Some observations about the U.S health care system at the beginning of the 21st century

Edward J. Burger, Jr.

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There are a number of key observations one can make about the American health care system which set it off from most other systems — how it is organized and how it is financed.

One feature is that the system is always in flux. We are forever making changes, experimenting with new organizations, attempting innovation. This contrasts, for example with the British or German experience where change comes only slowly and stability and constancy are more the rule[1].

A second characteristic concerns expenditures for health care. The United States spends far more for medical care — both in absolute terms and per capita — than does any other nation. As a result, *the* political issue regarding how we arrange for medical care is money. While it is true that no industrialized nation is immune from concerns for cost of medical care (save, perhaps, Norway), the experience in the United States sets this country off from all others. More on this later.

A third element that has consistently served as a principle to guide health care arrangements and their financing in the U.S. is an accepted combination of public and private components. At the present time, equally between private and governmental sources.

A fourth important characteristic is the combining of the philosophy and elements of market forces and economic competition with the traditions of professionalism. This political philosophy has exercised a strong influence over the shape of clinical medicine in the name of efficiency in recent years, raising second order questions in its wake. Is the market ethic effective in its overarching goal? Should one expect a market to work where purchasers of service (patients), by definition, cannot possess an adequate amount of information? Can a market work efficiently in medicine which is marked by an unusual elasticity of demand? Perhaps equally important is the question, is the application of an economic market compatible with what we think of as the traditions of professionalism in medicine?

How much does it cost? The record of expenditures and trends

In 1970, the U.S. spent roughly 7% of its gross domestic product on medical care[1]. Beginning two years earlier, there were heard abroad in the land cries of "crisis in health care."[2]. Crisis had two components — excess spending and inadequate or uneven access for its citizens to medical care. That level of spending was sufficient to propel President Nixon and his advisors to embrace medical care as a presidential issue and search for remedies to modulate the rate of rise of spending. President Nixon's response was a series of proposed legislative programs for financing medical care, a number of experiments

M.D., Sc.D., FACP.
President of Institute for Health Policy Analysis, Washington, D.C. Tel.: 202-463-0673, Fax.: 202-463-0674,
E mail: ejburger@worldnet.att.net

to organize care and, for a short while, price freezes[3,4].

In spite of these innovations and interventions, national health care expenditures continued to rise. In the 1980's, health expenditures reached and exceeded 8 % of GDP — this in spite of a large number of experimental efforts to modulate costs and prices — coalitions among businesses, labor and government designed to moderate the rate of rise of spending. By the late 1960's, three sectors of the economy most immediately affected by increasing spending levels — business, government and the insurance industry — joined together to slow the rate of spending. This became the engine for a series of instruments and programs all known collectively by the title, managed care. All of the variations of managed care have in common rules for determining financial reimbursement for medical care procedures and services, elaborate and strict limits and accounting for payment and oversight and judgments about what procedures are covered by insurance payments.

Overwhelmingly, managed care plans replaced traditional fee-for-service arrangements, particularly for employment-based insurance (the majority). Employees typically were offered a series of choices of managed care plans representing marginal variations in terms of premiums, and benefits. Physicians, too, made elections about which managed care plans they would serve.

Managed care did succeed in slowing the rate of medical care spending between 1990 and 1997. (Fig. 1). At the same time, managed care, by definition, imposed constraints and burdens on both patients and physicians. Insurance premiums rose. According to the rules of each plan, patients had a limited choice of physicians from whom they could receive reimbursed care. Disease and disability recognized before a patient joined a plan typically was not covered financially until a period of time had elapsed.

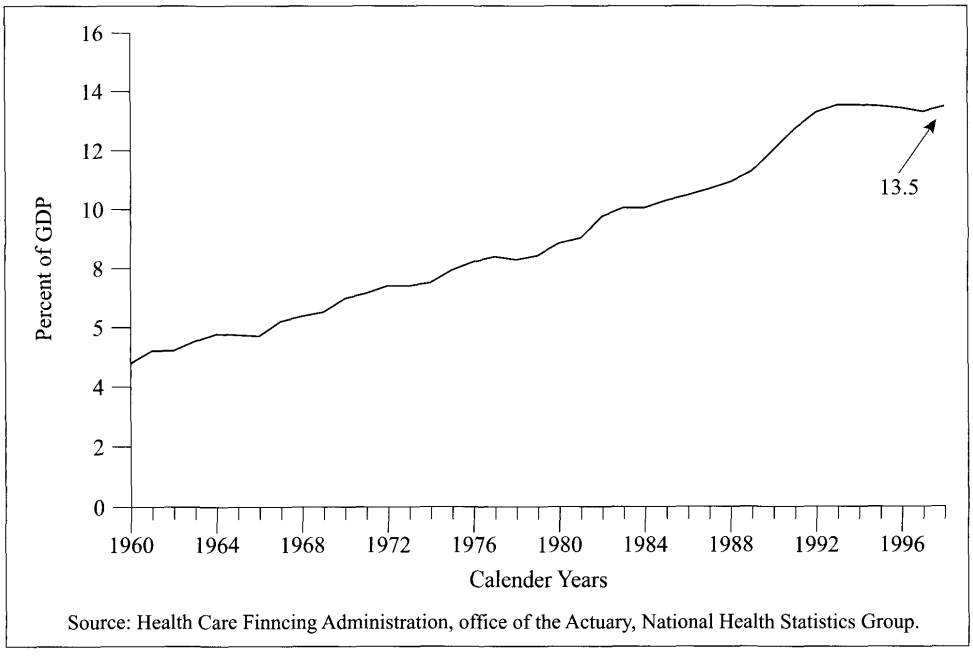
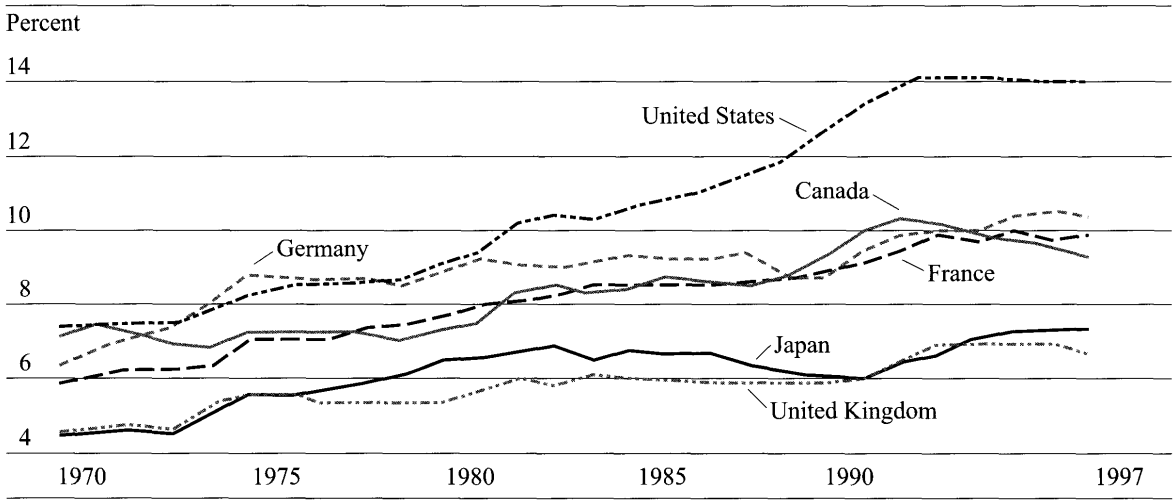


Fig. 1 National Health Expenditures as a Share of Gross Domestic Product (GDP): Calendar Years 1960-1998



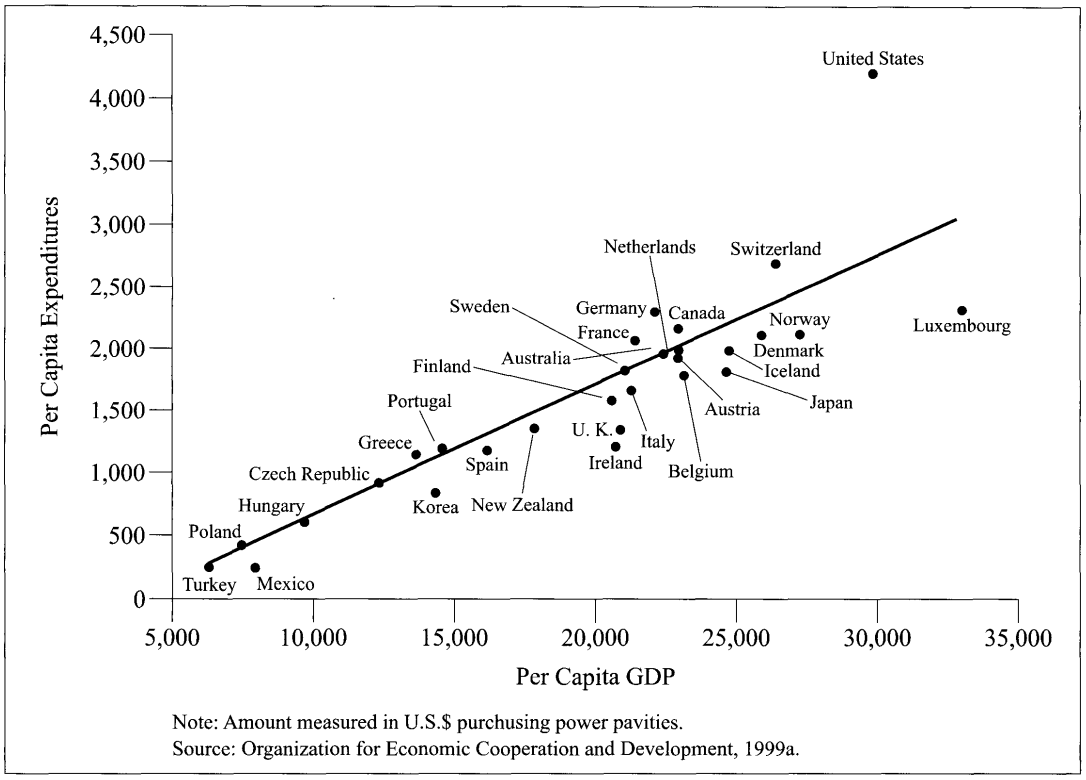
Source: OECD Health Data 98: A Comparative Analysis of Twenty-nine Countries (Parts: Organization for Economic Cooperation and Development. 1998)

Fig. 2 Percentage Of Gross Domestic Product (GDP) Spent On Health In Six OECD Nations, 1970-1997

During this 7-year period, national spending did remain fairly stable at around 13 % of GDP. However, the political cost was substantial. Public complaints about the constraints and complexity of managed care arrangements rose to a high pitch as seen, for example, in a very large number of legislative proposals introduced in the individual states to compensate for or blunt the offending features.. Further, by the end of the 1990's, the effectiveness of managed care to moderate prices and expenditures had begun to reach its limit. National expenditures in 1997 claimed 13 % of GDP. By 2004, they had risen again to approach 15% of GDP (Fig. 2).

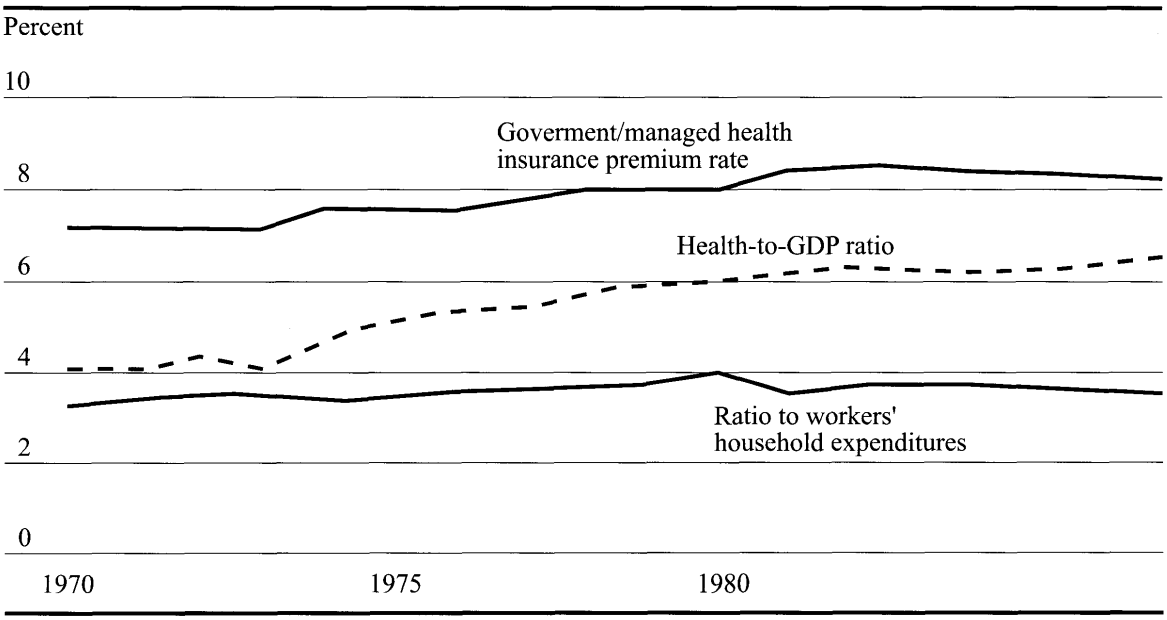
U.S. per capita health spending has consistently exceeded per capita spending in OECD countries by enormous margins. (Fig. 3). In 2001, the median expenditure by OECD countries was 44% of that of the U.S. The median of GDP absorbed by health in the non-US OECD countries in 2001 was 8.3% compared to 13.9% in the U.S[5]. According to present trends, health care spending in the U.S. is expected to exceed the annual growth of GDP by about 2 percentage points which means that it will claim 18.4% of GDP by the year 2013[5]. A particularly revealing demonstration of this high expenditure can be seen in figure 3 which attempts to examine health care spending relative to measures of nations' wealth. The record in most countries suggests a reasonably close relationship between the two. The greater the level of economic activity, the larger the per capita spending devoted to health care. The outstanding outlier is the United States spending increases far exceed the general rate of economic growth.

It is instructive to examine Japan's experience in this regard (Fig. 4). In this case, where a political consensus and arrangements exist to control health care spending, health spending has remained consistently close to 6% of GDP over several years.6. An unfortunate aspect of the American experience has been the relative absence of organized, constructive contribution to the political process controlling costs of physicians and their institutions. Further, there is no institutionalized mechanism for bringing



Note: Amount measured in U.S.$ purchusing power pavities.
Source: Organization for Economic Cooperation and Development, 1999a.

Fig. 3 Distribution of per Capita Income and per Capita Health Care Expenditures: 1997



Sources: Kosei Tokei Kyokai, "1990 Trends in the Nation's Health." *Kindai No Shupan* 37. no.9 and Kokai Tokei Kyokai, *Hoken to Nenkin no Dokou* (Tokyo Kosei Tokei Kyokai, 1989, 63. 107.

Fig. 4 Changes in the Ratio of Health Care Expenditures in Japan, 1970-1985

contribution from the medical profession to this on-going political debate. With the passage of time and in the face of this deficit, American medicine has found itself without standing in discussions of the matter.

In the United States, with this new cost pressure, have come several efforts by insurance companies, government and employers to constrain spending. In many cases, these have shifted additional financial burdens to patients and imposed further limitations of medical care to patients. In turn, members of the public have become increasingly anxious and restive over loss of financial coverage for health care and constraints on choice. Throughout these years, as is well known, large numbers of Americans — estimated at 45 million — are without financial coverage for health care. Because medical care expenditures have "escaped" the intended limits of managed care and because those attempting to control those costs placed further uncomfortable restrictions on care and reimbursement for care, ever increasing numbers of middle class, employed individuals can be expected shortly to seek political relief. That is, the nation can be expected shortly to enter upon one of its periodic reexaminations of how medical care is organized and paid for. One can reasonably guarantee that the next president will have no choice but to engage health care as a priority policy area. A recent study suggests that, alongside the prominence of the war in Iraq and terrorism on the political agenda, health care and health care cost are near the top of the list of concerns of the American public at this time of national election.[7].

What are the causes of this high rate of health care spending?

One factor certainly is an ever-increasing ability to intervene effectively in disease and disability. An increasing science base makes this possible. At the same time, this factor also raises public expectations and demands. This is the item leading to the unusual elasticity of demand for medical care mentioned at the outset of this article. The more the public believes medicine can treat disease effectively, the more it is demanded.

A second factor is the labor-intensive character of medical care. In the 1930's in the United States, there were on average 3 non-physicians — mostly nurses — for each physician. In the 1990's, that ratio was estimated to be 14 to 17 ancillary persons for each physician.

A third factor usually mentioned in this list is the large and increasing component of technology in medicine. Medical practice is evermore capital intensive as well as labor intensive. This leads to a further, interesting observation. In most economic sectors, technology is introduced to replace labor. In medicine, by contrast, the introduction of new technology does not result in the exchange of capital for labor but often the addition of more labor with each new technological item. Further, in the case of imaging devices, for example, new forms of technology often do not supplant older ones but rather add to an ever lengthening list.

A fourth factor is perhaps the large amount of wealth in the U.S. available for purchasing medical care. The very large GDP further encourages the exercise of demand for medical care. Further, this phenomenon is not constrained by any effective mechanisms for rationing care.

A further contributor to the costliness of the American health care system is that the system is a highly complex and broadly distributed system. Much of this complexity arises from the mosaic of public and private components, the wide variety of private plans and the admixture of for-

profit and not-for-profit institutions and financial coverage schemes. An important byproduct of this complexity is excessively high administrative costs. The current, total national expenditure for medical care, public and private, is $1.6 trillion. The administrative component is of the order of 25%. The corresponding figure in Canada is 11%. Perhaps most interesting is the fact that the most efficient of all of the American arrangements is the federal government's Medicare program for the elderly. The administrative cost for this program is close to 5%.

How did we get here? A bit of history

As this article pointed out at the beginning, a constant, underlying characteristic of health care in the U.S. has been the combination of private and public interests and arrangements. This pattern had an early beginning in the 19th century when America was largely a rural society. Most aspects of medicine, from education to practice, had a heavy overlay of proprietary character. Practitioners provided private care on a fee-for-service basis. Care for the less wealthy was provided as a charitable service. Medical schools were typically private and proprietary.

A privately supported commission in 1910 led to the re-formulation of support for medical education[8]. In 1927, a second and important private commission, the Committee on the Costs of Medical Care, undertook a 5-year study of the organization and financing of medical care[9]. Among the 5 recommendations of the committee were two which proposed that medical care be provided *via* organized groups of practitioners and that medical care should be universally available and paid for through a scheme of universal insurance.

These recommendations, which might have established universal medical financing for all times, failed to be accepted by President Roosevelt who was then attempting to introduce a program for Social Security. Since then, several presidents have sought to resolve the complex health care financing issue but without success.

The private provision of insurance began during the depression with the birth of the not-for-profit organizations known as Blue Cross and Blue Shield. Commercial, for-profit insurance became available during World War II when employers, not permitted to raise salaries, offered benefits, including health benefits, instead of wages. This, essentially, was the beginning of the linkage between employment and financial coverage for health care.

The most prominent governmental programs for financing of medical care were initiated in 1965. Medicare is a federal government program which underwrites most of the costs of medical care for the elderly. Medicaid is a combined federal-state program for the "medically indigent." These two programs plus some provisions for children's medical care, exist alongside (and in some cases intertwined with) a very complex mosaic of private insurance arrangements for the majority of the population.

Is there an upper limit to health care spending?

This is becoming an evermore important question. In 1970, spending for medical care represented less than 1/10th personal consumption spending and was the 5th largest component after food, housing, transportation and household operation. In 2001, medical care represented 18.2 % of personal consumption spending and was the largest component[5]. This has led to a beginning discussion around the question, is there an upper limit to spending for health? In practice, this question, perhaps, has two components:

- What level of spending is politically acceptable?

- From a purely economic point of view, what level is truly affordable? Is it conceivable that spending for medical care will depress other sectors? Will that distress be felt excessively on low income segments of society, as some have suggested?

One can promise that, with a pattern of ever-increasing expenditures, these questions, which have generally been avoided, will become increasingly prominent matters of academic and political discussion.

Some concluding observations

In the United States, we continue to have a mixed and complex mosaic of financing arrangements for medical care. Cost pressures in recent years have led many employers to reduce benefits, demand increased employee contributions or drop coverage all together. We are about to enter upon a season when how we organize medical care and how we pay of it will become prominent political issues — once again.

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