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ESSAYS ON TRENDS, INNOVATIVE IDEAS AND CUTTING-EDGE RESEARCH IN HEALTH CARE

Why America Spends More on Health Care

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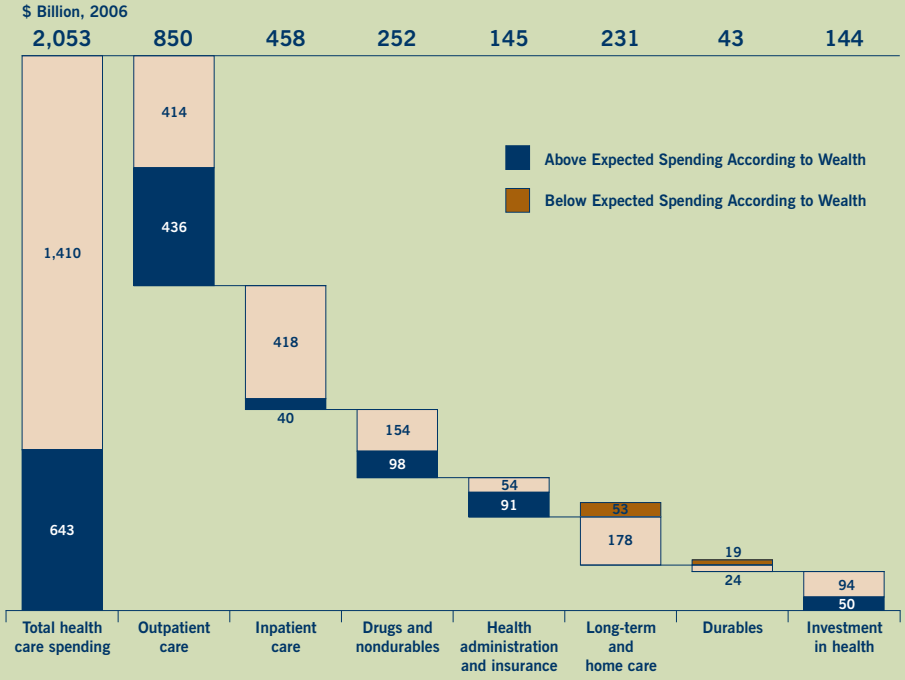
Tackling escalating costs is a critical component of the discussion around health care reform in the United States. According to recent research by the McKinsey Global Institute (MGI) that compares the American health care system with those of other countries in the Organisation for Economic Co-operation and Development (OECD), the U.S. spends nearly $650 billion more on health care than one would expect based on its wealth.[1] This higher spending accounts for more than 30 percent of the total $2.1 trillion spent annually in the U.S. for health care.

Strikingly, our work indicates that these added costs are not attributable to greater prevalence of high-cost diseases in the U.S. relative to other developed countries. Rather, they appear to result from a mix of systemic factors inherent to the way health care is organized and delivered in the U.S. In this essay we examine the components of above expected spending and the factors that may be responsible for the high costs.

Figure 1. Actual vs. Expected Health Spending in the U.S.



Source: OECD: McKinsey Global Institute analysis

Outpatient Costs Account for Two-Thirds of the Added Spending

Outpatient spending in 2006 was $436 billion above the level predicted given U.S. wealth – accounting for fully two-thirds of the net additional spending across all sectors of the health care system. These additional costs represent more than half of the $850 billion spent in this large and fast-growing sector (Figure 1). Thus, the first focus of reformers seeking to control costs has to be outpatient care.

The two largest categories of outpatient spending are same-day hospital care and visits to physicians' offices, which saw cost increases of 9.3 percent and 7.9 percent per year, respectively, between 2003 and 2006. The reason for this cost growth is not the volume of visits, which has been increasing only modestly, but the rise in costs per visit. Per visit costs have been surging due to more care being delivered in each visit, a shift toward more complex and expensive procedures including CT and MRI scans, and absolute price increases for equivalent procedures. A marked shift in visits from general practitioners to specialists is also likely playing a role in boosting costs.

Several forces explain this rising intensity of outpatient care. First, the highly profitable nature of outpatient care prompts growing investment in the resources needed to support outpatient care, fueling additional use and spending. In fact, U.S. hospitals earn a significant percentage of their profits from elective same-day care.

Second, most U.S. physicians are paid on a fee-for-service basis and have the incentive and freedom to offer more care. The result is higher physician compensation in the U.S., which translates into $64 billion in additional costs to the system. While specialists in other OECD countries earn an average of 3.9 times the per capita GDP in their country, this ratio is 6.5 for U.S. specialists. U.S. generalists earn over 4 times per capita GDP compared to less than 3 times GDP for their OECD peers.

The U.S. also has experienced a much more pronounced shift than other countries from the inpatient to the outpatient setting. Sixty-five percent of care delivery costs in the U.S. are now outpatient related, compared to

an OECD average of 52 percent. In theory, the strong outpatient orientation of the U.S. system should save money since fixed costs in outpatient settings tend to be lower than for inpatient stays. We estimate, however, that these inpatient savings offset only about one quarter of the additional costs found in the outpatient sector.

Inpatient Use Is Lower but Costs Are Higher

Spending for inpatient services was $40 billion higher than expected after adjusting for wealth, representing 6 percent of net additional spending and roughly 9 percent of all inpatient expenditures. The greater reliance on outpatient care helps to constrain inpatient spending by lowering admission rates and shortening stays. As a result, the U.S. produces just over half as many inpatient days as other countries. However, the cost per bed day in the U.S. is well over double the OECD average, driving inpatient spending above expected levels. Higher per capita rates of surgical procedures, more expensive labor and non-labor inputs, and higher fixed costs per bed due to the smaller scale and lower use rates of most American hospitals all contribute to the higher costs. Particularly noteworthy are the high rates of cardiac and orthopedic surgeries and the cost of the implantable devices used in these procedures.

Drugs Are More Expensive but We Consume Fewer

Above expected spending on pharmaceuticals accounts for $98 billion, or 15 percent, of the net additional spending adjusted for wealth estimated in our analysis. This is not because Americans buy more pharmaceuticals (in fact, they use fewer) but because drug prices are 50 percent higher in the U.S. for equivalent products and the U.S. uses a more expensive mix of drugs. When accounting for differences in mix, we find that the "average" pill in the United States is 118 percent more costly than in OECD peer countries—despite the fact that generic usage rates are higher in the U.S.

Observers have offered a variety of reasons why drug prices are higher in the U.S., including arguments that Americans are simply paying their "fair share" given their wealth, that Americans are subsidizing pharmaceutical research and development for the rest of the world, and that sales and marketing expenditures are higher in the U.S. Our analyses found, however, that none of these explanations alone can fully account for the higher U.S. drug expenditures, although collectively they could account for the difference.

Health Care Financing Structure also Plays a Role

The cost of running government health programs and private payers' administrative expenses contributed $91 billion to above expected spending (14 percent of all such spending across the system). Of this amount, $63 billion (10 percent of the system total) is attributable to private payers and included expenses related to sales and marketing, medical management, health information technology systems, customer service, claims processing, company profits, and taxes paid to the government. These types of expenses are much lower in countries with less reliance on private payers, however the U.S. actually spends $19 billion *less* on administration than would be predicted given its payer mix.

Public administration expenses for Medicare, Medicaid and other government programs account for the remaining $28 billion in higher than expected U.S. spending on administration (4 percent of total spending above what we would predict for U.S. wealth). These public-sector administrative expenses are roughly six times the OECD average per covered life and have been growing rapidly in recent years.

Other Sectors

Three final sectors round out the accounting of health spending. Investments in health contributed $50 billion to spending above the level predicted (8 percent of net spending above expected). These figures include spending on public health, research, and capital investments in health facilities. U.S. spending is actually lower than expected for long-term and home care and for durable medical equipment.

Designing a Framework for Reform

The U.S. can choose to spend more on its health system than its peers, but it is by no means clear that its citizens are getting $650 billion worth of extra value. Parts of the U.S. health care system, such as its best hospitals, are clearly world-class; but in other respects, such as life expectancy and infant mortality rates, and the fact that more than 46 million people in the U.S. are uninsured, the system is not delivering.

Because higher than expected U.S. costs are systemic, corrective responses must address the underlying dynamics of escalating costs across the system, seeking to influence the organization and functioning of the delivery system, the way the system is financed or intermediated, and the demand for health care.[2]

Steps to improve the delivery system need to break the cycle of over-payment for new technologies, which leads to high profits and provides incentives for overinvestment in additional capacity and innovation at the expensive end of the spectrum. Payment system reforms also must move away from the skewed incentives of fee-for-service mechanisms toward systems that reward value. Reforms to Medicare reimbursement methods will be key, given the wide reach of the program and the tendency for other payers to adopt Medicare methodologies.

On the demand side, efforts to improve population health have a key role to play in controlling future cost growth. Although disease prevalence is currently no higher in the U.S. than in peer OECD countries, the health of the U.S. population is declining, contributing to an estimated $20 to $40 billion in added costs between 2003 and 2005. Rising obesity rates are a prime culprit and portend explosive growth in chronic health problems and related spending. Analyses suggest, for example, that lowering the rate of obesity to its 1980 level could reduce spending by $60 billion annually.[3] Equally important will be imparting a heightened sense of value consciousness to U.S. consumers and providing them with the incentives and information to make efficient choices about their health care consumption.

The rising costs of U.S. health care are straining the system itself, the larger U.S. economy and even the international competitiveness of the private sector. It is only by understanding why costs are escalating that the Administration and Congress can begin to address not only the paramount questions of access and quality but also the issue of why the system costs American citizens so much. ■

1. "Accounting for the Cost of Health Care: A New Look at Why Americans Spend More," McKinsey Global Institute, December 2008. http://www.mckinsey.com/mgi/publications/US_healthcare/index.asp
2. "A Framework to Guide Health Care System Reform," McKinsey Global Institute, January 2007. www.mckinsey.com/mgi
3. Mango PD and Riefberg VE. "Three Imperatives for Improving U.S. Health Care," *McKinsey Quarterly*, December 2008.

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