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MONDAY, MAY 14, 2012

Why Does the U.S. Spend More on Health Care than Other Countries?

Everyone knows that the U.S. spends far more on health care than other countries, but do you know how much more? In 2009, the U.S. spent 17.4% of GDP on health care (using OECD data). The closest contenders are Netherlands (12% of GDP), France (11.8%), Germany (11.6%), Denmark (11.5%), and Canada (11.4%). The U.S. has higher per capita GDP than these countries, so the gap in absolute spending is even higher. In 2009, the U.S. spent \$7,960 per person on health care, and the closest contenders were Switzerland (\$5,144 per person) and Netherlands (\$4,914).

When I hear people argue that the U.S. should follow the path of the UK health care system, I sometimes find myself thinking: "You mean that U.S. health care spending per person should be slashed by 56%, from \$7,960 per person to \$3,487 per person? Really?"

What accounts for these differences in health care spending across countries? David Squires assembles some of the evidence in "Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices and Quality," a May 2012 "issue brief" written for the Commonwealth Fund. I ran across it [here](#) at [Larry Willmore's Thought du Jour blog](#). I'll also contrast and compare it with a paper by David M. Cutler and Dan P. Ly, "The (Paper)Work of Medicine: Understanding International Medical Costs," which appeared in the Spring 2011 issue of my own [Journal of Economic Perspectives](#). For readability, footnotes and references to exhibits are omitted from the quotations below.

Higher U.S. health care spending is not because Americans on average are notably less healthy.

As Squires sums up: "U.S. has smaller elderly population and fewer smokers, but higher obesity rates. ... Higher rates of obesity undoubtedly inflate health spending; one study estimates the medical costs attributable to obesity in the U.S. reached almost 10 percent of all medical spending in 2008. However, the younger population and lower rates of smoking likely have an opposite effect, reducing U.S. health care spending relative to most other



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countries."

Higher U.S. health care spending is not because the U.S. has more doctors or hospital beds.

"There were 2.4 physicians per 1,000 population in the U.S. in 2009, fewer than in all other study countries except Japan. Likewise, patients had fewer doctor consultations in the U.S. (3.9 per capita) than in any other country except Sweden. Hospital supply and use showed similar trends, with the U.S. having fewer hospital beds (2.7 per 1,000 population), shorter lengths of stay for acute care (5.4 days), and fewer discharges (131 per 1,000 population) than the OECD median ..."

Prices for brand-name drugs are much higher in the U.S., but generics are cheaper.

Squires writes: "[P]rices for the 30 most-commonly prescribed drugs are one-third higher than in Canada and Germany, and more than double the prices in Australia, France, Netherlands, New Zealand, and the U.K. Notably, prices for generic drugs are lower in the U.S. than in these other countries, whereas prices for brand-name drugs are much higher."

Cutler and Ly confirm this general pattern, but also put the potential cost savings in perspective: "However, because pharmaceuticals are only about 10 percent of U.S. healthcare spending, the overall amount that could be saved by moving to U.S. government monopsony purchasing of drugs is relatively small—perhaps 20 to 30 percent of pharmaceutical spending, or 2 to 3 percent of total medical costs. These cost savings also would have to be weighed against the possibility of reduced incentives for investment and innovation in the pharmaceutical industry. The dollar amount of excess pharmaceutical payments in the United States is approximately the total amount of pharmaceutical company research and development (R&D)."

U.S. doctors are paid more, but they also live in an economy with a more unequal distribution of wages.

Squires writes: "U.S. primary care physicians generally receive higher fees for office visits and orthopedic physicians receive higher fees for hip replacements than in Australia, Canada, France, Germany, and the U.K. ... U.S. primary care doctors (\$186,582) and particularly orthopedic doctors (\$442,450) earned greater income than in the other five countries ..."

Cutler and Ly confirm: "The average U.S. specialist physician earns \$230,000 annually—

78 percent above the average in other countries Primary care physicians earn less (they earn \$161,000 on average), but the same percentage more than their peers in other countries. ... If we reduced all physician incomes in

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the United States to match the international ratio of physicians' incomes to per capita GDP, U.S. healthcare spending would be lower by roughly 2 percent. However, these seemingly high salaries for U.S. physicians appear less high in the context of the broader income distribution." Cutler and Ly go on to point out that high-compensation workers in the U.S. economy earn more than their international counterparts in just about every profession--after all, that's part of what it means to say that the U.S. has a less equal distribution of income.

Some medical device technologies like scanning are more widely used in the U.S; some like hip replacements are not.

"In 2009, the U.S., along with Germany, performed the most knee replacements (213 per 100,000 population) among the study countries, and 75 percent more knee replacements than the OECD median (122 per 100,000 population). However, the U.S. performed barely more hip replacements than the OECD median, and significantly less than several of the other study countries ..."

"Relative to the other study countries where data were available, there were an above-average number of magnetic resonance imaging (MRI) machines (25.9 per million population), computed tomography (CT) scanners (34.3 per million), positron emission tomography (PET) scanners (3.1 per million), and mammographs (40.2 per million) in the U.S. in 2009. Utilization of imaging was also highest in the U.S., with 91.2 MRI exams and 227.9 CT exams per 1,000 population. MRI and CT devices were most prevalent in Japan, though no utilization data were available for that country. ... [T]he U.S. commercial average diagnostic imaging fees (\$1,080 for an MRI and \$510 for a CT exam) are far higher than what is charged in almost all of the other countries ..."

The U.S. does a relatively poor job of managing chronic disease.

Squires writes: "[Consider] rates of potentially preventable mortality due to asthma (for those between ages 5 and 39) and lower-extremity amputations due to diabetes per 100,000 population. On both measures, the U.S. had among the highest rates, suggesting a failure to effectively manage these chronic conditions that make up an increasing share of the disease burden."

Many chronic diseases share the general property that if they are well-managed every single day, with a combination of drugs, lifestyle, and certain kinds of monitoring of physical conditions, it is possible to reduce the need for enormously costly episodes of hospitalization. As the [Centers for Disease Control puts it](#): "Chronic diseases—such as heart disease, cancer, and diabetes—are the leading causes of death and disability in the United States. Chronic diseases account for 70% of all deaths in the U.S., which is 1.7 million each year. These diseases also cause major limitations in daily living for almost 1 out of 10 Americans"

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Prices for hospital stays are substantially higher in the U.S.

Squires points out: "[H]ospital stays in the U.S. were far more expensive than in the other study countries, exceeding \$18,000 per discharge compared with less than \$10,000 in Sweden, Australia, New Zealand, France, and Germany." And remember, these higher costs per hospital stay happen even though the stays themselves are on average shorter in the U.S.

The tougher question is to what extent these higher costs per hospital stay reflect a larger quantity of concentrated and effective high-tech care being provided, and to what extent its just a matter of higher prices. The evidence here is mixed. It does appear that for some conditions, Americans receive more hospital care. Cutler and Ly write: Americans also receive more-intensive care than do Canadians. While the population-adjusted hospital admission rates are about the same in the two countries, additional procedures are provided to those with the same diagnosis in the United States. For example, people with a heart attack in the United States are twice as likely to receive bypass surgery or angioplasty than are similar people in Canada." When it comes to cancer survival rates, Squires points out: "The U.S. had the highest survival rates among the study countries for breast cancer (89%) and, along with Norway, for colorectal cancer (65%)."

On the other side, the more aggressive use of heart surgery in the U.S. as compared to Canada doesn't seem to mean better health outcomes; instead, it reflects the existence of more heart-surgery facilities. Cutler and Ly: " On one side, the greater use of intensive therapies after a heart attack in the United States compared to Canada is not associated with improved mortality, though morbidity is more difficult to determine. Similarly, a recent study concluded that there was no systematic difference in outcomes in favor of the United States over Canada; if anything, Canadians had better outcomes in most circumstances ... [T]he province of Ontario has 11 open-heart surgery facilities, while the state of Pennsylvania, with roughly the same population as Ontario, has more than five times the number of heart surgery facilities. California is three times larger in population but has 10 times the number of heart surgery facilities. Given this difference in the number of facilities, it is simply impossible for physicians in Ontario to perform as many open heart surgery operations as those in Pennsylvania or California."

Also, not all cancer survival rates are better in the U.S. Squires writes: "However, at 64 percent, the survival rate for cervical cancer in the U.S. was worse than the OECD median (66%), and well below the 78 percent survival rate in Norway—indicating significant room for improvement."

Administrative costs of health care are much higher in the U.S.

Squires doesn't mention this point, but it is a main emphasis for Cutler and Ly. They write:

"[T]he U.S. healthcare system is in great need of administrative simplification. There are few other areas of the U.S. economy

where waste is so apparent and the possibility of savings is so tangible. ... Perhaps the most troubling difference between the U.S. and Canadian healthcare systems is the differential amount spent on administration. For every office-based physician in the United States, there are 2.2 administrative workers. That exceeds the number of nurses, clinical assistants, and technical staff put together. One large physician group in the United States estimates that it spends 12 percent of revenue collected just collecting revenue. Canada, by contrast, has only half as many administrative workers per office-based physician. The situation is no better in hospitals. In the United States, there are 1.5 administrative personnel per hospital bed, compared to 1.1 in Canada. Duke University Hospital, for example, has 900 hospital beds and 1,300 billing clerks. On top of this are the administrative workers in health insurance. Health insurance administration is 12 percent of premiums in the United States and less than half that in Canada.

"International comparisons of medical care occupations are difficult, but they suggest that the United States has more administrative personnel than other countries do. ... [T]he United States has 25 percent more healthcare administrators than the United Kingdom, 165 percent more than the Netherlands, and 215 percent more than Germany. The number of clerks of all forms (including data entry clerks) is much higher in the United States as well."

"What are all these administrative personnel doing? ... One part is credentialing—receiving permission to practice medicine in a particular hospital or for a particular health plan. The average physician submits 18 credentialing applications annually—each insurer, hospital, ambulatory surgery facility, and the like, requires a different one—consuming 70 minutes of staff time and 11 minutes of physician time per application. Verifying eligibility for services is also costly. Insurance information must be verified for 20 to 30 patients daily, including three or four patients for whom verification must be sought orally. Because people change insurance plans frequently and the cost-sharing they are charged varies with plan and with past utilization (for example, how much of the deductible have they spent?), the determination of what to charge a patient is especially difficult. ... Finally, significant time is spent on billing and payment collection. On average, about three claims are denied per physician per week and need to be rebilled. ... Three-quarters of denied bills are ultimately paid, but the administrative cost of securing the payment is very high. Provider groups in the United States employ 770 full-time equivalent workers per \$1 billion collected, compared to an average in other U.S. industries of about 100. By all indications,

the administrative burden is rising over time as insurance policies have become more complex, while the technology of administration has not kept pace."

Conclusion

The question of why the U.S. spends more than 50% more per person on health care than the next highest countries (Switzerland and Netherlands), and more than double per person what many other countries spend, may never have a simple answer. Still, the main ingredients of an answer are becoming more clear. The U.S. spends vastly more on hospitalization and acute care, with a substantial share of that going to high-tech procedures like surgery and imaging. The U.S. does a poor job of managing chronic conditions, which then lead to episodes of costly hospitalization. The U.S. also seems to spend vastly more on administration and paperwork, with much of that related to credentialing, documenting, and billing--which is again a particular important issue in hospitals. Any honest effort to come to grips with high and rising U.S. health care costs will have to tackle these factors head-on.

Posted by Timothy Taylor at 6:00 AM



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