**Problem Set Two Directions**: In order for you to find a viable solution to this nation’s healthcare crisis, you must first understand exactly how our nation’s healthcare system works. The answers to these questions are everywhere. However, look for answers in the course modules entitled, “Playlist” and “Resources.”

**Outcome**: Upon completing this problem set, you should have a better understanding of some of the problems of the American system of healthcare, and be prepared to participate in the class discussion when you are asked to do so.

1. About how much money per citizen does the United States currently spend on each citizen for healthcare?
2. Is this figure more or less than other comparable countries?
3. What assumptions could you draw from the information in questions one and two? Would your assumptions be correct?
4. Provide some data to back up any conclusions you draw in question three (i.e.- think about ways in which we could measure whether or not the money we spend on healthcare is producing the outcomes we desire).

**Read the Article *Causes of High Health Care Costs* by Amal Triveldi, MD, MPH to answer the following questions:**

1. Provide a possible solution to each of the factors that Dr. Triveldi says are the reasons health care costs are so high in the United States:
	1. Costly technology and drugs:
	2. Increased costs of healthcare goods and services:
	3. Marketing of new drugs and devices:
	4. Overuse of specialty care:
	5. High administrative costs:
	6. Physician’s fees:
	7. Malpractice costs:
	8. Defensive medicine:
	9. Aging population:

**Causes of High Health Care Costs**

By **Amal Trivedi, MD, MPH, The Alpert Medical School of Brown University; Providence VA Medical Center**

Health care costs in the US are disproportionately high for many reasons.

**Use of costly new technologies and drugs**

Such use may be the largest single factor increasing health care costs. Use may be appropriate or inappropriate, but in either case, cost is increased. An example of appropriate but costly treatment is the use of fibrinolysis or angioplasty to treat an MI; before the 1980s, when these treatments began to be used commonly, treating an MI was much less costly (but also less effective). On the other hand, many new and costly treatments, including some in popular use, are ineffective, offer only marginal advantages, or are used inappropriately for patients unlikely to benefit. An example is use of lower lumbar spinal fusion to treat chronic low back pain; many experts think this treatment is ineffective and/or grossly overused.

Use of many such costly treatments tends to vary considerably among geographic areas and among physician practices within a geographic area (termed practice variation). For some specific disorders (eg, coronary artery disease), health outcomes are no better in areas where adjusted health spending is high than in areas where it is low.

Corporate and governmental subsidization removes some economic disincentives to health care use and has been postulated to contribute to increased health care use (and thus costs).

**Increased costs of health care goods and services**

Drug costs have increased. One reason is the increasing cost of developing a new drug, often in the vicinity of $1 billion. The cost of drug development decreases the economic incentive to develop drugs with lower profit potentials, even those that could substantially benefit particular groups (eg, drugs to treat rare diseases) or public health in general (eg, vaccines, antibiotics).

**Marketing of new drugs and devices**

Intensive marketing to physicians and consumers (with direct-to-consumer advertising) has been suggested as a cause of overuse of costly new technologies and drugs. Some of these new measures may be no more effective than older, less costly ones.

**Overuse of specialty care**

Specialists are increasingly providing more care; reasons may include a decreasing number of primary care physicians and an increased desire by patients to see a specialist.

Specialty care is often more expensive than primary care; specialists have higher fees and may do more testing (often pursuing less common diagnoses) than primary care physicians. Also, evaluation and treatment of a patient who could have been managed by a single primary care physician may require more than one specialist.

**High administrative costs**

The percentage of health care dollars spent on administration is estimated to be 20 to > 30%. Most administrative costs are generated by private insurance, and most of those costs are generated by marketing and underwriting, processes that do not improve medical care; however, the Affordable Care Act limits the amount that private insurance can spend on administrative costs. Also, the existence of numerous private insurance plans in the same geographic area typically increases health care providers’ costs by making processing (eg, claim submission, coding) complicated and time-consuming.

**Physician fees**

Physicians in the US are more highly compensated than other professionals in the US and more than physicians in many other countries. This disparity occurs partly because physicians in other countries typically spend far less on their medical education and malpractice insurance than those in the US and have lower office overhead. Because physician fees account for only about 20% of total health care costs, even a significant reduction in physician fees would have only a modest effect on overall costs.

**Malpractice costs**

The issue of malpractice adds to the cost of medicine directly and indirectly (by triggering defensive medicine).

The direct cost is the malpractice insurance premiums paid by physicians, other providers, health care institutions, and medical drug and device manufacturers. These premiums, which cover claim settlements and malpractice insurance company overhead and profits, must ultimately be paid from health care revenues.

As onerous as premiums and the threat of lawsuits can be for individual physicians (particularly in certain high-risk specialties and geographic areas), the total annual malpractice premium amount paid in 2008 by physicians and institutions was about $12 billion, representing only about 0.6% of total annual health care costs. Actual malpractice settlements paid out in 2014 were $3.9 billion (< 0.2% of health care costs). Thus, even a major reduction in malpractice settlements would not lower total health care costs significantly, although it could greatly affect certain physicians’ practices.

**Defensive medicine**

Defensive medicine refers to diagnostic tests or treatments that providers do to guard against the possibility of malpractice litigation, even though such tests and treatments may not be warranted clinically. For example, a physician may hospitalize a patient who is likely to do well with outpatient treatment to avoid a lawsuit in the unlikely event of an adverse outcome.

The actual costs attributable to defensive medicine are difficult to measure. Few rigorous studies have assessed this cost, and estimates from these studies vary greatly, ranging from negligible to substantial (some experts believe that these costs are larger than direct malpractice costs). Some of the uncertainty lies in the fact that defensive medicine is defined subjectively (ie, it is the clinician’s reason for doing a test, not how unlikely or uncommon the disorder being tested for is). A clinician’s motivation is hard to determine, and different clinicians can reasonably vary in their assessment of the need for testing in a given case (except for a relatively few situations that have clear, sensitive, and specific guidelines for testing). In some survey studies of defensive medicine, physicians were asked whether and when they practice defensive medicine. However, such self-reporting may be unreliable, and such surveys often have a low response rate. Thus, the extent of defensive medicine is unknown.

Furthermore, even when defensive testing can be identified, calculating potential cost savings is not straightforward. Decreasing the amount of defensive testing involves a change in marginal costs (the cost of providing or withholding an additional unit of service), which are different from actual charges or reimbursements. In addition, studies of states that have enacted tort reforms to limit compensation to patients for iatrogenic injuries have had conflicting results about whether such reforms lower health care expenditures.

**Aging of the population**

Although often cited as a factor, population aging is probably not responsible for recent increased costs because the generation now in old age has not yet increased disproportionately; also, more effective health care has tended to delay serious illness in this generation. However, the aging of baby boomers may affect costs more as the proportion of the population > 65 increases from about 13% currently to almost 20% after 2030.

**Key Points**

* Use of costly new technologies and drugs may be the largest single factor among the many that increase US health care costs.
* Use of such technologies sometimes varies widely between geographic areas, and increased use does not always result in better clinical outcomes.
* The percentage of US health care dollars spent on administration is 20 to > 30%.
* Reducing physicians fees is not likely to decrease health care costs very much.
* Direct malpractice costs have a small effect on overall health care costs, but the costs of defensive medicine, done to guard against malpractice suits, are difficult to measure and largely unknown.
* Aging of the US population probably has not contributed greatly to the disproportionate increases in US health care costs but may do so as baby boomers age.

*Last full review/revision February 2016 by Amal Trivedi, MD, MPH*