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Health Care Spending in the United States Compared With 10 Other High-Income Countries
What Uwe Reinhardt Might Have Said

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In this issue of *JAMA*, Papanicolas and colleagues[1] compared health care spending in the United States with health care spending in a select group of 10 of the highest-income countries (United Kingdom, Canada, Germany, Australia, Japan, Sweden, France, the Netherlands, Switzerland, and Denmark). The authors examined drivers of spending across multiple dimensions, including general health system expenditures, population behaviors and health, labor costs and structural capacity, administrative costs, utilization, access and quality, cost of pharmaceuticals, and distribution and equity.

The principal findings in the report by Papanicolas et al are that in 2016, the United States spent 17.8% of its gross domestic product on health care, compared with a range of 9.6%-12.4% for the other countries studied and had almost double the health care spending per capita of US $9403 compared with a range of $3377-$6808 in the other countries. Although the United States spent more, the percentage of the US population with health insurance was 90%, compared with 99%-100% in the other countries. Most health care utilization rates in the United States, such as for hospital discharges and some common surgical procedures, were similar or slightly higher than in the other countries, but the prices of health care labor and goods, including pharmaceuticals and administrative costs, appeared to be the major drivers of the difference in overall spending between the United States and other high-income countries.

However, despite higher health care spending, the authors also report that the United States performed less well than the 10 other high-income countries on several important population health indicators. For example, life expectancy in the United States was the lowest of the countries studied at 78.8 years (range for the other countries, 80.7-83.9), and infant mortality was the highest (5.8 deaths per 1000 live births in the United States vs a range of 2.1-5.1 per 1000 for the other countries). The report also includes more details than in previous reports, including, for instance, health care expenditures by site and function of care; major determinants of health, including smoking, alcohol consumption, and obesity or overweight; physician workforce and workforce remuneration; utilization, including number of hip and knee replacements; and details about pharmaceutical costs.

The study by Papanicolas et al is similar to previous landmark investigations by Uwe Reinhardt and colleagues that compared health spending in the United States with spending in other countries.[2-4] Uwe died in November 2017. He was one of the longest tenured members of the *JAMA* editorial board—25 years—and has been widely recognized as one of the leading authorities in health care economics for more than 4 decades. For instance, since 1975, Uwe published 32 articles in *JAMA* on various aspects related to health care, including 2 articles in 2017,[5,6] one of which was published 2 weeks before his death.[5]

Undoubtedly, Reinhardt would have written a thoughtful and most likely provocative editorial to accompany the study by Papanicolas et al. What might Reinhardt have said about the findings in this report? It is difficult to imagine that anyone could capture his insight and wit, but some of the comments may have been similar to the following.

First, Reinhardt may have pointed out that the main findings related to health care spending are not new or surprising, ie, that health care spending in the United States is the highest in the world, and questions about value permeate virtually every sector of the health care system. In a series of studies by Reinhardt and colleagues that compared health care spending in the United States with spending in 29 Organisation for Economic Co-operation and Development (OECD) countries from 1990 to 2001, the main findings were that "the United States spends more on health

care than any of the other OECD countries spend, without providing more services than the other countries do."[2] Moreover, in a report from 2004, Reinhardt et al noted projections that suggested total national health care spending would "absorb as much as 18.4 percent of US GDP by 2013."[3] In the report by Papanicolas et al,[1] US health care spending in 2016 was estimated at 17.8% of the gross domestic product. More than a decade ago, Reinhardt was prescient in his estimate of current US health care costs.

However, Reinhardt would have acknowledged that the report by Papanicolas et al is far more comprehensive and detailed than previous articles and serves as an important reminder to US residents, policy makers, and legislators that health care reform in the United States has still not accomplished a great deal, although providing health insurance for an additional 20 million to 25 million people is a start in making health care in the United States more equitable. He also may have speculated that if only the 2008-2010 financial recession had been worse, more meaningful reform could have been possible, and that it would be difficult to imagine a presidential administration that is less capable than the current one to deal effectively with the complexities of the US health care system, although he probably would acknowledge that few previous administrations had much success.

Second, as Reinhardt repeatedly pointed out, high prices represent a major factor contributing to high health care spending in the United States. In a 2007 study, Reinhardt and colleagues reiterated their conclusion from their previous work on health care spending, indicating that "[t]he higher level of spending in the United States is primarily attributable to two factors: (1) the higher gross domestic product (GDP) per capita in the United States and (2) the much higher prices that Americans pay for health care services ('It's the Prices, Stupid!')."[4] Virtually all health care expenditures, including hospital stays, drugs, devices, physician and nurse salaries, and insurance administration, cost more in the United States than in other countries.

The report by Papanicolas et al[1] also found substantial differences in the administrative cost of health care (including activities relating to planning, regulating, and managing health systems and services), accounting for 8% in the United States compared with a range of 1%-5% in the other countries studied. The difference in administrative costs is far greater between the United States and other countries than in any segment of the health care system that these investigators studied. The challenge of administrative costs was recently detailed in a time-driven, activity-based costing study by Tseng et al,[7] and in an accompanying Editorial by Lee and Blanchfield.[8]

Reinhardt had addressed this issue, at least in part, in his comments about an article on health insurance premiums by private US health insurers that reported an average of 79.7 cents per premium dollar was spent by insurers on health care proper and 17.8 cents on the insurers' "operating costs," leaving only 2.7 cents per premium dollar as profits. Reinhardt noted that "[m]uch more troublesome is the 18 cents per premium dollar reported to cover the insurers' 'operating costs.' These include the cost of marketing, determining eligibility, utilization controls (eg, prior authorization of particular procedures), claims processing, and negotiating fees with each and every physician, hospital, and other health care workers and facilities. These operating costs are about twice as high as are the overhead costs of insurers in simpler health insurance systems in other countries."[6] Thus, he may have suggested that much effort and resources have been committed to ensuring that providing care in the United States is an expensive, time-consuming, wasteful administrative nightmare.

Reinhardt also strongly emphasized the importance of health care price transparency[9,10] and suggested that an important factor "facilitating high US prices for health care has been the shroud of secrecy draped over the health care prices negotiated in the private sector. Those prices were kept as trade secrets. Rare are the physicians, hospitals, imaging centers, or other clinicians or health care centers who post on their websites the prices for frequently performed procedures. Furthermore, few health care practitioners or centers are willing to quote prices over the phone for even standard procedures, such as a normal vaginal delivery."[9]

The implication is that if individuals knew more about the costs of health care services, they and their physicians would make better decisions. Reinhardt pointed out that there is price transparency in virtually every segment of the US economy except health care, but would raise the question why are prices hidden from patients? Perhaps it is not possible to determine the true costs of prices, or health care organizations are reluctant (or possibly embarrassed) to reveal the actual costs and price variability to patients, such as the wide variability of prices from hospital to hospital. For instance, how can a cesarean delivery cost $1100 in one hospital and $2500 in a hospital across the street? The care might be better, but not $1400 better. Why does the same device or drug cost 2 or 3 or even 10 times more in the United States than in Europe?

Third, the report by Papanicolas et al also would have given Reinhardt an opportunity to raise critical questions regarding a problem that the United States simply does not want to deal with: spiraling health costs. For instance, there are persistent questions, as he posed in his final *JAMA* Editorial, such as "Is there any economist or other expert, for example, who could be sure what percentage of the gross domestic product (GDP) the United States can 'afford' to spend on health care, or what level of spending on Medicare is 'sustainable'"?[5] In addition, he may have raised other pressing questions, such as what can be done about the many self-interested parties, including professional societies, patient groups, hospitals, drug and device manufacturers, and insurance companies, that profit from high health care spending? How can the US health care system and health care spending be recalibrated to ensure basic care for all US residents, particularly the less fortunate? How is it possible to overcome the shortchanging of many other important sectors of society, including education, infrastructure, and the environment, because of the high cost of health care?

On occasion Reinhardt would start a sentence "You Americans," despite acknowledging on other occasions how

much he loved this country. He frequently observed that some individuals in the United States get excellent care, but not everyone. He was befuddled that a country as great as the United States could tolerate such profound disparities in health—a great social injustice, he would say.

Numerous individuals have observed and commented on US health care economics and policy over the past 40 years, but few have done so with the insight, wit, courage, and charisma of Uwe. He has taught many (including us) so very much about health economics, and always with great intelligence and charm, and a wonderful sense of humor. While there is great uncertainty regarding many aspects of the US health care system, especially the critical challenges of controlling health care spending and improving health care outcomes, there is absolutely no uncertainty about one key factor—the US and international health care enterprise will certainly miss knowing what Uwe Reinhardt would say about current and future directions in health care and health care economics.

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