How Does the U.S. Health-Care System Compare to Systems in Other Countries?

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and

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Outline

- Dimensions of underperformance
  - Excessive spending
  - Poor health outcomes
  - Inadequate access to care
- Implications for reform
- Concluding thoughts

WHO Health System Rankings

Rank	Country
1	*France*
2	*Italy*
3	*San Marino*
9	*Austria*
10	*Japan*
36	*Costa Rica*
37	***United States***
38	*Slovenia*
39	*Cuba*

WHO Rankings

- Ranking methodology subjected to significant criticism in academic circles (*Science*, *Health Economics*)
- But oft cited as 'authoritative' nonetheless …
- Relatively poor U.S. rank in part attributable to
  - High levels of health spending
  - Relatively mediocre population health outcomes
  - Inequitable access for the uninsured

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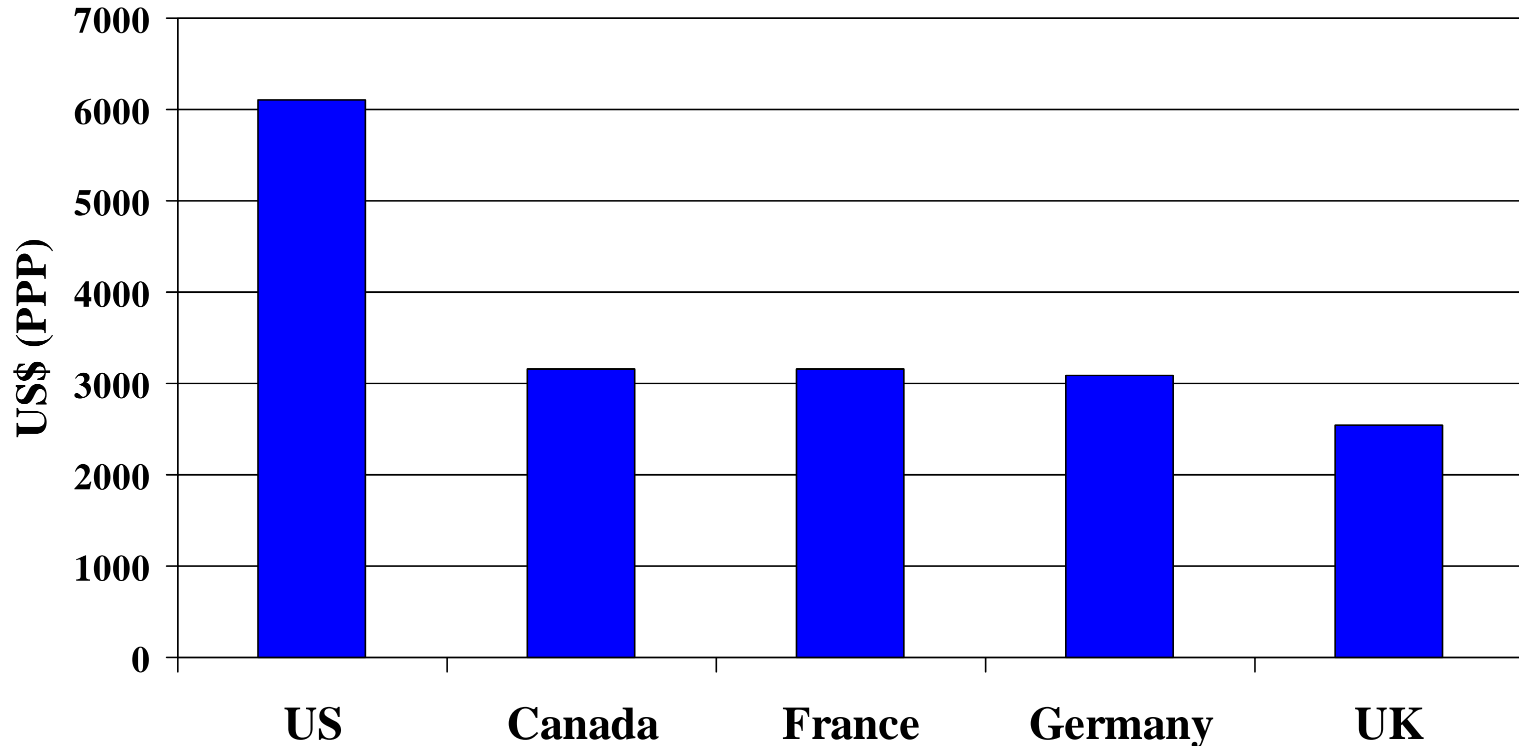
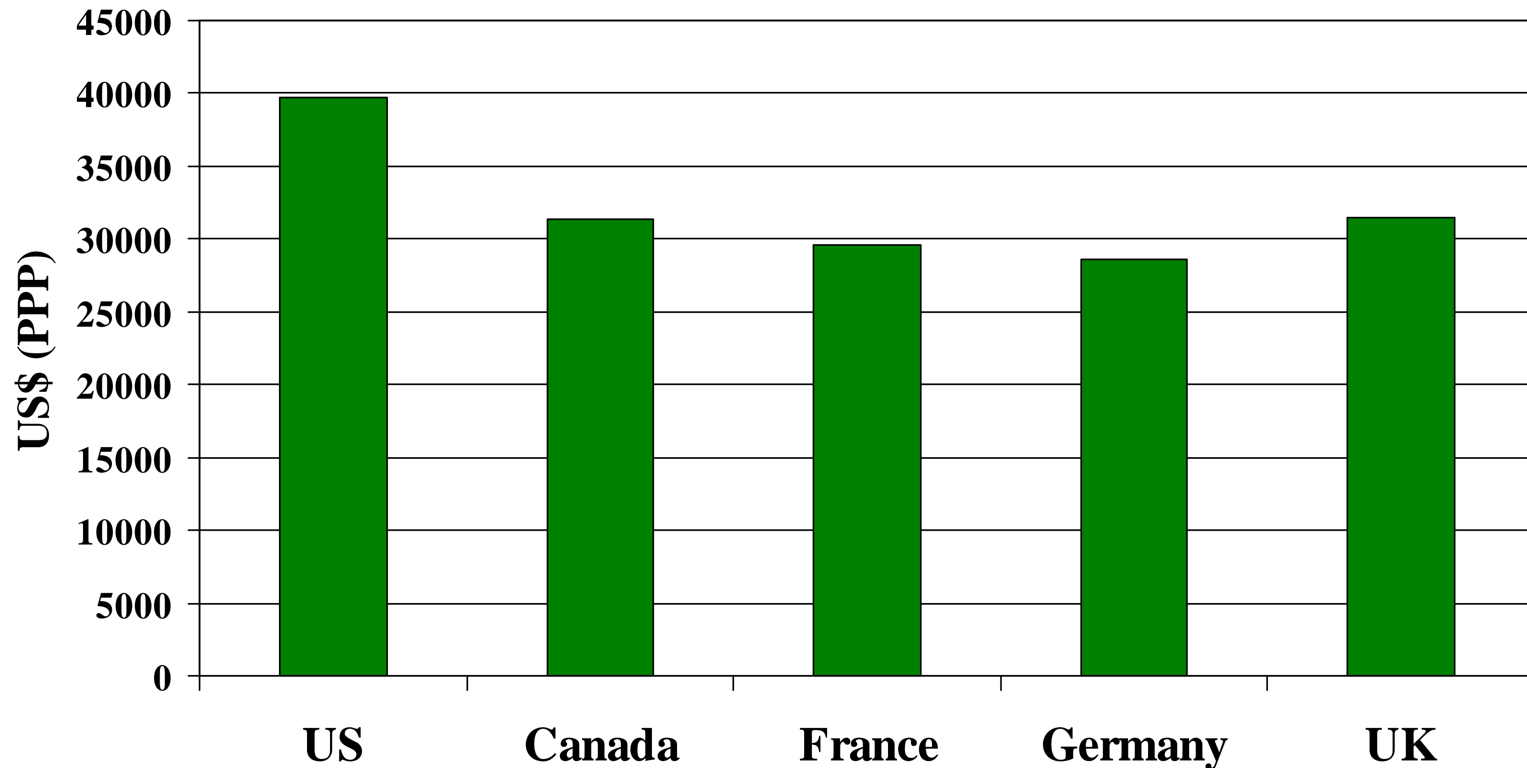
Is U.S. Health Spending Excessive?



Source: OECD Data, 2006

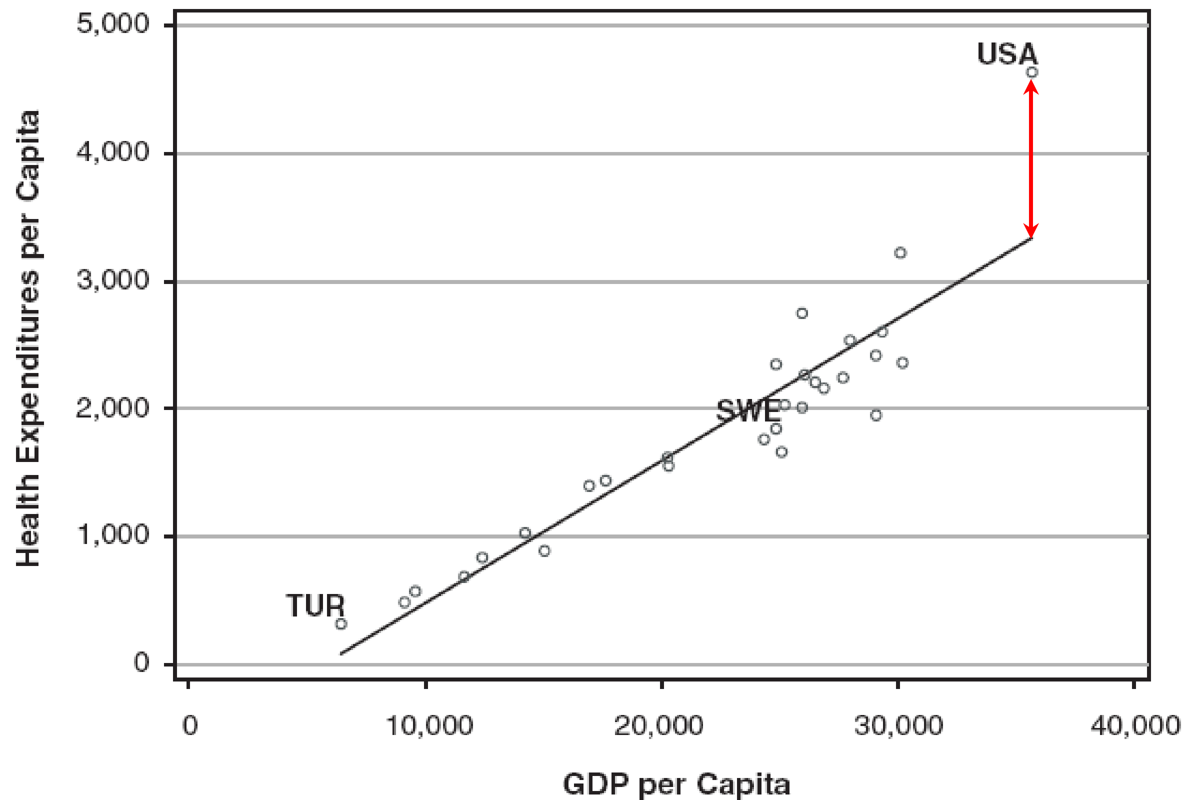
Is U.S. Health Spending Excessive?



Source: OECD Data, 2006

Figure 1-1

Fitted Regression Line for Health Expenditures per Capita and GDP per Capita, OECD Countries, 2000: Linear Specification[1]

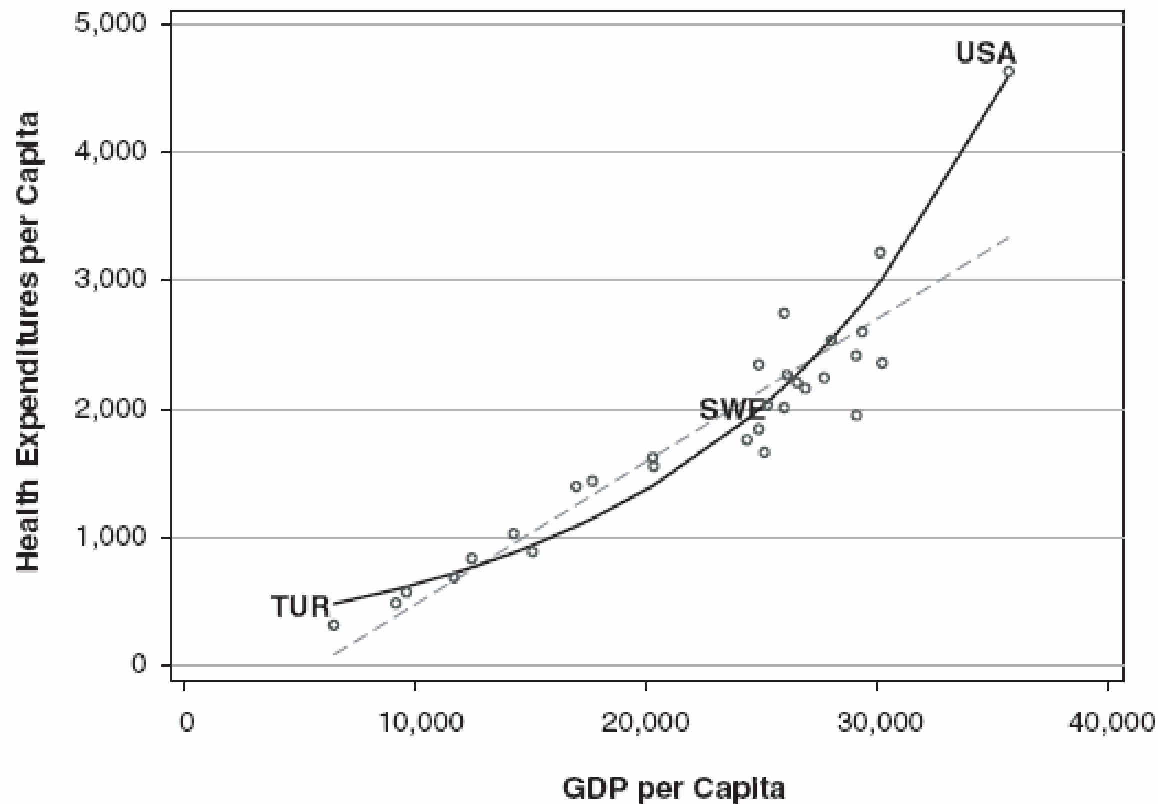


Source: Authors' analysis of OECD data.

Note: 1. Linear Regression: HealthExpPC = –628.74 + 0.1113 GDPPC, R^2 = 0.846

Figure 1-2

Fitted Regression Line for Health Expenditures per Capita and GDP per Capita, OECD Countries, 2000: Semilog Specification[1]



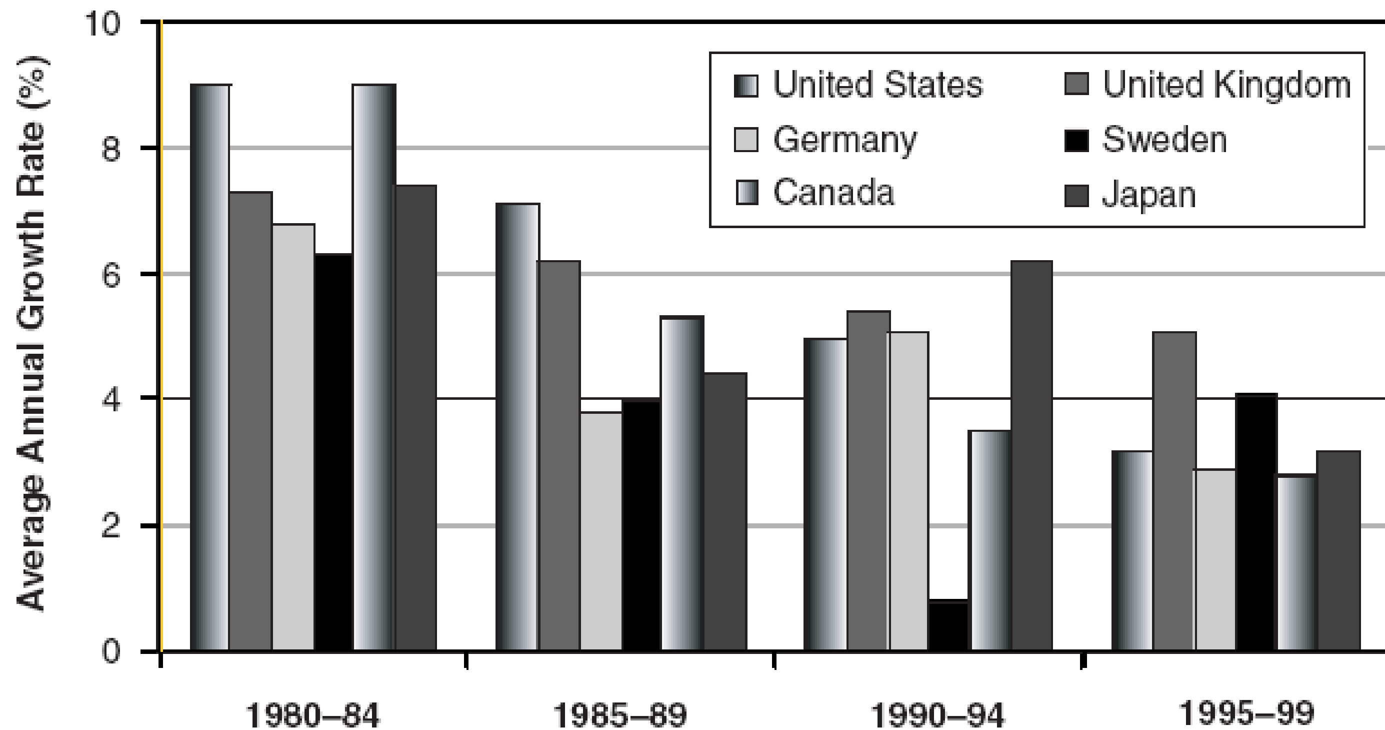
Source: Authors' analysis of OECD data.

Note: 1. Semilog Regression: log (HealthExpPC) = 5.66 + 7.7E-05 GDPPC, R^2 = 0.926

Actual and 'Expected' Spending

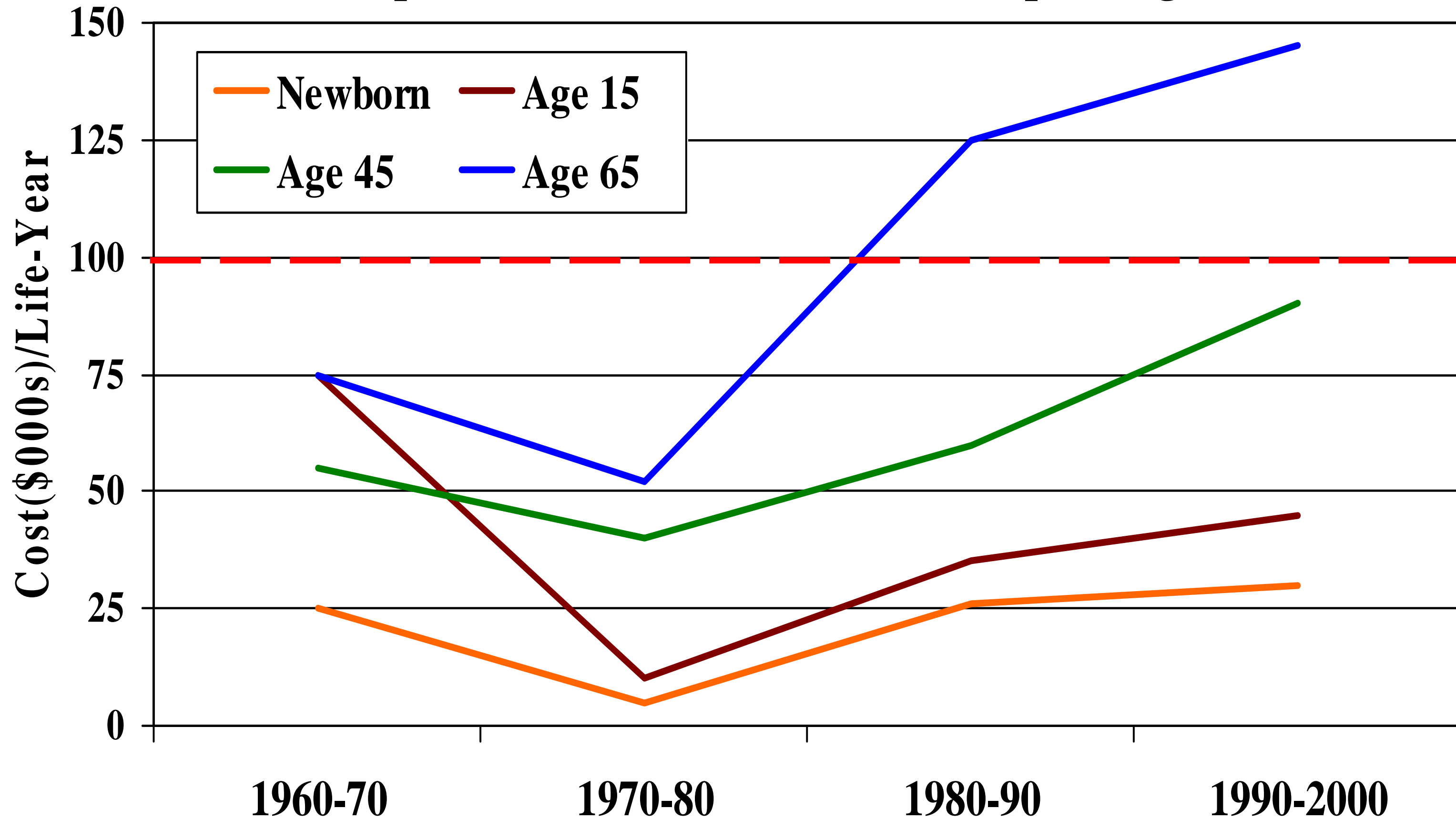
- The U.S. is an extreme value in both per capita GDP and health spending
  - Regressions are difficult to "fit" at extreme values
  - U.S. "residual" is sensitive to model specification
- Obvious U.S. spends more on health than other OECD countries
- But not obvious U.S. spends more than 'expected' given higher GDP

Figure 1-4
Growth in Health Spending per Capita (PPP$), Selected OECD Countries, 1980–99



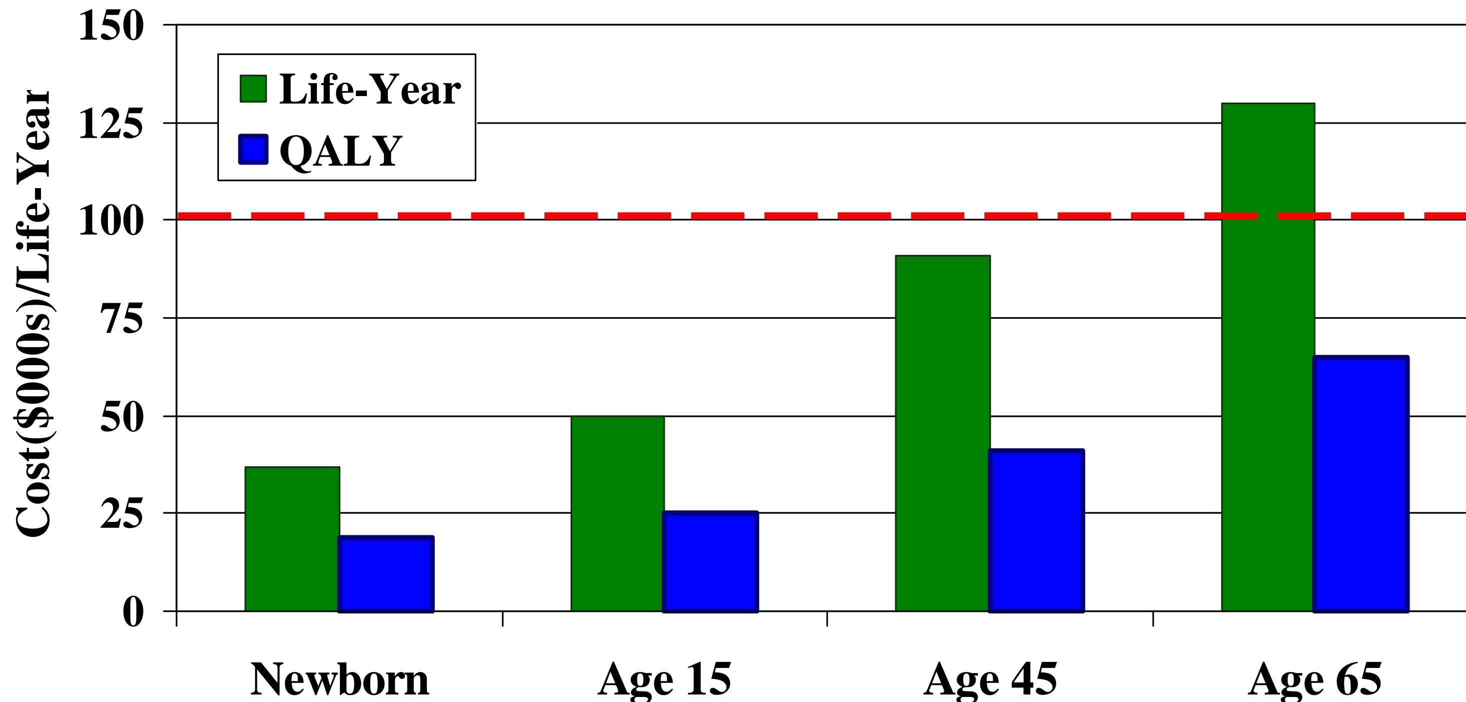
Source: Organization for Economic Cooperation and Development (2003).

Value of Health Spending



Source: Cutler et al. *New Engl J Med* 2006;355:920-27.

Value of Health Spending [cont]



Source: Adapted from Cutler D, ASHE Plenary Presentation, Madison, WI, 2006.
(http://healtheconomics.us/conference/2006/plenaries/powerpoint/cutler-madison.ppt)

Possible Sources of ‘Excess’ Spending

- Discretionary expenditures?
- Higher prices for health care inputs?
- Higher rates of obesity?
- Liability environment and defensive medicine?
- Excess capacity/duplication?
- Profit seeking and excessive competition?
- Direct-to-consumer advertising for drugs?

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Table 1-1
Comparison of General Population Health Metrics, United States and Selected Developed Countries, 2001

	Child Mortality (Age $\leq$ 5)[1]	Healthy Life Expectancy (Birth)[1]	Healthy Life Expectancy (Age 60)[1]
United States	9 (7)	66 (69)	15 (17)
White	7 (6)	67 (69)[2]	15 (17)[2]
Black	16 (13)	61 (65)[2]	14 (16)[2]
Australia	7 (5)	70 (73)	16 (19)
Canada	6 (5)	68 (71)	15 (18)
Denmark	6 (5)	69 (71)	16 (17)
France	5 (4)	69 (74)	16 (19)
Germany	5 (4)	68 (72)	15 (18)
Italy	6 (5)	69 (73)	16 (18)
Japan	5 (4)	71 (76)	17 (21)
Sweden	4 (3)	70 (73)	17 (19)
Switzerland	6 (5)	71 (74)	17 (20)
United Kingdom	7 (6)	68 (71)	15 (17)

Sources: World Health Organization (2004); U.S. Department of Health and Human Services (2004), race-specific data.

Notes: 1. Male (female). 2. Imputed from ratio of total to race-specific life expectancy in years.

Table 1-3
Comparison of Health Outcomes Relatively Insensitive to Health Care System Characteristics, 2000

	Homicide	Transport
United States	7.3	15.3
White	3.2	n/a
Black	26.1	n/a
Canada	1.4	9.3
Germany	0.9	10.1
Japan	0.6	8.3
Sweden	1.2	4.9
United Kingdom	0.7	6.0

Sources: World Health Organization (2004); U.S. Department of Health and Human Services (2002a).
Note: Death rate per 1,000.

TABLE 1-5

MEAN LIFE EXPECTANCY AT BIRTH, OECD COUNTRIES, ACTUAL AND STANDARDIZED BY OECD MEAN FATAL INJURY RATES, 1980–99

	Actual Mean	Standardized Mean	Ratio (Std/Act)
United States	75.3	76.9	1.022
Switzerland	77.6	76.6	0.988
Norway	77.0	76.3	0.991
Canada	77.3	76.2	0.986
Denmark	75.1	76.1	1.014
Germany	75.4	76.1	1.009
Iceland	78.0	76.1	0.975
Sweden	77.7	76.1	0.979
Japan	78.7	76.0	0.967
Australia	76.8	76.0	0.990
France	76.6	76.0	0.992
Belgium	75.7	76.0	1.004
Austria	75.3	76.0	1.008
Netherlands	77.0	75.9	0.987
Italy	76.6	75.8	0.989
United Kingdom	75.6	75.7	1.002

TABLE 1-6

FIVE-YEAR AGE-ADJUSTED CANCER SURVIVAL RATES, UNITED STATES[1] AND SELECTED EUROPEAN COUNTRIES[2]

	Breast (Female)	Cervical (Female)	Colon (Male)	Lung (Male)	Prostate (Male)	Thyroid (Female)
United States	82.8	69.0	61.7	12.0	81.2	95.9
White	83.9	71.8	62.5	12.0	82.7	95.7
Black	69.2	55.6	52.6	12.0	69.2	93.0
England	66.7	62.6	41.0	7.0	44.3	74.4
Denmark	70.6	64.2	39.2	5.6	41.0	71.7
France	80.3	64.1	51.8	11.5	61.7	81.0
Germany	71.7	64.1	49.6	8.7	67.6	77.0
Italy	76.7	64.0	46.9	8.6	47.4	77.0
Sweden	80.6	68.0	51.8	8.8	64.7	83.7
Switzerland	79.6	67.2	52.3	10.3	71.4	78.0

NOTES: 1. U.S. National Cancer Institute (2003), year of diagnosis 1986–88. 2. International Agency for Research on Cancer (2003), year of diagnosis 1985–89.

Common Limitations of Health Outcome Measures as System Performance Metrics

- Differences in outcome measures used
- Differences in measurement processes
- Heterogeneous treatment effects
  - Differences in population risk distributions (population heterogeneity)
  - Differences affecting treatment effectiveness (e.g., adherence)

Performance Metrics and Rankings

- Given lack of precision in available outcome measures as system performance metrics:
  - Cannot reliably conclude U.S. system performance “on average” is markedly worse than other large, high-income nations with diverse populations (a small league)
  - But cannot conclude U.S. system performance is markedly better either, despite higher levels of spending.
- Greater variance in access to treatment related to large uninsured population in U.S. creates a “drag” on U.S. outcome performance metrics “at the mean.”

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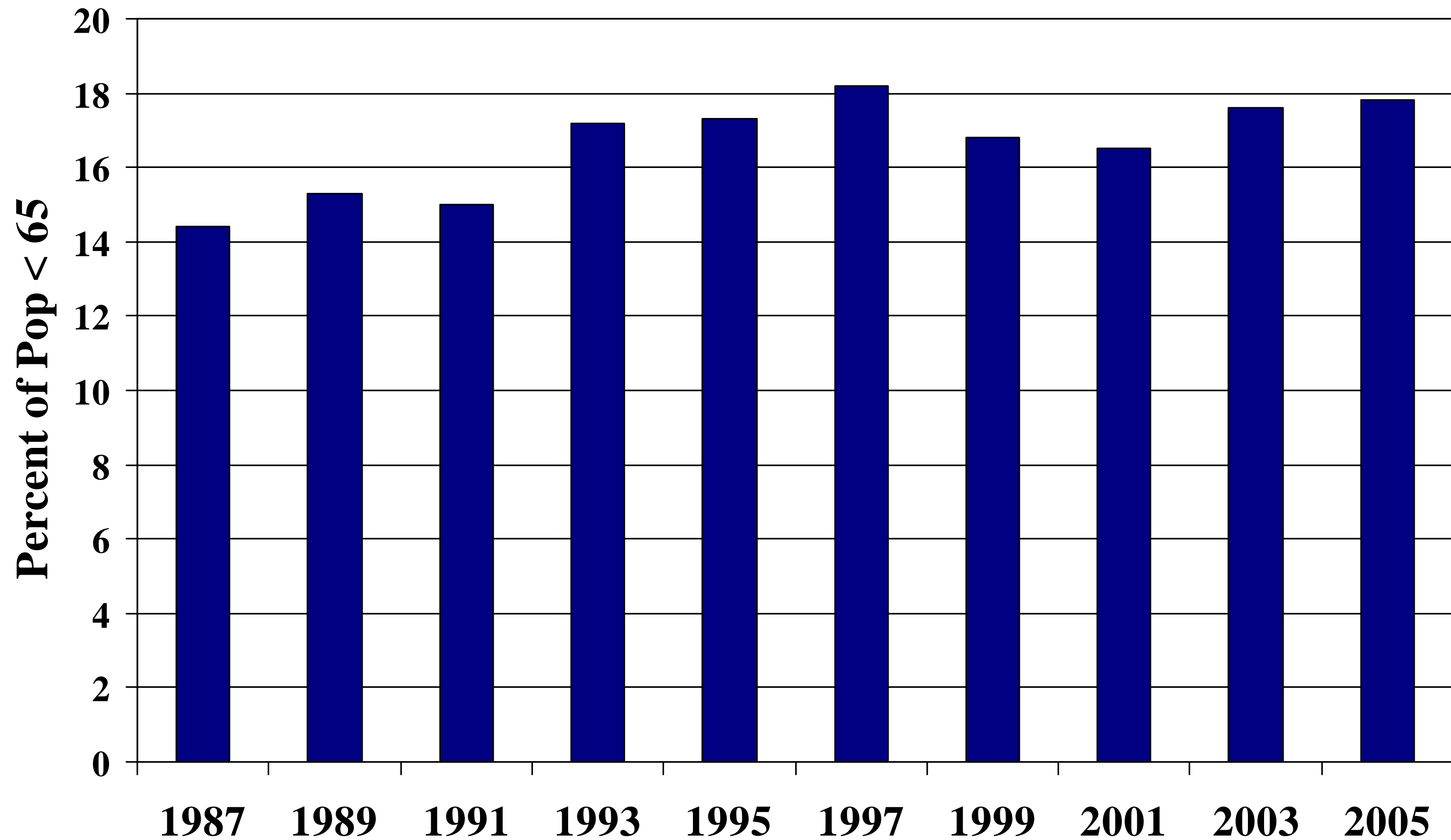
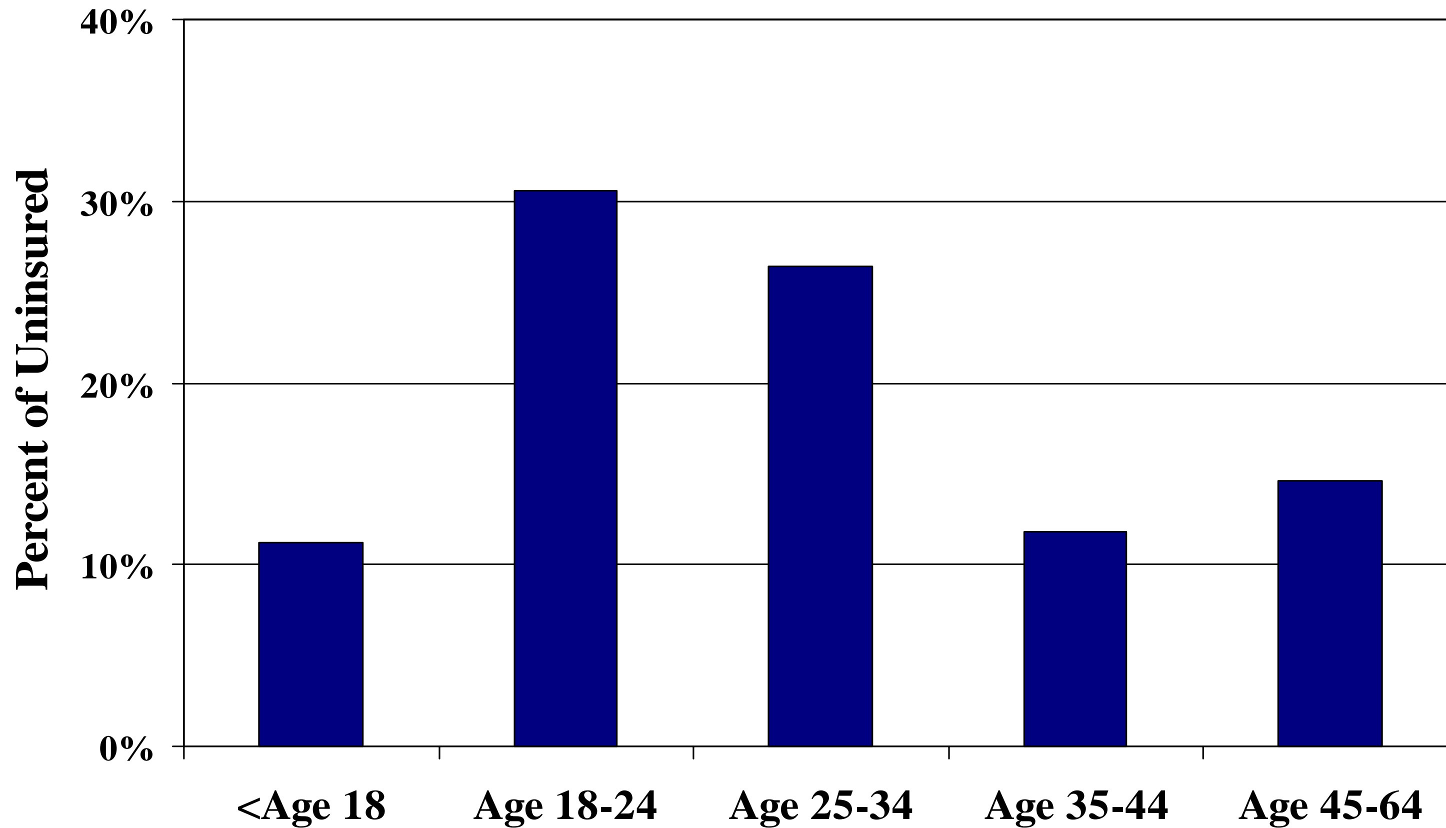
Uninsured Population Under Age 65, 1987 – 2005



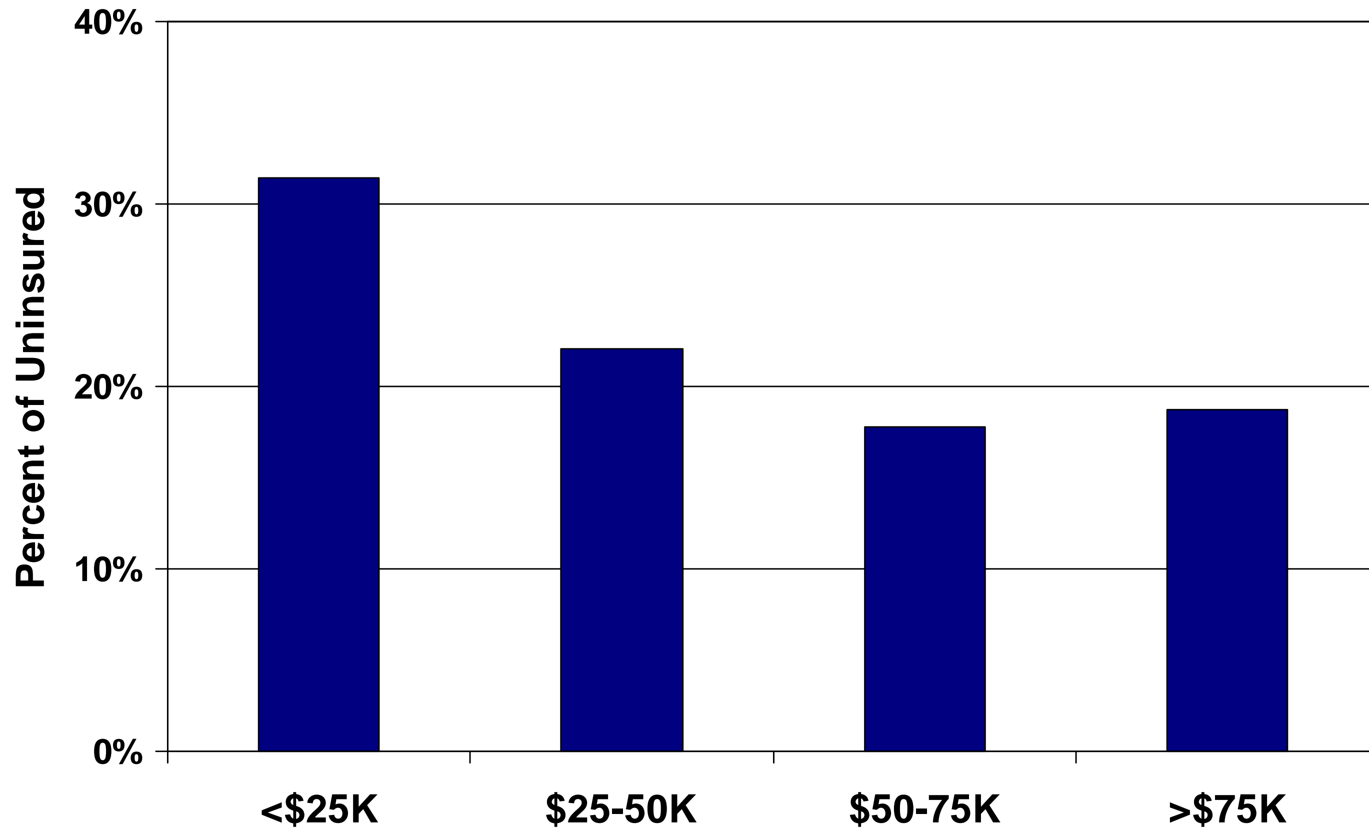
Source: US Census (P60-266 & P60-231), 2005, 2006

Uninsured Population Under Age 65, by Age Group, 2005



Source: US Census (P60-231), August 2006

Uninsured Population Under Age 65, by Income Category, 2005



Source: US Census (P60-231), August 2006

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Implications for Reform

- All developed countries systems face generally similar fiscal pressures associated an aging population and technological innovation.
- No health system has developed “the” solution; no existing model is ideal.
- Many potential lessons for reform from what works well elsewhere, but transferability to U.S. is not assured.

Single-Payer Systems

- The broad policy objective of “universal care” does not necessarily imply single-payer health systems.
- Nominal objectives of single-payer approach are to improve access, reduce administrative “waste,” and direct resources to where they are most needed.

Single-Payer Pros & Cons

Advantages

1. Improved access for disadvantaged
2. Some reduction in administrative redundancy
3. Ability to direct resources to most "needed" (e.g., rural areas; certain chronic diseases)
4. Larger risk pools

Disadvantages

1. Waiting lists & other barriers to care
2. Not all administrative costs are "bad" and in need of elimination
3. Lower incentives for adaptation, innovation, and change
4. Tax-based financing
5. Politicized medicine
6. Moral hazard

Single-Payer in California

- SB 840 = Canadian-style single payer
- Passed Assembly and Senate
- Fueled in part by managed care backlash, employer cutbacks, and the uninsured
- Short-run problem: would have eliminated CA's private health insurance market
- Long-run problem: would have reduced benefits and access for a large proportion of the insured
- Governor did not sign
- Longer-run problem: distraction from feasible alternatives

A Modest Reform Agenda

1. Markets should be allowed to work in the cases where we know they work well
2. Development of a more coherent strategy to evaluate new medical technologies and services
3. Transparency in contracts between health plans and enrollees
4. Imbue greater degree of price sensitivity within health services transactions
5. Improve marketing and coordination among existing public insurance programs

Example of #5: CA Coverage Matrix

Publicly Sponsored Programs						
Individuals unable to obtain private health insurance due to a medical condition	Children in moderate income families above 250% Monthly Income Guidelines	Children in moderate income families at or below 250% Monthly Income Guidelines	Pregnant women, Infants	Low- or no-income adults	Low-income individuals & families	Immigrants awaiting legal status
MRMIP Major Risk Medical Insurance Program 800-289-6574 www.mrmib.ca.gov	**Healthy Kids Plans** 510-763-2444 www.100percentcampaign.org **CaliforniaKids** 818-755-9700 www.californiakids.org **Kaiser Cares for Kids** 800-255-5053 www.kaiserpermanente.org	**Healthy Families Program** 800-880-5305 888-747-1222 www.healthyfamilies.ca.gov	**Medi-Cal** California's Medicaid Program 800-824-0088 888-747-1222 www.medi-cal.ca.gov **AIM** Access for Infants & Mothers 800-433-2611 www.aim.ca.gov **Healthy Families Program** 800-880-5305 888-747-1222 www.healthyfamilies.ca.gov	**Medically Indigent Adult Program (MIA)** also known as **County Indigent Program** Every county has a MIA program. In 34 rural counties however, the MIA program is known as the **County Medical Services Program (CMSP)** Contact local county social services agency www.dhs.ca.gov	**Medi-Cal** California's Medicaid Program 800-952-5253 www.medi-cal.ca.gov Or contact local county social services agency www.dhs.ca.gov	**Restricted Medi-Cal** California's Medicaid Program 800-952-5253 www.medi-cal.ca.gov **Family PACT** Family planning only 800-942-1054 Or contact local county social services agency www.dhs.ca.gov
MRMIP is a 36 month program. After that, subscribers can enroll in guaranteed coverage with private health plans. Under MRMIP, there is a $75K annual limit. Coverage increases to $200K per year (with a $750K lifetime limit) once subscriber moves to a guaranteed issue private insurance individual plan MRMIP offers a variety of medical services provided by HMOs and PPOs	Offers a variety of health, dental, and vision plans from which to choose, includes hospitalization Pre-existing health conditions covered	Offers a variety of health, dental, vision, and prescription plans from which to choose Pre-existing health conditions covered	Under AIM, comprehensive medical care for mother provided (not just maternity) Under AIM, mothers continue to be covered up to 60 days after delivery. After birth, infant is automatically enrolled into the Healthy Families Program up to age 1 After age 1, eligibility under the Healthy Families Program is reviewed and those within the allowable Monthly Income Guidelines continue with coverage as allowed under program rules Under Medi-Cal, pregnancy-related care (prenatal and delivery) is covered. Mothers are covered up to 60 days after delivery Pre-existing health conditions covered	Medically necessary physician and hospital-related services Depending on county, may provide coverage for other services such as dental and vision Benefits vary by county, please refer to social services agency in county of residence Pre-existing health conditions covered	Offers health, dental, vision, and prescription coverage Treatment for special health problems like breast cancer, kidney problems, nursing home needs, and AIDS Pre-existing conditions covered	Restricted Medi-Cal covers emergencies, pregnancy-related care (prenatal and delivery), kidney dialysis, treatment for breast and cervical cancer Family PACT provides comprehensive family planning services Pre-existing health conditions covered

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