EQUAL Health ◆ *Equitable Quality Universal Affordable*

Center for Policy Analysis

U.S Health Care: Myths and Facts

Members of the Equal listserv suggested covering these issues in presentations on health reform, in exchanges in September, 2009. The Center for Policy Analysis summarized their responses.

1. Who's more efficient, government or the private insurance market?

Efficiency means doing the best job at the lowest cost. Government programs do more of the job – covering the oldest and sickest people, for the most benefits – and at a lower cost than private insurance companies. Private companies spend about 20% of every dollar on administrative costs or profit. (Administrative waste on the provider end consumes another 11%.)[1] Medicare spends about 3% on administration, and nothing on profits. Community health centers (supported by federal and local government) have been documented to achieve better health outcomes with lower expenditures, fewer ER visits and fewer hospitalizations than private providers

While some people claim that Medicare costs are rising too quickly, it is private insurance premiums that are truly out of control. From 1970 to 2007, Medicare spending per beneficiary rose 8.5% a year while private insurance premiums increased 9.7% a year. Had private insurance premiums increased at the same rate as Medicare spending, since 1970 those private insurance premiums would be 33% lower than they are today. The difference between Medicare's ability to control costs and private insurance premiums is even more striking in the most recently compiled statistics. Over the period from 1997 to 2007, Medicare's cost per beneficiary rose on average 4.4% per year while private insurance premiums increased by 7.4% per year—a 30% difference over the full 10 years.[2]

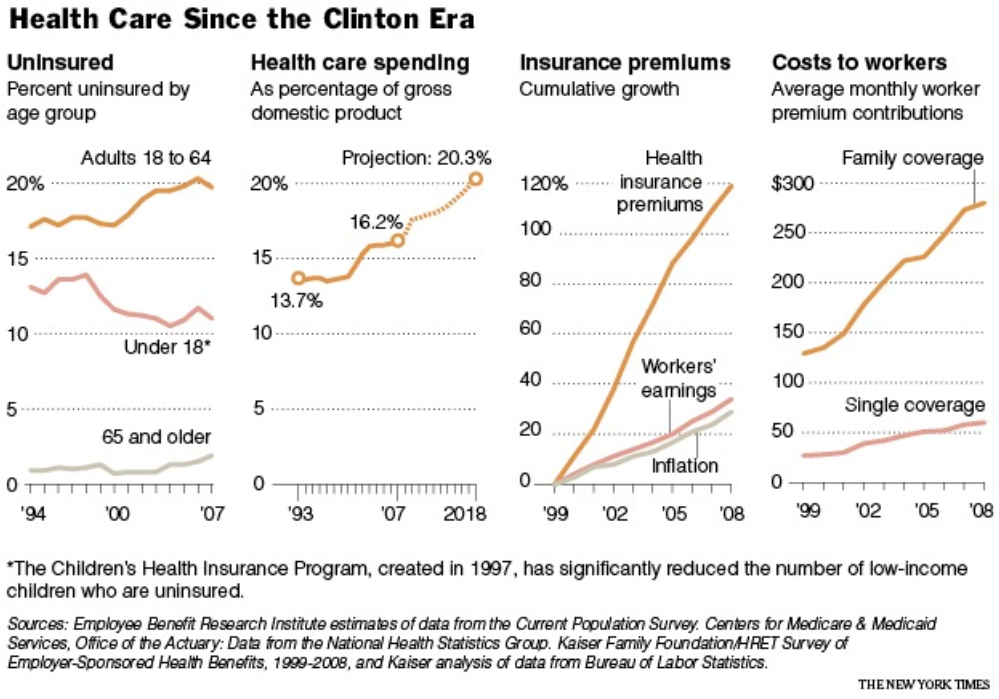
Two important factors contribute to efficient health care: First, budgets set responsible guidelines for how fast health care expenditures can grow. Medicare has a budget, unlike private systems; but the U.S. health care system overall does not have any set limits. Secondly, payment methods can provide incentives for inefficiency, especially in systems without budget caps. Traditional fee-for-service plans may encourage doctors to order income-generating medical tests and procedures with only secondary regard for the patient's benefit, compared with services that are not reimbursed such as discussion to explore a patient's condition. Salaries and capitation are the other major reimbursement methods. These can lead to under-service, unless there are other organizational and financial incentives that reinforce attentive care.

Both the highly respected, private sector Mayo Clinic and the public Veterans Affairs hospitals are fine examples of efficiency. Doctors are paid a salary; they don't earn more by ordering more tests. They coordinate health care records and have multi-disciplinary medical teams sharing information about a patient and manage to keep their costs lower. We can use the ingenuity of these successful American models to improve efficiency.

2. Are We Spending Too Much on Health Care?

In a word, Yes! There's ample research showing that other countries cover all their residents and spend less. Canada spent 9.7% of GDP on health care in 2008, Germany 10.7% and the U.S. 15.9%. U.S. employers have reported for years that the cost of health care is a major drain on their profitability. The annual spending rate for health care coverage grows faster than most other segments of the economy.

What's the primary difference? Higher prices.



Providers – hospitals, doctors, supply and technology companies - charge much higher rates than their counterparts abroad. Provider prices are marked up by 130% to 150% by insurance companies. And Canadians negotiate for the best drug prices on the world market. insurance companies have made the business decision to inflate prices to pay administrative salaries, legal and clerical staff for declining or rescinding coverage (not paying claims) and advertising, to generate profits for stockholders, and distribute additional stock options and bonuses for the management.

American private health care spends a lot for corporate profits and salaries that do not go to care. Non-profit insurers (or HMOs) pay salaries almost as high as for-profit companies. The former CEO of Mass Blue Cross recently took a $19 million golden parachute when he left; the current CEO gets $3 million in annual compensation. If this happens at Ford, you can always choose to buy another model car. But you can't disenroll from your employer's health plan.

Despite spending almost twice as much, the U.S. is rated 37th in the world for health. Men's life expectancy is 75.6 years and women's 80.8 years. Canadian men's life expectancy is 78.3 years and women's 82.9 years. In Germany, it's 76.5 for men and 82.1 for women.

We can spend the same amount as we do now, and have the best health care in the world.

3. Do We Pay Too Much for Drugs?

The other 19 western industrialized democracies keep drug costs as low as possible by negotiating for the best drug prices available on the world market. The U.S. does this for the Veterans Affairs system, and Medicaid, where drug prices are competitive with Canada and the world market. but not for the rest of the American population. It is illegal for our government to negotiate better drug prices through Medicare. In addition, pharmacies, hospitals and insurance companies mark drugs up even more to make a great profit from a captive market, which is us. Drug companies make a tidy profit overseas. In the U.S. they make a huge profit, historically about 15% a year, often three or four times the Fortune 500 average, and vying with the oil industry as the most profitable industry in the economy.

4. Could Importing Drugs Reduce Prices?

We don't have to import many drugs because we make a lot of them here. We do need to import the policies that make drugs affordable abroad. The U.S. needs to negotiate drug prices for individuals and systems, and to control markups on drugs.

The assertion that drug prices have to be high to pay for innovation has been proven false. Proportionately more new drugs are developed abroad than in the U.S.. Drug makers spend huge sums researching "me too" drugs to get around patents on existing blockbusters, advertising to promote products like Viagra, entertainment for physicians and legislators, and lobbying and political contributions to politicians in both parties so that the U.S. will neither negotiate drug prices, nor reimport drugs from other countries that do (that's all of them).

5. Can Prevention Programs Reduce Health Care Costs?

Yes and no. Clinical preventive services are vital for better health. For example, annual breast and cervical screenings for women can find cancer signs early and treat them less expensively. The

federally-funded Vaccines for Children program helps vaccinate millions of American babies to make sure our immunization rates are high and children don't die of preventable illnesses. Every $1 spent for a vaccine saves $7 in future medical expenses. Government programs can insist on providing these services.

Community-based prevention – safer neighborhoods, walkable cities, clean air and water, living wage policies – improve health without driving up hospital bills.

However, prevention alone won't result in savings to the system. Every dollar "saved" is **lost** income for someone in the health care system. Unless the government is able to effectively control the budget for the health care system as a whole, these providers - doctors, hospitals, supply and drug companies, as well as insurers - will drive up prices and procedures to assure that they maximize income.

6. Is Health Information Technology a Silver Bullet for Reducing Costs?

Of course not. There is no one "silver bullet." Health care is a complex system. And, as we said before, without an overall budget and other features, savings in one place are destined to pop up somewhere else. But HI technology can help. Take this example: a patient is referred to a specialist after some medical test results show a possible neurological problem. The neurologist needs to see the blood test results. These were done recently, but the paperwork was not transferred. Happens all the time. So what happens? The neurologist repeats the blood test. It's wasteful—and a hassle for the patient. Sharing test results and other health information electronically would save money. Similarly, electronic immunization registries, operating in most states, save doctors money with improved efficiency at the office and avoids duplicated treatments such as repeat immunizations for kids who come in with incomplete records. Results from communities that have Health Information Exchanges show reduced spending through electronic medical records by not duplicating tests.[cite?]

The VA has a 99.993% accuracy rate for prescription fills largely because it is an electronic system, compared to 3-8% error rate outside the VA.

7. Are there really 46 Million Americans Who Can't Get Health Care?

46 million Americans lack health care insurance at any point in time. Over the course of a year, millions more are uninsured A 2009 Harvard University study that found that 45,000 deaths a year in the U.S. - 1 every 12 minutes – are associated with lack of health insurance. A national study that followed adults under age 65 for 8 years found that those without health insurance were 40% more likely to have died than those with insurance.

People without insurance can get care if they can pay for it. But even this has severe consequences. If you sprain an ankle or have a sore throat, you might be able to pay for a simple appointment at a

retail clinic. But what if you need your diabetes or heart condition monitored regularly, or you need an operation with months of physical therapy afterwards, and expensive drugs? That's more than most of us can afford. In fact most people without coverage also have lower incomes. We try to do without, or may end up in an emergency room because we waited and let a small problem get big. That's the most expensive care. If we can't pay the expensive bill, the hospital raises its rates so that regular, insured patients pay more. That in turn means higher premiums for those with insurance.

Some people who are eligible for existing programs like Medicaid or the State Children's Insurance Program are not enrolled in them. Overwhelmingly, this is because these poorly funded programs ration services by constructing bureaucratic barriers to enrollment and retention. New national programs should avoid these well-known pitfalls.

8. Can Universal Coverage Be Achieved by Mandating Everyone to Buy Insurance?

Just like auto insurance, if everyone is *not* covered, rates will go up to compensate for those who are **NOT** insured. But there are some differences too. We can choose not to own a car. Enforcement is also an issue. You have to register your *car* each year, not yourself! Massachusetts took this approach, and reduced th**e** percent of uninsured to about 5%. But there are still 27,000 uninsured people on Cape Cod alone. Some people bought insurance, got the care they needed, then disenrolled.

Unless insurance is affordable, many Americans will have to make tough choices about paying the mortgage, buying food or medicine, and paying a health care insurance premium. Moreover, even if insurance is obtained, coverage may be denied. If you need a certain cancer drug, or a heart operation and your insurance does not want to pay, are you better off? Probably not.

9. Do We Need More Government Programs to Cover Low-Income People?

If the private market wants to help insure poor Americans, why don't they? Simple: it just isn't profitable. The average American family pays $13,375 a year for insurance premiums alone (Kaiser Family Foundation Sept 2009). (The 2009 Milliman Medical Index calculates that accounting for foregone wages adds about another $6,000 a year to the cost of insurance for a family of 4.) Poor families can't afford this! Some of the "low-cost" plans available have high deductibles (you get nothing until you've paid well over $1,000), high co-payments, and lousy coverage (like no dental care, no vision care, no child birth coverage, no prescription drugs, sometimes spotty coverage even for hospital care). This kind of coverage isn't helpful for anyone, including low-income people. Government care is available to help low-income Americans get the care they need. But when we separate government care only for the poor, the risk pool is more likely to have people who are sicker, which can mean their care needs are more expensive. The better solution is to have the government provide insurance for all of us in a single risk pool as we do now for Americans over age 65 in Medicare.

10. Bonus section: Summary of William Hsiao: Abnormal economics in the health sector. William C. Hsiao *Health Policy* 32 (1995) 125-139

Abstract: The implosion of centrally-planned economies has led to a widespread and uncritical belief that a free market is the best mechanism for structuring the economic and social sectors. This paper offers a critical analysis of the effectiveness of using free market principles to structure the health sector. We try to answer two questions: in what spheres can the market operate freely? In what spheres is government action required? According to economic theory, the market is only appropriate for producing and distributing private goods. This study analyzed health care and subdivides it into three categories (public, merit, and private goods) to clarify where the market has a legitimate role. Next, we analyze two of the five markets in the health sector--financing and delivery - and assess the respective roles of the market and government. Competitive markets have certain prerequisites. We identify the major market failures by evaluating where these conditions are not satisfied. Next, we draw on international experience to ascertain the seriousness of those failures and the capacity of government action to correct them. Lessons are drawn about the appropriateness of market strategies to finance and deliver health care.

Summary of Hsiao by Maggie Huff–Rousselle: Distortions in the Health Care Market Drive Up Prices Without Improving Care

We definitely need innovation. But our system was not designed to treat people with chronic disease (which now accounts for 75% of our spending).

The health sector is plagued by market distortions and failures, characteristics that can profoundly impact public health, especially for those goods and services that are a public good. The multiple barriers to market entry, and the inability of consumers to make adequately informed decisions in the health market, combine to give suppliers significant control over consumer demand. William Hsiao documents these failings compellingly

These market failures and distortions are particularly pronounced in the pharmaceutical sector where: 1) there is little incentive for research and development focused on the major health problems of the most disenfranchised segments of the world's populations, since such investments are unlikely to result in profitable business initiatives; 2) a lack of neutrality and transparency in providing scientific information means that, not only can consumers not make well-informed decisions, but physicians' prescribing decisions are also not adequately informed; 3) the cost of obtaining patent rights and the market muscle of patents in an era of globalization (along with capital investment issues) can reinforce barriers to market entry; and, 4) the barriers to market entry combined with the inability of both consumers and physicians to make informed decisions give suppliers tremendous influence over demand.

[1]http://www.pnhp.org/single_payer_resources/administrative_waste_consumes_31_percent_of_health_spending.php

[2] Http://www.cms.hhs.gov/nationalhealthexpenddata/downloads/tables.pdf (see table 13)