Why Does the U.S. Have High-Cost Low-Quality Healthcare?

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by Michael Edesess and Kwok L. Tsui

The U.S. has worse mortality rates than virtually all other developed nations, and yet it spends twice as much per capita on health care. How on earth has the U.S. racked up such an appallingly bad health-care record, and what is the solution? A recent edition of the Journal of the American Medical Association (JAMA) identified many of the problems but was not persuasive in prescribing a cure.

Let’s look at what ails the U.S. health-care system and the difficulties one encounters when trying to fix it. Three solutions — transparent pricing, telemedicine, and resource rationing — could help improve cost and quality problems that the U.S. health care industry faces today.

A litany of underperformance

The Nov. 13 JAMA confirms the basic fact that the U.S. spends twice as much as other developed nations do on healthcare but has worse outcomes.

As reported in an article in The Atlantic earlier this year, the United States has higher mortality rates in all population categories than do 16 other developed nations: Japan, Switzerland, Australia, Italy, France, Spain, Canada, Sweden, Austria, Norway, the Netherlands, Germany, Finland, the United Kingdom, Portugal and Denmark. And while U.S. life expectancies continue to increase, they are increasing at a slower rate than in other economically developed countries. (The Organization for Economic Co-operation and Development, the OECD, comprises the world’s most economically developed nations.)

A paper in the JAMA issue by Hamilton Moses III of the Alerion Institute and five coauthors, The Anatomy of Health Care in the United States, says that the U.S. ranks 19th out of 25 countries for its number of primary care physicians per 100,000 people. The debt-to-physician income ratio has doubled in the last generation, with primary care physicians having the highest debt ratio. The U.S. has fewer physicians per unit of GDP than almost all other developed countries. And while the number of physicians in most other developed countries is expected to rise, it is projected to remain flat in the U.S.

Says Richard A. Cooper in his JAMA article Unraveling the Physician Supply Dilemma, “Over the past decade, physician shortages have worsened, patients’ frustrations have increased. … Some
forecasters project that the shortages will further deepen, and many organizations and individuals are urging that residency training programs be expanded."

However, Cooper notes, others argue that additional physicians would simply work in places where there are enough already, inducing demand for unneeded care. "[O]ne view," says Cooper, "is that much of health care is wasted and, therefore, more physicians are not needed." In any case, Cooper says, "the expansion of residencies faces a wall of opposition."

Government funding for health research has declined in the last decade. Industry funding has slightly increased, but the total U.S. investment in health research has fallen since 2010.

The number of deaths from in-hospital medical errors is very high. A recent study based on 34 million U.S. hospitalizations in 2007 estimated that preventable in-hospital medical errors contribute to the deaths of at least 210,000 patients annually. (It is not clear however whether rates are higher or lower in other countries.)

Administrative costs in the private U.S. health-care sector are unusually high. The Moses et al. paper says that administrative costs as a percent of total spending are 13% for physicians and 8.5% for hospitals, and for insurers 12.3% for private payers but only 3.5% for public programs such as Medicare and Medicaid. According to Moses et al., "These costs compare unfavorably with what virtually every other care system in the world spends on accounting, insurance and management costs. … For instance, U.S. billing and insurance costs are 13.0% of revenue vs. 6.6% in Canada."

Causes of higher mortality and morbidity

Steven H. Woolf of Virginia Commonwealth University and Laudan Y. Aron of the Urban Institute, summarized their research findings in an earlier article this year in JAMA, "The U.S. Health Disadvantage Relative to Other High-Income Countries." Their summary makes for incredible reading. Not only are U.S. mortality rates higher per capita on average, but both U.S. males and females in almost all age groups – except after they succeed in reaching age 75 – have shorter life expectancies than in the 16 other developed countries. In addition, the U.S. ranks at or near the bottom in morbidity as well as mortality from multiple diseases and injuries.

According to the Woolf and Aron paper, U.S. infants are less likely to reach their first birthdays than infants born in peer countries. U.S. adolescents die at higher rates from motor vehicle crashes and homicides, have the highest pregnancy rates and have the highest prevalence of sexually transmitted infections. The U.S. has the second highest prevalence of HIV infection and the highest incidence of AIDS.

How can ill health and injuries be worse in so many categories in the U.S. — the most economically developed nation as measured in GDP per capita — than in countries that are its peers?

The Institute of Medicine report explored this question but could come up with only a hodge-podge of possible explanations. They include, according to the Moses et al. paper, factors not directly related to the quality of health care, such as "differences in cultural norms that affect healthy behaviors (gun
ownership, unprotected sex, drug use, seat belts), obesity and risk of trauma." The Woolf-Aron JAMA paper says that "people in the United States consume more calories per capita, are more likely to abuse drugs, are less likely to fasten seat belts, have more motor vehicle crashes involving alcohol and own more firearms than do people in other high-income countries. U.S. adolescents seem less likely to practice safe sex than adolescents in European countries. These problems are not products of the health care system."

But they say it is also due to deficiencies in the U.S. health-care system, which lacks universal health insurance coverage, offers weaker primary care than other nations, presents greater barriers to access and affordable care and coordinates care less well.

**Live free and die**

The author of The Atlantic article, Grace Rubenstein, attended a panel discussion at which the Woolf-Aron findings were presented. She quoted Woolf as saying that "our culture ‘cherishes independence’ and ‘wants to limit the intrusion of government in our personal lives.’ While those values serve us in some ways … our resistance to regulation ‘may work against our ability to achieve optimal health outcomes.’"

"Reading through the panel's suggested solutions, it's impossible not to notice that a number of these involve public money and policy, and so would have to get through Congress," Rubenstein wrote. "Many of the core recommendations read like the House Republicans' hit list: affordable health insurance for everyone, programs to encourage healthier behavior (read: nanny state), a stronger public safety net for people in poverty. There's even a hint of gun control.”

Another report coauthor on the panel, Paula Braveman, director of the Center on Social Disparities in Health at University of California, San Francisco, said, “Is it Americans' rugged individualism and the sense that the most important thing is the individual's freedom…?”

These comments prompt Rubenstein to speculate: “Might our national M.O., in other words, be summed up as ‘Live free and die?’"

**Causes of higher U.S. health-care costs**

Remember that the U.S. health problem is two-fold, according to the data in the JAMA and Atlantic articles: On the one hand, Americans have worse health and die younger than people in other developed nations. On the other hand, Americans pay twice as much for health care.

The health care industry’s increasingly large share of U.S. GDP is mostly due to higher prices, according to the Moses et al. article. Why are health-care prices so much higher than they were?

A paper by Uwe E. Reinhardt of the Wilson School of Public and International Affairs at Princeton University, The Disruptive Innovation of Price Transparency in Health Care, identified the problem with crystal clarity: It is a combination of opaque pricing and market power exercised by an increasingly consolidated hospital sector.
Reinhardt makes the interesting observation that the idea that “patients should have ‘more skin in the game’ through higher cost sharing, inducing them to shop around for cost-effective health care” is in practice “as silly as it has been cruel.” How can patients shop around for cost-effective health care when they can’t find out what the costs are?

To alleviate this problem, Reinhardt recommended improved insurer pricing mechanisms such as “reference pricing.” “Under that method,” says Reinhardt, “the insurer within a market area contributes only a set amount for a particular medical procedure, pegged on the lower price range for the procedure. The insured, fully apprised of the prices for the procedure charged by competing health-care service providers within the area, must then pay the full difference between that reference price and whatever higher price a hospital, physician, laboratory or imaging service chosen by the insured may charge.”

Reinhardt was critical of U.S. physicians and health-care organizations, saying that they “have always paid lip service to the virtue of the market, possibly without fully understanding what market actually means outside a safe fortress that keeps prices and quality of services opaque from potential buyers.”

**Transparency of quality of service**

Several papers in the *JAMA* issue also addressed the issue of quality transparency and the measurement of service quality. One of them, *Consumers Gaining Ground in Health Care*, made an assertion with which we disagree. It says, “Consumers should have better information about hospital and physician performance than they can glean from user reviews on Yelp, Zagatt’s, Angie’s List or other such sources.”

The implication is that a disorganized and un-quantified array of random comments by health-care users on websites is inferior to an organized system of quantified measures.

We disagree. The obsession with quantified measurement can go too far and has gone too far in many fields. In the area of health-care quality, a prospective consumer of healthcare is likely to find a better fit for her or his subjective requirements by perusing comments on a web forum than by reading quantified statistics that presume to accurately measure the quality of healthcare.

In the area of qualitative transparency, however, the same paper points to a favorable trend. “This year has also seen a leap forward in concepts like OpenNotes, a transparency movement that invites and enables patients to review not just their laboratory results and medication lists online, but their clinicians’ notes as well,” according to the paper. Nearly all patients who were given access to their clinician’s notes wanted to maintain that access after a year, as did the physicians.

But before issues like quality of service can be addressed, we must first agree on the appropriate metrics for the quality of health care. We have used mortality and life expectancy as the measures, but those are too blunt to compare the U.S. to other countries. The U.S. has higher levels of poverty, drug use and violence, for example, when compared to other nations, which make it extremely difficult to determine whether higher mortality rates are due to poorer healthcare or to other factors.
It is also important to look beyond the percentage of GDP spent on medical care as the metric by which the U.S. is compared to other countries. One must also consider the percentage of GDP spent on basic social services (food, housing, clothing and heat), as well as the money available for individual discretionary spending. Other countries outspend the U.S. on those social services.

According to the OECD health data (published in the newly released book The American Health Care Paradox, by Elizabeth H. Bradley and Lauren A. Taylor), in 2007, the rate of health-to-social service expenditures was 1.8 in the U.S. For France, Sweden, Austria, Switzerland, Denmark, Germany, Belgium, Italy, Finland, Norway, the U.K., Luxembourg, Japan, New Zealand, and a quite a few others it was 0.5.

So, while the U.S. may appear to outspend other developed nations purely on the basis of healthcare, when spending is viewed in this broader context, its overall spending is not extraordinary.

Remote medicine

More telemedicine and hospital-at-home services would comprise a major breakthrough in cost reduction and increase comfort and quality of care, in our opinion. A significant barrier to these shifts, however, is the fact that they are, for the most part, not reimbursable under current standard insurance coverage including Medicare and Medicaid.

One of us, Michael, a U.S. citizen who works and lives in Hong Kong, would at times have much preferred to converse with his U.S.-based primary-care physician by e-mail than go for a visit. But though the physician is very conversational in person, he will not respond to e-mail. The reason is obvious. Time spent engaging in e-mail conversations, however productive in terms of health-care delivery, is time for which the physician can receive no compensation. Such compensation structures need to change. Furthermore, remote care could be greatly abetted by telemedicine – sensors and instrumentation that can be used in the home, with readings transmitted to a physician’s office or clinic.

Pussyfooting around rationing

If it were not a toxic subject, rationing might be straightforwardly addressed by that name – but it cannot be. We noticed only one occurrence of the word “rationing” in the JAMA journal issue – and that time in a negative sense.

Instead, the topic is engaged with terms like “resource allocation” and “Resolving the Tension Between Population Health and Individual Health Care,” the title of one of the papers, by Harold C. Sox of the Geisel School of Medicine at Dartmouth. For example, the latter paper noted that “the optimal distribution of resources to address the needs of a population is not necessarily the best allocation of resources for many individuals in that population. Programs to reduce the incidence of heart disease may draw resources away from treating patients with heart disease.” If resources are allocated to the prevention of heart disease in the population, then those resources will be less available to treat patients who already have heart disease.
Resource allocation recognizes that resources are limited, and therefore, not everything can be done for everybody in every circumstance. There must be a means of allocating resources, of rationing them.

It is necessary, however, to pussyfoot around the idea of rationing in the U.S., even though other health-care systems like the U.K.’s treat it more straightforwardly. There is more than one mention in the JAMA papers of the “death panels” slogan, lamenting its stifling effect on planning the allocation of health care rationally and compassionately, especially when it comes to end-of-life services. One of the papers, The Toxic Politics of Health Care, by Donald M. Berwick of Harvard University, formerly President Obama’s administrator of the Centers for Medicare and Medicaid Services, even identified concerns over rationing as a possible source of rising anti-science sentiment in the U.S. “Many in the lay public are concerned that appeals to science are elitist, and may lead to rationing,” he wrote.

This sensitivity is understandable, especially in the U.S., where no one seems to want societal goals to impede any individual’s wants and needs. However, when it comes to healthcare, especially in the end-of-life stage when technological improvements can deliver increasingly marginal benefits at exponentially higher marginal costs, at some point we will have to confront the issue of resource limits head-on.

Michael Edesess, a mathematician and economist, is a visiting fellow with the Centre for Systems Informatics Engineering at City University of Hong Kong, a partner and chief investment officer of Denver-based Fair Advisors, and a project consultant at the Fung Global Institute. In 2007, he authored a book about the investment services industry titled The Big Investment Lie, published by Berrett-Koehler. His new book, The Three Simple Rules of Investing, co-authored with Kwok L. Tsui, Carol Fabbri, and George Peacock, will be published by Berrett-Koehler in spring 2014.

Kwok L. Tsui is a distinguished statistician and Head of the Systems Engineering and Engineering Management department and Chair Professor of Industrial Engineering at City University of Hong Kong.