

Cost Shifting Does Not Reduce the Cost of Health Care

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ALMOST EVERY POLITICAL PRONOUNCEMENT NOW emphasizes cost reduction as a central object of health care reform. The policy recommendations that follow, however, frequently aim at cost shifting rather than cost reduction. Shifting has popular appeal while reduction usually requires painful choices. To see the irrelevance of shifting for cost reduction, consider the proposal to prohibit health insurance companies from varying premiums according to enrollee's health status. This obviously reduces premiums for the sick but, not so obviously, also increases premiums for the healthy. Such a shift may be desirable on equity grounds but does nothing to reduce the real cost of care. Also, unless accompanied by a strict mandate, these shifts may lead to an increase in the uninsured because some healthy individuals will discontinue their health insurance coverage in response to higher premiums.

A subsidy is another example of a so-called cut in the cost of care, but also is just cost shifting. A subsidy reduces the cost for low-income eligible individuals by shifting the cost to higher-income taxpayers. Again, this may be desirable policy, but it is not a reduction in real costs. When eligibility for a subsidy includes those individuals and families with incomes up to 500% of the poverty level (approximately \$110 000 for a family of 4) as in one senate proposal,¹ even the shifting of costs is an illusion. It is impossible to collect enough taxes from those with incomes of more than \$110 000 to subsidize the poor and the sick and also help the numerous middle and upper middle income households. The latter will have to pay for their own health care one way or another. Also misleading is the claim that government is cutting the cost of care to families and individuals by requiring employers to provide health insurance (ie, an employer mandate). Abundant theoretical and empirical research shows that although employers appear to pay, the cost is actually passed on to workers through foregone wage increases or to consumers through higher prices.²

To prescribe policies that would result in cost reduction instead of cost shifting, it is useful to know why Americans will spend more than \$8000 per person this year for health care while the next highest spending country (it will probably be Switzerland) will spend about \$5500, and the av-

erage Organization for Economic Co-operation and Development country will spend less than \$4500 per person.³ There are many explanations for the differentials, some more applicable when comparing the United States to one country and some to another. The following generalizations, however, hold on average for comparisons between the United States and other high-income countries.

Higher Administrative Costs

The United States has a highly complicated inefficient system for funding health insurance and paying physicians, hospitals, and other providers of health services that relies primarily on employment-based insurance and income-tested insurance (eg, Medicaid). As long as the United States has hundreds of insurance companies competing for the business of millions of individual firms, 50 state bureaucracies administering complex rules governing subsidies, and hundreds of thousands of physicians and other clinicians having to bill for every individual service, US administrative costs will remain abnormally high.

Higher Ratio of Specialists to Primary Care Physicians

Specialists are more expensive to train and they make more use of expensive technologies and procedures. In Canada, one-half of all physicians are in family or general practice⁴; in the United States, fewer than one-third are primary care physicians (even including all pediatricians, all obstetricians/gynecologists, and one-half of all internists).⁵ A high ratio of specialists to primary care physicians might contribute to better health outcomes in some cases, but a significant overall effect has not been demonstrated. A decrease in the number of specialists and an increase in the number of primary care physicians results in delays and inconvenience for some patients in obtaining specialty care, but improves access to primary care and keeps costs down.

More Stand-by Capacity

Related to the higher ratio of specialists to primary care physicians is the greater investment in the United States in stand-by capacity. Expensive equipment and personnel are

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not used as intensively in the United States; this raises the cost per use. For example, compared with Canada, the United States has 4.22 times as many magnetic resonance imaging scanners per million persons, but performs 2.85 times as many scans. On average, each Canadian magnetic resonance imaging scanner accounts for 48% more scans than each US machine.⁶

Open-Ended Funding

Most private and public insurance in the United States is open-ended (ie, benefits are broadly defined), but there is no limit set on how much spending can result. An alternative, pursued in some other countries, is to define a fixed budget for health care, which clearly has a restraining effect on expenditures.

More Malpractice Claims

In the United States, more resources are devoted to the administrative, legal, and judicial costs arising from the malpractice insurance system. Defensive medicine also takes its toll. Legal limits on awards and an alternative dispute resolution system could lower these costs.

Less Social Support for the Poor

The poor usually have more health problems and lower education. Without adequate social support, it is difficult to take care of the poor who are sick on an outpatient basis. The result is a higher rate of hospital utilization, especially re-admission after discharge.

Higher Drug Prices

The United States has been subsidizing the rest of the world by allowing the drug companies to practice price discrimination by charging higher prices in the United States than in other countries for the same drug. It would not be difficult to stop this practice, but some analysts argue that this would result in a reduction in drug company research and development.

Higher Physician Incomes

After adjustment for the higher proportion of specialists and the cost of training, the difference between physician incomes in the United States and other countries is smaller than first appears, but relative to other occupations, US physicians still make more money.⁷ Reducing fees is an option

that Medicare often tries to exercise, but frequently backs off under political pressure. Moreover, reducing fees does not necessarily reduce expenditures because physicians can respond by recommending more visits and tests. A more fruitful approach would recognize that physicians' incomes after deducting practice expenses amount to only approximately 10% of total health expenditures,⁸ but physicians' decisions determine most utilization of care. The challenge to health reform is to implement systems in which physicians have the information, infrastructure, and incentive to practice cost-effective medicine. In such a system, high-physician income would be of minor importance as long as total spending was under control.

Conclusions

After considering the reasons health care spending is so much higher in the United States than in other countries, it seems that only large-scale reform of the way the country funds health insurance and organizes and pays for care will make a substantial, sustainable difference in the level of spending.⁹ Cost shifting does not solve the problem.

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