



Health Care Industry Trends

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The health care industry employs nearly 8 percent of the US workforce and is growing faster than most other industries. Spending on health care now accounts for more than 16 percent of GDP and continues to rise.¹ The delivery system for health care services includes doctor's offices, ambulatory care facilities, hospitals, rehabilitation centers, nursing and residential care facilities for the elderly and the mentally ill, and home health care providers.

The US health care system is unique among developed nations. Instead of a national insurance program, the US relies heavily on the private sector and has a fragmented system of many different sources of funding and types of coverage. Nearly three-fourths of the population is covered by private health insurance. This includes most of the working-age population and their dependents, covered by employer-provided insurance plans. Employers are not required by law to offer health insurance coverage to employees, but they get a tax break if they do so. The federal Medicare program covers almost all of the elderly and some of the disabled. The federal-state funded Medicaid and State Children's Health Insurance Program (SCHIP) provide a social safety net for the poorest families and for near-poor children. Finally, around 16 percent of the population has no insurance coverage at all.

This report describes key trends in the US health care industry, how the US health care system stacks up against other countries, and what the implications are for jobs in the US.

Key Trends

Rising costs. The most significant trend in the health care industry today is the rising cost of care. In 2004, employer health insurance costs rose 8 percent, almost three times the rate of inflation.² Since 2000, employee health insurance costs have risen by 36 percent, more than

¹ Cynthia Smith, Cathy Cowan, Stephen Heffler, Aaron Catlin, and the national Health Accounts Team, "National Health Spending in 2004: Recent Slowdown Led By Prescription Drug Spending," *Health Affairs*, January/February 2006.

² Marc Kaufman and Rob Stein, "Record Share of Economy Spent on Health Care," *Washington Post*, January 10, 2006.

twice the 12.4 percent increase in average earnings.³ During that same period, Medicaid costs have gone up by 63 percent.⁴

Prescription drugs are the fastest growing component of health care costs. Although rising prices are partly responsible, increased utilization is the main driver. Doctors are increasingly relying on prescription drugs to treat their patients. They have a widening array of new drugs to choose from, and the growth of direct advertising to consumers has spurred demand. Between 1995 and 2003, the number of prescriptions sold annually rose from 2.1 billion to 3.2 billion.⁵

New medical technologies also account for much of the increase in health care costs. A traditional X-ray machine costs \$175,000, while the current technology, a CAT scanner, costs \$1 million. A traditional cardiac balloon catheter cost \$500, while the latest technology, a treated stent, costs \$5,000.⁶ These expensive new technologies are being used on a broader array of patients. In addition, physicians prefer to prescribe the latest and best tests and devices for their patients.⁷

In the early 1990s, employers responded to rising health care costs by switching to managed care plans that limited patients' choice of physicians and hospitals and that required prior approval for certain high-cost procedures. In 1988, three-quarters of employees were enrolled in conventional fee-for-service plans, while one-quarter were enrolled in either an HMO or a preferred provider organization (PPO). By 1996, only one-quarter of employees were still enrolled in conventional plans, while three-quarters were enrolled in either an HMO or a PPO.⁸

However, in the late 1990s, a backlash from employees, bolstered by a tight labor market, forced employers to choose less restrictive health plans. Physicians and hospitals banded together into networks and used their increased bargaining power to force insurers to loosen controls and negotiate more favorable reimbursement rates. As a result, health care costs, which had leveled off in the mid-1990s, began climbing again in the late 1990s.

The federal government also sought to curb the rising costs of Medicare in the mid-1990s by limiting reimbursements to hospitals. This produced an actual decline in payments of 1.2 percent in 1998, which led to considerable financial instability among hospitals.⁹ A backlash from hospitals forced Congress to partially restore the reductions they had made in reimbursements.

The retreat from tightly managed care has left employers and the government searching for new ways to reduce health care costs. However, most of their efforts have focused on shifting costs,

³ Ceci Connolly, "Higher Costs, Less Care," *The Washington Post*, September 28, 2004.

⁴ Robert Pear, "Health Secretary Calls for Medicaid Changes," *The New York Times*, February 2, 2005.

⁵ Elizabeth Querna, "The Druggist is In," *U.S. News & World Report*, January 31, 2005.

⁶ American Hospital Association, "Overview of the U.S. Health Care System," www.hospitalconnect.com/aha/resource_center.

⁷ PriceWaterhouseCoopers, "Cost of Caring: Key Drivers of Growth in Spending on Hospital Care," Prepared for the American Hospital Association and the Federation of American Hospitals, February 19, 2003.

⁸ Marc L. Berk and Alan C. Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs*, March/April 2001.

⁹ Centers for Medicare and Medicaid Services (CMS), "Health Care Industry Market Update – Acute Care Hospitals," April 29, 2002.

rather than actually reducing them. Employers have been reducing prescription drug benefits, increasing co-pays and deductibles, and reducing retiree benefits to shift costs to employees. The federal government and the states have been arm wrestling over who's going to take responsibility for rapidly rising Medicaid costs. Meanwhile, many states have been cutting back on Medicaid expenditures, shifting the cost to providers, who are required by law to treat the uninsured.

One promising approach to actually reducing the cost of care is to focus on those patients who are the most costly to treat. Roughly 75 percent of all health care spending in the US is for the treatment of chronic diseases.¹⁰ Yet, the main focus of the US health care system is on the treatment of short-term, acute health problems. As a nation, the US emphasizes expensive cures for diseases, rather than cost-effective prevention. As a result, a recent national study found that patients with chronic diseases typically receive only 56 percent of the recommended care for their condition, based on the best available medical evidence and research.¹¹

Under the current system, chronic care is simply not as profitable as acute care. Insurance plans are more likely to pay more than \$30,000 for an amputation than the \$150 it would take for a diabetic to see a podiatrist to prevent diabetes-associated foot problems.¹² Since the average person changes insurance carriers every six years, and the complications associated with many chronic conditions don't show up for many years, insurance companies are not likely to realize the savings from investments in prevention. Those savings are more likely to be realized by their competitors. Insurance companies are also concerned that if they do a good job of serving the chronically ill, they will attract more of them. That would end up adding risk, and therefore cost.

Some health plans are currently experimenting with wellness or prevention programs, and with disease management programs that focus on the needs of a population of patients who have a specific chronic condition such as asthma or diabetes, where well-established guidelines exist for treatment. To date, evidence of the effectiveness of disease management programs is mixed. Part of the problem may be the turnover within plans, which makes it difficult to capture benefits that only show up over time.

The benefits are more likely to show up among Medicare beneficiaries, who have less turnover and greater need. Nearly 80 percent of all Medicare beneficiaries have at least one chronic condition, and nearly half have three or more chronic conditions. In addition, 5 percent of beneficiaries account for nearly half of the program's total expenditures.¹³ The Centers for Medicare and Medicaid Services (CMS) is currently conducting a large-scale pilot program to improve chronic care.¹⁴ If successful, other health plans could follow suit.

¹⁰ Centers for Disease Control and Prevention, "The Power of Prevention," US Department of Health and Human Services, 2003.

¹¹ Elizabeth A. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine*, 2003; 348.

¹² Ian Urbina, "In the Treatment of Diabetes, Success Often Does Not Pay," *New York Times*, January 11, 2006.

¹³ Centers for Medicare and Medicaid, "Health Care Industry Market Update – Managed Care," March 24, 2003

¹⁴ Nora Super, "Medicare's Chronic Care Improvement Program: What is its Potential?" *National Health Policy Forum Issue Brief No. 797*, May 10, 2004.

Changing industry structure. A second major trend is the changing structure of the industry. Three main factors are driving this restructuring. Advances in medical technology have made it possible to perform many procedures in an outpatient setting that previously required hospitalization. Incentives in the Medicare payment system have reduced hospital length of stay, shifted some care to outpatient settings, and shifted other care to skilled nursing facilities. And managed care has reduced unnecessary hospitalizations and hospital days.

Hospitals have seen the biggest changes. Since 1980, hospital inpatient admissions have declined by 14 percent and hospital length of stay has also declined by 14 percent.¹⁵ As a result, the number of hospitals has fallen by 16 percent, and the number of hospital beds per 100,000 in the population has fallen by 34 percent.¹⁶ Hospitals treat patients who are much sicker than in the past, and who are also discharged more quickly than in the past.

Many of the patients being discharged from hospitals are transferred to skilled nursing facilities. Between 1980 and 1997, nursing home care was one of the fastest growing components of the Medicare program, growing at an average annual rate of 30 percent.¹⁷ In 1987 there were a total of 14,050 nursing homes with a total of 1.48 million beds, compared to 16,840 nursing homes with a total of 1.76 million beds in 1996. This represents a growth of almost 20 percent in ten years.

The biggest change in the industry, however, has been the rapid growth of freestanding ambulatory care centers and specialty hospitals. These facilities include heart hospitals, orthopedic hospitals, surgical hospitals and ambulatory surgery centers, cancer hospitals and centers, dialysis clinics, pain centers, imaging centers, mammography centers, and providers of many other specialty services. Their number is increasing rapidly. The number of Medicare-certified ambulatory surgery centers doubled in the past decade, and now exceeds the number of hospital-owned outpatient surgery departments with which they compete.¹⁸ The number of specialty hospitals has tripled.¹⁹ And the compound annual growth rate of ambulatory surgeries performed in freestanding centers or physician offices is three times the rate for hospital-based, out-patient surgeries.²⁰

This rapid growth is due to several factors. Advances in anesthesia and in surgical equipment and techniques (such as arthroscopic surgery) now make it possible to perform a wider range of procedures on an out-patient basis. Reimbursement rates for these procedures are relatively favorable, particularly for cardiovascular and orthopedic surgery. Physicians, who have chafed at the restrictions placed on them by hospitals and insurers, are able to gain more control over

¹⁵ Gloria J. Bazzoli, Linda R. Brewster, Gigi Liu, and Sylvia Kuo, "Does U.S. Hospital Capacity Need to be Expanded?" *Health Affairs*, November/December 2003.

¹⁶ American Hospital Association, "TrendWatch – Chartbook 2004," www.hospitalconnect.com.

¹⁷ Centers for Medicare and Medicaid Services, "Health Care Industry Market Update – Nursing Facilities," May 20, 2003.

¹⁸ Lawrence P. Casalino, Kelly J. Devers, and Linda R. Brewster, "Focused Factories? Physician-Owned Specialty Facilities," *Health Affairs*, November/December 2003.

¹⁹ John K. Inglehart, "The Emergence of Physician-Owned Specialty Hospitals," *The New England Journal of Medicine*, January 6, 2005.

²⁰ VHA, "The Doctor is Out: Physician Competitors in the Marketplace," *VHA Research Series*, 2003.

their practice, and they are also able to share in the profits. On average, physician ownership exceeds 50 percent at the specialty hospitals in which they have a share.²¹

These freestanding outpatient facilities pose a significant challenge to hospitals by drawing away doctors, patients, and hospitals' most profitable services. Cardiology services alone can account for one-quarter of hospital admissions and one-third of hospital revenue.²² Orthopedic procedures are also one of a hospital's most profitable services. These are the two services most often found in specialty hospitals.

There is another trend reinforcing the shift to freestanding outpatient facilities. During the 1990s, managed care gave physicians an incentive to band together into large medical groups to build a large patient base and to gain negotiating leverage with health plans. They tended to be multi-specialty groups in which primary-care physicians played a central role in referring patients. However, as health plans have retreated from managed care, primary-care physicians are no longer the gatekeepers, and there is less need for physicians from different specialties to be linked to each other.

As a result, and in parallel with the growth of specialty hospitals, there has been a shift toward single-specialty medical groups since the late 1990s.²³ These medical groups can pool their resources to invest in the latest technologies, establish their own freestanding facilities, negotiate favorable terms with health plans, and avoid much of the administrative and regulatory complexity associated with hospitals. Since a high volume of patients has been shown to lead to higher quality and lower costs,²⁴ this combination of single-specialty medical groups and specialty hospitals has the potential to achieve the same kind of advantages that have accrued to "category killers" in other industries.

There is evidence that freestanding outpatient facilities treat patients with better insurance coverage, lower risk, and less complex medical needs than those who receive treatment at hospitals.²⁵ There is also evidence that patients prefer the convenience, ambience, and efficiency of these freestanding facilities, and that staff prefer the regular hours and better work environment. If those trends continue, it is likely that the market will be increasingly segmented, and hospitals will be left with higher-risk patients with more complex medical needs, victims of trauma, and those with little or no health insurance coverage.

Hospitals are attempting to avoid this fate by making it more difficult for new freestanding facilities to enter the market. In 2003, the hospital industry convinced Congress to impose an 18-month moratorium on new physician-owned specialty hospitals, citing potential conflict of interest from self-referrals. When that moratorium expired in June of 2005, CMS extended it for

²¹ Inglehart.

²² Kelly J. Devers, Linda R. Brewster, and Paul B. Ginsburg, "Specialty Hospitals: Focused Factories or Cream Skimmers?" *Issue Brief*, Center for Studying Health System Change, April 2003.

²³ Lawrence P. Casalino, Hoangmai Pham, and Gloria Bazzoli, "Growth of Single-Specialty Medical Groups," *Health Affairs*, March/April 2004.

²⁴ John D. Birkmeyer, et al., "Surgeon Volume and Operative Mortality in the United States," *The New England Journal of Medicine*, November 27, 2003.

²⁵ Ariel, Winter, "Comparing the Mix of Patients in Various Outpatient Surgery Settings," *Health Affairs*, November/December 2003.

6 months to review its procedures for enrolling specialty hospitals in the Medicare program. To hedge their bets, hospitals are also financing their own freestanding facilities.

Pressure to Improve Quality. Another major industry trend is increasing pressure to improve the quality of care. Both external pressures and internal enablers have caused the industry to seek new ways to improve organizational performance and health outcomes. This trend has implications for the practice of medicine and the roles payers, practitioners and consumers play in the delivery of health care.

One strategy to improve quality is to require health care providers to measure and report on the quality of care they provide. A number of national organizations, including the National Committee for Quality Assurance (NCQA), the Joint Commission on Accrediting Healthcare Organizations (JCAHO), the Centers for Medicare and Medicaid Services (CMS), and the National Quality Forum (NQF), have developed measures of health care quality for use by health plans, hospitals, nursing homes, home health agencies, and clinicians. CMS has launched websites that contain quality information voluntarily reported by hospitals and nursing homes. Federal legislation in 2005 established a system of voluntary reporting of medical errors by hospitals. Some states have gone even further to make such reporting mandatory.

This system of tracking quality and making the results available to consumers is intended to introduce competition into the health care system. Proponents believe that as consumers become more informed about care options, quality, and costs, providers will face pressure to adopt new competitive practices based on improved care and customer satisfaction. With better information, patients are likely to take better care of themselves and cooperate more with treatment plans. But they also may demand a greater say in their care and increased access to clinicians and to treatments, which may increase costs.

Another strategy to improve quality reinforces reporting by also rewarding higher quality care. CMS and other payers are experimenting with new pay for performance schemes that offer financial incentives to providers to improve their quality outcomes on 10 clinical measures for Medicare patients. Those hospitals in the top 20 percent get a bonus, while those hospitals in the bottom 20 percent will get a 0.4 percent reduction in their annual Medicare fee schedule update. CMS is building similar systems for nursing homes and for physicians.

A number of private organizations have adopted similar pay-for-performance schemes. Two insurers, WellPoint Inc. and United Health Group, have begun rating hospitals and rewarding high-quality care. For example, if the hospital scores high on quality for bypass operations, it gets a bonus of 1 to 4 percent on top of its fixed fee for the procedure.²⁶ The Leapfrog group, a coalition of employers and other organizations who buy health care, also rewards hospitals for improvements in quality. The organization surveys hospitals on a variety of quality measures and makes the results available to employer members, who share them with their employees. These groups, along with many others, have now joined together in the Bridges to Excellence Coalition to push for the expansion of pay for performance programs.

²⁶ The Digital Hospital. (2005, March 28, 2005). *Business Week*.

A third strategy to improve quality is to adopt information technologies. Health care is the one of the most, if not the most, complex sectors of the economy.²⁷ The industry's fragmentation not only contributes to redundancy and waste, it also makes it extremely difficult to build the infrastructure needed to improve quality and performance. Because patient information usually resides in different places, clinicians often do not have full knowledge of their patients' medical history, condition, or current treatments. For example, most doctors have no idea what the average blood pressure is of their cardiac patients. In fact, many do not know how many heart patients they have or how many have been prescribed a particular drug.²⁸ This type of customer and product information is routinely available in other industries, where it is used to support decision making and quality improvements, but not in health care.

Many errors and costly redundancies could be avoided if the industry improved the way it managed and shared patient information. In a 1990 cross sector survey of American industries, health care ranked 38th out of 53 in its investments in information technology.²⁹ However, in 2004, the American Health Information Management Association found that 40 percent of the respondents to their annual survey were engaged in the implementation of new information systems, and only 10 percent said they had no foreseeable plans to upgrade their systems. National policy is pushing the industry in this direction.³⁰ The US Department of Health and Human Services has established the Office of the National Coordinator for Health Information Technology to support the widespread adoption of health information management systems within 10 years.³¹ Dr. David J. Brailer, the head of that office, predicts that tech investments could lead to \$140 billion a year in cost savings by 2014, or an estimated 6 percent of health-care spending in that year.³²

A final strategy for improving quality is to establish standards and care protocols based on advanced medical knowledge and best practices for patients with common conditions. This information would aid clinicians in the development of diagnosis and treatment plans, and ensure far more consistency in care and outcomes.³³ New technology-enabled decision-support systems could provide doctors and other clinicians with access to this information at the point of practice, further ensuring the dissemination of best practices throughout the industry.

New decision support systems based on standardized protocols could clearly make a big difference in the quality of care. However, the acceptance of these innovations by the medical community has been slow.³⁴ Studies show that it takes an average of 17 years for new medical

²⁷ *Crossing the Quality Chasm: A New Health Care System for the 21st Century*. (2001). Washington, DC: Committee on Quality of Health Care in America, Institute of Medicine.

²⁸ The Tech Guru: Dr. Gerald Burns, A former trauma surgeon champions life saving data. (2005, March 28, 2005). *Business Week*.

²⁹ Wasting Disease. (2005, July 15, 2004). *The Economist*.

³⁰ Zender, A. (2005). *Ready for the EHR? A New Survey Measures EHR Implementation and Individual Readiness*. Retrieved April 4, 2005, from www.ahima.org

³¹ *Health IT Strategic Framework*. (2004). Washington, DC: Office of the Coordinator for Health Information Technology.

³² Timothy J. Mullaney and Arlene Weintraub, "The Digital Hospital," *Business Week*, March 28, 2005.

³³ *Crossing the Quality Chasm: A New Health Care System for the 21st Century*. (2001). Washington, DC: Committee on Quality of Health Care in America, Institute of Medicine.

³⁴ Reed, M. C., & Grossman, J. M. (2004). *Limited Information Technology for Patient Care in Physician Offices* (No. NO. 89). Washington, DC: Center for Studying Health Systems Change.

knowledge to be incorporated into practice, and even then, much of the new knowledge fails to reach, or is never adopted by, many clinicians. One reason is because standardized protocols run counter to the culture of medicine that is highly individualistic and perpetuates a craft-based occupational model. Most doctors and other clinicians are trained to draw upon their years of education and clinical experience in the delivery of care, and therefore resist a more standardized approach to care. However, if clinicians are unable to access and use today's knowledge and technologies, they will be even less prepared to integrate more advanced knowledge and technologies that will surely come in the years ahead.³⁵

Aging Population. A much-cited trend these days is the aging of the population. By 2025, 18.5 percent of the population will be age 65 or over, compared to 12.4 percent in 2000. That represents an 80 percent increase in the actual number of elderly Americans.³⁶ Many observers have concluded that this trend will significantly increase the demand for health care services.

There are predictions that, as demand increases, there will be shortages of doctors, nurses, and pharmacists. The number of doctors entering practice has been around 20,000 a year for the past two decades. However, studies suggest that the medical needs of an aging population will require anywhere from 50,000 to 200,000 more than the number currently in the pipeline by 2020.³⁷ A shortage of nurses already exists and is expected to get worse over the next decade as Baby Boomers retire.³⁸ The biggest bottleneck is a shortage of faculty in nursing schools to train new nurses. In addition, more than 40 percent of nurses currently working in hospitals report high levels of dissatisfaction and burnout. Pharmacists, too, are currently in short supply, at a time when the number of prescriptions to be filled is rising rapidly.³⁹ The new Medicare prescription drug benefit is likely to add to this burden. However, following a decline in the late 1990s, the number of applications to pharmacy schools is now increasing once again.

There is some evidence to support the conclusion that an aging population will put a significant strain on the current system. Historical data show that as people age, their use of medical services increases. Research by the Center for Studying Health System Change found that per-person spending on health care increased by an average \$40 a year for individuals between 18 and 50 years old. Between ages 50 and 64, however, spending accelerated, increasing by an average of \$152 a year.⁴⁰ Average per-person spending on health care for individuals 65 and over is three times the spending for individuals ages 34 to 44.⁴¹

³⁵ *Crossing the Quality Chasm: A New Health Care System for the 21st Century.*

³⁶ Laura B. Benko, "Boomer Bust?" *Modern Healthcare*, July 28, 2003.

³⁷ Myrle Croasdale, "Physician Work Force Estimates Far Apart," *AMNews*, June 20, 2005.

³⁸ American Association of Colleges of Nursing, "Nursing Shortage Fact Sheet," www.aacn.nche.edu, accessed 12/6/05.

³⁹ American Foundation for Pharmaceutical Education, "Facts at a Glance: The Pharmacist Shortage," www.afpenet.org, accessed 12/6/05.

⁴⁰ Bradley C. Strunk and Paul B. Ginsburg, "Aging Plays Limited Role in Health Care Cost Trends," Center for Studying Health System Change, *Data Bulletin* No. 23, September 2002.

⁴¹ Uwe Reinhardt, "Does the Aging of the Population Really Drive the Demand for Health Care?" *Health Affairs*, November/December 2003.

Many hospitals are responding to the aging of the population by building new facilities and expanding existing ones. In particular, they are investing in new units to treat heart, joint, and cancer patients, because these conditions are common among the elderly.

However, it's unclear whether the expected influx of hospital patients will actually materialize. It's likely that a growing proportion of patients will receive care at freestanding surgery centers and ambulatory care centers to take advantage of the greater efficiency and convenience these facilities offer. And it's also likely that advances in genomics and preventive care will moderate the effects of aging, offsetting much of the demand for traditional hospital services.

New medicines are on the horizon to combat traditional age-related conditions. New anti-osteoporosis drugs are in development to prevent broken bones. New cholesterol-lowering drugs called statins are demonstrating effectiveness in preventing Alzheimer's disease and in reducing the incidence of cardiovascular disease. Other drugs are targeting specific types of cancer. And genetic research is under way to develop products that would slow aging, prolong youthfulness, and forestall age-related ailments.

Chronic disability rates among the elderly have been falling since 1982. The percentage of the elderly with debilitating conditions fell by 1.6 percent annually between 1982 and 1994. Since then, it has fallen by 2.6 percent annually. If that decline continues, there will be 40 percent fewer elderly with disabilities in 2027 than without these improvements. Cancer rates have also been falling by 1 percent annually since 1992.⁴²

Some of these gains can be attributed to better health education and preventive medicine. For instance, smoking rates have dropped significantly over the past several decades due to greater public awareness about the health risks. That greatly reduces the incidence of emphysema and cancers associated with smoking. As a result, the elderly are much healthier today than in the past, and that trend is accelerating.

Better health makes it possible for the elderly to live longer and more independently. The ability to live independently, along with changing preferences among the elderly, is driving demand for home health services. During the 1990s, services delivered at home to recovering, disabled, chronically or terminally ill persons was one of the fastest growing expenditures in Medicare.⁴³ A study by JPMorgan projects that the industry will continue to grow at an annual rate of 5 to 10 percent.

In addition, an increasing number of the elderly are choosing hospice care at home, rather than living out their last days in an acute-care institution. Since Medicare first offered the hospice benefit in 1982, the number of providers has grown from 31 to 3,100.⁴⁴ Although the Medicare reimbursement rates for hospitals and nursing homes were cut in the 1990s, the rates for hospice service were increased, making it a more attractive option. Since Medicare beneficiaries incur around 28 percent of their total medical costs in their last year of life, and half of that in the last

⁴² Laura B. Benko, "Boomer Bust?"

⁴³ Centers for Medicare and Medicaid Services, "Health Care Industry Market Update – Home Health," September 22, 2003.

⁴⁴ Julie Piotrowski, "The Business of Care for the Dying," *Modern Healthcare*, November 4, 2002.

two months of life, a continuing shift to less-expensive hospice care could deliver significant cost savings, as well as better quality at the end of life.

Outsourcing. A final trend worth mentioning is outsourcing by health care institutions, mainly hospitals. While hospitals have been slower than most other industries to adopt outsourcing, the practice is growing, driven mainly by the pressure to cut costs.⁴⁵ The most common functions affected are information technology, finance, and support areas like food service, housekeeping, and laundry. Clinical functions are the least affected.

Although the off-shoring of some medical services, along with “medical tourism,” has received a lot of attention in the press, these practices are very limited and represent just a tiny fraction of all the work that has moved overseas in recent years.⁴⁶ Some hospitals rely on radiologists in Australia, India, Israel, and Switzerland to read and interpret scans from their patients in the US, but this practice is mainly being driven by the exploding demand for the use of new imaging technologies and the corresponding shortage of trained radiologists in the US.⁴⁷ There’s evidence that the supply of radiologists is catching up the rising demand.⁴⁸ Meanwhile, Medical tourism is constrained by insurance coverage, which rarely extends to voluntary procedures performed in other countries.

It is likely that the outsourcing trend will continue in health care. Information technology functions, in particular, are likely to be outsourced as hospitals face mounting pressure to adopt new clinical information systems and computerized physician order entry systems to promote patient safety. Currently, most hospitals lack the expertise in-house to deploy these systems, and they will need to turn to outside vendors and partners for help.

However, hospitals face a number of constraints on their outsourcing activities. One is the threat that they might lose their non-profit status if they outsource too many of their functions to for-profit entities. In 2004, a medical center in Illinois was stripped of its non-profit status and received a \$1.1 million local property tax bill after a review board determined that it relied too heavily on for-profit entities to provide hospital services.⁴⁹ Congress is also gearing up to take a look at this issue.

Another constraint is concern about privacy issues. The Health Insurance Portability and Accountability Act (HIPAA) places strict limits on the use of patient information, provides a mechanism for individuals to file complaints, and imposes civil penalties on institutions or individuals that violate its provisions. Outsourcing work that involves sensitive patient information could make patients uneasy and increase the risk of legal action.

Finally, outsourcing clinical functions could undermine hospital efforts to improve the quality of care. The fragmentation of hospital operations is currently one of the biggest obstacles to

⁴⁵ VHA, “Hospitals Increasingly Outsourcing Key Functions,” Press Release, February 4, 2000.

⁴⁶ Susanna Moon, “2004 Outsourcing Survey: Outsiders Moving In,” *Modern Healthcare*, September 27, 2004.

⁴⁷ The Associated Press, “Some U.S. Hospitals Outsourcing Work,” December 6, 2004.

⁴⁸ Radiological Society of North America, “Radiologist Shortage Over? Survey Says Yes,” www.rsna.org, accessed 12/6/05.

⁴⁹ Michael Romano, “Outsourcing Everything,” *Modern Healthcare*, April 5, 2004.

improving the quality of care. Further fragmentation through outsourcing could increase the number of hand-offs and increase the likelihood of errors.

International Comparisons

Although the cost of care is on the rise in all OECD countries, the U.S. system is by far the most expensive in the world. US citizens spend 53 percent more for their health care than anyone else in the world.⁵⁰ This difference cannot be attributed to higher volume or higher quality of care. On most measures of healthcare usage, the U.S. falls below the OECD median. The U.S. trails other OECD countries on outcome measures like life expectancy and infant mortality, occupying the bottom quartile of industrialized countries.⁵¹

In cross-country comparisons of patients with common conditions, the U.S. healthcare system lags other OECD countries. Several countries are equally successful in reducing overall mortality, and some even achieve better results with younger patients.⁵² In addition, the U.S. system lags in basic quality measures like citizen satisfaction. In international surveys of citizen satisfaction with their healthcare systems, Canada and European nations consistently earn higher marks than the U.S.⁵³ Patient-reported medication errors, medical mistakes, or lab errors in the US are the highest among the advanced industrialized countries.⁵⁴ And half of sick adults in the US report that they didn't visit a doctor, get the recommended treatment, or fill a prescription because of the cost, a rate nearly double the next-highest country.

The higher costs Americans pay for health services can be attributed to a number of factors. First, the inputs of care, like salaries, medical equipment, pharmaceuticals, and other supplies, are more expensive in the U.S. than in other countries. The buying power of the U.S. healthcare system is weak by international standards. In other parts of the world, like Canada, Europe, and Japan, the government controls the financing and, in the case of England, the provision of health care. The monopolistic powers of these national systems enable them to extract bigger discounts from providers of health services and products. Prescription drugs, for example, are generally much cheaper in other industrialized countries than they are in the United States.⁵⁵ And the cost of a procedure in Canada is one-third the cost for the same procedure in the U.S.⁵⁶

⁵⁰ Gerard F. Anderson, Peter S. Hussey, Bianca K. Frogner and Hugh R. Waters, "Health Spending in the United States and the Rest of the Industrialized World," *Health Affairs*, July/August 2005.

⁵¹ Anderson, G. F., Uwe, E. R., Hussey, P. S., & Petrosyan, V. (2003). The Prices, Stupid: Why The United States Is So Different From Other Countries. *Health Affairs*, 22(3).

⁵² Doctuer, E., Suppanz, H., & Woo, J. (2003). *The US Health System: An Assessment and Prospective Directives for Reform* (No. 350): OECD.

⁵³ Anderson, G. F., Uwe, E. R., Hussey, P. S., & Petrosyan, V. (2003). The Prices, Stupid: Why The United States Is So Different From Other Countries. *Health Affairs*, 22(3).

⁵⁴ Cathy Schoen, Robin Osborn, Phuong Trang Huynh, Michelle Doty, Kinga Zapert, Jordon Peugh, and Karen Davis, "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," *Health Affairs Web Exclusive*, November 3, 2005.

⁵⁵ The Health of Nations. (2004, July 15, 2004). *The Economist*.

⁵⁶ Anderson, G. F., Uwe, E. R., Hussey, P. S., & Petrosyan, V. (2003). The Prices, Stupid: Why The United States Is So Different From Other Countries. *Health Affairs*, 22(3).

Second, the average hospital stay, although shorter than most OECD countries, is typically more labor intensive in the United States.⁵⁷ And third, the fragmented structure of the US health care system creates a costly administrative burden that far exceeds what other nations must bear. The multiple payer system in the US is inherently more expensive than the single payer systems found in other industrialized countries. Each insurer in the US must maintain its own claims processing facilities, which increases overhead costs. Providers must deal with multiple insurance products, and keep track of different eligibility requirements, co-payments, referral networks, and approval requirements. To manage this complexity, U.S. providers must maintain complicated billing, cost accounting, and internal auditing systems.⁵⁸ As a result, administrative overhead accounts for as much as 31 percent of healthcare expenditures in the U.S., as opposed to just 16.7 percent in Canada.

Implications for Employment

The high cost of health care in the U.S. relative to other industrialized nations has serious implications for the U.S. economy. To be competitive, US-based companies either need to find ways to offset their higher health care costs, or they need to find ways to move jobs off shore to countries where health care costs are lower.

Health care costs for current and retired workers add as much as \$1,500 to the cost of every car or truck produced by Big Three automakers in the US.⁵⁹ By comparison, Toyota spent \$186 on health and pension costs on every car built globally in 2003. That figure fell by 3 percent from the previous year, while health care costs for the Big Three rose by 16 percent. US automakers have been shifting production to Canada, where health care coverage for auto workers and their families is less than one-fifth the cost in the US, yielding a \$4 per hour wage advantage.⁶⁰ In general, benefit costs account for 28.8 percent of compensation for private sector production workers in the US, compared to 17.0 percent in Japan, 16.6 percent in Canada, and 17.6 percent in the UK. Three-fourths of the difference is due directly to the different health care system in the US.⁶¹

The good news for the US is that, beyond the cost differential, the health care systems in all industrialized countries face many of the same problems. The cost of health care spending per person is rising in all industrialized nations at a relatively similar rate. All industrialized countries have been slow to invest in information technology that can reduce errors and improve quality and efficiency, and they have been slow to adopt evidence-based standards and protocols. Access to care is also a common problem. In some countries, like Canada and England, wait time for services are very high, whereas America's mixed funding arrangement leaves 44 million people without healthcare.⁶²

⁵⁷ Reinhardt, U. E., Hussey, P. S., & Anderson, G. F. (2004). U.S. Health Care Spending in an International Context. *Health Affairs*, 23(3), 10 - 26.

⁵⁸ Woolhandler, S., M.D., M.P.H., Campbell, T., M.H.A., & Himmelstein, D. U., M.D. (2003). Costs of Health Care Administration in the United States and Canada. *New England Journal of Medicine*, 349(8), 768-775.

⁵⁹ John D. Stoll, "The Health Care Crisis," *Ward's Auto World*, February 1, 2005.

⁶⁰ Kirstin Downey, "A Heftier Dose to Swallow," *The Washington Post*, March 6, 2004.

⁶¹ Labor Research Association, "The Auto Industry Crisis is a Health Care Crisis," 2005.

⁶² The Health of Nations. (2004, July 15, 2004). *The Economist*.

It's possible that adopting a single-payer system in the US could close much of the gap with other countries. Eliminating the fragmentation created by the current system could reap huge savings by reducing administrative costs and by making it possible to negotiate lower prices for drugs and other medical supplies and devices. It could also speed the introduction of information technology, which could further reduce paperwork, increase efficiency, and improve quality of care. But this solution is unlikely in the current political environment.

Focusing more on chronic conditions could also reap huge benefits. As mentioned above, chronic conditions are the leading cause of illness, disability, and death in the US, and account for the bulk of health care spending. By organizing care delivery along the lines of specific conditions, such as diabetes, cancer, and cardiovascular disease, it would be possible to bring together the best available medical evidence, the necessary practitioners and equipment, and the patients who need treatment. Since most patients respond to similar treatments, it would also be possible to standardize care delivery into routine protocols. That would pave the way for introducing methods to improve quality and efficiency that have proven effective in other industries, but have so far had limited impact in the current fragmented environment.

However, focusing more attention on managing chronic conditions could have a profound impact on hospitals, which have come to rely on the income from treating the effects of chronic illness. Hospitals are already under considerable pressure to cut costs, and they are under siege from the growing ranks of freestanding facilities. As the more modern, more patient-friendly, and potentially more efficient freestanding facilities demonstrate an advantage in quality and cost in a market where these factors are becoming increasingly transparent, they are likely to attract growing numbers of patients and change the competitive landscape dramatically.

This trend could lead to a two-tiered health system in the US. As patients with insurance and the ability to pay seek care at freestanding facilities, hospitals will be less able to cross-subsidize care for the elderly, disabled, poor, and uninsured, at a time when there are increasing numbers of elderly to serve and likely increases in the ranks of the uninsured, because they are unable to afford rising deductibles and co-insurance payments, or because states have trimmed their Medicaid rolls.⁶³ How the nation chooses to respond to this challenge will have a profound impact on the ability of all American businesses to compete in the global economy.

⁶³ Stuart H. Altman, David Shactman, and Efrat Eilat, "Could U.S. Hospitals Go the Way of U.S. Airlines?" *Health Affairs*, January/February 2006.