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An Analysis on U.S. Health Care Spending

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Executive Summary

The United States is the biggest spender in the world when it comes to health care. That segment of the market accounted for 16.2 percent of the gross domestic product in 2007, a sharp increase from 5.2 percent 40 years ago. The Consumer Price Index reveals the same trend growing from 22.3 in 1960 to 351.1 in 2007. This paper attempts to scratch the surface to discover some of the primary drivers for the uncontrolled spiral spending in the healthcare sector. The author finds that the primary factors revolves around the internal mechanism that drives demand and supply. A price-insensitive demand, as a result of low out-of-pocket expenses, and on the other hand, a responsive provider, offering an abundance in new technology, new drugs, innovative outpatient practices, have all contributed to a very expensive health care system. In addition, highly-priced physician care, which is partly attributed to malpractice litigation, and a high cost in administration fees via the multi-layered, multi-payer, multi-state system have in their turn furthered the already exorbitant health care cost. Help is on the way – not so fast, not quite sure? The Affordable Health Care for America Act and the Patient Protection and Affordable Care Act possess very noble goals, which include expanding coverage to more Americans and help address some of the inequalities plaguing the most vulnerable of society, for example children with pre-existing conditions. However, this law fails to address the issue of spending. It does not specifically address the internal logic that governs high utilization of medical care – it does not address the insensitive-to-price demand and uncontrollable, and maybe questionable, supplier provisions in new technology, new drugs and new outpatient practices.

HEALTH CARE SPENDING

Introduction

As the National Center for Health Statistics (NCHS), a division of the Centers for Disease Control and Prevention (CDC), marks its 50 years (1960-2010) of data collection and analysis, the nation is debating whether it can sustain its spending habits when it comes to health care. The Affordable Health Care for America Act, a house bill that did not pass the Senate, and the Patient Protection and Affordable Care Act, which was signed into law by President Barack Obama in March 2010, are recent attempts by the U.S. Congress primarily to address the issue of expanding coverage and also to reduce the federal deficit over the next decade.

Spending as a Share of GDP

Over the past 40 years, spending on healthcare has increased from a modest 5.2 percent up to16.2 percent in 2007 and is projected to continue on this path unless holistic measures are pursued (see Table 1). The same picture is portrayed when analyzing data of national expenditure per capita. The amount spent has increased from $148 per capita in 1960 to $7,421 in 2007 (see Fig. 2). However, such measures should be analyzed with caution because they are not adjusted for inflation. A better indicator to assess whether the United States is really overspending in terms of healthcare would be to look at the data of other countries with health systems of repute, like France or Canada. An analysis of the data of the countries participating in the Organization for Economic Co-operation and Development (OECD) Health Data shows the U.S. is spending much more than its counterparts relative to GDP (see Fig. 3). The U.S. comes first with 15.3 percent of GDP as its share for health expenditure with Switzerland coming at a distant second with 11.3 percent share of its GDP in 2006.

	1960	1970	1980	1990	2000	2005	2006	2007
GDP/ Billions	$526	$1,039	$2,790	$5,803	$9,817	$12,422	$13,178	$13,808
National Health Expenditure/ Billions	$27.5	$74.9	$253.4	$714.1	$1,353.2	$1,980.6	$2,112.7	$2,241.2
National Health Expenditure/ Capita	$148	$356	$1,100	$2,814	$4,789	$6,687	$7,062	$7,421
Percentage of GDP	5.2	7.2	9.1	12.3	13.8	15.9	16.0	16.2

Table 1. Growth in National Health Expenditure as a Percentage of GDP
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.

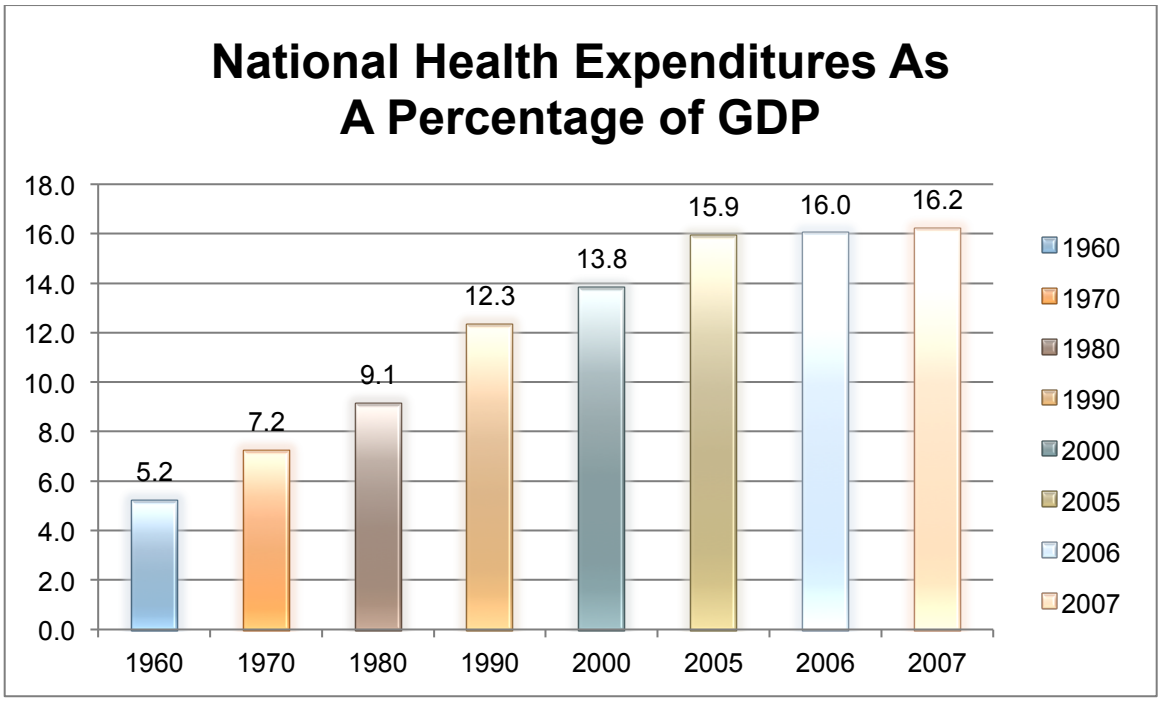

Fig. 1: Growth in National Health Expenditure as a Percentage of GDP

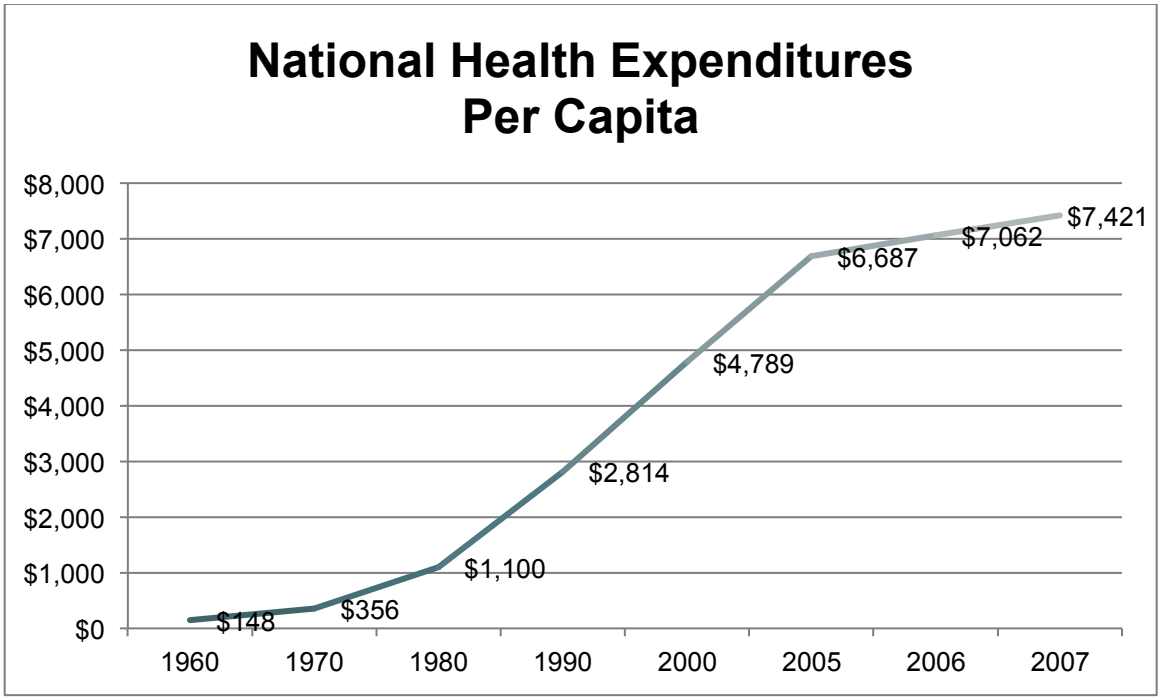

Fig. 2: Growth in National Health Expenditure per Capita

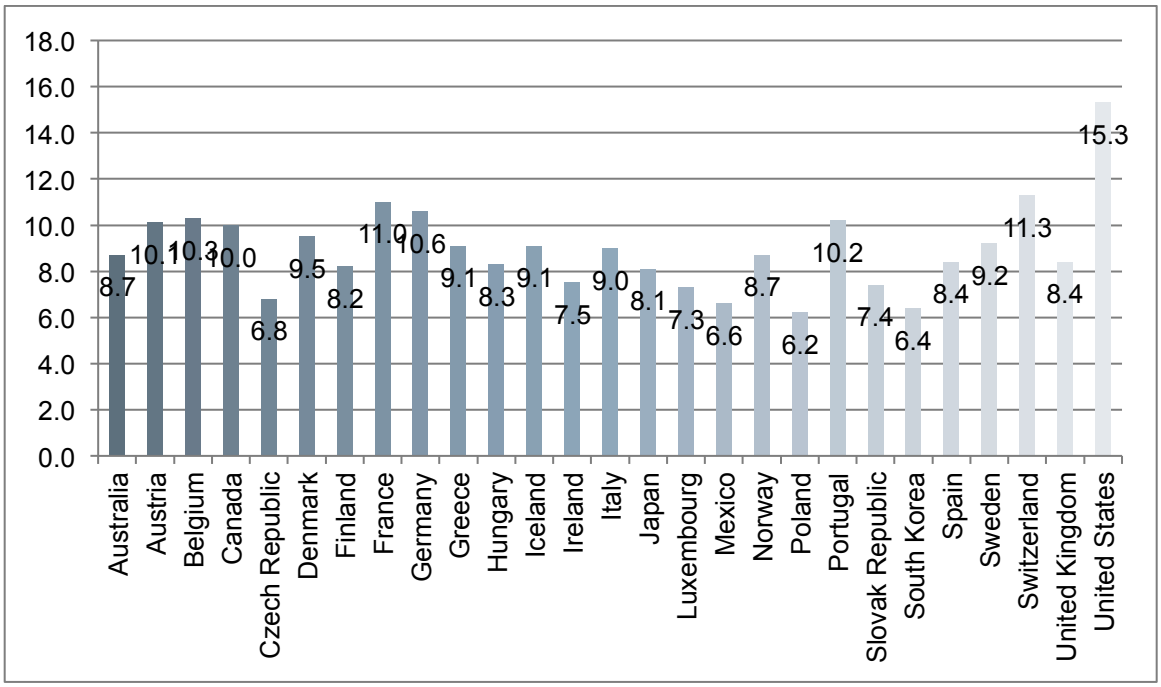

Fig. 3: National Health Expenditure as a Percentage of GDP for OECD Countries

SOURCE: The Organisation for Economic Co-operation and Development Health Data File 2008, incorporating revisions to the annual update. Available from: http://www.ecosante.org/oecd.htm.

Health Care Consumer Price Index

The Consumer Price Index (CPI) is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services.[1] Table 2 shows the unsurprising trend of dramatic increase in Medical Care CPI from a modest 22.3 in 1960 to 351.1 in 2007. Duly note that the CPI for food items has increased to a much lesser extent from 30.0 to 202.9 during the same time period. The Medical Care CPI is divided into two main sectors: (1) Medical Care Services, MCS, and (2) Medical Care Commodities, MCC. MCS is then subdivided into three further components: (a) Professional Services, (b) Hospital and Related Services and (c) Health Insurance. The second sector, MCC, is divided into two further components, which consists of: (a) Prescription Drugs and (b) Non-Prescription Drugs and Medical Supplies. Duly note the two biggest jumps are Physicians' and Dental Services under (a) Professional Services bouncing from a 21.9 and 27.0 to a 303.2 and 358.4 respectively during the 1960-2007 period. The second component under Medical Care Services, Hospital & Related Services also made a huge jump from 69.2 to 498.9 during the 1980-2007 period.

The second category of health care spending, MCC, followed suit with a raised CPI of 290.0 in 2007 compared to a 46.9. The more noticeable change was under Prescription Drugs which jumped from 54.0 to 369.2 during the 1960-2007 period with Non-Prescription moving only from 120.36 to 156.8 during the measured 1990-2007 period.

(United States Department of Labor)[1]

	1960	1970	1980	1990	2000	2005	2006	2007
All items	29.6	38.8	82.4	130.7	152.4	172.2	195.3	207.3
Food	30.0	39.2	86.8	132.4	148.4	167.8	190.7	202.9
Medical Care	22.3	34.0	74.9	162.8	220.5	260.8	323.2	351.1
(1) Medical Care Services	**19.5**	**32.3**	**74.8**	**162.7**	**224.2**	**266.0**	**336.7**	**369.3**
a. Professional services	**---**	**37.0**	**77.9**	**156.1**	**201.0**	**237.7**	**281.7**	**300.8**
Physicians' services	21.9	34.5	76.5	160.8	208.8	244.7	287.5	303.2
Dental services	27.0	39.2	78.9	155.8	206.8	258.5	324.0	358.4
Eyeglasses and Eye care	---	---	---	117.3	137.0	149.7	163.2	171.6
Services by other medical prof.	---	---	---	120.2	143.9	161.9	186.8	197.4
b. Hospital & Related Services	**---**	**---**	**69.2**	**178.0**	**257.8**	**317.3**	**439.9**	**498.9**
Hospital services	---	---	---	---	---	115.9	161.6	183.6
Inpatient	---	---	---	---	---	113.8	156.6	178.1
Outpatient	---	---	--	138.7	204.6	263.8	373.0	424.2
Hospital rooms	9.3	23.6	68.0	175.4	251.2	---	---	---
Other inpatient services	---	---	---	142.7	206.8	---	---	---
Nursing Homes & Adult Day Care	---	---	---	---	---	117.0	145.0	159.6
c. Health Insurance	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**113.5**
(2) Medical Care Commodities	**46.9**	**46.5**	**75.4**	**163.4**	**204.5**	**238.1**	**276.0**	**290.0**
a. Prescription Drugs	**54.0**	**47.4**	**72.5**	**181.7**	**235.0**	**285.4**	**349.0**	**369.2**
b. Nonprescription Drugs & Medical Supplies	**---**	**---**	**---**	**120.6**	**140.5**	**149.5**	**151.7**	**156.8**
Internal & Respiratory over-the-counter drugs	---	42.3	74.9	145.9	167.0	176.9	179.7	186.4
Nonprescription Medical Equipment and supplies	---	---	79.2	138.0	166.3	178.1	180.6	185.1

Table 2. Consumer Price Index by Medical Care Components 1960 -2008

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index. Various releases. 2008 data available from: http://www.bls.gov/cpi/cpid08av.pdf.

Discussion

The limited scope of this paper cannot fully delve into the mechanisms of why the U.S. spends so much on healthcare, an amount largely disproportionate from its peers. According to the 2008 McKinsey Global Institute report, the U.S. spends $650 billion more on healthcare than peer OECD countries, even after adjusting for wealth.[2] The reasons why the U.S. spends so much are multi-layered and involves both the supplier and consumer side. Firstly, one should examine provider capacity growth to respond to the surge in outpatient care. Outpatient care accounts for more than two thirds of the $650 billion.[3] While it can mistakenly seem that outpatient should reduce costs, in fact, it's doing quite opposite. The United States delivers more outpatient care and is therefore investing more in that type technology and facilities. For example, nearly 90 percent hernia surgeries was outpatient versus 40 percent in the United Kingdom in 2003.[4] The greater convenience for patients and increased availability of services and the innovation in noninvasive laparoscopic cholecystectomy surgery that are offered in outpatient settings have most probably resulted in increased utilization of such medical services. Therefore, even though lesser in price compared to inpatient care, the increased incidence of outpatient care has had a disproportionate effect that ended rising the overall health care cost.

In concert with the outpatient setting paradigm, the McKinsey report also talks about patient price insensitivity. With declining direct out-of-pocket expenditures from a 47 percent in 1960 to 12 percent in 2006, the insured consumer is relatively insensitive to price hikes. As such, unlike other markets, the insured consumer does not shop wisely. Price-value decisions are not necessarily fully explored, and many times, health care decisions and treatment is primarily

[2] The 13 OECD countries are Austria, Canada, Czech Republic, Denmark, Finland, France, Germany, Iceland, Poland, Portugal, South Korea, Spain and Switzerland.

[3] (McKinsey & Company, 2008)

[4] (Russo)

made by the provider – who has, of course/ an inherent incentive to provide more care. To further complicate the dynamic, even the cost-conscious insured consumer has to face the challenge of accessing healthcare information, something which is mainly under the realm of the provider. Therefore, this lack of understanding and even lack of information increasingly pushes the consumer to rely on the provider to help in regards to making choices for the type of treatment, the necessity of the treatment, the recurrence of the treatment and the types of drugs.

The ripple effect goes on, further extrapolates the McKinsey report, the judgment-based nature of the physician because the patient rely so much on his verdict almost always places the final say on the provider – he or she has more cards to play with than the patient. Furthermore, the incidence of tests and procedures and new drugs and clinical trials is much more prevalent in the U.S. Were those tests always warranted? From the National Center for Health Statistics data, the number of MRI/CT/PET scans at the Physician office or hospital outpatient department visits more than quadrupled from 3.9 per 100 patient visits in 1996 to 12.6 in 2007, a little more than decade later.[5] It has been argued that the underlying reason for this surge in testing and procedures is because physicians have started practicing defensive medicine, out of fear for malpractice litigation, which itself has in turn raised physician costs because of litigation insurance. Consequently, we can see how every part of the puzzle is interrelated and how each actor drives the cost of the other further and further without any price controls. Finally, the report talks about the U.S. multi-payer system with Medicare, Medicaid and multiple insurance providers and multistate rules and regulations – redundancies and inefficiencies are bound to take place in comparison to the other more unified systems as in the OECD countries.

[5] (U.S. Department of Health and Human Services)

Conclusion

The Affordable Health Care for America bill and its successor, the enacted Patient Protection and Affordable Care Act, both have very noble intentions. Expanding coverage to Americans, preventing discrimination against children with pre-existing conditions, banning insurance companies from dropping coverage or limiting coverage or for limiting choice of personal physicians and a plethora of other ambitious goals are indeed signs of positive change for the health care consumer. The Congressional Budget Office claims the bill will reduce deficit by $143 billion over the first decade and by $1.2 trillion over the second decade. Cost cutting measures proposed are by the act includes: reducing premiums, bringing costs down for Small businesses, helping pay for early retirees, reducing the "Hidden Tax" on insured Americans, preventing bankruptcy, preventing illness and reducing out of pocket costs all sound amazing.[6] But none of those measures directly address on how they are going to cut spending. It seems to me that the bill is not going to attack the problem at hand but deal with other related issues while leaving the core issue to itself: spending. I am a firm believer in that access to quality affordable health care is an inalienable human right, but this bill is not going to reform health care for the better. The issues discussed – the internal mechanism with high capacity and incidence in outpatient care, price-insensitive demand, consumer obligated reliance on provider for health information, malpractice litigation, the spiral of medical technology and its possible unwarranted use and the inefficiencies that may result and the rush to the market of new drugs all remain mostly untouched by the massive health reform. While these are the factors, which are keeping costs so high and are currently not being addressed, chances that the new reform health care law will bring the United States at a more harmonious level with controlled spending that would eventually ripple benefits throughout the nation seem quite grim.

[6] (Congressional Budget Office)

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