Why Are Our Health Care Costs So High?

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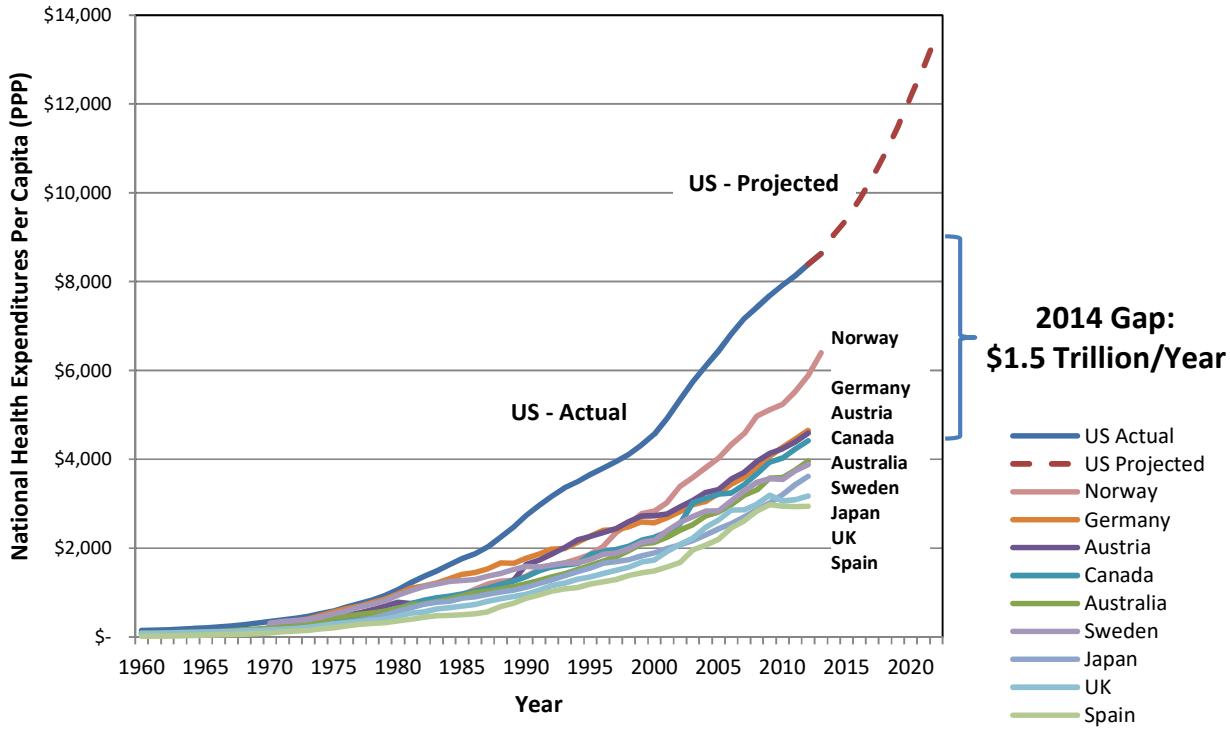
Researchers and policy-makers debate the quality of U.S. health care relative to other countries, but there is no argument about its relative cost: U.S. health care is the most expensive in the world. We spend significantly more of our national income on health care than any other country, and this has been true since the 1970s. [See Figure 1.] Taxpayer-funded government health programs are busting the federal budget, and the retiring baby boom generation will make the problem worse.[1,2]

Figure 1. Annual National Health Expenditures Per Capita (US $PPP)[3]



People have many theories about why U.S. health care costs are so high, including a number of misconceptions – e.g.:

- *We spend more because we're a wealthy country.* While wealthy countries clearly spend more of their GDP on healthcare, our GDP per capita is actually lower than several European countries that spend less on health care than we do (Luxembourg, Ireland, Switzerland & Norway).
- *We over-utilize clinical services*. Table 1 shows how the U.S. compares with other OECD countries in several measures of health care utilization. While we are on the high end, we are the largest utilizers in only one category – angioplasty procedures. [4]

Table 1. Clinical Assets and Utilization, U.S. vs. OECD Countries[5]

	US	OECD Median	OECD Top Quartile	OECD Max	OECD Country with Max Utilization
Practicing MDs per 1,000 population	2.4	3.2	3.7	5.0	Greece
Doctor visits per capita	4.0	6.4	7.6	13.7	Japan
Practicing RNs per 1,000 population	10.4	8.8	11.9	31.0	Norway
Acute care beds per 1,000 population	2.7	3.4	4.8	8.2	Japan
Psych beds per 1,000 population	0.3	0.6	0.9	2.8	Japan
Hospital discharges per 1,000 population	119	161	190	279	France
Acute care ALOS (days)	5.6	6.7	7.4	19.8	Japan
MRI units per 1,000 population	26.6	7.1	13.5	40.1	Japan
CT Scanners per 1,000 population	33.1	14.3	27.9	101.6	Japan
Cardiac bypass procedures per 100,000 population	137	62	82	142	Belgium
Angioplasty procedures per 100,000 population	453	184	235	453	United States
C-Sections per 1,000 live births	233	309	250	281	Ireland
Generic Dispensing Ratio [reversed sign]	76%	35%	25%	9%	Luxembourg

Legend	
	Below Median
	Third Quartile
	Highest Quartile

- *We over-invest in medical technology*. We have a healthy appetite for new medical technology, but we're not a major outlier. For example, we have more MRIs and CT scanners per capita than the OECD median, but Japan has 50% more MRIs and 3 times as many CT Scanners per capita as we do. If our utilization of MRI and CT scans were reduced to the OECD median (despite our higher-than-median GDP per capita), we would cut health care costs by less than 1%.[6]
- *We spend too much on end-of-life care.* Comparative statistics on end-of-life care are hard to find, but the evidence that exists suggests that most developed countries spend considerable resources on end-of-life care. *The Economist* ranked the U.S. in the upper third of advanced economies on "Quality of Death," a measure of access to lower-cost end-of-life care such as hospice and palliative care.[7]
- *The fragmentation of our health care sector limits economies of scale and raises cost.* While our system is more fragmented than single-payer systems, it is comprised of very large companies like CVS Health, UnitedHealthcare, Anthem, Kaiser Permanente, HCA, and Providence St. Joseph Health, which can potentially achieve substantial economies of scale internally. With over $190B in revenue in 2018, CVS Health is actually larger than Britain's National Health Service (~$160B in expenditures in 2017/18). Our complex contracting environment does raise costs [see below], but not enough to explain our high cost position.
- *Many health care markets are too concentrated to be competitive*. This is the flip side of the fragmentation argument. While high provider concentration in a metropolitan area does raise costs,[8] this effect can't explain much of our total cost problem. As the Justice Department and FTC said in their 1996 Statement of Antitrust Enforcement in Health Care, "Most hospital mergers and acquisitions do not present competitive concerns."[9] And, a recent analysis by

MedPAC found that hospital concentration had a weak positive, but statistically insignificant correlation with costs per discharge in 2017. [10]

Root Causes of Our Cost Problem

As Uwe Reinhardt and colleagues pointed out in a 2003 paper entitled, "It's the Prices, Stupid," and his colleagues reaffirmed earlier this year, the proximate cause of high U.S. health care costs is high factor prices.[11] Salaries for doctors and nurses are high; drug and device costs are high; supply costs are high; technology costs are high; etc. Why are factor prices in the U.S. so high? There are several root causes:

- *Government subsidies for private health insurance.* The U.S. has subsidized healthcare through tax-advantaged employer-sponsored health insurance since World War II.[12,13] These subsidies averaged almost $2,600 per employee per year in 2015.[14] Health insurance is inherently inflationary, and subsidized health insurance is more so. Separating payments from benefits inevitably creates moral hazard – an incentive to overutilize services once you have bought insurance. Insurers try to control this through deductibles, co-pays, and direct controls (e.g., pre-authorizations), but none of these mechanisms is perfect. High-deductible health plans are less susceptible to moral hazard than "first-dollar" plans, but they also increase financial risk for low-income members.
- *Overlapping and expensive government programs*, including Medicare, Medicaid, CHIP, the VHA and BIA systems, national, state, and local "safety net" programs, and other programs totaling $1.6 trillion in 2017, not including federally sponsored medical research. To put this in context, $1.6T in government expenditures is almost as much as the *combined* national health expenditures for Japan, Germany, France, and England.[15] And, this understates the true cost, because of the large and growing cross-subsidization of Medicare and Medicaid by private payers. Government health programs are harder to control than private insurance because of the lack of competitive benchmarks and political pressures to expand benefits. The cost of government health care in the U.S. has also been inflated by arcane reimbursement schemes, [16,17] direct subsidies,[18]and improper payments (fraud), which the GAO estimated to be over $75 billion in 2017.[19]
- *Administrative inefficiencies*, driven by:
  - The long-term process of replacing out-of-pocket payments with private health insurance. Since 1960, the combination of private health insurance and government programs has reduced out-of-pocket spending from 56% to less than 20% of national health care expenditures.[20] This transition has required multiple insurers to contract with multiple providers, an expensive "many-to-many" process made more costly by consolidation and restructuring on both sides.
  - Heavy-handed legal and regulatory schemes such as self-referral laws, fraud and abuse laws, certificate of need laws, overly protective professional standards and scope-of-practice laws,[21] HIPAA regulations, health and safety regulations, etc., often from multiple jurisdictions, and all subject to frequent changes.[22]
  - Medico-legal costs, driven by our tort law system.[23, 24] The overall impact of practicing "defensive medicine" on cost is undoubtedly much greater than the more easily quantified damages paid by defendants in civil suits.

  - The replacement of paper medical records with electronic health records, an expensive but necessary step to improve quality and consistency of care.[25]
- *Unhealthy lifestyles.* While unhealthy behaviors are not unique to the U.S., we are the most obese developed country, and obesity is one of the most expensive human conditions.[26,27]

These factors alone don't fully explain why U.S. health care costs are higher than in other developed countries. The other important factor is *sector-wide price controls* in these countries. Because they committed early on to providing universal health care to all their citizens, they have had to impose price controls to keep their budgets balanced. Some countries control prices directly by owning hospitals and employing providers (e.g., the United Kingdom's National Health Service) or setting prices for private providers (Canada). Other countries use complex funding schemes to regulate private insurers and providers (Canada, Germany, France, Switzerland). In all cases, the commitment to universal coverage combined with limited government resources has kept an artificial lid on salaries, wages, and prices of drugs, supplies, equipment, etc. for decades. National price controls have also forced global suppliers (e.g., pharmaceutical manufacturers and device manufacturers) to sell their products in these countries at a discount, relying on private purchasers in the U.S. to cover a disproportionate share of their costs.

Norway shows what can happen to government-funded health care expenditures as government resources wax and wane. Norway's health system is 90% government-funded and is heavily dependent on tax revenues from North Sea oil reserves. Through 2013, while oil prices were rising, Norway ranked fourth behind the U.S., Switzerland, and Luxembourg in health care spending per capita and was catching up with us (as was Switzerland). Since 2014, however, as oil prices have flattened, Norway's health expenditures per capita relative to ours have dropped back. In other words, health care spending in Norway is dependent on government budgets. Switzerland's per capita national health expenditures, which are much less dependent on oil prices, have continued to increase and are now nearly 80% as high as ours.[28]

Implications

The debate over "Medicare for all" in the current presidential race has put the issue of government-guaranteed universal coverage back on the table.[29] If affordability is our principal concern, moving to some type of government-controlled, taxpayer-supported health care funding may be the best way to keep a lid on costs. On the other hand, should affordability be our main concern? What about quality of care? Access to advanced diagnostics and therapies? Longevity? Government price controls, however imposed, will inevitably reduce investment in hospitals, doctors, and health care technologies of all types. Some of this investment is clearly wasteful, and there are certainly gaps in our current health care sector that need to be filled (e.g., primary care, behavioral care, maternal care).

But the health sector has never been more vibrant than it is today, with innovations in pharmaceuticals, medical devices, digital tools, and new services improving peoples' lives on a daily basis. Would a nationalized health sector constrained by federal budgets and directed by CMS bureaucrats and consultants keep this innovation going? Would it do a better job of delivering the health care most Americans want? Or are we better off with competing insurers and providers keeping each other on their toes? Most critiques of Medicare for All focus on the cost of the transition and the additional taxes that would have to be raised to avoid crippling budget deficits, and these are valid concerns. But the long-term question is whether nationalizing one-fifth of the U.S. economy will be good for the country.

Given the experience with government health programs so far (including a short-lived unsuccessful experiment in Bernie Sanders' Vermont), it sounds like a bad bet.

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