

Understanding the debate about reducing health care costs: Part II
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In this three-part series we are examining the question, Why are US health care costs so high relative to the rest of the industrialized world and what should be done about it?

We began Part I by dividing the possible diagnoses into two categories: Those that blame *quantity* of medical services used, and those that blame the *price* at which those services are sold. We reached the conclusion that the excess-quantity diagnosis has a kernel of truth to it but is grossly inaccurate. We found that overuse of medical services has been documented for only a tiny sliver of the thousands of medical goods and services sold in modern countries, and that overuse is dwarfed by underuse. We explored several reasons why underuse might be so common, including the high cost of medical care, a widespread tendency to avoid medical care even when cost is not an issue, and limited hours in the physician's day.

In this article, we will examine the quantity and price of health care in the US compared with other countries. We will conclude that high US prices are the main reason US per capita spending is double that of the rest of the industrialized world. We will then explore the main reasons US prices are so high, namely, the absence of competition throughout nearly the entire health care system and high administrative costs.

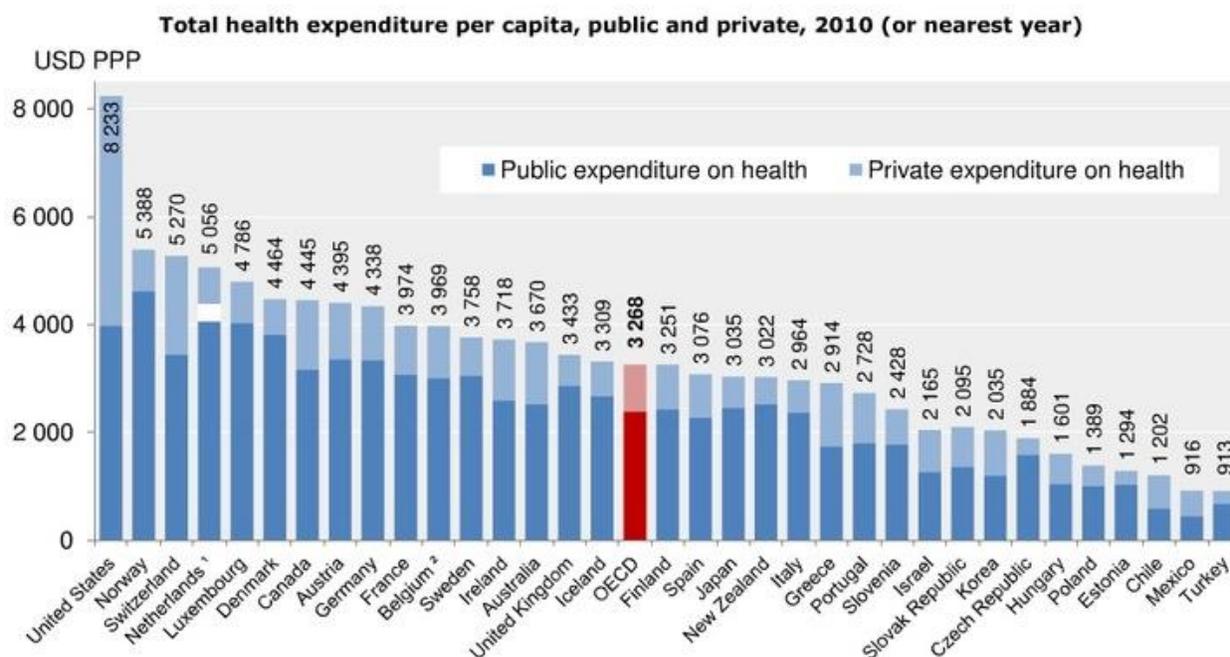
US prices and utilization rates compared with other countries

The US spends far more per person on health care than any other country in the world, and Minnesota is among the most expensive states (we ranked number 13 in 2014). In other words, if the 50 states were countries, Minnesota would be the thirteenth most expensive country on the planet.

Figure 1 shows health care spending per person in the 34 countries that are members of the Organization for Economic Cooperation and Development (OECD), a coalition of nations that formed after World War II to share economic data. All but three of these countries (Chile, Mexico, and Turkey) have been industrialized for a long time. We see that US per capita spending was \$8,233 in 2010 while the next most expensive country, Norway, spent only \$5,388 per person, or just 65 percent of the US level. This ratio of US to other-country spending has remained roughly the same for at least three decades. In 1984, US per capita spending was \$1,637 and the OECD average was \$871. [1]

Figure 1:

US spends two-and-a-half times the OECD average



1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.

2. Total expenditure excluding investments.

Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Data 2012.

Table 1: US and MN per capita health spending, selected years 1991-2014

Year	US(\$s)	MN(\$s)	MN-US(\$s)	% difference
1991	2,672	2,698	-26	-1.0%
1995	3,266	3,355	89	2.7
2000	4,118	4,524	406	9.9
2005	5,740	6,332	592	10.3
2010	7,094	7,782	688	9.7
2014	8,045	8,871	826	10.3

Source: Centers for Medicare & Medicaid Services, *Health Expenditures by State of Residence, 1991-2014 Summary Tables*, June 2017 <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html>

Table 1 presents data on US and Minnesota per capita spending prepared by the Office of the Actuary of the Centers for Medicare and Medicaid Services (CMS). Table 1 indicates Minnesota per capita spending was about even with the US average during the early 1990s, then shot up to 10 percent above that average by 2000 and has stayed there since.

If you have read Part I of this series, you should be able to predict the answer to this question: Is US spending on health care high because Americans use more medical care than people in other countries, or is it because we are charged more for medical care? According to the research, the answer is the latter – our prices are unusually high. I quote from two of the better known papers on this subject, a 2003 paper in *Health Affairs* by Anderson et al. and a 2014 paper in *Lancet* by Lorenzoni et al.:

The data show that the United States spends more on health care than any other country. However, on most measures of health services use, the United States is below the OECD median. These facts suggest that the difference in spending is caused mostly by higher prices for health care goods and services in the United States
<http://content.healthaffairs.org/content/22/3/89.full> [2]

The higher health spending reported in the USA is not simply a result of the country's greater wealth or of the age structure of its population. Even the larger prevalence of risk factors – including obesity – explains only a small part of the reported differences. OECD Health Care Quality Indicators show that the US healthcare system is doing well in several areas (e.g., cancer care), but less well in others (particularly the primary care sector). Overall, the quality of the care provided does not seem to explain the higher health expenditure in the USA. OECD work on comparative price levels in health suggests that the prices, rather than volumes, of health services contribute the most to explaining the higher US spending, in line with the conclusions of scholarly work.
[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)60571-7/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60571-7/fulltext) (requires registration) [3]

Anderson et al. presented data on hospital, physician, and nurse supply, and utilization of hospital and physician services, for all 28 nations that were part of the OECD in 2000. Table 2 presents the data for just the US and the OECD average for 2000, as well as for 2015. The appendix presents 2015 data for the US and nine other OECD countries. The only indicator in Table 2 that is favorable to the US is “nurses per 1,000.” The other data demonstrate that in both 2000 and 2015 America had fewer doctors and hospital beds per capita and Americans got fewer physician and hospital services than people in other industrialized countries. A comparison of the 2000 and 2015 data indicates the gap between the US and other countries grew between those years for doctor supply, visits to doctors, hospital bed supply, and average length of stay in a hospital. The worst change was in doctor visits: We saw our doctors almost as often as citizens of other countries in 2000, but by 2015 we were seeing our doctors only 60 percent as often. [4]

Research comparing the prices of specific medical goods and services across countries demonstrates jaw-dropping differences between US prices and those of other countries. Table 3 shows that the prices of four procedures in the US greatly exceed their price in six other

Table 2: Supply of nurses, doctors and hospital beds, and use rates of physician and hospital services, US and OECD average, 2000 and 2015 (or nearest years)

	2000		2015 ^[a]	
	<u>US</u>	<u>OECD avg.</u>	<u>US</u>	<u>OECD avg.</u>
Nurses per 1,000 residents	8.3	7.6	11.2	8.9
Doctors per 1,000	2.8	3.1	2.6	3.3
Doctor visits per capita	5.8	5.9	4.0	6.8
Acute care beds per 1,000	3.0	3.8	2.9	4.7
Admissions per 1,000 ^[b]	118	154	126	154
Average length of stay (days)	5.9	6.4	4.8	7.5

[a] The 2015 data included 35 OECD countries while the 2000 data included 28. The additional countries included in the 2015 data tended to be poorer than the US.

[b] The OECD report referred to “discharges,” not “admissions.”

Sources: 2000 data from Gerard Anderson et al., “It’s the prices stupid: Why the United States is so different from other countries,” *Health Affairs*, 2003;22:89-105; 2015 data from *OECD Health Statistics 2016*.

Table 3: Prices of four procedures in seven countries (2015)

	<u>Knee replacement</u>	<u>Angioplasty</u>	<u>Appendectomy</u>	<u>Cataract surgery</u>
S. Africa	\$7,795	\$6,510	\$1,786	\$1,186
Spain	6,687	7,839	2,003	1,719
Australia	15,941	11,164	3,814	3,037
NZ	16,508	13,677	6,199	2,740
UK	18,451	7,264	8,009	3,145
Switz	20,132	10,066	6,040	2,114
US	28,184	31,620	15,930	3,530

Source: International Federation of Health Plans, *2015 Comparative Price Report*

Table 4: Prices for four drugs are much higher in the US

Xarelto Humira Harvoni Avastin^[a]

S. Africa	\$48	\$552	--	\$956
Spain	101	822	18,165	1,534
Switz	102	1,253	16,861	1,752
UK	126	1,362	22,554	1,745
US	292	2,669	32,114	3,950

[a] Xarelto is for blood clots, Humira for arthritis, Harvoni hepatitis C, and Avastin cancer.
Source: International Federation of Health Plans, *2015 Comparative Price Report*.

Table 5: Percent of residents in 11 countries who said they skipped care because of cost (2016); per capita expenditures (2015)

	<u>Medical care</u>	<u>Dental care</u>	<u>Per capita expenditures</u>
Switz	8%	21%	\$6,935
Norway	10	22	6,567
Netherlands	8	11	5,343
Germany	7	14	5,267
Sweden	8	19	5,228
Canada	16	28	4,608
Australia	14	21	4,420
France	17	23	4,407
UK	7	11	4,003
NZ	18	22	3,590
US	33	32	9,451

Source: Robin Osborn et al., "In new survey of eleven countries, US adults still struggle....," *Health Affairs*, 2016.

countries surveyed, and Table 4 shows that the price of four drugs in the US greatly exceeds their price in four other countries. Table 5 offers indirect evidence of two conclusions we have already drawn: Americans do not use more medical care than people in other countries, and prices are very high in the US. The table shows that Americans are far more likely to skip medical care because they can't afford it.

Why are US prices so high?

The most fundamental reason US prices are high is that competition is non-existent or weak throughout the American health care system, and neither Congress nor the Minnesota legislature

has enacted laws to authorize effective regulation. In this section I discuss the conditions necessary for effective competition and compare those to the conditions that prevail in the health insurance and medical sectors.

For competition to be powerful enough to force sellers to produce high-quality goods and services at the lowest price possible, two conditions must be met: Sellers and buyers must be so numerous that no seller or buyer can set, or influence the setting of, prices; and sellers and buyers must have accurate information about the quality of the good or service in question. The health care system meets neither of these criteria.

Few sellers: Our system is highly consolidated

Let's take the first criterion – numerous sellers and buyers. With the exception of some local markets for primary care, the supply side (the seller side) of the entire health care system has long been highly consolidated, and the consolidation is getting rapidly worse. Consolidation is occurring both vertically and horizontally. An example of vertical consolidation is an insurance company buying a hospital or a hospital buying a clinic. An example of horizontal consolidation is an insurance company merging with another insurance company.

A few large sellers control nearly all insurance and hospital markets, and many markets for specialty care (for example, cardiology), drugs, and durable devices. According to a report <http://www.gao.gov/assets/670/667245.pdf> by the Government Accountability Office, “[E]nrollment [in 2013] was concentrated among the three largest insurers in most states. Specifically, in each of the three market segments [individual, small group, and large group], the three largest insurers had at least 80 percent of the total enrollment in at least 37 states.” (p. 4) Here in Minnesota three insurance companies, Blue Cross Blue Shield, Medica and HealthPartners, have controlled 70 percent of the insurance market for the last two decades.

Concentration among hospitals is similar. The number of hospitals in the US dropped from 7,156 in 1975 to 5,564 in 2015. As of 2011, 60 percent of US hospitals were part of chains https://scholar.harvard.edu/files/cutler/files/jsc130008_hospitals_market_share_and_consolidation.pdf According to a 2016 review of the American hospital industry by Becker's Hospital Review, <http://www.beckershospitalreview.com/lists/50-things-to-know-about-the-hospital-industry-2016.html> the largest hospital chain in America today is for-profit Community Health Systems; it owns 129 hospitals. Two or three hospital chains have dominated most local markets in the US for the last quarter-century, and the concentration is getting worse as these chains expand their geographic reach and their ownership of non-hospital providers including clinics, nursing homes, pharmacies, and ambulance services. In rural areas, concentration is typically much worse than in urban areas.

Poorly informed buyers

In addition to numerous buyers and sellers, competition requires informed buyers. A well informed buyer is someone who has accurate information about both price and quality. But in no segment of the health care system are buyers well informed about quality, and accurate price information is available for only a few goods and services.

I will discuss here four barriers to accurate price and quality information:

- (1) Complexity: Medical care is complex (unlike toasters humans are not all built the same);
- (2) Control: Health care professionals cannot influence, much less control, many factors that affect the outcomes of medical treatment (such as income, education, insurance coverage, and stress at home or work);
- (3) Attribution: It is often impossible to determine which patient “belongs” to which doctor; and
- (4) Cost: Collecting the data to measure cost and quality even crudely and crunch all the numbers, taking into account factors beyond doctor and hospital control, is very expensive.

I'll review each of these barriers briefly.

Patient complexity means the medical treatments that account for the vast majority of US spending consist of bundles of goods and services, not just one good or service, and those bundles differ from one patient to the next. Cancer treatment, for example, varies widely depending primarily on the health of the patient. For healthy patients, cancer treatment amounts to periodic screens (colonoscopies, mammograms, etc.) and exploratory tests for a few of those patients. But for patients diagnosed with cancer, treatment can include surgery, chemotherapy, radiation, home health care and hospice services, and even treatment for bone fractures, depression, and other problems caused by radiation and chemotherapy.

How would a clinic or hospital estimate a price or quality for all the goods and services in the bundle called “cancer treatment” for even one patient? How would that be done for the “average” patient? How would we know an “average cancer patient” if we saw one? Would it solve the “bundled product” problem if someone were to break the “cancer treatment” bundle into, say, 1,000 individual goods and services and publish a price and “quality grade” for each one in a large book? Of course not. Even assuming the price and quality of cancer care can be measured accurately one good or service at a time, making sense of so much data is impossible.

We can ask the same questions for acute conditions like pregnancy, concussion, wounds, and infections. How would an accountant for a hospital or a clinic manager, a researcher for *Consumer Reports*, or anyone else determine accurately the price or “quality grade” for treatment of, say, gunshot wounds? How accurately could they estimate a price for all goods and services for individual patients with gunshot wounds even after an initial evaluation?

Turning to barrier number two: The inability of doctors and other health care professionals to control factors that have profound influences on the cost and outcomes of medical treatment. These factors include the patient’s health at the time of presentation to the clinic or hospital, and the patient’s income, education and insurance coverage. Hundreds of studies have demonstrated a correlation between these factors and the outcomes of medical treatment. Despite decades of effort, no method has been devised to adjust cost and quality scores accurately for these factors.

Research on the impact of “pay-for-performance” programs on clinics and hospitals that treat sicker and poorer patients illustrates the distorting role of non-medical factors like income. That research demonstrates that when insurers attempt to reward and punish doctors for performance on “quality measures” such as mortality rate after surgery or percent of diabetics who received an annual eye exam, doctors who treat a disproportionate share of the sick and the poor are punished. The same problem afflicts measurements of cost. When insurers attempt to reward and punish doctors for “efficiency,” they wind up punishing doctors who see sicker patients. The doctors who treat an above-average percent of sick or poor patients look more expensive, but they appear to be expensive only because their patients are more expensive. To take one of many examples, a paper published recently in the *Journal of the American Medical Association* by Lena Chen et al. found that physicians who treated Medicare patients who were sicker and poorer than average scored worse on both quality and cost measures.
<http://jamanetwork.com/journals/jama/article-abstract/2646718>

Next I take up barrier three: The attribution problem. It is often impossible to determine which patient “belongs” to which doctor or health care professional. This is especially true for patients with chronic illnesses and those who have had surgery. Patients undergoing treatment for cancer, diabetes, depression, and hundreds of other diseases, and patients who undergo surgery, see multiple health care professionals in the course of a year or in the course of a single “episode” of the disease. If a patient sees five doctors and three allied health care professionals (for example, a nurse and a physical therapist), by what logic do we decide that only one of those health care professionals was responsible for that patient? If we decide we want to divide responsibility among those eight professionals, by what logic do we do that?

Last but not least, cost constitutes an intractable barrier to well informed buyers in the medical and insurance markets. Reporting even crudely accurate grades on the cost and quality of all or most goods and services provided by all or most doctors, hospitals, nursing homes, home care providers, etc., will be extremely expensive. Consider these numbers:

- There are 8,000 services in *Current Procedural Terminology*, the manual used by American physicians to bill Medicare and all other insurers;
- there were 15,000 diagnoses in the ninth iteration of the *International Classification of Diseases*, a list of codes developed by the World Health Organization, and 68,000 in the tenth iteration that went into effect in the US in 2015; and
- the quality of each of the 8,000 services, and each bundle of services provided to treat each of the 15,000 (or 68,000 diagnoses), could be measured (crudely) multiple ways, for example, the quality of a clinic’s care of its diabetic patients could be measured by whether patients were hospitalized, whether their blood sugar and cholesterol counts are under certain levels, whether they had an annual foot exam, whether they answer a question on a survey that they were “satisfied” with their care, etc.

Although health policy researchers have shown much interest in measuring the cost and quality of medical care, they have shown no interest in measuring the cost and quality of measurement itself. One of the extremely rare reports on how much it costs to measure quality appeared in a 1997 paper on a report card published annually by New York’s Department of Health on surgeons who performed coronary artery bypass graft (CABG) surgery in 31 New York

hospitals. According to the paper, this report card required five people at the Department of Health to maintain the state's database, a sixth person at the Department of Health who functions as a "utilization review agent ... to audit a sample of 50 cases from half the hospitals each year," and a "data coordinator" at each of the 31 hospitals. [5] That's a total of almost 40 people to report on quality for just one procedure in one state.

The cost of estimating the cost and quality of even a *few* treatments provided by even *some* of the 850,000 US physicians and 5,560 US hospitals has never been estimated, but it is unquestionably high. Even if it were possible to overcome the first three barriers to well informed buyers – the complexity of medical care, the difficulty of adjusting grades on cost and quality for factors outside provider control, and the near impossibility of determining which patients "belong" to which doctors and hospitals – it would probably remain impossible to create the political support to raise taxes or premiums high enough to pay for report cards on all (or even many) medical services delivered by all (or even many) providers. And even if it were possible to do so, the cost would swamp any savings achieved by turning patients into shoppers because the system is now so highly consolidated.

Competition is not working

Competition has had almost a century to prove it can work in health insurance, and much longer than that to demonstrate it can work in medicine. It has not worked. In this section we have explained why: Competition works well only when numerous buyers and sellers exist, and when buyers have accurate information on cost and quality, and neither criterion is met in the insurer, hospital and other major sectors of the health care system. That will never change. One can imagine rolling back the consolidation that has occurred over the last few decades, but the consolidation that existed even three or four decades ago was enough to cripple competition in most sectors of the health care economy. But it is not possible to imagine demolishing even one, never mind all four, of the barriers that prevent the publication of accurate price and quality information for the vast majority of medical goods and services.

All other industrialized nations have recognized that competition does not work well or at all in health insurance and medical care and have implemented *price* regulation throughout all or most of those sectors. All industrialized nations, including the US, have recognized that *quality* of medical care cannot be guaranteed by competition, and have implemented numerous regulations governing quality. To take some obvious examples of laws and regulations governing quality in the US, doctors cannot practice medicine without years of training and a license from a state medical board, hospitals are subject to inspections by a variety of government agencies, and health care professionals and institutions can be sued for malpractice or violation of criminal laws governing patient safety. But among the industrialized nations, only the US refuses to regulate fees and prices. [6]

High administrative costs

One of the predictable consequences of weak competition in any sector is that goods and services in that sector are sold at an unnecessarily high price. The price might be high because the sellers are inefficient, that is, their costs of production are higher than necessary. Or they might be high

because the sellers charge profits that are higher than necessary to draw enough resources and talent into that market. Often both defects exist – sellers are inefficient and they get away with excessive profits.

The hospital sector represents an example of a sector where profits are not excessive but where excessive costs of production (administrative costs) drive prices up. Profits (“surpluses” in the case of non-profits) are not excessive in most hospitals; in fact in many hospitals, especially rural hospitals, profits are non-existent. The drug industry, on the other hand, is an example of a sector where both inefficiency and excessive profits are significant causes of high prices. In this paper I will refer to all costs, including profits, that do not go directly to doctors and other health care providers for patient care as administrative costs or overhead.

Administrative costs play a significant role in driving American health care costs above those of other countries. Administrative costs are incurred by both the insurance sector (insurance companies and government programs like Medicare) and the provider or medical sector (doctors, hospitals, nursing homes, etc). Table 6 presents data on the administrative costs of insurers and providers. All of the overhead you see in Table 6 amounts to about one-third of America’s entire annual health care bill, which now exceeds \$3 trillion.

It would be absurd to claim that all the administrative costs shown in Table 6 are unnecessary. No human enterprise, be it a high school marching band or an insurance company, can function with zero administrative costs. The question before us is whether the costs shown in the table could be reduced. The answer to that question is yes. Research demonstrates that the costs of administering both the insurer and provider sectors are higher than necessary, and they are growing.

I begin with the insurance sector. Table 6 presents administrative costs as a percent of total spending for four types of insurers – insurance companies, self-insured employers (employers who act as their own insurer by setting aside enough money to pay the medical bills of their employees), Medicaid, and Medicare. What we see is that US insurance companies have high overheads (20 percent) compared with the other types of insurers on the list. Insurance companies have high overhead costs because they pay for functions that the other types of insurers either pay less for or nothing at all. These include:

- * marketing (advertisements and commissions for salespeople),
- * underwriting and other activities designed to gauge the probability that an enrollee or potential enrollee will need medical care,
- * limiting patient choice of provider (creating networks of clinics and hospitals that enrollees are incentivized to use),
- * micromanaging doctors (arguing with them about when patients should be hospitalized, monitoring their ordering behavior and influencing them with financial carrots and sticks),
- * collecting premiums,
- * lobbying,
- * management salaries, and
- * profits and surpluses.

Table 6: Administrative costs of insurers and providers as a percent of expenditures

• Insurance companies	20% ^[a]
• Self-insured employers	10% ^[b]
• Traditional Medicaid	4-5% ^[c]
• Traditional Medicare	2% ^[d]
• Drug companies	62% ^[e]
• Hospitals	24-25% ^[f]
• Physicians	26% ^[f]
• Nursing homes	19% ^[f]
• Home care agencies	35% ^[f]

(a) America’s Health Insurance Plans <https://www.ahip.org/health-care-dollar/>

(b) “HMO-ectomy,” *Businessweek*. Self-insured employers are those who insure themselves. They do that by setting aside enough money to pay for the medical bills of their employees as they come due. Most self-insured employers will hire insurance companies to process claims but not to bear insurance risk.

(c) Traditional Medicaid means un-privatized Medicaid programs, that is, programs in which a state agency pays doctors and hospitals directly and does not funnel payments through insurance companies.

(d) Lisa Potetz et al., *Medicare Spending and Finance: A Primer*, Menlo Park, CA: Kaiser Family Foundation, p. 5; Congressional Budget Office, *Single-payer and All-payer Health Insurance Systems Using Medicare’s Payment Rates*, 1993, Washington, DC, p. 26. Medicare overhead is measured as a percent of Medicare’s revenues, not its expenditures. Medicare is designed to take in more money than it spends. Measuring Medicare’s overhead by revenue would make Medicare’s overhead look even lower than 2 percent.

(e) Uwe A. Reinhardt, “An information infrastructure for the pharmaceutical market,” *Health Affairs* 2004;23:107-12, Exhibit 1. Reinhardt reports that administration was 41 percent of expenditures by “13 large ... pharmaceutical companies” in 2002 and profit was 21 percent.

(f) All figures except the 25 percent figure for hospitals are from Steffie Woolhandler et al., “Costs of health care administration in the United States and Canada,” *New England Journal of Medicine*, 2003;349:768-75. <http://www.pnhp.org/publications/nejmadmin.pdf>. The 25 percent figure for hospitals is from David Himmelstein et al., “A comparison of hospital administrative costs in eight nations: US costs exceed all others by far,” *Health Affairs*, 2014;33:1586-94.

The low overhead of the traditional Medicare program (to be distinguished from the less efficient Medicare Advantage program) compared with the average 20 percent overhead of the US insurance industry illustrates how insurer overhead might be reduced. The traditional Medicare program spends just 2 percent of its expenditures on overhead. That’s because Medicare either does not incur the costs listed above (e.g. underwriting, limiting patient choice, profit, and lobbying) or it does incur analogous costs but those costs are much lower.

The evidence that doctors, hospitals and other providers spend more than is necessary on administrative costs comes mainly from comparisons of administrative spending in the US and other countries, primarily Canada. Woolhandler et al. reported that physician and hospital

overhead in Canada was 67 percent lower than that in the US as of 1999, while Pozen and Cutler http://journals.sagepub.com/doi/pdf/10.5034/inquiryjrnl_47.02.124 found it was 66 percent less in 2002. [7]

Research conducted by three Canadians and three Americans presented similar findings for physicians. The authors reported that the cost of getting paid (which is of course not the only overhead cost physicians incur) incurred by Canadian doctors was 27 percent of the cost incurred by American doctors in 2006. The authors noted that the difference was due both to the number of payers – Canada has one payer for most medical services while the US has over 1,000 – and to the widespread use of managed care tactics by US insurers. The authors concluded, “To some extent, these costs [the additional costs in the US] result from having a multi-payer system and from attempts by multiple payers to manage cost and care. Having multiple payers clearly generates more administrative costs than a single-payer system.” [8]

Table 7 presents data from one of the few papers that compares the overhead of hospitals in the US to hospital overhead in other countries besides Canada. The authors noted that hospital overhead was lowest in countries that used budgets to control hospital spending, which is possible only in countries with one payer. In countries with multiple payers (the US and the Netherlands), payment is made on a per-patient basis, which requires that hospitals bill for every service given to every patient.

Table 7: Hospital spending on administration as a percent of hospital costs 2010

<u>US</u>	<u>Canada</u>	<u>Netherlands</u>	<u>England</u>	<u>Scotland</u>	<u>Wales</u>
25%	12%	20%	15%	12%	14%

Source: David Himmelstein et al., “A comparison of hospital administrative costs in eight nations: US costs exceed all others by far,” *Health Affairs*, 2014;33:1586-94.

Table 8: Overhead of private and public insurers, dollars per capita, 2010

<u>US</u>	<u>Canada</u>	<u>France</u>	<u>Germany</u>	<u>Netherlands</u>
587	147	274	233	183

Source: David Himmelstein et al., “A comparison of hospital administrative costs in eight nations: US costs exceed all others by far,” *Health Affairs*, 2014;33:1586-94.

Research comparing the administrative costs of the insuring sector among countries shows a similar pattern – very high costs in the US versus other countries. Table 8 presents data for five countries, four of which have multiple-payer systems and one of which (Canada) has a single-payer system. [9] You can see that insurer-sector overhead is much higher in the US than in the other four countries, that the other multiple-payer countries shown (France, Germany and the Netherlands) have much lower insurer overhead costs than the US, and that Canada’s single-payer system has the lowest insurer overhead.

The research we have reviewed indicates that administrative costs are high in the US for clinics, hospitals and insurers compared with other countries. When we add up the administrative costs of all providers and all insurers in the US, how does that total compare with totals in other countries? That calculation has been done only for the US and Canada. [10] The few studies that have compared total (insurer plus provider) overhead in the US and Canada report that per capita spending would fall by 10 to 15 percent if the US administered its health care spending as efficiently as Canada does. A 1991 report by the US Government Accountability Office <http://archive.gao.gov/d20t9/144039.pdf> concluded that US spending would fall by 10 percent if it were administered as efficiently as the province of Ontario administered its single-payer system. [11] Woolhandler et al. have shown that all administrative costs in the US absorb 31 percent of our health care dollar versus 16 percent for Canada, [12] which suggests that the difference in administrative costs accounts for a third to a half of the 35 percent difference between US and Canadian per capita health care costs.

The paper by Pozen and Cutler cited earlier lends support to that conclusion. Pozen and Cutler examined the difference between total hospital and physician spending in the US and Canada and concluded that 39 percent of the difference was due to higher administrative costs for US doctors and hospitals.

Conclusions

In Part I of this series we reviewed the research on overuse and underuse of medical care in the US and concluded there is very little evidence for the argument that overuse of medical care is a primary cause of high US health care costs. In this paper we continued our investigation into the overuse argument by comparing US prices and utilization rates with those of other countries. This investigation confirmed the conclusion reached in Part I that overuse – excessive utilization of medical care – cannot explain high US costs. It demonstrated, rather, that high prices in the US are the primary factor in our high per capita costs.

We then investigated two factors that drive US prices to such high levels – the absence of effective competition and administrative costs. We saw that neither of the two conditions required for effective competition, numerous sellers and informed buyers, are met, and that US administrative costs are high, in part because of the multiplicity of insurers and in part because of the burdensome cost-control tactics used by the insurance industry. This concludes our investigation into the *causes* of high US health care costs. We are now prepared to discuss the debate about *solutions* to the high cost of care in the US. We will do that in Part III.

Appendix: Expenditure and utilization data for 10 OECD nations^[a]

	Health care spending (2015)		Doctors/1,000			Doc visits	Hospital beds/1,000
	Per cap	% GDP	(1990)	(2000)	(2015)	(2014)	(2014)
Switzerland	\$6,935	11.5%	3.0	3.5	4.1	3.9	4.6
Norway	6,567	9.9	2.6	2.9	4.4	4.3	3.8
Germany	5,267	11.1	3.1	3.6	4.1	9.9	8.2
Sweden	5,228	11.1	2.9	2.9	4.1	2.9	2.5
Denmark	4,943	10.6	3.1	3.4	3.7	4.5	2.7
Canada	4,608	10.1	2.1	2.1	2.5	7.6	2.7
France	4,407	11.0	3.1	3.3	3.1	6.3	6.2
UK	4,003	9.8	1.4	1.8	2.8	5.0	2.7
Italy	3,272	9.1	2.4	2.8	3.9	6.8	3.3
US	9,451	16.9	2.4	2.8	2.6	4.0	2.9
OECD avg	3,814	9.0	2.4	3.1	3.3	6.8	4.7

[a] In a few cases, the years for data listed are not the same as the year shown at the head of the column. In those cases, the data are from the nearest year for which data are available.

Source: *OECD Health Statistics 2016*.

[1] Gerard Anderson et al., “It’s the prices, stupid,” *Health Affairs*, 2003;22:89-105.

[2] Ibid.

[3] Luca Lorenzoni et al., “Healthcare policy and expenditure in the USA versus other high-spending OECD countries,” *Lancet*, 2014;384:83-92.

[4] The fact that Americans get fewer physician and hospital services does not mean we never exceed the OECD average in specific services. Anderson et al. also presented data on MRIs, CT scanners, angioplasty, and dialysis. That data showed that America had more MRIs per capita than other countries and slightly fewer CT scanners, and we received more angioplasty and dialysis than other countries. These services (imaging, angioplasty, and dialysis) constitute a tiny fraction of total spending on doctors and hospitals.

[5] E. L. Hannan et al., “Public release of surgery outcomes data in New York: What do New York state cardiologists think of it?” *American Heart Journal*, 1997;134:1120-28.

[6] Medicare, Medicaid and the VA are, of course, exceptions to the statement that the US refuses to regulate fees and prices. But even here there are exceptions. Medicare, for example, cannot use its bargaining power to negotiate prices with the drug industry, and many states have handed over to the insurance industry their authority to determine the fees and prices paid for the care of Medicaid enrollees.

[7] Alexis Pozen and David Cutler, “Medical spending differences in the United States and Canada: The role of prices, procedures and administrative expenditures,” *Inquiry* 2010;47:124-34.

[8] Dante Morra et al., “US physician practices versus Canadians: Spending nearly four times as much interacting with payers,” *Health Affairs*, 2010;1443-50, 1447.

[9] Table 8 reflects the costs of all private insurers (which are relatively high) and all public insurers (which are relatively low). Even countries with single-payer systems have private insurance companies that sell coverage for

services the single-payer program doesn't cover. The public single-payer program in Canada incurs administrative costs of only 1 percent of its expenditures, but because its expenditures are limited primarily to physician and hospital bills, two-thirds of Canadians buy supplemental insurance, and a substantial portion of the premiums paid on that insurance that pays for overhead (probably 20 percent) adds to the total overhead of Canada's insurance sector.

[10] The Organization for Economic Cooperation and Development reports every year on the administrative costs for the insurer sector, but only the insurer sector. The OECD reports no data on medical-sector overhead. Research into administrative costs began in the early 1990s. The early research focused almost exclusively on Canada-US comparisons. As the Office of Technology Assessment put it in a 1994 report <http://ota.fas.org/reports/9417.pdf>, "Most of the empirical literature on administrative costs compare the U.S. and Canadian health care systems. These studies indicate that administering the Canadian system consumes a substantially smaller proportion of health care spending than does the U.S. system." (p. 11). Both conclusions stand today: What little research we have comparing total administrative costs between the US and other countries examined Canada and the US; and Canadian overhead costs remain low compared with US costs.

[11] US General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, Washington DC, 1991, p. 65, Table 5.1.

[12] Steffie Woolhandler et al., "Costs of health care and administration in the United States and Canada," *New England Journal of Medicine*, 2003; 349:768-75.