37th overall according to the World Health Organization ranking of health system performance.<sup>38</sup>

The question remains whether we get value for the highly specialized, intensive style of care practiced in the U.S. The Commonwealth Fund 2002 International Health Policy Survey of Sicker Adults does suggest that we pay a price for our uniquely American approach to health care. Americans are more likely to be seeing multiple physicians and taking multiple medications. More things can and do go wrong when care is provided by multiple parties. Of the five nations surveyed (U.S., U.K., Canada, Australia, and New Zealand), the U.S. had the highest serious medical error rate (Exhibit

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<sup>35</sup> Levit, et al.

<sup>36</sup> Steffie Woolhandler and David Himmelstein, "The Deteriorating Administrative Efficiency of the U.S. Health Care System." *New England Journal of Medicine*, May 2, 1991: 1253-1258.

<sup>37</sup> Gerard Anderson, Uwe Reinhardt, Peter Hussey and Varduhi Petrosyan. "It's The Prices, Stupid: Why The United States Is So Different From Other Countries." *Health Affairs* (May/June, 2003):89-105

<sup>38</sup> World Health Organization, *World Health Report, 2000: Health Systems, Improving Performance*. World Health Organization, Geneva 2000.

27). Survey respondents in the U.S. were also more likely to report having tests duplicated and not having their medical records available when they went for care<sup>39</sup> (Exhibit 28).

Despite our costly health care system, other countries have moved more rapidly to adopt electronic medical records and electronic prescribing. The Commonwealth Fund 2000 International Health Policy Survey of Physicians found that 59 percent of primary care physicians in the UK have electronic prescribing, as do 52 percent of percent in New Zealand, compared with 17 percent in the U.S.<sup>40</sup>

### **Conclusion**

If we have the world's costliest health system yet still fail to provide everyone with access to care—and fall far short of providing the safe, high-quality care that it is possible to provide—the conclusion that there is room for improvement is inescapable.<sup>41</sup> Only by facing this fact squarely and putting into action the best ideas and experiences across the U.S. and around world can we achieve a vision of American health care that includes: automatic and affordable health insurance for all, accessible care, patient-responsive care, information- and science-based care, and commitment to quality improvement.<sup>42</sup>

Fortunately, there are examples of high performance in health care in both the private and public sectors. The Council on Accountable Physician Practices in the U.S., which includes more than 17,000 physicians in 14 large group practices, has demonstrated that it can provide superior quality care, as measured by widely used HEDIS quality indicators, more efficiently than in other settings.<sup>43</sup> The Veterans Administration has markedly improved its performance in the last decade on both quality

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<sup>39</sup> Robert Blendon et al., “Common Concerns Amid Diverse Systems: Health Care Experiences In Five Countries” *Health Affairs* (May/June 2003): 106–121.

<sup>40</sup> The Commonwealth Fund 2000 International Health Policy Survey of Physicians. [http://www.cmwf.org/programs/international/2000\\_intl\\_chartpack.pdf](http://www.cmwf.org/programs/international/2000_intl_chartpack.pdf)

<sup>41</sup> Karen Davis, et al., *Room for Improvement: Patients Report on the Quality of Their Health Care*. The Commonwealth Fund, April 2002, and Karen Davis, et al. *Mirror, Mirror on the Wall: The Quality of American Health Care*. The Commonwealth Fund, forthcoming.

<sup>42</sup> K. Davis, C. Schoen, and S. Schoenbaum, “A 2020 Vision for American Health Care.” *Archives of Internal Medicine*, Vol. 160, No. 22: 3357–62.

<sup>43</sup> Council of Accountable Physician Practices, *Why Accountable Physician Practices Are Essential to the Future of American Medicine*. January 2003.

and efficiency.<sup>44</sup> The U.S. Bureau of Primary Health Care has improved effective management of diabetic patients in community health centers that participate in learning collaboratives to improve quality of care.<sup>45</sup>

But these success stories are far too isolated. If we are to achieve a truly high-performance health system, bold action is required. The following steps would start us on this course:

- **Public reporting of cost and quality data on physicians, hospitals, nursing homes, other health care providers, and health plans.** CMS has been a leader in posting nursing home quality data on its website, but this is just a modest beginning. If we are serious about doing better, we need to know where we stand.
- **Broad-scale demonstrations of: a new approach to health insurance coverage, science-based benefits, use of modern information technology, and high-quality care.** I served on the Institute of Medicine committee which issued a report last fall calling for statewide demonstrations of health insurance coverage for all, model chronic care and primary care initiatives, information technology, and medical malpractice.<sup>46</sup> The \$50 billion in the budget resolution for improving health insurance coverage would go a long way toward putting these recommendations into action in five or more states.
- **Investment in health information technology.** Other countries are quickly surpassing the U.S. in the adoption of electronic medical records and electronic prescribing. They are doing so because the government has been willing to invest in the infrastructure and establish the standards required to make this potential a reality.
- **Development and promulgation of clinical guidelines and quality standards.** It is long past time to simply pay for services rendered without establishing a

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<sup>44</sup> Kizer KW, Demakis JG, Feussner JR, “Reinventing VA Health Care: Systematizing Quality Improvement and Quality Innovation.” *Medical Care*, June 2000: p17-16.

<sup>45</sup> D. Stevens, *Changing Practice, Changing Lives: Large Scale Improvement in Health Centers Across the Nation*. Presentation at Institute for Healthcare Improvement National Forum, December, 2002.

<sup>46</sup> Institute of Medicine, *Fostering Rapid Advances in Health Care*. The National Academies Press, November 2002.

scientific-basis for effectiveness—not just for new drugs but for consultations, procedures, and tests. This could be accomplished through an expanded mandate for the CMS Medicare Coverage Advisory Committee or establishment of a new National Institute on Clinical Excellence and Effectiveness.

- **Paying for performance.** Medicare and private insurers tend not to vary payment rates with quality. They pay for defects, whether those defects are surgeries that need to be repeated; infections that arise from failing to use state-of-the-art technology, such as catheters impregnated with antibiotics for heart valve patients; or medication errors. CMS has embarked on some modest initiatives to begin testing paying-for-performance rewards. Medicare can and should be a leader in promoting quality. These efforts need to be substantially expanded and best practices documented and disseminated. Medicare’s leadership can be instrumental in moving private payers as well; to date, very few private insurers have instituted “value-based purchasing” strategies.<sup>47</sup>
- **Investment in research.** We urgently need to gather evidence on what works to improve care, eliminate waste and ineffective care, and promote greater efficiency, including use of modern information technology, team work, and improved care processes. Any industry that fails to invest in research to improve quality and efficiency is going to be a backward industry. The federal government pays \$455 billion for health care in the U.S. but devotes only \$300 million to the budget of the Agency for Healthcare Research and Quality for learning effective ways to improve the performance of the U.S. health system. The quality report on U.S. health care due to be issued this fall is an important starting point. But it needs to be followed with an investment in research up to the task for ensuring that the U.S. is a high-performing health system worthy of the 21st century.

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<sup>47</sup> Vittorio Maio, Neil Goldfarb, Chureen Carter, and David Nash, *Value-Based Purchasing: A Review of the Literature*. The Commonwealth Fund, May 2003 and Neil Goldfarb, Vittorio Mario, Chureen Carter, Laura Pizzi and David Nash, *How Does Quality Enter Into Health Care Purchasing Decisions?* The Commonwealth Fund, May 2003.



# American Health Care: Why So Costly?

**Karen Davis**

**President, The Commonwealth Fund**

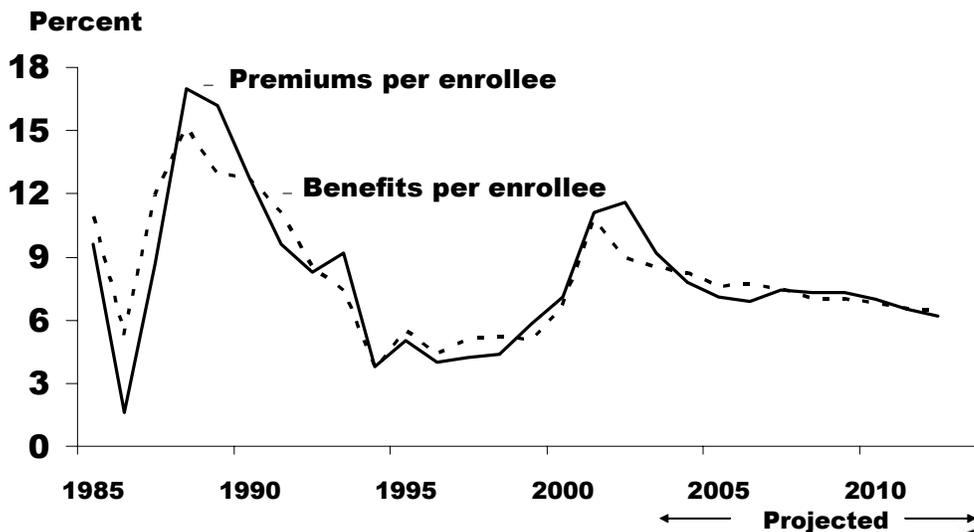
**June 11, 2003**

**Hearing on Health Care Access and Affordability: Cost  
Containment Strategies**

**Senate Appropriations Committee**

**Labor, Health, and Human Services, Education and Related  
Agencies Subcommittee**

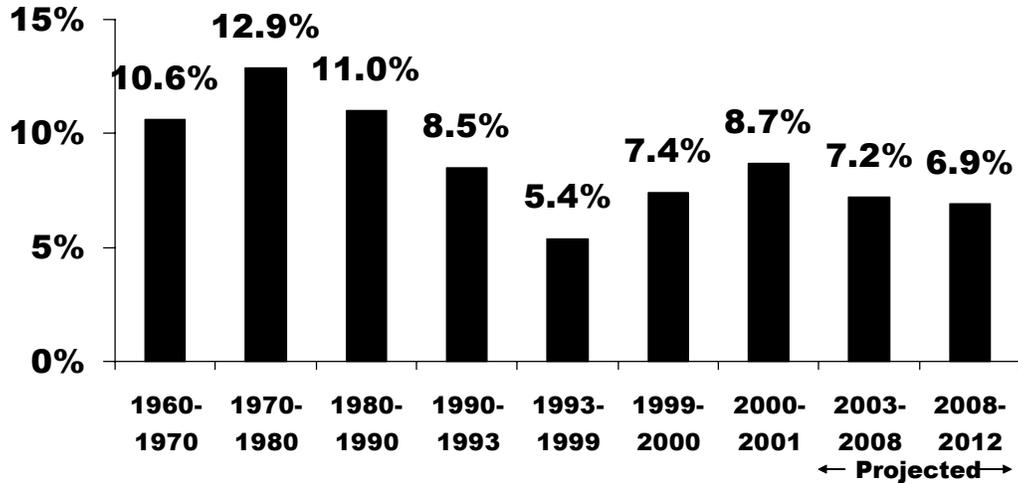
## Growth in Per Enrollee Private Health Insurance Premiums and Benefits, 1985 - 2012



Source: Heffler et al., "Health Spending Projections for 2002-2012," *Health Affairs*  
(Web Exclusive February 7, 2003)



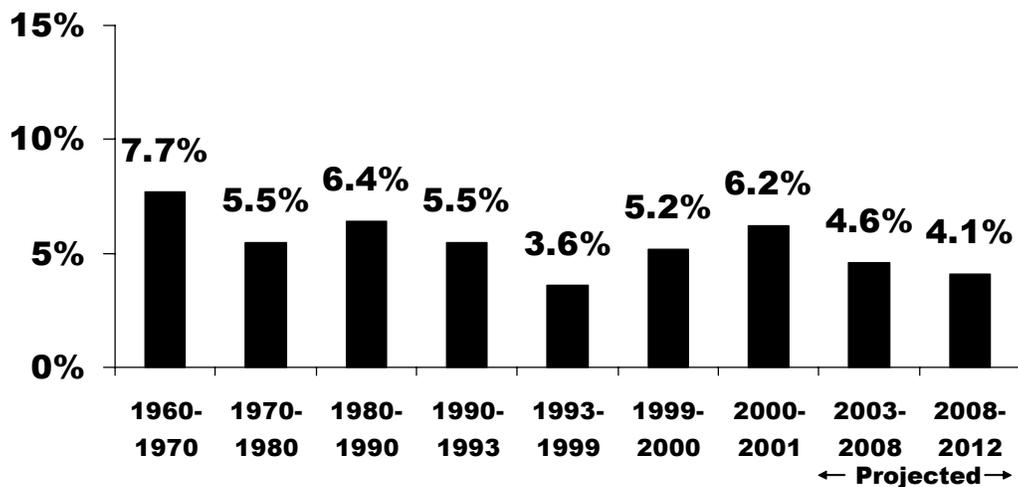
### National Health Expenditures Average Annual Percentage Growth, Selected Calendar Years 1960-2012



Source: Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* (January/February 2003): 154-164 and Heffler et al., "Health Spending Projections for 2002-2012," *Health Affairs* (February 7, 2003).



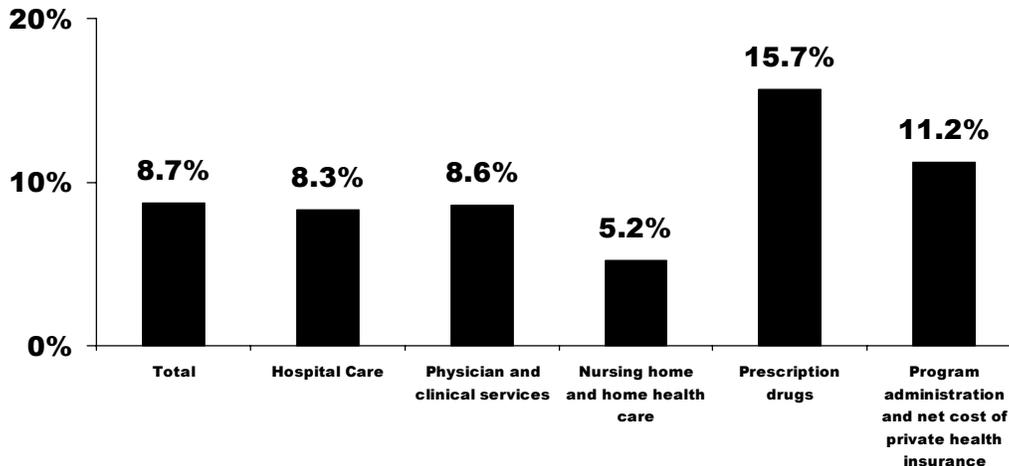
### Real National Health Expenditures Average Annual Percentage Growth, Selected Calendar Years 1960-2001



Source: Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* (January/February 2003): 154-164 and Heffler et al., "Health Spending Projections for 2002-2012," *Health Affairs* (February 7, 2003).



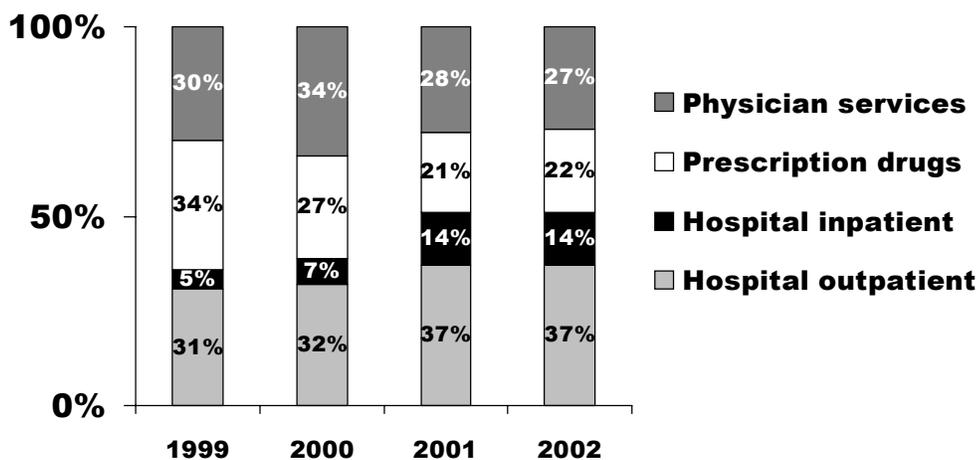
### National Health Expenditures Percentage Growth by Service, 2000 - 2001



Source: Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* (January/February 2003): 154-164



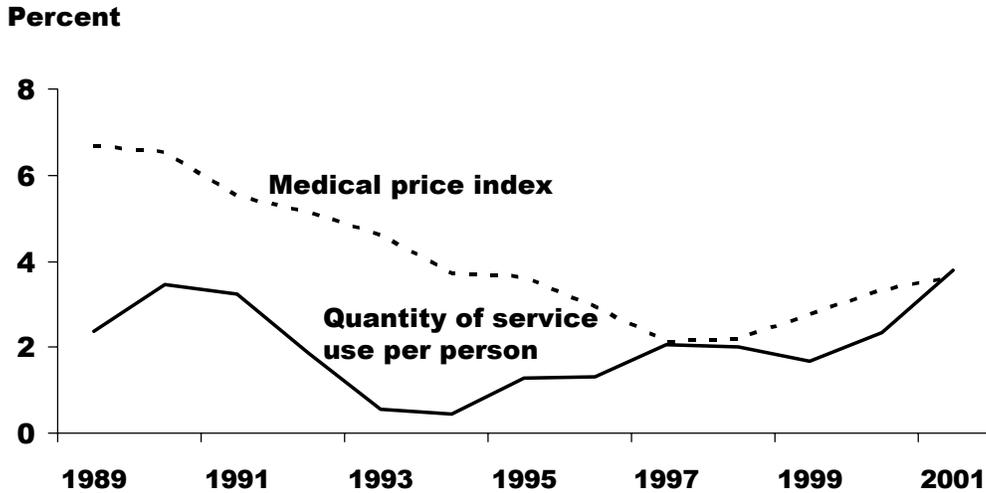
### Shares of Overall Health Care Spending Growth, 1999-2001



Source: Bradley Strunk and Paul Ginsburg, "Tracking Health Care Costs: Trends Stabilize but Remain High in 2002." *Health Affairs* (Web Exclusive, June 11, 2003.)



## Annual Percentage Change in Medical Price Index and Quantity of Service Use Per Capita, 1989-2001 6



Source: Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* (January/February 2003): 154-164



## Decomposition of Hospital Spending Trends, Annual Percentage Change, 1994-2002 7

	Spending on hospital services	Hospital prices	Quantity*
1994	1.8%	4.0%	-2.2%
1995	.8	3.7	-2.8
1996	.5	1.8	-1.2
1997	1.3	1.7	-0.4
1998	3.4	1.9	1.5
1999	5.8	2.5	3.2
2000	7.1	3.3	3.6
2001	12.0	3.6	8.0
2002**	11.2	4.1	6.8

\*Calculated as the residual of the hospital spending and hospital price trends

\*\* Data through June 2002, compared with corresponding months in 2001

Source: Bradley Strunk, Paul Ginsburg and Jon Gabel, "Tracking Health Care Costs: Growth Accelerates Again in 2001." *Health Affairs* (Web Exclusive, September 25, 2002.)



## Physicians' Net Income from Practice of Medicine, 1999, and Percent Change, 1995-1999

	Average reported net income	Percent change in income, adjusted for inflation		
	1999	1995-97	1997-99	1995-99
<b>All patient care physicians</b>	<b>\$187,000</b>	<b>-3.8%*</b>	<b>-1.2%*</b>	<b>-5.0%*</b>
<b>Primary care physicians</b>	<b>\$138,000</b>	<b>-5.4*</b>	<b>-1.1</b>	<b>-6.4</b>
<b>Specialists</b>	<b>\$219,000</b>	<b>-3.5*#</b>	<b>-0.6</b>	<b>-4.0*#</b>

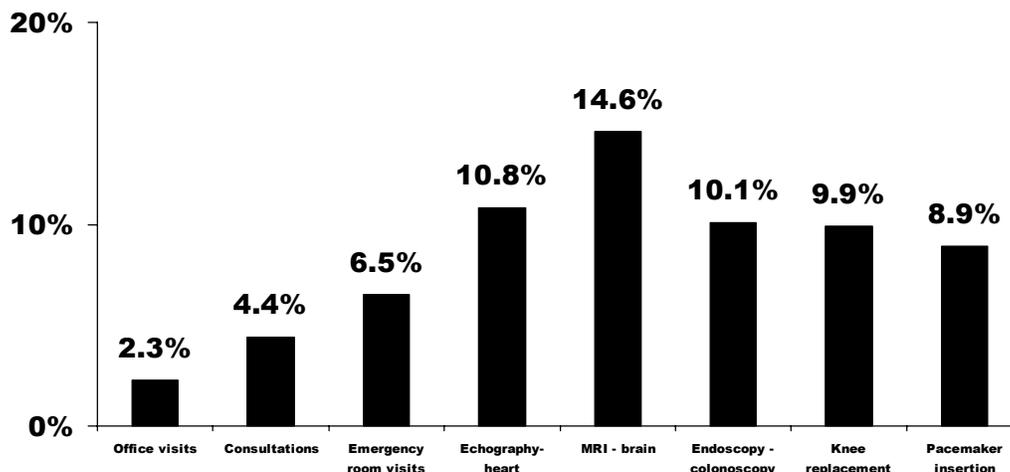
\*Rate of change is statistically significant at  $p < .05$ .

#Rate of change for specialists is significantly different from change for primary care physicians at  $p < .05$ .

Source: Marice C. Reed and Paul B. Ginsburg, *Behind the Times: Physician Income, 1995-99*. Center for Studying Health System Change, Data Bulletin No. 24, March 2003.



## Percentage Growth in Medicare Per Capita Use of Physician Services, by Selected Type of Service, 2001-2002

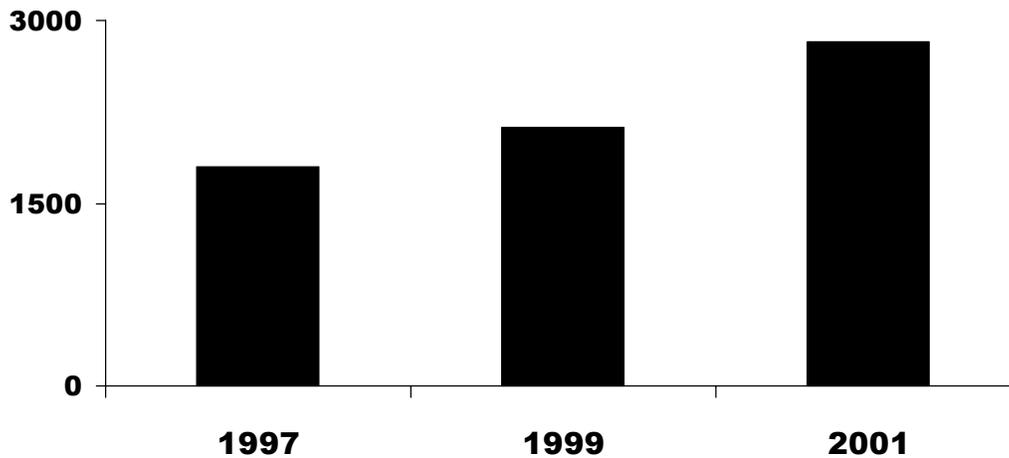


Source: Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*. March 2003



## Growth in Ambulatory Surgery Procedures Provided to Medicare Beneficiaries, 1997, 1999, 2001

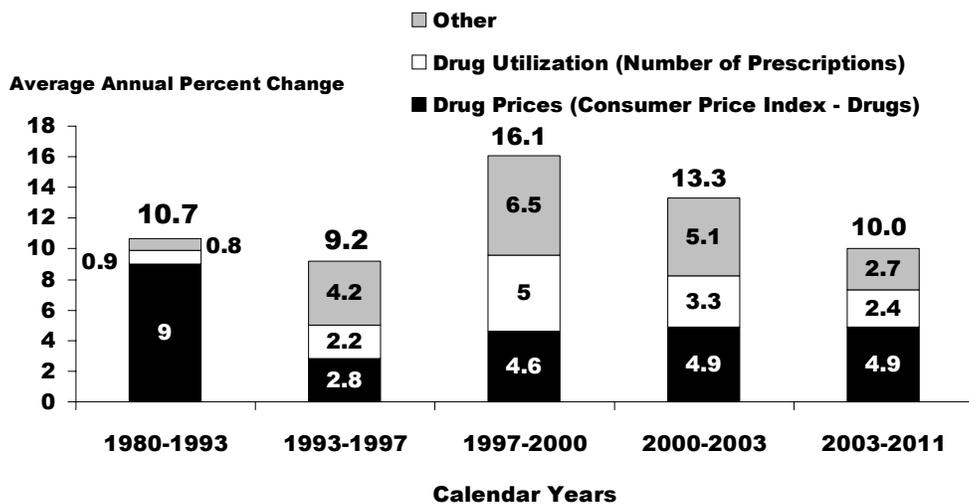
Number of procedures



Source: Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*. March 2003



## Factors Accounting for Growth in Prescription Drug Spending per Capita, 1980-2011



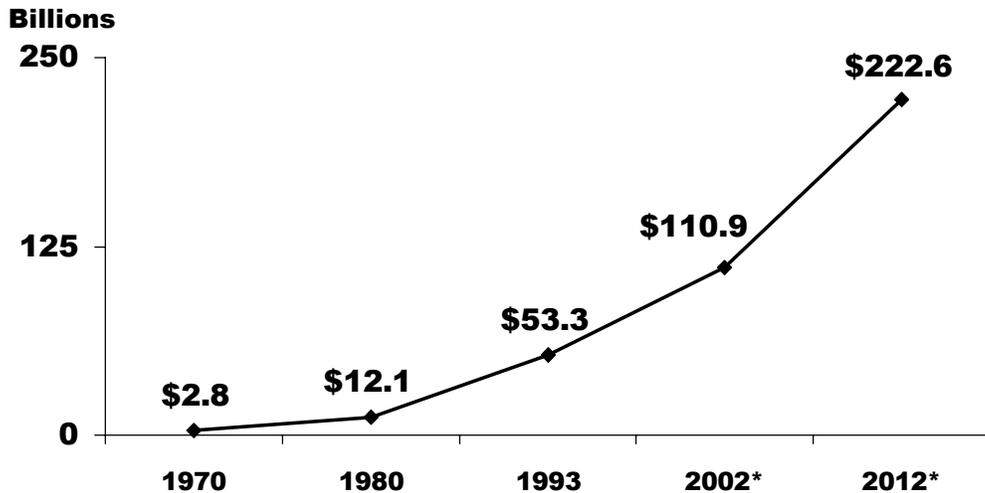
Note: Data for 2000-2011 are projections.

"Other" includes quality and intensity of services, and age-gender effects.

Source: Centers for Medicare and Medicaid Services, The CMS Chart Series. 2003



## Net Cost of Private Health Insurance and Government Program Administration, (in billions) 1970–2012 <sup>12</sup>

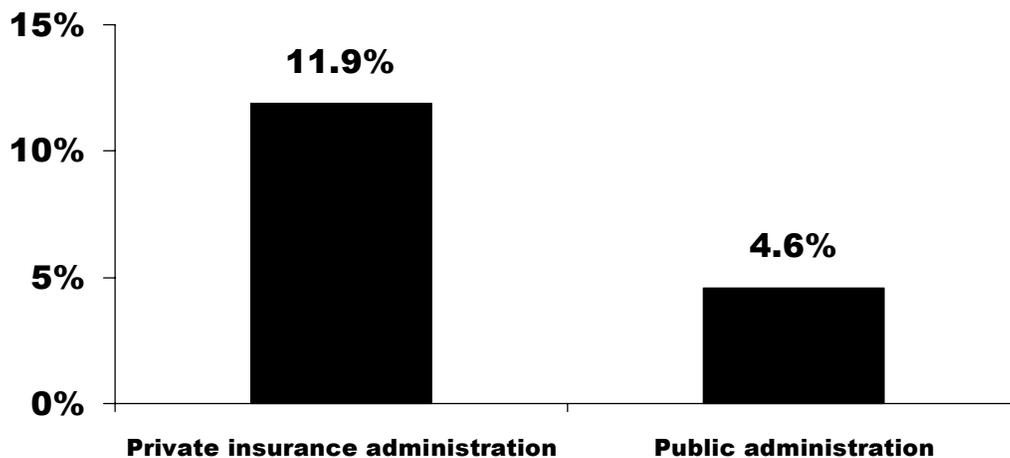


\*Projected

Source: Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* (January/February 2003): 154–164 and Heffler et al., "Health Spending Projections for 2002–2012," *Health Affairs* (February 7, 2003).



## Private Insurance Administrative Costs as a Percent of Private Insurance Outlays and Public Program Administration as a Percent of Public Outlays, 2001 <sup>13</sup>

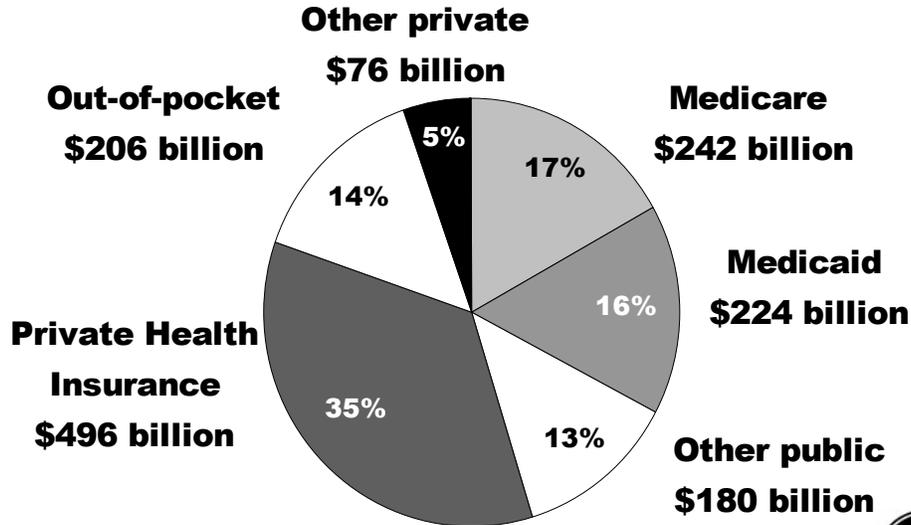


Source: Calculated from Centers for Medicare and Medicaid, "National Health Expenditures, by Source of Funds and Type of Expenditure." Available at <http://www.cms.hhs.gov/statistics/nhe/historical/t3.asp>



## National Health Expenditures by Source of Funds, 2001

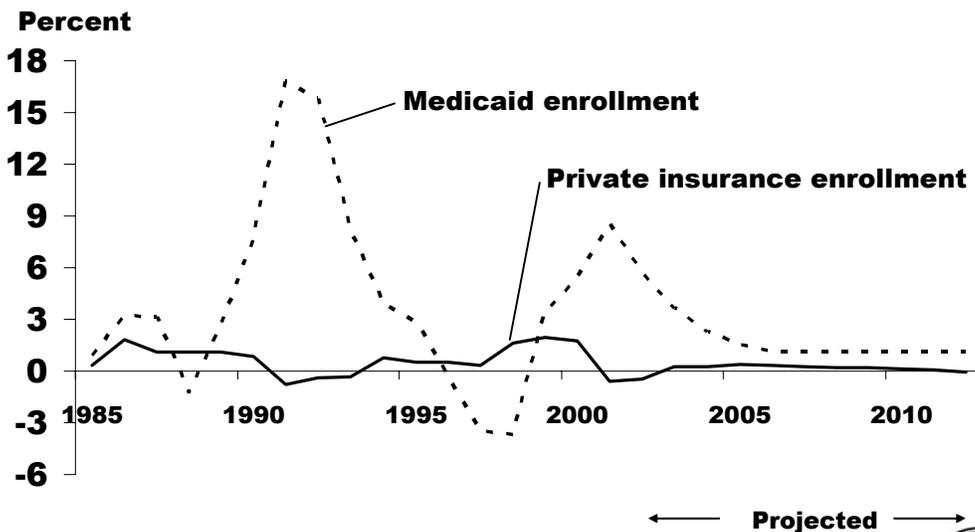
**Total National Health Expenditures = \$1.4 trillion**



Source: Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* (January/February 2003): 154-164



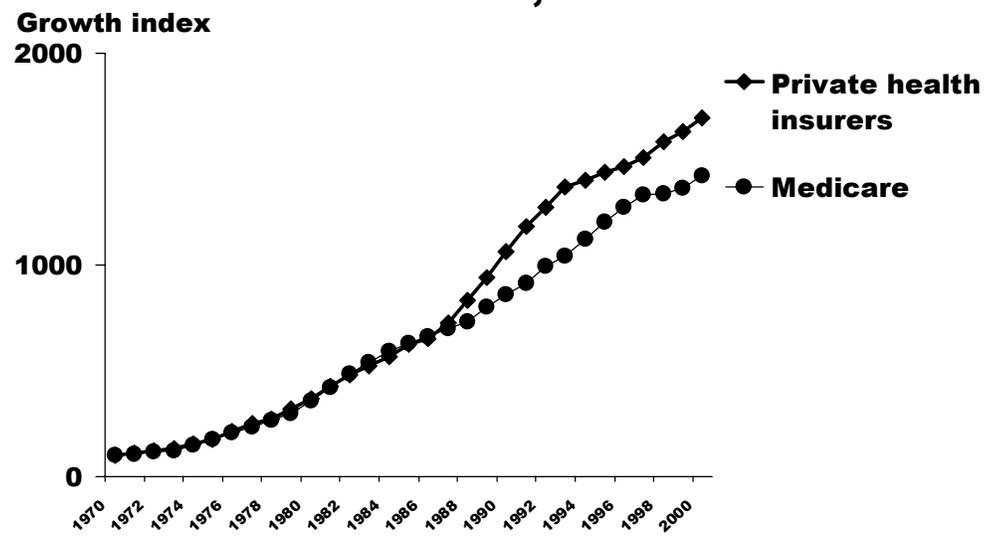
## Percentage Change in Private Health Insurance and Medicaid Enrollment, 1985-2012



Source: Heffler et al., "Health Spending Projections for 2002-2012," *Health Affairs* (Web Exclusive February 7, 2003)



### Cumulative Growth in Per Enrollee Payments for Comparable Services, Medicare and Private Insurers, 1970-2000\*

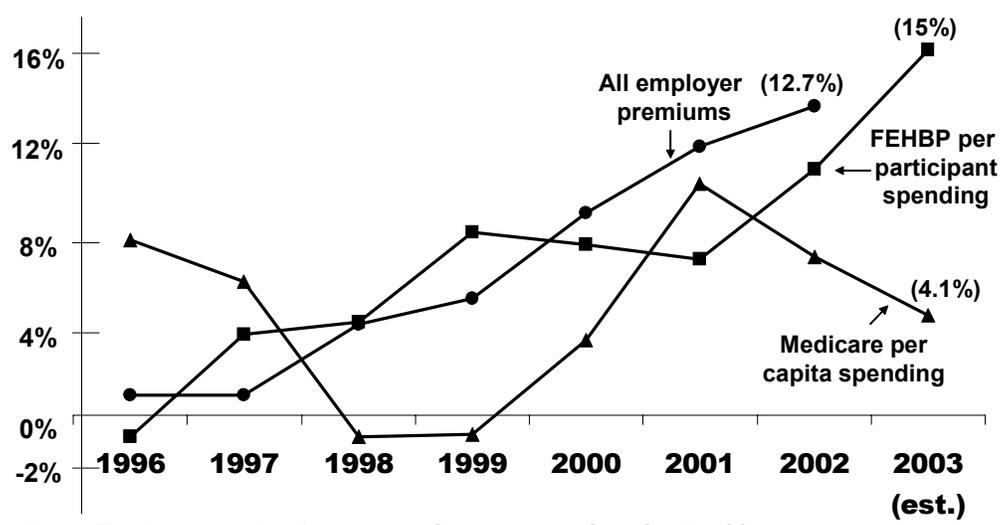


\*Includes hospital care, physician and clinical services, durable medical equipment, and other professional services.

Source: Christina Boccuti and Marilyn Moon, "Comparing Medicare and Private Insurers Growth Rates in Spending Over Three Decades." *Health Affairs* (March/April 2003)



### Spending Growth: FEHBP, All Employers, and Medicare

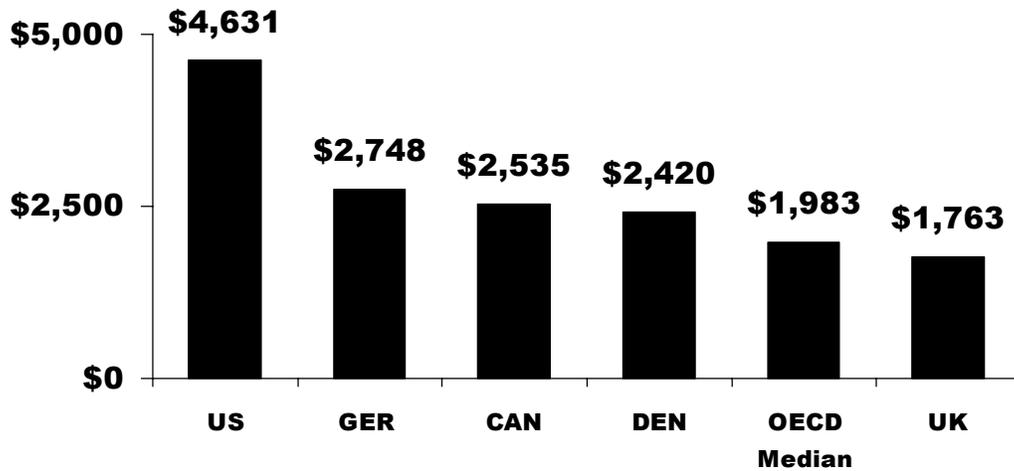


Note: Employer premium increases reflect coverage for a family of four.

Source: Mark Merlis, *The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform* Briefing for The Henry J. Kaiser Family Foundation, May 30, 2003.



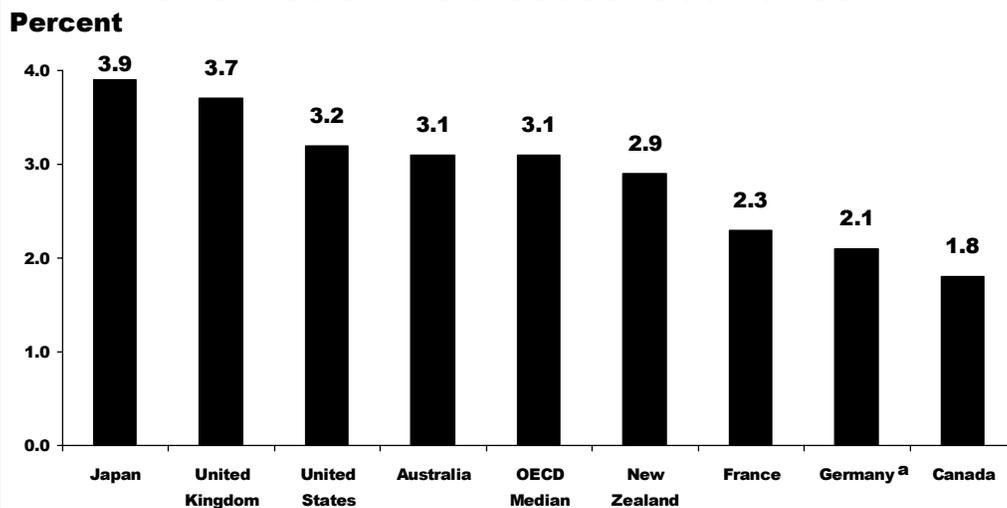
### Per Capita National Health Expenditures in Selected Countries, 2000



Source: Anderson, et al. "It's the Prices, Stupid: Why The United States is So Different from Other Countries." *Health Affairs* (May/June 2003): 89-105



### Average Annual Growth Rate of Real Health Care Spending per Capita Between 1990 and 2000 in Selected Countries

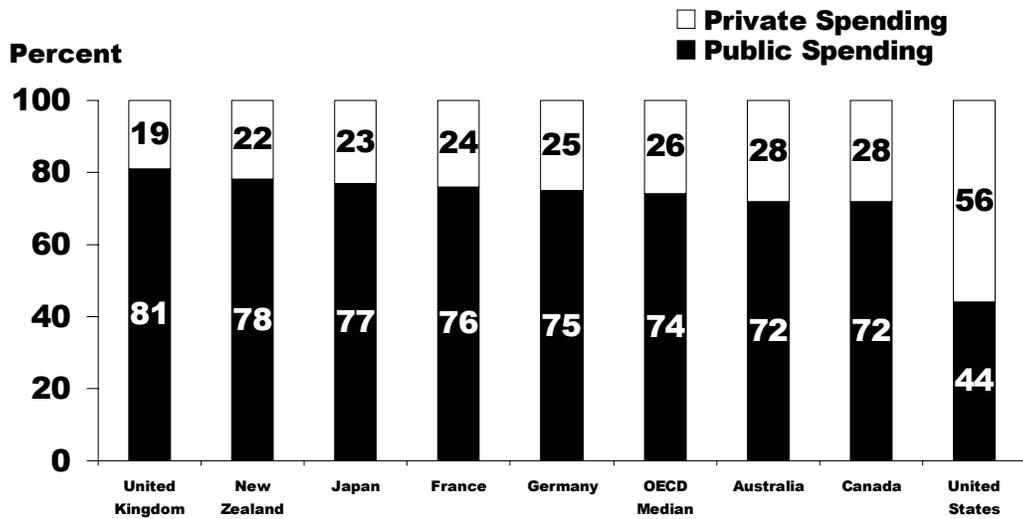


<sup>a</sup> 1992-2000

Source: Anderson, et al., *Multinational Comparisons of Health Systems Data, 2002*. The Commonwealth Fund, October 2002.



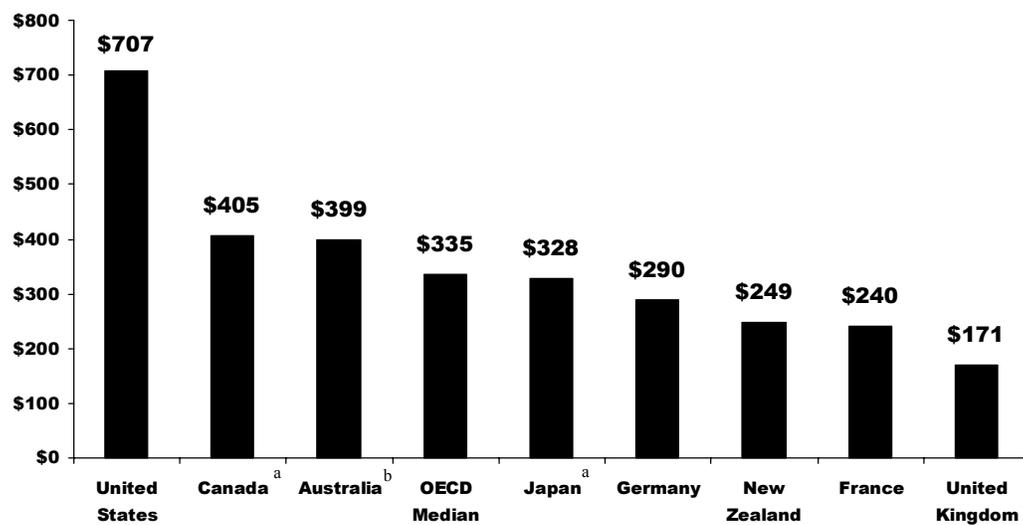
### Distribution of Public and Private Health Care Spending in Selected Countries, 2000



Source: Anderson, et al., *Multinational Comparisons of Health Systems Data, 2002*. The Commonwealth Fund, October 2002.



### Per Capita Out-of-Pocket Health Care Spending in Selected Countries, 2000

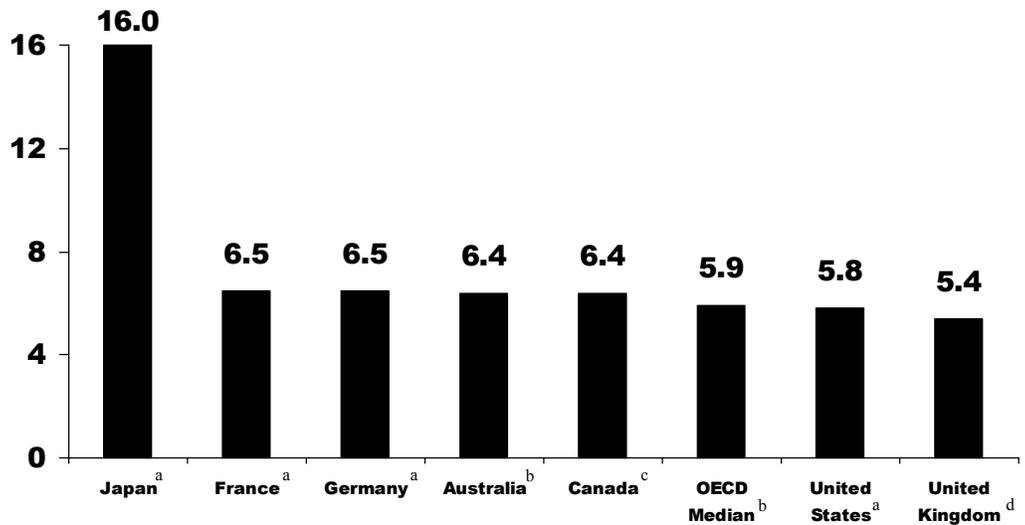


<sup>a</sup> 1999, <sup>b</sup> 1998, <sup>c</sup> 1996

Source: Anderson, et al., *Multinational Comparisons of Health Systems Data, 2002*. The Commonwealth Fund, October 2002.



### Per Capita Annual Number of Physician Visits, Selected Countries

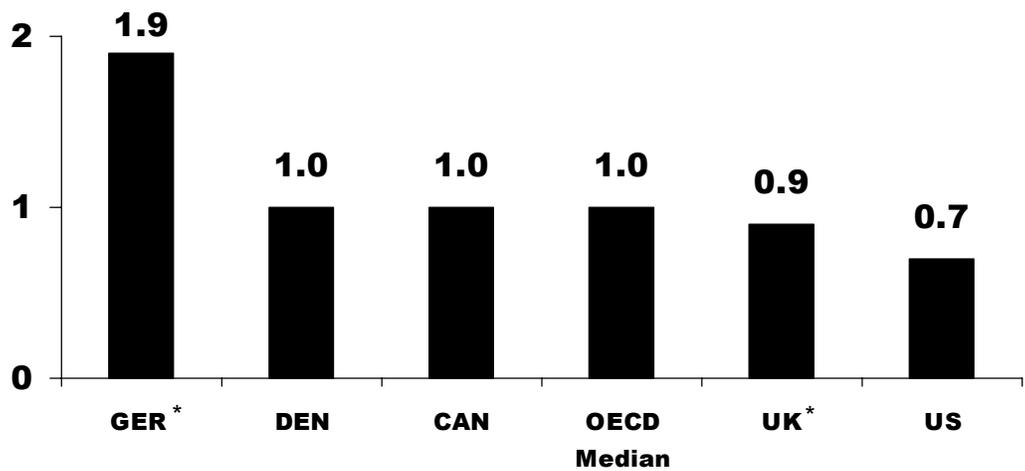


<sup>a</sup> 1996, <sup>b</sup> 2000, <sup>c</sup> 1999, <sup>d</sup> 1998

Source: Anderson, et al., Multinational Comparisons of Health Systems Data, 2002. The Commonwealth Fund, October 2002.



### Per Capita Acute Care Hospital Days Selected Countries, 2000

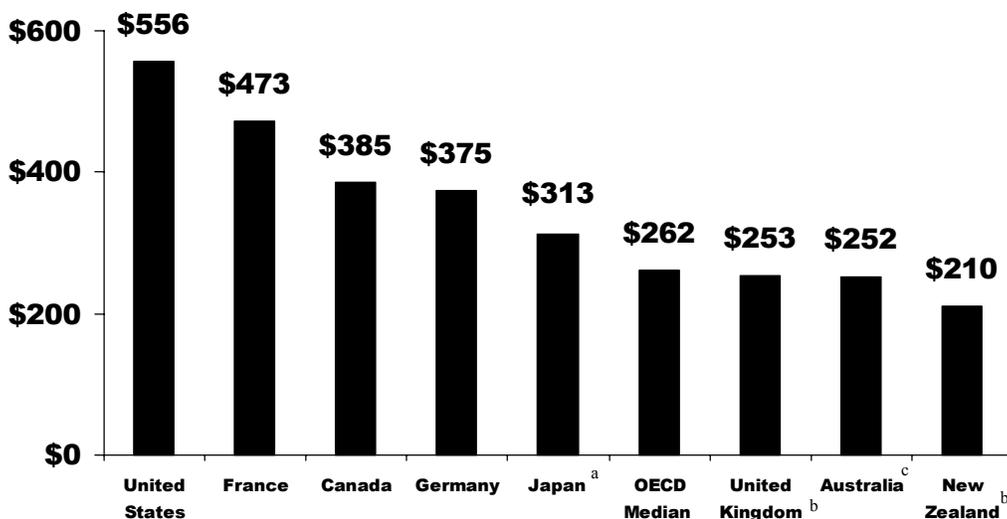


<sup>\*</sup>1999

Source: Anderson, et al. "It's the Prices, Stupid: Why The United States is So Different from Other Countries." *Health Affairs* (May/June 2003): 89-105



### Per Capita Spending on Pharmaceuticals, 2000

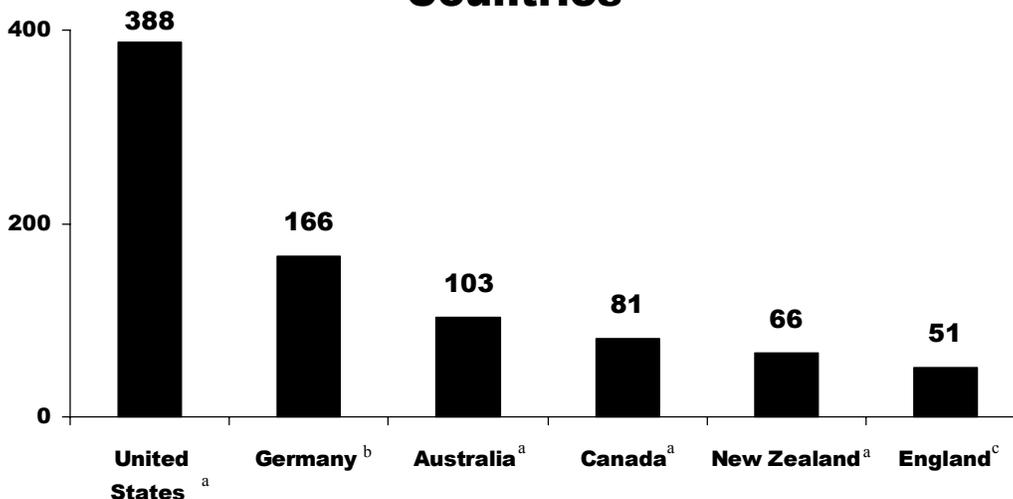


<sup>a</sup> 1999, <sup>b</sup> 1997, <sup>c</sup> 1998

Source: Anderson, et al., Multinational Comparisons of Health Systems Data, 2002. The Commonwealth Fund, October 2002.



### Coronary Angioplasty Procedures per 100,000 Population in Selected Countries

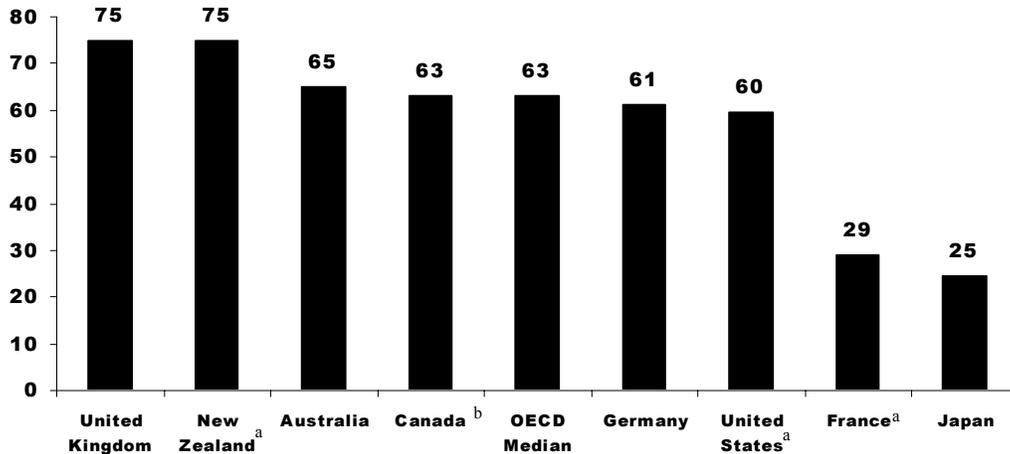


<sup>a</sup> 1999, <sup>b</sup> 1997, <sup>c</sup> 2000

Source: Anderson, et al., Multinational Comparisons of Health Systems Data, 2002. The Commonwealth Fund, October 2002.



### Age-Standardized Mortality Rates for Acute Myocardial Infarction per 100,000 Population in 1999 in Selected Countries



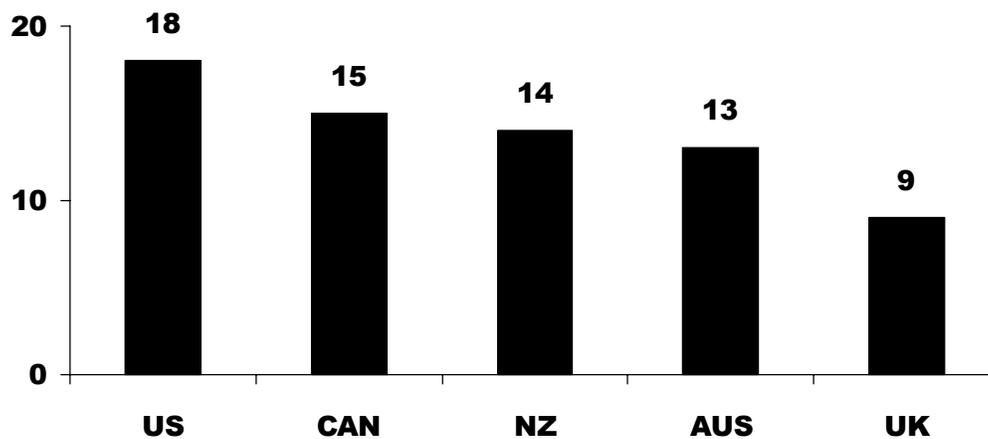
<sup>a</sup> 1998, <sup>b</sup> 1997

Source: Anderson, et al., Multinational Comparisons of Health Systems Data, 2002. The Commonwealth Fund, October 2002.



### Percent of Sicker Adults Reporting Medical Errors Causing Serious Problems, 2002

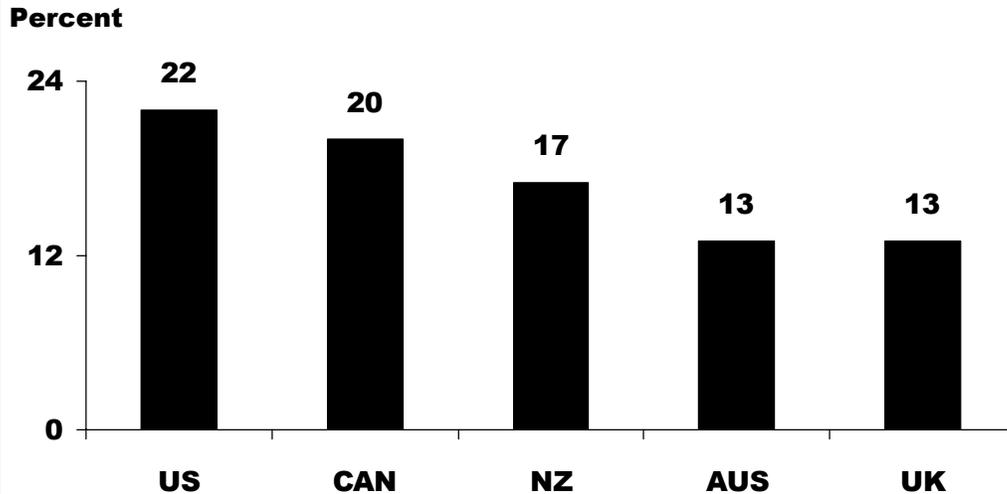
Percent



Source: Commonwealth Fund 2002 International Health Policy Survey of Sick Adults



## Percent of Sicker Adults Reporting Being Sent for Duplicate Tests by Different Health Professionals, 2002



Source: Commonwealth Fund 2002 International Health Policy Survey of Sick Adults



## Acknowledgments

- **Barbara Cooper, Senior Program Officer, co-author**
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