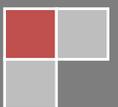


Drivers of Health Care Costs

A Physicians Foundation White Paper

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Executive Summary

For many years and in countless articles, physicians have been the scapegoat for rising health care costs in the United States. In fact, they have been blamed by many critics for the United States leading the world in health care expenditures.

A close examination of the data indicates that this blame is misplaced – that delving into key components in health care spending reveals something else. While there is general disagreement among the so-called experts as to the degree of impact of each component, almost everyone seems to agree that new technology – not physicians – is number one on the list of contributors to rising health care costs.

We have examined data on the leading key components and found that chronic disease conditions, life style – including obesity and addictions, administrative expenses, hospitals, pharmaceuticals, mandated insurance benefits, aging, end-of-life care, defensive medicine and health disparities have all had anywhere from a moderate to significant impact on rising overall health care costs.

In the final section, entitled “Interesting Statistics about U.S. Health Care System”, we examine why infant mortality rates can be a poor indicator of the success or failure of a health care system. The same applies for life expectancy statistics. Issues such as medical innovation need also to be considered in the general discussion of a health care system’s success or failure.

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In light of the string of federal budget deficits, combined with a U.S. national debt approaching \$17 trillion, the largest in the world – it is understandable that observers are scrutinizing health care costs which accounted for 17.9 percent of the nation’s GDP in 2010, or almost \$2.6 trillion. As the second highest component in national health expenditures at 20% (hospital care is 31 percent), physician/clinical services have captured everyone’s attention. Physician/Clinical services include health care services within the Department of Defense (higher costs in times of war), Indian Health Services, laboratory services, outpatient care centers and the portion of medical laboratory services and physician services in hospitals that are billed independently. Some critics have suggested that physicians’ incomes and the fact that physicians direct most health care spending (80% is a frequently used number) are the real culprits in rising health care costs. But let us look at all of the relevant components that contribute to health care costs.

Physician / Clinical Services

Years ago the iconic Mike Royko, a Pulitzer Prize winning journalist who penned columns for the *Chicago Daily News*, the *Chicago Sun-Times* and the *Chicago Tribune*, received a poll about “doctors’ earnings” which laid at their feet considerable responsibility for rising health care costs. Royko, it should be noted, was revered for his style of not suffering fools or tolerating sacred cows. Considered so straight-forward and honest, he even criticized the new owner of the newspaper where he was employed – “No self-respecting fish would want to be wrapped in a ----- newspaper.” In short, he told it like it is.

Here is how Royko responded in his column to the poll critical of physicians’ incomes and their role in rising health care costs.

“The poll tells us that the majority of Americans believe that doctors make too much money. The pollsters also asked what a fair income would be for physicians. Those polled said, ‘oh, about \$80,000 would be OK.’

How generous. How sporting. How stupid.

You could conduct the same kind of poll about any group that earns \$100,000 plus and get the same results. Since the majority of Americans don’t make those bucks, they assume that those who do are stealing it from them.

It is also stupid because it didn’t ask key questions, such as: ‘Do you know how much education and training it takes to become a physician?’

If those polled said, no, they didn’t know, then they should have been disqualified. If they gave the wrong answers, they should have been dropped. What good are their views on how much a doctor should earn if they don’t know what it takes to become a doctor?

Or maybe a question should have been phrased this way: ‘How much should a person earn if he or she must (a) get excellent grades and a fine educational foundation in high school in order to (b) be accepted by a good college and spend four years taking courses heavy in math, physics, chemistry and other lab work and maintain a 3.5 average or better, and (c) spend four more years of grinding study in medical school, with the 3rd and 4th years in clinical training, working 80-100 hours a week, and (d) spend another year as a low-pay, hard-work intern, and (e) put in another 3 to 10 years of post-graduate training, depending on your specialty and (f) maybe wind up \$100,000 in debt after medical school and (g) then work an average of 60 hours a week, with many family doctors putting in 70 hours or more until they retire or fall over?’

As Mr. Royko went on to say, “Based on what doctors contribute to society, they are far more useful than the power-happy, ego-tripping, program-spewing, social tinkerers.

But propaganda works. And, as the stupid poll indicates, many Americans wrongly believe that profiteering doctors are the major cause of high medical costs.

Of course doctors are well-compensated. They should be. Americans now live longer than ever. But who is responsible for our longevity – lawyers, Congress, or the guy flipping burgers in a McDonald’s?

Let us talk about medical care and one of the biggest problems we have. That problem is you, my fellow Americans.

Yes, you, eating too much and eating the wrong foods; many of you guzzling too much hooch; still puffing away at \$2.50 a pack; getting your daily exercise by lumbering to the fridge to the microwave to the couch; doing dope and bringing crack babies into the world; filling the big-city emergency rooms with gunshot victims; engaging in unsafe sex and catching a deadly disease while blaming the world for not finding an instant cure. You and your habits, not the doctors, are the single biggest health problem in this country. If anything, it is amazing that the docs keep you alive as long as they do.”

The fact that this all came from Mike Royko gives it extra credence, and makes his comments especially prescient.

Writing about the physicians’ role in health care costs, in an article that recently appeared in *Health Affairs*, Mark Smith referred to the 80% of health care costs directed by physicians. He noted that: Physicians decide (that) “you’re going to be hospitalized; you need an MRI; you’re going to get a stent; you need a knee replacement.” But despite the fact that they direct this spending, they are not necessarily the principal beneficiaries of it (especially now).

In addition, Smith noted, “Consider the economics of joint replacement. Medicare pays, on average in California, \$18,000 for a total hip replacement (\$16,336 to the hospital and \$1,446 to the surgeon). A recent study asked 1200 members of the public, ‘How much do you think Medicare pays an orthopedic surgeon for a total hip replacement?’ On average, patients thought that Medicare paid surgeons \$11,000 for the procedure. (Interestingly, patients reported they thought that Medicare *should* pay \$18,000 to the surgeon.) Cutting the surgeon’s fee by 27 percent saves Medicare \$390. While the numbers are higher in the commercial market, approximately the same ratio of payments exists; the bulk of the money goes to hospitals and device manufacturers.”

We can only imagine that some elected lawmakers (or their staffs) have the same misunderstanding of physicians’ income as the general public. Or, as cognitive psychologist Amos Tversky famously said, “Whenever there is a simple error that most laymen fall for, there is always a slightly more sophisticated version of the same problem that experts fall for.”

Smith also worries about physician burnout and a looming, if not already present, serious physician shortage. When writing about physician compensation, well-known Princeton medical writer and economist Uwe Reinhardt wrote: “One can think of several reasons why physician compensation in the United States is relatively more generous than elsewhere. First, physicians in most other nations face a powerful single buyer (monopsony) for health services. As the McKinsey Global Institute and Mark Pauly have shown, market power (or regulation) translates into relatively lower prices for health services, including the services of physicians. Second, U.S. physicians must make a larger financial investment in their education than their counterparts in many other countries do; they must recover the debt they incur as part of the educational process. Third, the incomes of highly skilled health care workers – notably physicians – are determined partly with reference to the incomes that equally able and skilled professionals can earn elsewhere in the economy. Because the U.S. distribution of earned income for all occupations is wider than it is in most other OECD countries, the relatively high incomes offered skilled professionals in the United States may well have served to pull up the incomes of American physicians relative to the incomes of their peers abroad.”

With respect to physician training, Dr. Reinhardt weighs in on the subject this way: “Suppose that in country A physicians get free training through a taxpayer-financed educational system, while in country B physicians finance their own education and then, once trained, are paid higher fees. If country A classifies these training expenses as education rather than health care spending, which country would report higher health care costs? Is that difference in health care costs real or an artifact of labeling?”

Journalist Christopher Beam, who writes for *Slate*, had this to say about “American doctor salaries.” *“They are high for several reasons. The first is the cost of education. In France and Great Britain, students go directly to medical school after high school, and their entire educations are free. In the United States, students must first get a bachelor’s degree before attending medical school, and the average medical students’ debt is \$155,000 (editors’ note: closer now to \$200,000). Then come at least three years of residency, which usually pays less than \$50,000 a year. Finally, there is the notion of opportunity costs.*

Presumably, many doctors could have opted for jobs on Wall Street or in management consulting instead of choosing to go to medical school. 'They sit in the Princeton eating clubs,' says health care economist Uwe Reinhardt, 'and one guy just got a starting job at Goldman for \$150,000. Another guy says, 'I'm going to medical school to take on \$35,000 a year in debt.'

But none of this really matters because doctors' salaries aren't a large enough chunk of health care spending in the United States to make a difference. According to Reinhardt, "doctors' net take-home pay (that is income minus expenses) amounts to only about 10% of overall health care spending. So if you cut that by 10 percent in the name of cost savings, you'd only save about \$24 billion. That's a drop in the ocean compared with overhead for insurance companies, billing expenses for doctors' offices, and advertising for drug companies. The real savings in health care will come from these expenses."

Complicating the entire issue for physicians (and certainly adding to practice costs, at least initially), particularly those in smaller private practices, is that there are 551 certified medical information software companies in the United States selling 1,137 software programs. According to *Business Week* (June 21, 2012), "Their products have one thing in common: They don't communicate with one another, and this is by design. EHR vendors which charge as much as \$25,000 (and much more) per doctor for a system and a monthly subscription fee on top of that, want to lock out competitors while locking in customers for life." This is just another reason why David Bronson, MD, President of the American College of Physicians, said that "The burdens are worsening as physicians must contend with the costs and hassles of implementing new quality reporting standards and electronic health records. This is one of the reasons many of physicians are becoming employed; they just can't sustain their practices." He went on to say that high burnout rates are driving many physicians to move away from clinical practices and could deter some from entering the profession. For more on this important issue of burnout and morale, see The Physicians Foundation website at www.physiciansfoundation.org which includes our recent (September 2012) comprehensive survey of 630,000 physicians in the United States.

Earlier this year, a Colorado physician discussed the issue of medical practice sustainability with the *Wall Street Journal*. “His family practice uses electronic health records, calls up patients at home to check on their progress, and coordinates with other specialists and hospitals – all the things that policy makers and insurers say should improve patient care. But many of these enhancements aren’t reimbursed under traditional insurance contracts that pay mostly for face-to-face visits with patients.” It is not sustainable under the current payment system,” he says. “There simply is just not enough money to go around to provide the services that we provide.” The upshot: Doctors fear a squeeze as they try to ramp up changes in tandem with evolving reimbursement schemes. “You’re asking a practice that may be only marginally viable as a business to invest in significant infrastructure,” says Glen Stream, President of the American Academy of Family Physicians, in the *Wall Street Journal* article.

Hospitals

Hospital costs during 2010 in the U.S. constituted \$814 billion or 31.4% of all health care expenditures.

As mentioned in *Health Care News* in September 2012, “*At the heart of President Obama’s signature health care law is a simple idea: bigger is better. His law incentivizes massive mergers of systems and providers into big players in the marketplace, binding them together to share costs. These new health care behemoths will be managed from Washington, with regulators wielding control from on high.*

That’s just one problem. When it comes to health care, “bigger is better” isn’t true. And consumers will pay a huge price for this mistake. The president’s health care law contains rafts of new regulations, benchmarks, and taxes for providers to deal with. Since these limit profit margins and create new administrative costs, they make it very appealing for health care providers to merge into gigantic, sprawling systems of care. A recent report in The Washington Post notes, ‘The health care industry is increasingly turning to consolidation as a way to cope with smaller profit margins and higher compliance costs that many anticipate when the federal government’s health care reforms under (Obama’s law) take effect.’ Across the health care industry, we’re seeing the merger trend continue to rise.

These larger mergers don't actually translate to better care or to savings for patients. The Wall Street Journal recently reported on a patient from Nevada whose echocardiogram bill came to \$373 before a merger and then \$1,605 after a merger.

The same treatment, in the same office, by the same cardiologist, separated by just six months – but with a price point far higher because the physicians had been purchased by a hospital system, allowing for a much higher price to be charged.

The larger a hospital system gets, the more monopolistic control it can exercise over a market, putting insurers at a disadvantage when it comes to negotiating rates. Obama's law accelerates the process, giving these large entities even more incentive to merge through the creation of accountable care organizations (ACOs). These large health care entities will destroy any hope for competition in a marketplace, driving out or buying out independent doctors and extracting as much money as possible from taxpayer-funded entitlements and the privately insured."

We have written previously about our strong belief that bigger is not better, and it appears that new studies confirm that assertion.

An August 2012 article in *The Wall Street Journal (WSJ)* discussed the overall issue. "Major health insurers say a growing number of rate increases are tied to physician-practice acquisitions. The elevated prices also affect employers, many of which pay for their workers' coverage. A federal watchdog agency said doctor tie-ups (Note: physician practices/hospital consolidations) more likely resulting in higher Medicare spending as well, because the program pays more for some services performed in a hospital facility.

This year, nearly one-quarter of all specialty physicians who see patients at hospitals are actually employed by the hospitals, according to an estimate from the Advisory Board Co. That is more than four times as many as the 5% in 2000. The equivalent share of primary-care physicians has doubled to about 40% in the same time frame. Traditionally, most doctors who see patients at hospitals are in independent practice.

The structural shift is being driven partly by declining reimbursements for physicians, particularly in certain specialties like cardiology. Doctors are also being pressed to make new investments, such as introducing electronic medical records, and some are attracted to the idea of more regular hours with fewer administrative headaches.

Medicare pays substantially more for certain services if they are performed at hospital facilities. A 15-minute doctor visit, for instance, cost the program about \$70 last year at a free-standing practice, but the same visit ran about \$124 if it was billed as hospital-outpatient, according to the Medicare Payment Advisory Commission. That difference can bump up reimbursements after an acquisition if a hospital system upgrades a clinic to become an outpatient facility, or moves services into a hospital site.

With private insurers, hospital systems with strong market heft can often negotiate higher rates for physician services than independent doctors get. The differential varies widely, anywhere from 5% or less to between 30% and 40%, industry officials say.

Other industry officials suggest the costs often mushroom even more. In a letter sent to some doctors in Nevada, Wellpoint, Inc. said the cost for a spine MRI, or magnetic resonance imaging, done at a free-standing center in the area ranged from \$319 to \$742, while the same test done by a hospital would run between \$1,591 and \$2,226.”

A letter to the editor of the WSJ on September 4, 2012 is instructional: “It would behoove Medicare and all other insurance carriers to provide private-practice physicians with incentives to stay independent. Increasing fees to these physicians will still be less costly than paying for the same services performed in a hospital out-patient setting.”(Editors’ note: Agree!)

A September 14, 2012 article, also in the WSJ, described the concern over consolidation felt in California. “California’s attorney general has launched a broad investigation into whether growing consolidation among hospitals and doctor groups is pushing up the price of medical care, reflecting increasing scrutiny by antitrust regulators of medical-provider deals.

The probe, which has been under way for several months, is examining hospital systems' reimbursement from the insurers, according to people with knowledge of the matter. The regulator appears to be focusing on whether the systems' tie-ups with physicians, as well as ownership of hospitals, have given them the market power to boost prices in a way that violates antitrust law, these people said."

As physicians find it increasingly difficult to sustain their practices during times of declining reimbursements, increased regulation, little negotiating power with insurers, growing practice costs, new EHR requirements, and combined with the always constant threat of a malpractice suit, who can blame physicians for looking to hospital systems for employment? But overall costs will continue to escalate.

One final footnote on the subject: It is interesting to note, as reported in the August 2012 media release of the Ambulatory Surgery Center Association, that, *"when asked whether they would prefer a doctor who is employed by a hospital or who owns his own office, 55 percent (of Americans /poll respondents) say they want a physician who owns and supervises his or own practice."*

Medical Malpractice / Defensive Medicine

One of the difficulties in recognizing the overall importance of the medical malpractice / defensive medicine issue as it relates to health care costs is that the physicians' cost of insurance premiums represents "only" about 1-2 percent of overall health care spending. But that 1-2% represents \$27 - \$54 billion dollars. Further complicating the issue is the Congressional Budget Office (CBO) estimate (mentioned in the Social Security Advisory Board Report in 2009) that "imposing limits on malpractice awards would only lower malpractice premiums by about 6 percent nationwide, resulting in a modest savings on total health care expenditures of less than 0.2 percent."

The Robert Wood Johnson Foundation (RWJF) Report of 2008 gives short shrift to the premium cost issue, pointing out an article in Science and Technology by Sloan and Chepke, where it was estimated “that over a 30-year period (1970-2000), medical malpractice premiums increased from 5.5 percent to 7.5 percent of total physician practice expenses, so premiums cannot be an important cost driver. Research on whether defensive medicine affects spending is challenging because liability risk pushes physicians in the same direction as fee-for-service payment incentives – providing more services.” It should be noted, however, in reference to fee-for-service medicine (FFS), that the traditional FFS payment system doesn’t really exist anymore. Medicare price controls, which insurers emulated, took care of that mechanism. As a physician pointed out in the *Wall Street Journal* (October 19, 2012), “The only FFS practices remaining are cosmetic surgery and those physicians who accept cash only.”

But others point to the considerable cost of defensive medicine – ordering extra tests because of a fear of a lawsuit – which Phillip K. Howard (Chairman of Common Good) estimates at over \$200 billion a year.

Another problem with the malpractice lawsuit system is that 54 cents of the malpractice dollar goes to lawyers and administrative costs, according to a 2006 study in the *New England Journal of Medicine*. Some critics of the current system also point to former Senator John Edwards, who, for example “made a fortune bringing in cases against hospitals for babies born with cerebral palsy. Each of those tragic cases was worth millions in settlement. But according to a 2008 study at the National Institutes of Health, in nine out of ten cases of cerebral palsy, nothing done by a doctor could have caused the condition.”

The U.S. Department of Health and Human Services reports that “Americans spend more per person on the cost of litigation than any other country.” No surprise there. The report goes on to say that the U.S. had 50% more malpractice claims filed per 1000 population than the United Kingdom and Australia, and 350% more than Canada. The fact that two-thirds were dropped, dismissed, or found in favor of the defendant certainly confirms that the present system simply is inefficient and does not work.

And, *American Medical News* (September 2010) adds that physicians prevail 90% of the time when a malpractice case does go to trial.

According to the American College of Obstetricians and Gynecologists (ACOG), one in 10 obstetricians have stopped delivering babies, unable to pay malpractice premiums on the order of \$1,000 per baby (probably a low estimate for today).

Those who like to lowball the costs of defensive medicine claim that it is difficult to separate it from the effects of other factors that lead to more intensive use of resources including the diffusion of new technology, the incentives of the fee-for-service form of reimbursement and the factors accounting for regional variation in spending. This is the rationale given in the Social Security Report previously mentioned for lower estimates of the costs of defensive medicine. An article on the subject in *Health Affairs* (September 2010) concludes that “defensive medicine practices exist and are widespread, but their impact on medical care costs is small.”

But Richard A. Epstein, a professor of law at the University of Chicago and a senior fellow at the Hoover Institute – while he estimates malpractice premiums constituting less than 1% of the total U.S. health care bill (*WSJ*, June 30, 2009) – does believe that defensive medicine adds as much as 10 percent to health care costs. At a total health care cost of \$2.7 trillion estimated in 2011 – the 10% estimate figures to be \$270 billion! Author Marc Siegel, MD, puts it simply: “Fear of malpractice suits compel doctors to over treat when confronted with sick patients.”

As mentioned in a recent *NEJM* article (August 1, 2012), its authors mention that “more than 75% of physicians – and virtually all physicians in high-risk specialties – face a malpractice claim over the course of their career. Regardless of whether a claim results in liability, the risk of being sued may cause physicians to practice a type of defensive medicine that increases costs without improving the quality of care.”

But lost in almost all of the discussions of the impact of medical malpractice premiums and defensive medicine is the considerable agony and trauma suffered by those more than 75% of physicians and their families because of liability suits (or the threat of them).

The biennial surveys by The Physicians Foundation (www.physiciansfoundation.org) in 2008, 2010 and 2012 demonstrate how important the issue is to practicing physicians which impacts greatly on their sense of morale and optimism. This considerable (human) cost must be considered in examining efforts to change the present system, even if experts cannot agree on the financial costs.

As an article in *Health Affairs* (September 2010) points out, “Physicians can insure against malpractice awards, but they cannot insure against the psychological costs of being involved in litigation, including the stress and emotional toll.”

Technology

According to a report from the Robert Wood Johnson Foundation (RWJF), its authors agree that technological change is the most important driver of health care spending increases over time. A technical review panel convened to advise CMS on future health care costs trends concluded that about half of real health expenditure growth is attributable to medical technology, “where new options for diagnosis and treatment often replace older technologies when none existed before.” The RWJF goes on to say that advancing technology may have a particularly large impact on spending in the United States because of “few requirements that effectiveness be demonstrated before technologies are used broadly and concern that their application tends to go beyond those patients likely to benefit the most from them.”

In late September 2012, an article in *JAMA* indicated that total knee replacement surgeries have soared 161.5% among Medicare participants in the past 20 years, and will continue to grow as the USA’s 77 million baby-boomers age. In 2010, people aged 65 and older underwent 243,802 operations to replace damaged knees or to “revise” previous replacements – up from 93,230 in 1991. At about \$15,000 each, the total knee replacement tab for patients at every age is now about \$9 billion.

By comparison, and according to the Kaiser Family Foundation, Medicare spending for 2011 was estimated at \$550 billion. The good news as pointed out by *USA Today* is that such procedures have eased the pain and improves quality of life especially for a rapidly aging population. The bad news is that it “can be viewed as another stress on government, individuals and businesses struggling with current growth in health care costs.”

Just another example of new technology is robotic surgery which is now performed in more than 36% of hospitals across the USA, according to PWC’s Health Record Institute. According to an August 19, 2010 article in the *New England Journal of Medicine*, the cost of robotic surgery was estimated to be \$2.5 billion and growing.

Defining new technology as encompassing the use of any new procedure, drugs or devices, the Congressional Budget Office estimated in 2008 that technology so defined, accounts for anywhere between 38 percent to more than 65 percent of new health care spending.

Administrative Expenses

Princeton medical writer and economist, Uwe Reinhardt, suggests that the U.S. health care administrative overhead load is huge by international standards. “The McKinsey Global Institute estimated that excess spending on health administration and insurance accounted for as much as 21 percent of the estimated total excess spending (\$477 billion in 2003). Brought forward, that 21 percent of excess spending on administration would amount to about \$120 billion in 2006 and about \$150 billion in 2008.”

The McKinsey team estimated that about 85 percent of this excess administrative overhead can be attributed to the highly complex private health insurance system in the United States. “Product design, underwriting and marketing account for about two-thirds of that total. The remaining 15 percent was attributed to public payers that are not saddled with the high cost of product design, medical underwriting and marketing, and that therefore spend a far smaller fraction of their total spending on administration.”

The Institute of Medicine and the Centers for Medicare and Medicaid (CMS) estimate that administrative costs in the U.S. health care system consume an estimated \$361 billion annually, 14 percent of all health cost expenditures in the nation. Administrative costs are defined as “including spending by public and private health insurers other than actual payments to providers and costs incurred by other system participants, including providers, employees, and consumers, in dealing with insurers.”

In the Robert Wood Johnson Foundation (RWJF) report entitled: *High and Rising Health Care Costs*, “Administrative costs were noted as a key reason why spending in the United States exceeds that of other advanced countries.”

According to a National Academy of Social Insurance report for the RWJF, overall administrative costs for physicians are in the range of 25-30% of practice revenues. One study cited in the report found costs related to claims and utilization management amounting to 10% of practice revenues. Still another study, which estimated insurance-related costs in most cost centers and included an estimate of physicians’ time spent on insurance matters, estimated costs for a primary care office of 15% of revenues.

A U.S. Congress Office of Technology Assessment report on administrative costs in health care, cited an (American Medical Association) AMA 1988 socio-economic survey which indicated that, way back then, the value of physicians’ time spent on insurance issues were: \$17.4 billion on non-physician salaries, \$ 6.64 billion in physician time spent on administration, and \$19.54 billion in other administrative costs, for a total of \$43.58 billion in 1991.

Of course, the number of physicians has greatly expanded since 1991 along with increased administrative time spent on more regulation, not to mention a plethora of new ones included in the Patient Protection and Affordable Care Act – therefore rendering the \$43.58 billion number far lower than today.

Pharmaceutical Costs

According to the 2010 Kaiser study, while spending on prescription drugs (\$259.1 million) accounts for only 10% of total health care expenditures, its rapid growth has received considerable attention (a 114% increase since 2000, compared to 88% for both hospital and physician/clinical services combined). However, the 2010 average annual spending growth from 2009 was lower for prescription drugs (1.2%) than for hospitals (4.9%) or physician/clinical services (2.5%). A large part of these rising costs is reflected in the trend away from chemical agents to biological agents which are significantly more expensive to manufacture and to administer.

Mandated Insurance Benefits

According to the Council for Affordable Health Insurance report (CAHI): Health Insurance Mandates in the States 2011, a health insurance “mandate” is a command from a governing body, such as a state legislature, to the insurance industry or health plans to include coverage for (or less frequently, offer coverage for) a particular health care provider, benefit and/or patient population. Some examples are:

- Providers such as chiropractors, podiatrists, social workers and message therapists;
- Benefits such as mammograms, well-child care, drug and alcohol abuse treatment;
- Populations such as non-custodial children and grandchildren.

The total mandate count in 2011 is 2,262, up from 2,156 in 2010. “Today the majority of states have more than 40 mandates each – some have more than 60 - and the accumulated impact of those dozens of increases has made health insurance unaffordable for many Americans.” Rhode Island and Virginia (70) have the most mandated benefits with Maryland (67), Minnesota (65) and Connecticut (63) close behind. Idaho (13) has the least mandated benefits, followed by Alabama (19), Michigan (23), Hawaii (24) and Utah (26).

(Note: Mandates in Signatory Society States of The Physicians Foundation are: AK(37), CA (56), CO (58), CT (63), FL (49), GA (45), HI (24), LA (51), NC (55), NE (47), NH (46), NJ (47), NY (61), SC (30), TN (41), TX (62), VA (70), VT (46), and WA (58).)

Strangely enough, the report does not give overall cost estimates of the mandates. But it does say, unequivocally, that “one of the biggest cost drivers in our health care system is the steady proliferation of federal and state-based coverage mandates.” According to the CAHI research and annual analysis, “mandated benefits currently increase the cost of basic health insurance from slightly less than 10 percent to more than 50 percent.” The CAHI concludes that “government interference in the health care system is steadily increasing. So too is the cost of (health) insurance.”

Life Style

Some 47% - 50% of Americans account for zero percent of all health care spending. A positive life style had much to do with it.

Chronic diseases are the most common and costly of all health problems, but they are also the most preventable. According to the CDC’s National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), our common, health-damaging but modifiable behaviors – tobacco use, insufficient physical activity, poor eating habits, and excessive alcohol use –are responsible for much of the illness, disability, and premature death related to chronic disease.

- More than 43 million (about 1 in 5) U.S. adults smoke.
- 1 in 5 U.S. high school students are current smokers.
- More than one-third of all U.S. adults fail to meet minimum recommendations for aerobic physical activity based on the 2008 Physical Activity Guidelines for Americans. As reported in *The Week* (August 17, 2012), a global study found that the U.S. ranked among the most physically lazy countries in the world, with 40% of Americans engaging in little or no physical activity. Greece was found to be the most active country in the Western world with just 15% inactive.
- Only 1 in 3 U.S. high school students participated in daily physical education classes.
- More than 60% of U.S. children and adolescents eat more than the recommended daily amounts of saturated fat.
- Only 24% of U.S. adults and 20% of U.S. high school students eat five or more servings of fruits and vegetables per day.

Obviously, one important way of encouraging prevention is to begin with obesity. A recent article in the *Journal of the American Medical Association (JAMA)* pointed out that in 2010, more than 35% of adults and 16% of children aged 2-19 years were obese.

A recent *Wall Street Journal* article tracks the overall U.S. obesity rate as being 17% in 1997, 22% in 2002 and 28% in 2011. The maximum load or weight limit for a CAT scanner to accommodate an obese patient was 300 pounds in 1997, 490 in 2002 and 660 in 2011. New machines are being built for heavier patients, and hospitals and physicians will have to pay as much as 40% more for the larger sized scanner which now costs up to \$650,000.

Chronic Diseases / Conditions

According to federal data, the costliest 1% of patients account for 20% of all health care spending in the United States. Ten percent of the population consumes 63% of the total health care dollars in the country. People with three or more chronic disease conditions generally fall into that 1% - according to Linda Dunbar, RN, PhD, and Vice President of Care Management at Johns Hopkins Healthcare.

Experts seem to all agree that more than 75% of health care costs are due to chronic conditions such as heart disease, cancer, stroke, diabetes and arthritis. The National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) says that chronic diseases cause 7 in 10 deaths each year in the U.S. and that, alarmingly, the percentage of U.S. children and adolescents with a chronic health condition have increased from 1.8% in the 1960s to more than 7% in 2004. Although chronic diseases are obviously more common among older adults, (nearly 1 in 2 adults live with at least one chronic illness, and 88% of Americans over 65 have at least one chronic health condition) they affect people of all ages and are now recognized as a “leading health concern of the nation.”

The NCCPDHP points out the following about key chronic diseases:

- Heart disease and stroke are the first and third leading causes of death, accounting for more than 30% of all U.S. deaths each year.
- Cancer, the second leading cause of death, claims more than half a million lives each year.

- Diabetes is the leading cause of kidney failure, non-traumatic lower extremity amputations, and new cases of blindness each year among U.S. adults aged 20-74 years.
- Arthritis, the most common cause of disability, limits activity for 19 million U.S. adults.
- Obesity has become a major health concern for people of all ages. 1 in every 3 adults and nearly 1 in every 5 young people aged 6-19 are obese.

Chronic diseases are the most common and costly of all health problems, but they are also the most preventable. Four common, health-damaging, but modifiable behaviors – tobacco use, insufficient physical activity, poor eating habits, and excessive alcohol use – are responsible for much of the illness, disability, and premature death related to chronic diseases.

All experts agree that in order to get a better handle on rising health care costs, we must better address the costliest 10 percent which account for 63% of health care costs.

Aging

The previously mentioned authors of the RWJF Report entitled *“High and Rising Health Care Costs: Demystifying U.S. Health Care Spending”* agree that technological change is the most important driver of health spending increases over time and that population aging plays only a minor role. Just as in examining all of the components driving health care costs, there is room for much disagreement.

For example, the Social Security Advisory Board’s report entitled *“The Unsustainable Cost of Health Care”*, reiterates that “most research on the effect of aging on health care spending has found relatively small effects.” Mentioned in the report is a CBO review of the literature which estimates that from 1940 to 1990 population aging only accounted for about 2 percent of overall health care cost growth.

But the aging of the baby boomer generation over the next 25 years or so is expected to play a large role in the increased cost of Medicare and Medicaid. “According to the CBO’s most recent Long-Term Budget Outlook projections, aging will account for about 44 percent of growth in the two programs through 2035.”

End of Life Care

WNET, N.Y. Channel 13 reported recently on the Health Care Financing Administration (HCFA) end-of-life spending trends study of 1993 which looked at data for 1975, 1980, 1985 and 1988. Although somewhat dated, it remains one of the most extensive studies in the field.

“Their findings belie perceptions that a larger percentage of medical expenses are accounted for by terminally ill persons whose lives were prolonged by expensive technology. Gerald Riley, a HCFA actuary, conducted the analysis with colleague James Lubitz and published in the 1993 New England Journal of Medicine. They found no evidence that elderly persons in the last year of life account for a larger share of Medicare expenditures today than before the onslaught of technology. In fact, Medicare paid the exact same percentage for patients in the last two months of life in 1976 as in 1988. This implies that heroic efforts to preserve life in the last months did not have a disproportionate effect on increasing the proportion of Medicare outlays. Riley says that if life-preserving efforts had become more frequent, there would have been an increase in the percentage of dollars spent in the last couple of months of life.”

More data on end-of-life care included:

- 27 to 30 percent of Medicare payments cover the cost of care for people in the last year of life.
- 12 percent of Medicare spending covers people who are in the last two months.
- 10 percent of Medicare beneficiaries account for 70 percent of program spending.

Reuters Health reported in October 2010 that “health care costs at the end of life show no signs of leveling off, according to new research from the United States and Canada published in the *Archives of Internal Medicine*. But other trends over the past decade, including a sharp increase in use of hospice services, could point the way toward bringing these costs down while improving patient care,” Dr. Jonathan Bergman of the University of California at Los Angeles, author of one of the studies, told *Reuters Health*.

“We end up spending about a third of our overall health care resources in the last year of life,” Bergman said. “It represents a huge avenue for improvement.”

“Bergman and his team did find that hospice patients were about 20 percent less likely to receive high-intensity care, for example admission to the intensive care unit, two or more emergency department visits, or cardiopulmonary resuscitation. They also received fewer imaging tests, which are costly and are known to have no benefit for dying prostate cancer patients. Evidence suggests that hospice care can cut health care costs, especially for cancer patients, Berman and his team note, although they did not look at cost in their study.”

According to a *Wall Street Journal* analysis of Medicare data reported in July 2012, a “sliver of the sickest patients account for the majority of health care spending. In 2009, the top 10% of Medicare beneficiaries who received hospital care accounted for 64% of the program’s hospital spending. Medicare patients rack up disproportionate costs in the final year of life. In 2009, 6.6% of the people who received hospital care died. Those 1.6 million people accounted for 22.3% of total hospital expenditures.”

Health Disparities

The U.S. Department of Health and Human Services’ Centers for Disease Control and Prevention, issued a Health Disparities and Inequalities Report for the United States in 2011. It states that the existence and persistence of substantial disparities in mortality, morbidity, risk behaviors, and hazardous environmental exposures between and among segments of the U.S. populations have been well-documented. The socioeconomic circumstances of persons and the places where they live and work strongly influences their health. Educational attainment and family or household incomes are two indicators used commonly to assess the influence of socioeconomic circumstances on health. A substantial proportion of the child and adult population is vulnerable to health problems because of insufficient resources.

Richard Cooper, MD, argues that it is economic disparity that drives health care utilization and therefore health care spending.

He goes on to say that “Poorer people are demonstratively sicker and cost more to treat than do economically stable people by a large margin. Therefore, the key to lowering health care costs is to reduce poverty and increase wealth.” A poll commissioned by the Canadian Medical Association which was reported in an editorial of the *Globe and Mail* in August of 2012, substantiates Dr. Cooper’s claims by suggesting that low-income Canadians are in significantly worse health than those with higher income and more education. The survey, carried out by Ipsos Reid, found that just 39 percent of those who earn less than \$30,000 believe their health is excellent or good, compared with 68 percent of those who earn \$60,000 or more. Those in the latter group also reported that they smoke less, sleep and exercise more and eat more vegetables.

Another article in the *Globe and Mail* went on to say that: “One in four Canadians earning less than \$30,000 annually have delayed or stopped taking prescription drugs because they did not have money to pay for the treatment. By contrast, fewer than one in 30 citizens earning more than \$60,000 a year has had trouble paying for necessary medication, according to the survey commissioned by the Canadian Medical Association. “What is particularly worrisome for Canada’s doctors is that in a nation as prosperous as Canada, the gap between the haves and have-nots appears to be widening.”

That gap is widening in the United States as well. A report in the *New York Times* magazine on August 19, 2012, describes its impact. The Census Bureau tracks a category that the government calls “deep poverty”; families are said to be in deep poverty if they earn less than 50 percent of the poverty line – which means around \$11,000 a year for a family of four, not including food stamps or other noncash support. The number of families in deep poverty grew sharply during the recent recession and its aftermath, and in 2010, the share of Americans whose families made less than half of the poverty line hit a record: 6.7 percent of the population, or 1 in 15 Americans. The numbers are even higher for children, disturbingly so. In 2010, 1 in every 10 American children lived in deep poverty.”

These numbers are sobering and lead to tragic consequences, including poorer health. The poor health also leads to higher health care costs and poorer outcomes.

Between 2003 and 2006 the Joint Center for Political and Economic Studies estimated the total direct and indirect costs of health inequities affecting racial and ethnic minority populations, including lost wages and productivity – exceeded \$1.2 trillion.

The Urban Institute says that among African Americans and Hispanics, the health care cost burden of three preventable conditions – high blood pressure, diabetes and stroke – was about \$23.9 billion in 2009.

Conclusions

According to a Henry J. Kaiser Family Foundation Study in May 2012 entitled: *Health Care Costs – A Primer – Key Information on Health Care Costs and their Impact*, the U.S. spent \$2.6 trillion on health care in 2010.

Half of health care spending is used to treat just 5% of the population. “A recent study (David Squires: Explaining High Health Care Spending in the U.S., May 2012) found that U.S. health care spending is higher than that of other countries most likely because of higher prices and perhaps more readily accessible technology; and greater obesity, rather than higher income, an older population, or a greater supply of utilization of hospitals and doctors.

As mentioned in the Kaiser study, “another factor which may help explain rising health spending is the falling share of health care expenditures that Americans pay out-of-pocket. Between 1970 and 2010, the share of personal health expenditures paid directly out-of-pocket by consumers fell from 40% to 14%. Although consumers face rising health insurance premiums over the period which affected their budgets, lower cost sharing at the point of service likely enabled consumers to use more health care, leading to expenditure growth.”

Clearly, to achieve cost savings in our health care system, experts must look at those factors that are driving health care costs above the gross domestic product (GDP), population growth and inflation.

Nearly one-third of all health care spending goes to paper work and administration;
(*Newsweek*: The Cost of Hope, June 4 and 11, 2012)

- Technology, which most experts agree accounts for the greatest rise in health care costs;
- Chronic conditions, which account for up to 75% of all health care costs;
- Obesity, which often leads to diabetes which begets peripheral vascular disease and coronary disease which begets congestive heart failure;
- Life style behavior including addiction
- Inefficient medical liability system
- End of life costs
- Legislative mandates – especially health insurance mandates
- Half of all health care expenditures are used to treat just 5% of the population. (It would seem that this represents the most fertile area for cost savings.)

The literature and data simply do not point to physicians as a primary or even secondary cause of rising health care costs. Physicians have been a favorite target of critics for years for cost increases, but the facts indicate otherwise.

Interesting Statistics about the U.S. Health Care System

Compiled by HealthReformQuestions.com

Did You Know?

America's infant mortality rate is higher than 47 other countries, according to the *U.S. CIA World Fact Book*, including many much less developed countries and many countries with government-run health care systems.

Infant mortality rates can be a poor indicator of the success or failure of the health care system and that America's high infant mortality rate is partially driven by the U.S. commitment to save the smallest newborns.

- U.S. Counts More Babies as Born Alive than other Countries Do: Many babies who are born too premature have little to no hope of living. Yet the United States counts these babies as born alive and therefore as infant deaths, when other developed countries categorize them as "still-born." Analysts estimate that this fact alone could inflate the United States infant mortality rate by 40 percent. (*National Institute for Health*)
- Other Demographic Factors: Factors such as obesity, substance abuse, race, and age contribute to the United States misleadingly high infant mortality rate. For example, teenagers who give birth are more likely to have low-weight babies, who are less likely to survive. The United States has a much higher rate of teenage births than do other OECD countries. (*National Bureau of Economic Research and the American Enterprise Institute*)
- A study for the National Bureau of Economic Research found that if you control weight at birth alone, the United States has a lower infant mortality rate than does Canada. (*National Bureau of Economic Research*)

America ranks 42nd among countries for life expectancy at birth. (MSNBC)

But did you know...that this measure doesn't tell us much about the effectiveness of the U.S. health care system?

- The flaws in infant mortality (discussed previously) also affect the life expectancy numbers.
- Demographic and life style factors (such as obesity, incidents of smoking) also have a profound effect on a population's life expectancy, and have little reflection on the effectiveness of the health care system.
- The United States also has a much higher rate of death due to accidents and crime than other developed countries, which reduces the average U.S. life expectancy. This is a serious problem on its own, but it is largely unrelated to the quality of our health care system.

A better assessment of a health care system's effectiveness is how it addresses actual illnesses.

- Did you know that the United States is ranked #1 in the world for "responsiveness to the needs and choices of the individual patient"? (*World Health Organization*)
- Did you know that the United States has the highest survival rate of any OECD country? (*Forbes* and the *Lancet Oncology Journal*)

Americans should also be aware of ways that the American system is actually superior.

Did You Know?

The United States leads the world in new medical innovations?

- A 2009 study shows American scientists won the Nobel Prize in 33 out of the previous 40 years, whereas scientists from the entire rest of the world won it in only 25 out of those 40 years (often it was shared between Americans and non-Americans). Additionally, of the top 27 drugs and devices, U.S. physicians, companies, and scientists had a hand in developing 20 of them, whereas European physicians, companies and scientists only had a hand in 14. (*Cato Institute*)

- This means that even the health care that patients are getting in Canada, Europe, Australia, and other places is partly due to the creative capacities of the U.S. health care system.

Americans actually report significantly shorter waiting times than patients in other countries?

- Just 5 percent of Americans report having to wait more than four months for elective surgery, compared to Australia (23 percent), Canada (27 percent), New Zealand (26 percent) and the United Kingdom (38 percent). (*OECD report*)
- Americans had more access to new cancer fighting drugs than Canadians or Europeans because of their longer approval process. In some cases, it took Canada more than 180 days longer to green light a new cancer treatment than in the U.S. (*Fraser Institute*)
- Canadians periodically have to turn to the United States for the use of their highly specialized medical facilities. For example, in 2007, a woman from Calgary, Canada had to be flown to Montana to deliver quadruplets, because there were no adequate neonatal facilities available. Similarly women from Alberta, Canada had to be transferred to Montana to deliver babies because of a shortage of neonatal facilities. (*CBC News*)

The United States spends more than any other country in the world on health care and more Americans worry about the cost of medical care than other countries. Yet did you know that there many reasons why the U.S. spends more, and that some of those are because of government policies that drive up costs?

- **Working Hard to Save Every Life:** The United States develops most new health care techniques and treatments, and makes use of these new innovations to try to save lives that other countries might deem hopeless. As described previously, babies born prematurely receive extensive—and expensive—treatment protocols. These extreme measures can be costly. (*American Enterprise Institute*).
- **A Complex Multi-party Payer System:** Most working age Americans obtain health insurance through their employers. They do not pay directly for health services, and they don't even directly choose their health insurance provider.

This means that many Americans have no reason to consider cost when making health care decisions, which encourages overconsumption and makes it possible for health service providers to charge higher prices. (*Health Affairs* and *Forbes*).

It's not just health insurers between us and our doctors; it's also the government.

The federal government runs Medicare and Medicaid, two expensive government insurance programs that cover about 30 percent of the Americans (*The Henry J. Kaiser Family Foundation*). The way these programs are operated has a profound effect on the private market.

- **Government Regulations:** Governments require insurers to include more and more treatments and services in our insurance policies. This encourages over-consumption of some procedures, and means that we are paying to finance many treatments that we may not want, need, or use. State and federal mandates raise health insurance premiums by between 10 and 50 percent. (*Council for Affordable Health Insurance*)
- **Lawsuits Encourage Defensive Medicine, Raise Costs:** Hospitals and doctors fear costly medical malpractice suits so carry insurance and issuing unnecessary tests to minimize the potential for lawsuits. . These push our overall health care spending higher, and affect the insurance prices for all Americans. Analysts estimate that the medical malpractice increase health care costs by between 7.2 and 12.7 percent. (*Heartland Institute* and *Pacific Research Institute*)