



# High and rising health care costs: Demystifying U.S. health care spending

By Sarah Goodell, M.A. and Paul B. Ginsburg, Ph.D., based on a research synthesis by Ginsburg

## SUMMARY OF KEY FINDINGS

- > Health insurance is becoming increasingly difficult for workers—and their employers—to afford. Premiums increased 114 percent between 1999 and 2007, while workers' earnings increased only 27 percent.
- > U.S. spending on health care—as a percentage of GDP—is more than six percentage points higher than the average for other developed countries.
- > Technology—not demographics or medical malpractice—is the key driver of health spending, accounting for an estimated half to two-thirds of spending growth.
- > Other important drivers of health care spending include health status (particularly obesity) and low productivity gains in the health care sector.

## Why is this issue important to policy-makers?

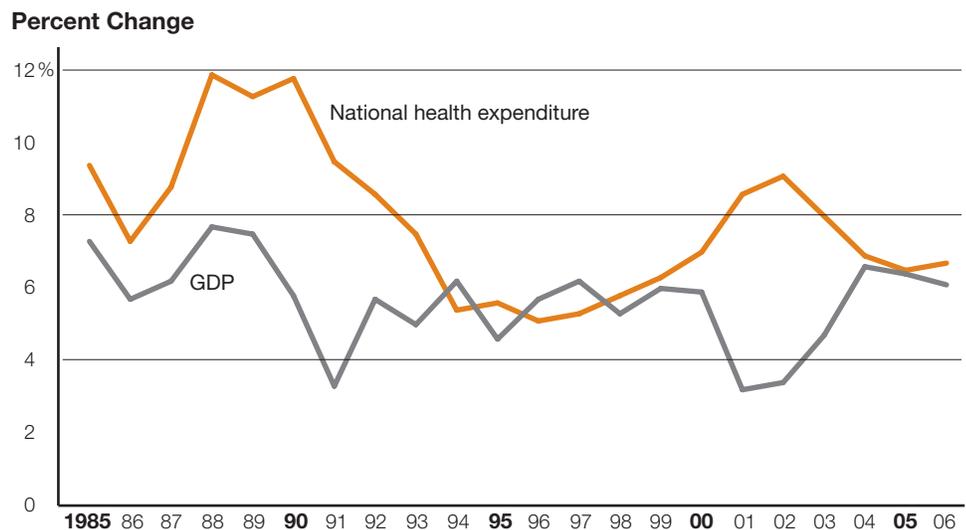
- In 2006, the United States spent \$2.1 trillion, or 16 percent of gross domestic product (GDP), on health care. This translates to \$7,026 per person annually (Reference 1).
- U.S. spending on health care is greater than that of any other developed country, yet unlike other countries, which provide near-universal coverage, 16 percent of Americans are uninsured (Reference 2).
- Without steps to restrain growth, increases in health care spending will eventually consume almost the entire GDP.

## What are the historical data on health spending?

**Between 1985 and 2006, health care spending increased by an average of 7.7 percent per year, while GDP increased 5.6 percent per year (Figure 1).**

The data on health spending are from the National Health Expenditure Accounts (NHEA) maintained by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary. The NHEA are considered the gold standard for U.S. spending data (Reference 3).

Figure 1. Annual Growth Rate of Health Spending and GDP, 1985–2006



Source: Centers for Medicare and Medicaid Services (Reference 3)

**Hospital care and physician and clinical services are by far the largest components of spending.** Hospital care accounted for 31 percent and physician and clinical services accounted for 21 percent of overall health care spending in 2006. Prescription drugs accounted for only 10 percent of overall spending, although that is 40 percent higher than its share in 1970 (Reference 4).

Prices, efficiency and insurance administration are the most important reasons U.S. spending is higher than spending in other countries.

#### HEALTH CARE SPENDING: KEY CONCEPTS

**Costs.** Costs can mean the cost of a unit of service, the price of that service or the cost or price of all services an individual or a nation uses annually. This brief focuses on spending, which combines unit costs and rates of use, both in the aggregate and by component, such as hospital care, physician services, prescription drugs and other services.

**Cost trends vs. premium trends.** Costs trends and health insurance premium trends are often mistakenly used interchangeably—the two are distinct but linked. Over time, trends in spending on health care services covered by insurance drive premium trends, but the premium trend can diverge from the cost trend during any given period.

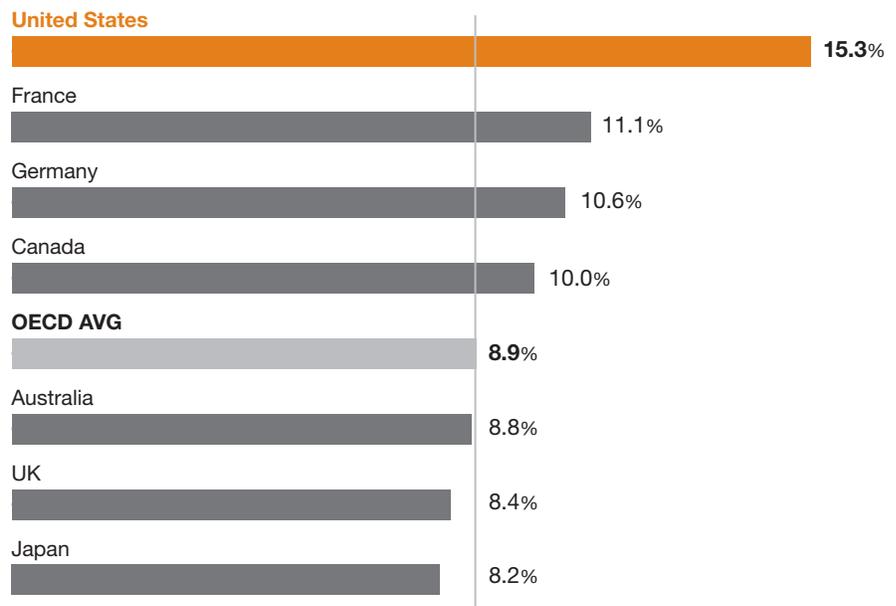
**Per capita health care spending increases each year.** Although the rate of spending growth may decrease or increase from one year to the next, total health care spending always increases annually.

**Level of spending vs. trends in spending over time.** A given factor may contribute to health spending being high at a moment in time but may not be a major driver of spending growth over time.

#### How does U.S. health care spending compare with other countries?

**U.S. spending on health care as a percent of GDP is more than six percentage points higher than the average for other developed countries (Figure 2).** The average health expenditures as a percent of GDP for other developed countries is just below 9 percent compared with more than 15 percent for the United States (Reference 5).

Figure 2. Health expenditures as a share of GDP, 2006



Source: Organization for Economic Co-operation and Development, 2008 (Reference 5)

Note: While the OECD data for the United States is based on NHEA data, adjustments are made to be comparable to data on other nations resulting in lower figures.

**Prices, efficiency and insurance administration are the most important reasons U.S. spending is higher than spending in other countries.** One study estimated that relative to OECD countries the U.S. pays 70 percent higher prices for drugs, has substantial excess capacity and low productivity in outpatient facilities, and spends six times more on insurance administration (Reference 6).

**Although U.S. spending on health care is higher overall, there is some disagreement on whether the rate of growth is higher as well.** Several researchers have concluded that the growth trends are similar (Reference 7). A more recent study casts doubt on that conclusion, finding that between 1985 and 2002 “excess” growth (growth not attributed to demographics or growth in income) in health care spending was 0.6 percent for OECD countries compared with 2.0 percent for the United States (Reference 8).

# Medical technology, not aging or medical liability, is driving U.S. health care spending growth.

## What is driving health care spending growth?

**Medical technology is the driving force behind the growth in U.S. health care spending.** Estimates of the contribution of medical technology to health care spending growth range from 38 percent to more than 65 percent (Reference 13). Technology drives spending both through the substitution of higher cost services for lower cost services and the expansion of available treatments (Reference 14). Because technology is often measured as a residual, that is, what remains after all other factors are measured, its contribution to spending growth can be overstated if other factors are not accurately measured, however.

**Obesity is a significant factor driving health spending, accounting for an estimated 12 percent of the growth in recent years (Reference 15).** Reducing obesity or improving overall health status can save money in the short and intermediate term, but some of the savings will be offset by increased longevity and the cost of diseases that are most prevalent during old age. Studies that do not take into account the increased longevity may exaggerate the contribution of health status to spending growth (Reference 16).

**The increase in the percentage of people with health insurance accounted for approximately 10 percent to 13 percent of the historical growth in spending (Reference 17).** With increases in the uninsured over the last decade, however, insurance coverage has not contributed to the recent growth in health spending and will not be a driver in the future unless policies change to increase the number of people with insurance.

**Demographics account for a very small percentage of the growth in spending (Reference 19).** Despite differences in methodologies, studies consistently conclude that aging has not been a major factor in driving health care spending and will not become one, despite aging baby boomers.

**Productivity gains in the health care sector have probably been lower than in other industries.** This may be a result in part from little price competition among health care providers because of extensive third-party payment and to payment policies that reward more units of service rather than efficient care for an episode of illness.

**Medical malpractice is not a major driver of spending trends (Reference 20).** Premiums for liability coverage and defensive medicine do contribute to health spending at any moment in time, but they are not a large factor nor are they a significant factor in the overall growth of health care spending.

## ARE HEALTH CARE COSTS TOO HIGH?

There are several concerns about the high and rising health care costs in the United States, including the affordability of insurance and stresses on government budgets from commitments to provide insurance. In addition, there is concern about a lack of value for the resources devoted to health care.

**Affordability:** Premiums increased 114 percent between 1999 and 2007 while workers' earnings increased only 27 percent (References 9 and 10). Health insurance is unaffordable to many workers and their employers. One study estimates that almost all of the increase in the uninsured is a result of health spending growing more rapidly than income (Reference 11). Governments also face the strain of health care spending growing more rapidly than their revenue base.

**Competitiveness in the Global Economy:** U.S. businesses argue that they cannot be competitive with their foreign counterparts because of the high cost of employee health benefits. Economists tend to dismiss this concern, arguing that employers pass on increases in premiums to their employees. One study disputes this theory by showing that during periods of rapid health spending growth, fully shifting premium increases to workers would require wages to decline even before adjusting for inflation—a rare event (Reference 12).

**Value:** Studies have estimated very high value—improved outcomes in relation to costs—for selected medical technologies, but these results are sensitive to the choice of technologies and the period studied. Many technologies that have high value for some patients are applied too broadly, yielding little benefit to many patients.

# Policy Implications

**Policy-makers have a number of options available to restrain health care spending growth, none of which are easy. With research consistently showing that medical technology is the largest cost driver, applying technology more selectively to patients needs to be an element of any long-term approach. To accomplish this, policy-makers could:**

- > **Increase funding for research on effectiveness.** This is the beginning of an approach that supports the appropriate application of medical technology to the patients likely to receive the highest benefit.
- > **Reform provider payment systems.** Distortions between payments and costs of services lead to undesirable provider incentives to emphasize the most profitable services. These unintended incentives tend to favor services incorporating new technologies.
- > **Increase use of consumer financial incentives and support.** To the degree that consumers bear some of the financial risk of medical spending, they are likely to be judicious concerning the use of technologies with low value to them as patients. For this to work as intended, however, patients must be provided information on treatment alternatives and their effectiveness, and on the quality of different providers of care, and must face incentives to favor more efficient providers. Use of this approach is limited by the need to maintain adequate financial protection for the costs of illness or injury.

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