



FUNDAMENTALS OF U.S. HEALTH POLICY

Do We Spend Too Much on Health Care?

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There is no question that the United States spends a great deal on health care, both in absolute dollars and relative to other high-income countries: in 2018, U.S. health care spend-

ing totaled \$3.6 trillion, which amounted to 17.7% of the gross domestic product (GDP) and \$11,200 per capita — almost twice as much as many other high-income countries.¹ The details of where that money comes from and where it goes are instructive, and they highlight misperceptions that often skew the public debate. Most privately insured Americans get their insurance through their jobs, with a small share getting coverage through the Affordable Care Act marketplaces (see line graph).² The biggest expenditure categories are physicians and hospitals, rather than prescription drugs; although the amount going to prescription drugs is growing, the proportion of health care spending going to

drugs is fairly stable (see bar graph).²

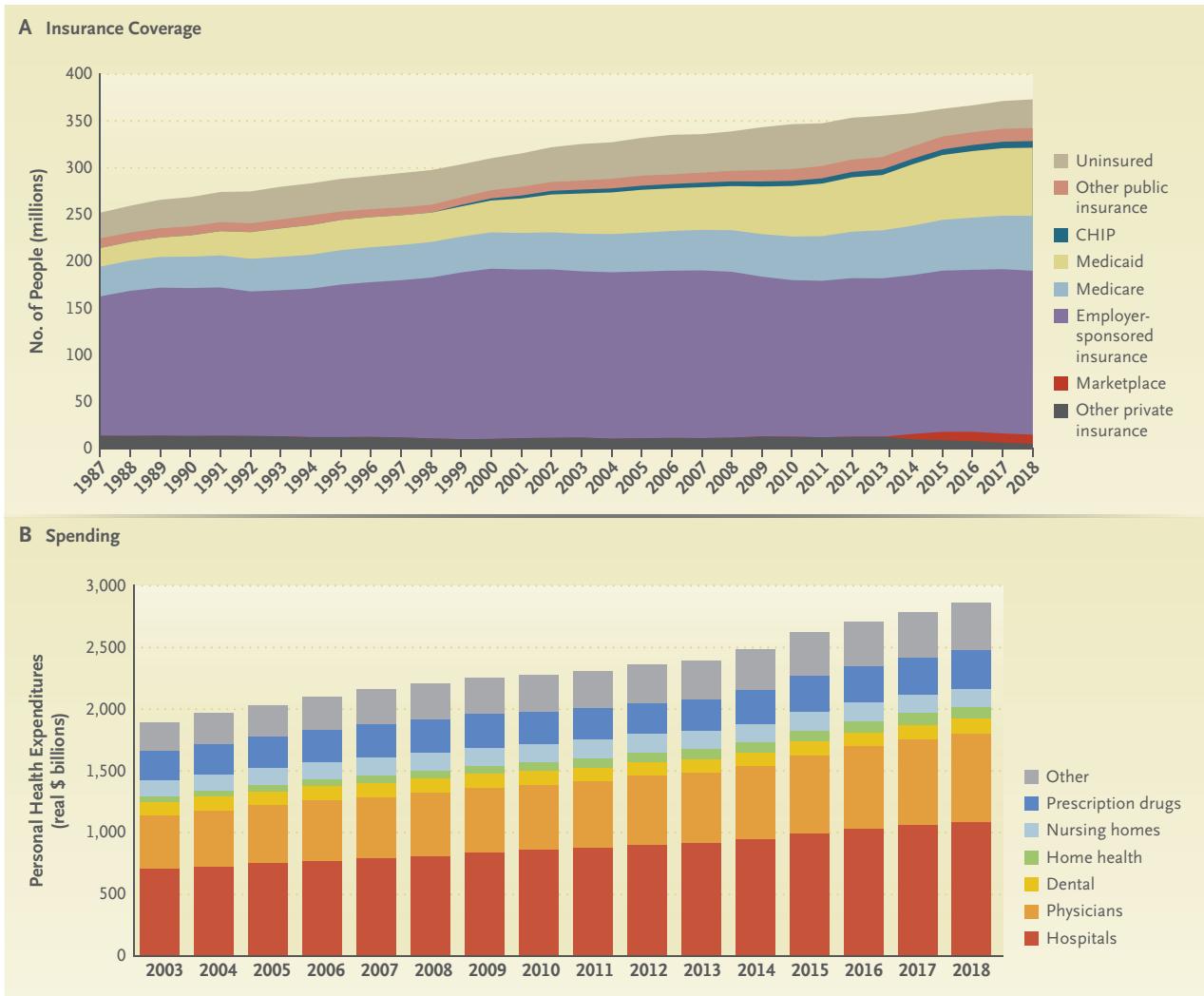
Many people view more spending as inherently undesirable and wasteful. There is a kernel of truth to this shorthand, given the evidence that we could achieve the same outcomes but spend less if we spent more effectively — or that we could achieve better health at current spending levels. But this insight doesn't tell us what to do about it. Many strategies have been deployed for reducing spending, but policies focused only on spending less may do more harm than good.

So do we in fact spend too much on health care? One way of answering this question is to assess why we spend so much more than other countries do. Many

studies have taken this tack, assessing how much of the higher spending in the United States is attributable to higher prices and how much to greater quantities of services.

The first problem with these analyses is that as nations and people grow richer, they're willing to spend a greater share of income on health care. The fact that U.S. incomes are nearly 25% higher than U.K. incomes, for example, suggests that we would be spending 15 to 25% more on health care, all else being equal (the same point highlights the challenges of putting all Americans, with very disparate incomes, into a single insurance plan).³

Second, our measures of quantity don't adequately capture the quality or intensity of care, misleadingly suggesting that spending differences must be attributable to price when there are probably unmeasured differences in quality or intensity that mas-



U.S. Health Insurance Coverage by Source and Spending by Type of Care.

Data are the authors' tabulations from National Health Expenditures tables, Centers for Medicare and Medicaid Services, 2020.² CHIP denotes Children's Health Insurance Program.

querade as higher prices. For example, some studies compare numbers of physician visits or scans per capita, sidestepping the important issues of whether countries vary in terms of physician specialization or whether they are using 0.5-, 1.2-, or 3.0-Tesla MRI machines. Small differences in these attributes can generate large differences in prices. The question ought to be whether the expenditures on greater quality or intensity, appearing as higher

prices, are generating care improvements of sufficient value — a very different exercise from taking on prices alone.

The third problem with these comparisons is that prices, quantities, and quality affect one another, so they aren't independent policy levers: a change in prices would also change the quantity and quality of care. Knowing whether prices are "too high" hinges on understanding the forces that determine these prices

and on whether lower prices would result in desirable or undesirable changes in the care delivered. For example, high prices that result from anticompetitive mergers suggest different policy reactions than high prices that result from patients choosing more expensive providers over less expensive ones: for patients, 10% higher perceived quality might be worth paying 30% more. If prices truly reflect patient demand for valued care, then administrative-

ly setting lower prices may harm patients. Furthermore, administratively setting prices below market levels risks achieving short-term savings at the cost of reducing valuable long-run innovations. Similarly, most health care spending is on labor, and wages depend on forces outside health care (such as the wages aspiring physicians would be paid if they chose to be lawyers instead); regulation thus has limited power to lower prices without generating offsetting quality effects.

A better way to determine whether we spend too much on health care is to assess our health outcomes relative to how much was spent to achieve them — to see how much health benefit we get for every dollar spent. There's evidence that we overspend on some kinds of care and under-spend on others, including prevention, vaccines, and basic care for the uninsured. High-value care doesn't mean cheap care, and low-value care doesn't mean expensive care: some expensive treatments generate enormous value, such as cures for hepatitis C and rapid stenting after a heart attack; and some low-cost care is wasteful, such as antibiotics for viral infections or annual check-ups for well patients. We can't simply say we spend too much; rather, we're not spending on consistently high-value care.

Viewed through this lens, health system reforms — such as changes in insurance design, patient cost sharing, payment reform, or price regulation — should be judged by whether they move us toward higher-value use of resources, rather than by whether they reduce spending. Moving to higher-value care is

much harder than reducing spending, because it requires spending more on certain types of care while saying no to things that improve health at a cost that's too high.

Promises of reforms that will both reduce spending and improve outcomes are popular to make, but evidence (and Congressional Budget Office scoring) suggests that they're difficult to keep. Most preventive care improves health but doesn't save money. Health insurance expansions improve financial security and health but increase spending. Paying primary care physicians to coordinate care across settings or “hot-spotting” programs that target patients with high health care use may improve the quality of care but don't reduce spending.

All of which is not to say that the amount we spend on health care is irrelevant. Spending more on health care means spending less on other priorities — both for individuals and for governments. These trade-offs increase the importance of getting high value for every dollar spent, because more health care spending means less spending on education, food, housing, infrastructure, and other societal needs. And as spending on public programs grows, the taxes needed to finance those programs come with mounting economic consequences. Crowding out other spending has different implications for different populations and payers, but it means that we can't spend 100% of GDP on health care. The debate about *whether* health care is a right sidesteps the more difficult and important question of *how much* health care is a right that should be ensured through public programs.

There are multiple drivers of the quantity and value of health care delivered — and thus opportunities for innovation. The way health care is paid for highlights the misalignment of incentives to assess value within health care and relative to other priorities. Medicaid, jointly financed by the states and the federal government, is constrained by states' ability to borrow. A recession or cost-increasing treatment therefore hampers Medicaid's ability to insure the poor without impairing other state-government priorities such as education. Medicare, financed by the federal government, can operate at a deficit for longer — but has limited tools for moving toward paying for value. It's prohibited from using cost-effectiveness in coverage decisions, and although fee-for-service payment is not the only culprit, Medicare's limited alternative payment schemes suffer from weak incentives and inadequate measurement. Moreover, Medicare has outsized effects on coverage and spending throughout the health care system, given its size and the precedent it sets for private insurers, infrastructure investment, and incentives for innovation.

Coverage by employer-sponsored insurance plans is shaped by the wages that employees are willing to give up for their health insurance benefit, but this trade-off is further distorted by the tax-subsidizing of generous plans (with greater subsidies for higher-income workers), which drives more of workers' compensation toward richer insurance benefits that cater to higher-income employees. Reducing this regressive tax subsidy would greatly improve both equity and the value of care,

but it has proven politically fraught. On the patient side, cost sharing is often misperceived as merely a mechanism for shifting costs to enrollees, but it can help limit the use of low-value services. Crude cost-sharing implementations, such as across-the-board high deductibles or copayments, however, can discourage high-value as much as low-value spending.⁴

Thus, the options available to policymakers must be assessed on the basis of their effects on both spending and health outcomes. Higher payments for high-value services may spur innovations that improve the length and quality of life. But these advances bring tough choices, and a one-size-fits-all solution probably can't both achieve public policy goals and meet individual priorities. There is a strong rationale for public

plans to ensure that all people have access to highly beneficial care, regardless of their ability to pay. Public programs could cover many more people if their resources were focused on high-value care, rather than on covering all services for fewer people. But many people may be willing to pay more for innovations even of limited or uncertain health benefit, and insurers can tailor plans to generate value to attract enrollees. If we're willing to pay \$150,000 for each quality-adjusted extra year of life (a commonly used estimate), then we ought to view a 10% increase in spending per capita as a good investment if it extended average life expectancy by 2.5 days. That number may give readers pause — hence the importance of clarifying our spending priorities and focusing on care that produces real value for patients. With such a focus, we could feel more confident

that higher health care spending was worth it.

Disclosure forms provided by the authors are available at NEJM.org.

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 An audio interview with Dr. Baicker is available at NEJM.org

People with Hepatitis C Who Inject Drugs — Underserved, Not Undeserving

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The development of highly curative direct-acting antiviral (DAA) therapy for hepatitis C virus (HCV) infection has transformed clinical management of HCV and provided the impetus for the World Health Organization's ambitious HCV-related targets for 2030. These targets include marked improvements in prevention (including expanded harm reduction for people who inject drugs), upscaling of HCV screening and linkages between screening and other health ser-

vices to enable treatment for 80% of people with chronic hepatitis C, and a 65% reduction in HCV-related deaths and a 90% reduction in new infections from 2015 levels.¹

Of 71 million people with chronic hepatitis C globally, an estimated 6.1 million are people who inject drugs, and injection drug use is responsible for most new infections in many countries.² To reduce the burden of HCV, public health and clinical responses should focus on key

populations: people with advanced liver disease (to reduce HCV-related mortality) and those at high risk for transmitting HCV (to reduce the incidence of HCV infection). Although these populations overlap, the latter is younger, is more highly marginalized, and tends to lack access to care.

A comparison of HCV responses in Australia, Canada, and the United States is informative (see table). Starting in 2013, the licensing of expensive DAA regi-