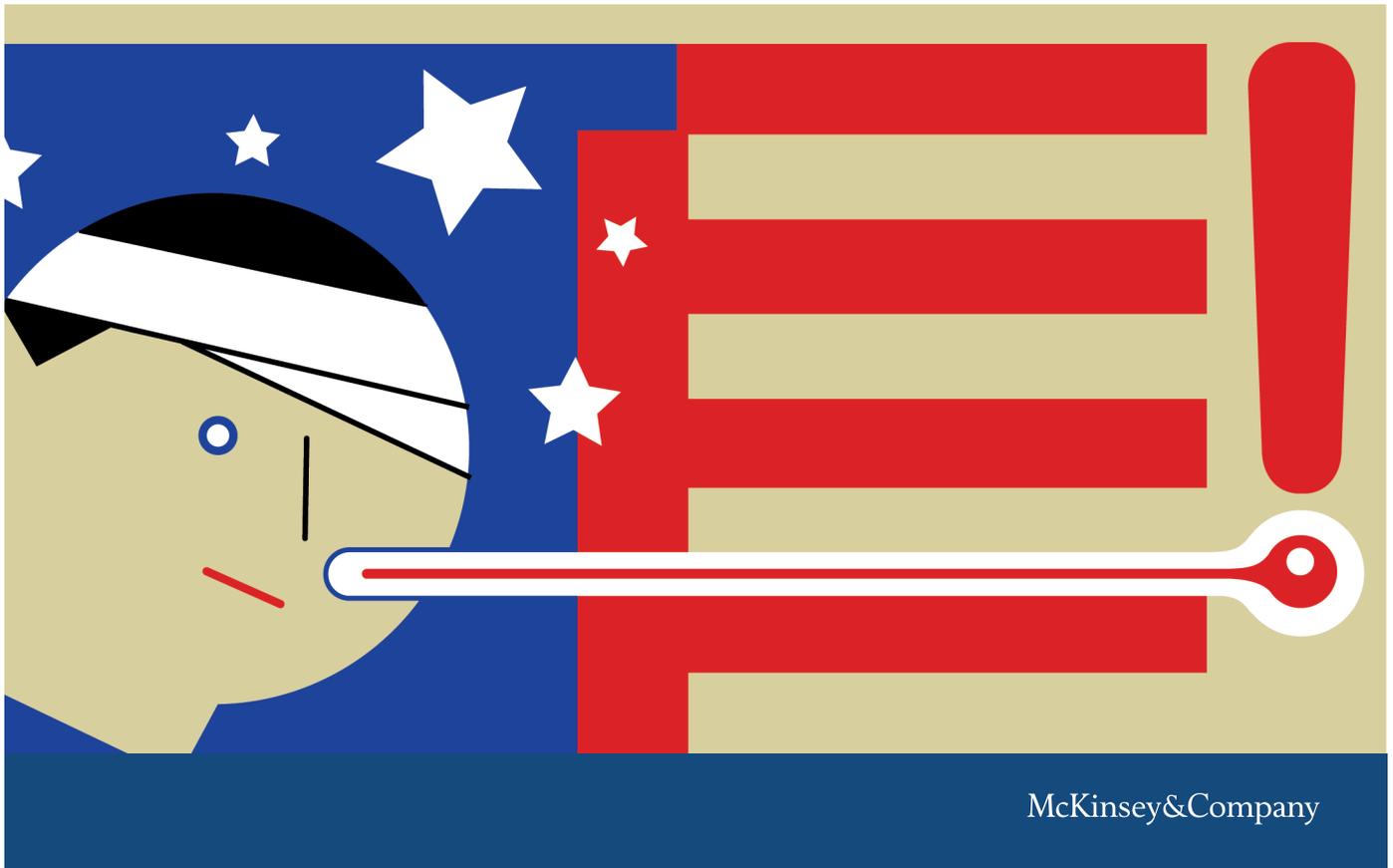


HEALTH CARE

December 2008

Why Americans pay more for health care

The United States spends more on health care than comparable countries do and more than its wealth would suggest. Here's how—and why.



The health care debate in the United States excites great passion. Issues such as how to make care available, to structure insurance, and to rein in spending by the government, corporations, and individuals frequently take center stage. Often missing, though, are basic economic facts. New research from the McKinsey Global Institute (MGI) and McKinsey's health care practice sheds light on a critical piece of the puzzle: the cost of care.

Our research indicates that the United States spends \$650 billion more on health care than might be expected given the country's wealth and the experience of comparable members of the Organisation for Economic Co-operation and Development (OECD). The research also pinpoints where that extra spending goes. Roughly two-thirds of it pays for outpatient care, including visits to physicians, same-day hospital treatment, and emergency-room care. The next-largest contributors to the extra spending are drugs and administration and insurance.

It's not clear whether the United States gets \$650 billion worth of extra value. Parts of the US health care system, such as its best hospitals, are clearly world class. Cutting-edge drugs and treatments are available earlier there, and waiting times to see physicians tend to be lower. Yet the country lags behind other OECD members on a number of outcome measures, including life expectancy and infant mortality. Furthermore, access to health care is unequal: more than 45 million Americans lack insurance.

The challenge for health care reformers is to retain the current system's strengths while addressing its deficiencies and curbing costs. That won't be easy. Our research on the system's costs and the incentives underlying them indicates that without the involvement of all major stakeholders (such as hospitals, payers, and doctors) reform is likely to prove elusive. The research also suggests that while there are many possible paths to reform, it is unlikely to succeed unless it deals comprehensively with health care demand, supply, and payments.

A \$650 billion spending gap

Across the world, richer countries generally spend a disproportionate share of their income on health care. In the language of economics, it is a "superior good." Just as wealthier people might spend a larger proportion of their income to buy bigger homes or homes in better neighborhoods, wealthier countries tend to spend more on health care.

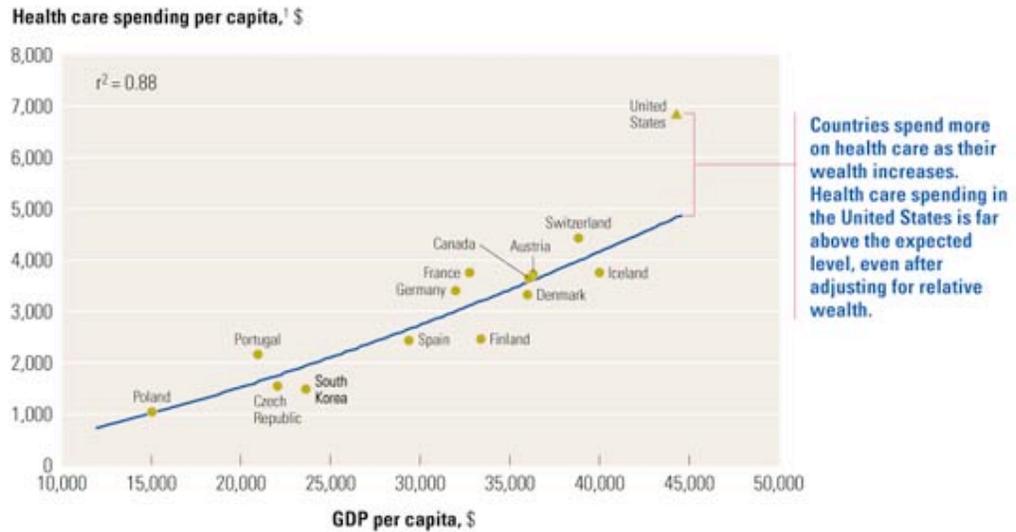
Yet even accounting for this economic relationship, the United States still spends \$650 billion more on health care than might be inferred from its

wealth. MGI arrived at this figure by using data from 13 OECD countries to develop a metric called estimated spending according to wealth (ESAW), which adjusts health care expenditures according to per capita GDP. No other developed country's spending above the ESAW level approaches that of the United States (Exhibit 1).

EXHIBIT 1

More than expected

Trendline of countries' expected spending according to wealth, 2006



Countries spend more on health care as their wealth increases. Health care spending in the United States is far above the expected level, even after adjusting for relative wealth.

r^2 is the proportion of variance explained by a regression.

¹Adjusted for purchasing-power parity.

Source: Organisation for Economic Co-operation and Development (OECD)

Is it paying so much more because its people are less healthy than those of other countries? Our research indicates that the answer is no. While lifestyle-induced diseases, such as obesity, are on the rise in the United States, the most common diseases are, on average, slightly less prevalent there than in peer OECD members. The factors contributing to the lower disease rates include the relatively younger (and therefore less disease-prone) population of the United States, as well as the low prevalence of smoking-related problems. Factoring in the average cost of treatment for each disease, we still find that the relative health of the US population does not account for the higher cost of health care.

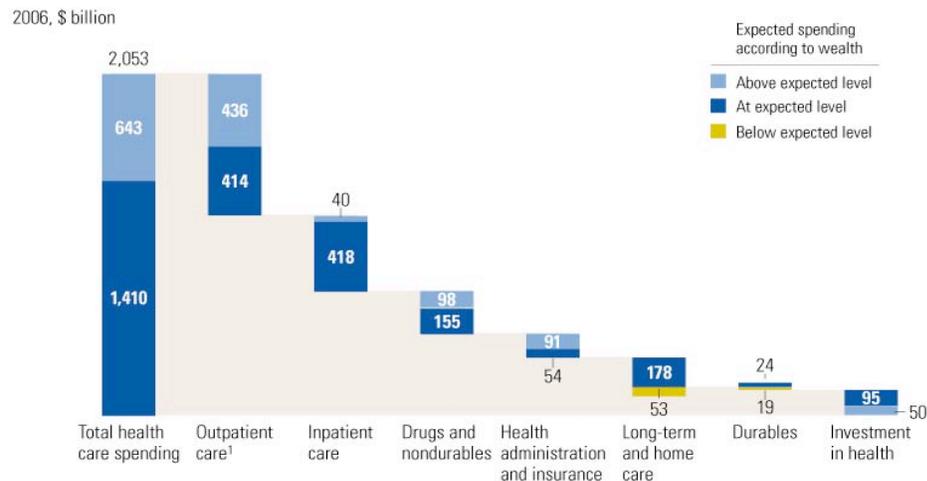
Analyzing the problem

MGI broke down health care costs into their components to identify the sources of this higher-than-expected spending (Exhibit 2). Outpatient care is by far the

largest and fastest-growing part of it, accounting for \$436 billion, or two-thirds of the \$650 billion figure. The cost of drugs and the cost of health care administration and insurance (all nonmedical costs incurred by health care payers) account for an additional \$98 billion and \$91 billion, respectively, in extra spending. By contrast, US expenditures on long-term and home care, as well as on durable medical equipment (such as eyeglasses, wheelchairs, and hearing aids), is actually less than would be expected given the country's wealth.

EXHIBIT 2

High outpatient costs



¹Outpatient care includes care in the offices of physicians and dentists, same-day visits to hospitals (including emergency departments), ambulatory surgery, diagnostic-imaging centers, and other same-day care facilities.

Source: Organisation for Economic Co-operation and Development (OECD); McKinsey Global Institute analysis

Outpatient care

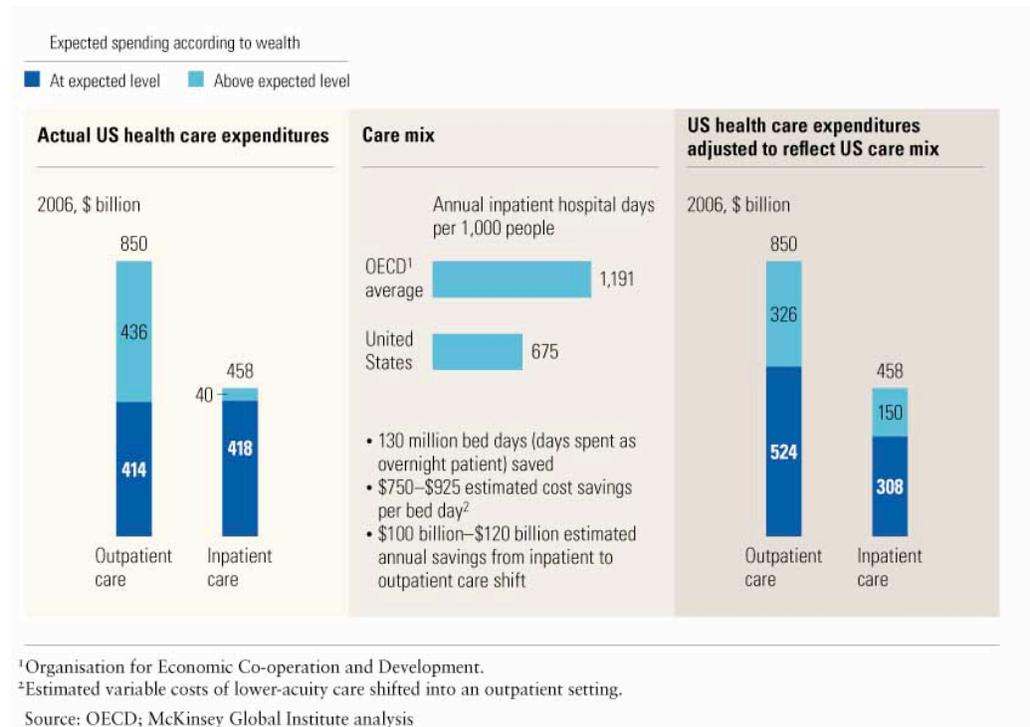
The high and fast-growing cost of outpatient care reflects a structural shift in the United States away from inpatient settings, such as overnight hospital stays. Today, the US system delivers 65 percent of all care in outpatient contexts, up from 43 percent in 1980, and well above the OECD average of 52 percent. In theory, this shift should help to save money, since fixed costs in outpatient settings tend to be lower than the cost of overnight hospital stays. In reality, however, the shift to outpatient care has added to—not taken away from—total system costs because of the higher utilization of outpatient care in the United States.

We evaluated the economic impact of this structural shift by analyzing US inpatient care and comparing it with the practices of other OECD health

systems. We estimate that the United States saves \$100 billion to \$120 billion a year on inpatient care thanks to shorter hospital stays and fewer hospital admissions. If we attribute these savings to the US health system’s ability to provide care in outpatient settings, that would reduce above-ESAW outpatient expenditures—but only to \$326 billion. This enormous figure still represents half of the US health care system’s \$650 billion in extra costs (Exhibit 3).

EXHIBIT 3

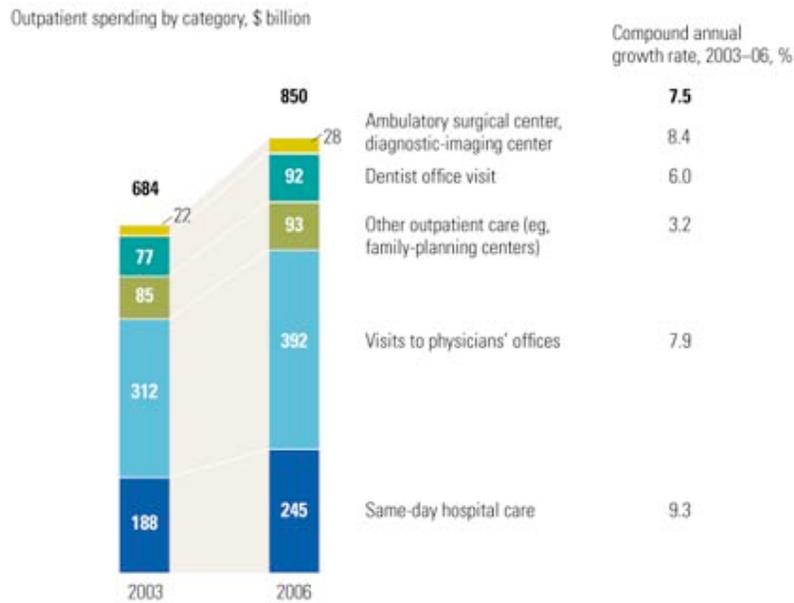
Still costly



The two largest and fastest-growing categories of outpatient spending are same-day hospital care and visits to physicians’ offices (Exhibit 4). From 2003 to 2006, the cost of these two categories increased by 9.3 and 7.9 percent a year, respectively. Growth in the number of visits played only a modest role in explaining the increase in costs—the number of same-day hospital visits rose by 2.1 percent annually, and the number of visits to physicians’ offices remained relatively flat during this period.

EXHIBIT 4

The doctor is in



Source: Analysts' reports; Medical Expenditure Panel Survey (MEPS), US Census Bureau; Organisation for Economic Co-operation and Development (OECD); US Department of Health and Human Services; US Medicare Payment Advisory Commission (MedPAC)

Far more important was a surge in the average cost per visit resulting from factors such as the additional care delivered during visits, a shift toward more expensive procedures (for example, diagnostic ones such as CT and MRI scans), and absolute price increases for equivalent procedures.¹ In all likelihood, costs have also gone up because over the past decade there has been a marked shift in the delivery of care, from general practitioners to specialists.

Behind those proximate causes, several forces contribute to the rising cost of outpatient care across the entire range of settings, not just same-day hospital stays and visits to physicians' offices. For starters, outpatient care is highly profitable—US hospitals earn a significant percentage of their profits from elective same-day care—which prompts investments in the facilities and people supporting it. These investments can be recouped only by offering more (and more expensive) services. The significant degree of discretion that physicians have over the course and extent of outpatient treatment also probably plays a role, as does the fee-for-service reimbursement system, which creates financial incentives to provide more outpatient care.

Finally, there is no effective check on it. On average, the out-of-pocket expense of patients represents only 15 percent of the total cost, so they are relatively

insensitive to it and apt to follow the advice of their physicians. Other countries also have low out-of-pocket expenses but use supply-oriented controls to compensate for the lack of demand-side value consciousness.

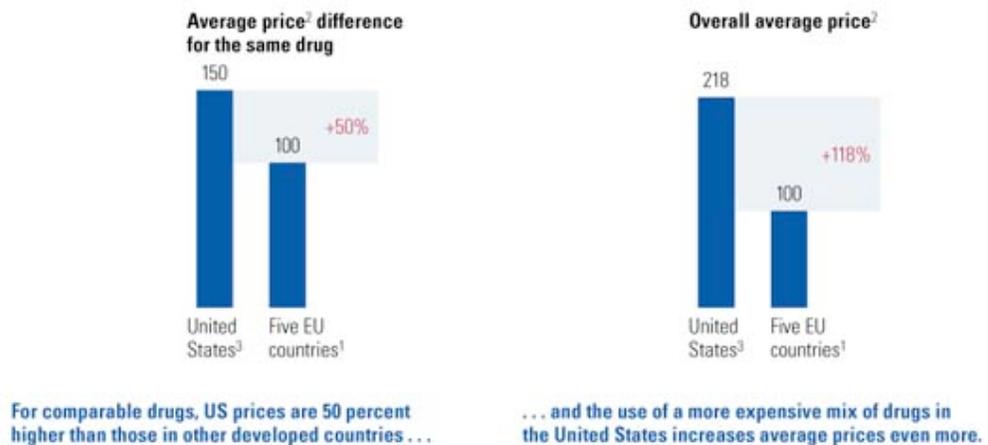
Pharmaceuticals

After outpatient care, the category with the highest above-ESAW expenditures, at \$98 billion, is prescription drugs—not because Americans are buying more of them but rather because they cost 50 percent more than equivalent products in other OECD countries (Exhibit 5).² The United States also uses a more expensive mix of drugs; the price of a statistically average pill is 118 percent higher than that of its OECD equivalents. One reason is probably that new drugs, which tend to carry a price premium, are widely prescribed one to two years earlier in the United States than in Europe.

EXHIBIT 5

A high premium

\$ per pill; index: average price for five EU countries¹ = 100



¹ France, Germany, Italy, Spain, and United Kingdom.

²Assumes 15 percent rebates from manufacturers to payers and pharmacy benefit managers.

³Manufacturer price.

Source: IMS Health; McKinsey Global Institute analysis

Several frequent explanations for higher US drug prices deserve examination. One is the wealth of the United States, which enables it to spend more on economically superior goods, such as drugs. Another is that high US prices subsidize research and development for the rest of the world. Marketing and sales spending by companies is higher in the United States than in other OECD countries (which generally restrict direct-to-physician or consumer advertising), and that also could play a role.

But none of these factors, by itself, can explain the gap between the price of drugs in the United States and the rest of the OECD. When we adjust for US wealth, we find that the country's branded-drug prices should carry a premium of some 30 percent, not 77 percent for branded small-molecule drugs. Similarly, if global pharma R&D spending—\$40 billion to \$50 billion in 2006—were financed entirely through higher branded-drug prices, the US price premium over similar countries would be 23 to 28 percent. Finally, in 2006 the sales and marketing expenditures of US pharma companies came to \$30 billion to \$40 billion, only 17 to 23 percent of current US prices.

Health administration and insurance

The third-largest source of above-ESAW spending is health administration and insurance, at \$91 billion. In this category, the United States spent \$486 per capita in 2006—twice the outlay of the next-highest spender, France, with \$248, and nearly five times the average of \$103 across peer OECD countries.

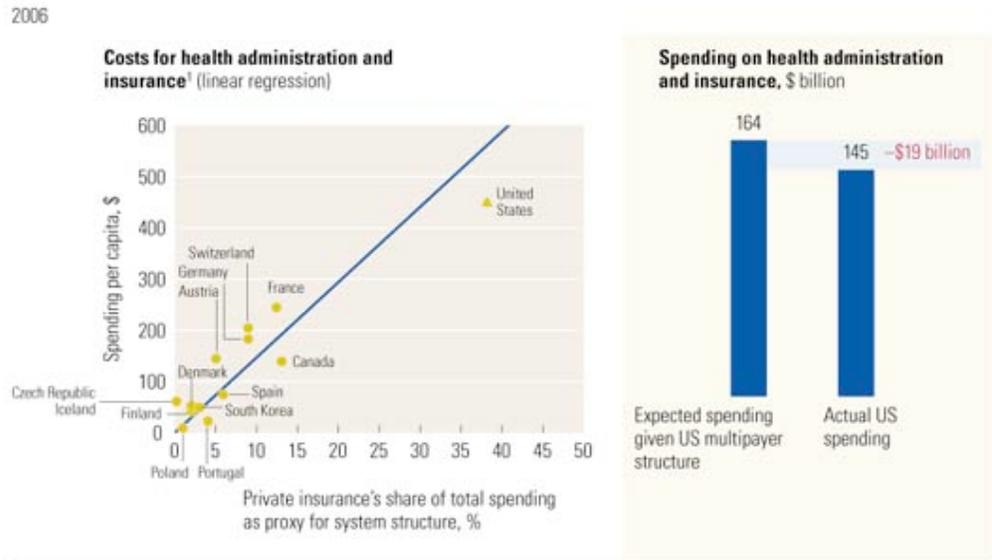
Of the \$91 billion in above-expected spending, \$63 billion is attributable to private payers. Profits and taxes—a negligible expense in OECD countries with single-payer systems—account for nearly half of this total. The cost of public administration for Medicare, Medicaid, and other government programs accounts for the remaining \$28 billion in US above-ESAW spending.

These higher costs largely reflect the diversity and number of payers as well as the multistate regulation of the US health care system. Its structure creates additional costs and inefficiencies: redundant marketing, underwriting, claims processing, and management overhead. In other OECD countries, with less-fragmented payment systems, these costs are much lower. Interestingly, we find that given the structure of the US system, its administrative costs are actually \$19 billion less than expected, suggesting that payers have had some success in restraining costs (Exhibit 6).

Of course, the US multipayer system could create value to the extent that it develops effective programs to promote health and prevent disease, competes to drive down prices, innovates to improve customer service or benefits, or offers patients greater choice. But do the virtues of the US system outweigh its inefficiencies, and can these inefficiencies be reduced within its current structure?

EXHIBIT 6

An added burden



¹Adjusted for purchasing-power parity.

Source: Organisation for Economic Co-operation and Development (OECD); McKinsey Global Institute analysis

A framework for reform

The United States can take no single path to address the level and growth of every one of its health care costs. Any reform effort should involve all of the system’s stakeholders, for the inclusion of hospitals, payers, and doctors in the reform effort will increase the odds of arriving at a plan for change that each party will truly embrace. Furthermore, each party can play a distinct role in addressing the full spectrum of issues that must be part of any major system overhaul. For each of these areas, there are several possibilities for reform—such as raising public awareness, creating appropriate incentives, mandating desired behavior, and taking direct action.

For health care reform to generate lasting improvements in cost, quality, access, and equity, it must effectively address supply, demand, and payment.³ A number of our McKinsey colleagues recently completed an effort to determine what would be required to change trends in health care costs fundamentally. Here, we briefly lay out the principal issues for consideration by all health care reformers.

Demand

The general health of the US population is a significant issue. Although disease is no more prevalent in the United States than in peer OECD countries, the

health of its population is falling, and this decline contributes to the growth in medical costs. In fact, our analysis suggests that in the two-year period from 2003 to 2005, the decline raised them by \$20 billion to \$40 billion. Reformers should therefore focus on the preventative efforts that present the largest opportunity to improve overall health and thereby save money.

Equally important is the lack of any real value consciousness. In the United States, the “average” consumer of health care pays for only 12 percent of its total cost directly out of pocket (down from 47 percent in 1960), as well as for 25 percent of health care insurance premiums, a share that has stayed relatively constant for the last decade. Well-insured patients who bear little, if any, of the cost of their treatment have no incentive to be value-conscious health care consumers.

Moreover, even if they wanted to be value conscious, they don’t know enough. Despite recent efforts to expand consumer access to information on health care, its cost and quality remain opaque—arguably more so than in any other consumer industry. Consumers also know vastly less than providers do and therefore understandably rely on the advice and guidance of physicians. If Americans are to become more value-conscious consumers of health care, reformers must therefore determine how to create an appropriate level of price sensitivity and to give patients the right information, decision tools, and incentives.

Supply

In many industries, such as consumer electronics, innovation tends to drive down prices. The opposite is true in health care, where lower prices don’t necessarily boost sales and may even create the perception of low quality. Instead, innovation tends to focus on the development of increasingly more expensive products and techniques. High-priced technologies, from imaging to surgical equipment, also mean higher reimbursements for providers, who therefore demand cutting-edge products. So what emerges is a constant cycle of cost inflation along the entire health care value chain—from manufacturers of health products to equipment manufacturers to physicians to hospitals to payers and, ultimately, to employers and patients. At each step, the stakeholders absorb part of the cost increase and attempt to pass an even larger one onto the next stakeholder. Reformers must determine how to address this cost inflation cycle while retaining the beneficial aspects of innovation.

Intermediation

Medicare and many commercial payers base their reimbursements for inpatient care on episodes or diagnosis-related groups (DRGs). This forces

providers to bear part of the risk of treating a patient and largely creates incentives to use resources efficiently. But fee-for-service reimbursement, the predominant method in outpatient treatment, does not have that effect and actually gives providers strong financial incentives to provide more (and more costly) care, not more value. Fear of malpractice suits boosts care volumes too. Our research indicates that the direct costs of malpractice are limited—about \$30 billion in 2006—but the risk of litigation creates an incentive to err on the side of caution. Reformers therefore need to develop more effective financing and payment approaches ensuring that care providers have the right incentives to give patients an appropriate type and amount of care.

Medicare’s role in influencing coverage and pricing dynamics also bears investigation. Private payers use this public program as a critical benchmark, more often than not following its lead, when they make decisions about which new procedures and technologies to reimburse. Because Medicare essentially uses a cost-plus formula to set reimbursement rates, it puts care providers under less pressure to reduce expenses than it could with another reimbursement mechanism. What’s more, trends in the reimbursement rates of commercial payers are strongly correlated—but inversely—with Medicare pricing trends: private insurers grant providers higher increases when Medicare reimbursements grow more slowly. This suggests both that Medicare prices partly drive so-called market prices and that care providers have a significant amount of pricing power with private insurers. Reformers need to determine how public programs, such as Medicare and Medicaid, can lead the market toward rational change in reimbursement approaches and levels.

Reform won’t be easy. But armed with the facts about what the United States spends on different aspects of health care, how much above what might be expected that spending really is, and the underlying economic dynamics of the system, policy makers will have a better chance to curb the growth of costs. 

About the Authors

Diana Farrell is director of the McKinsey Global Institute, and **Eric Jensen** is a consultant in McKinsey’s Washington, DC, office, where **Bob Kocher** is a principal.

Notes

¹CT (computerized tomography) and MRI (magnetic resonance imaging) scans are diagnostic tests that provide high-resolution pictures of the structure of any organ or part of the body requiring examination.

²Fifty percent represents the weighted average premium for branded drugs (77 percent), biologics (35 percent), and generics (-11 percent).

³For more on a reform framework encompassing supply, demand, and payment for care, see Diana Farrell, Nicolaus P. Henke, and Paul D. Mango, “Universal principles for health care reform,” mckinseyquarterly.com, February 2007;

and Jean P. Drouin, Viktor Hediger, and Nicolaus Henke, “Health care costs: A market-based view,” mckinseyquarterly.com, September 2008.

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