

# OBTAINING VALUE FOR DOLLARS: A LOOK AT HEALTHCARE SPENDING IN THE UNITED STATES

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*“Compared to other countries, the United States does not set value for its healthcare spending; we spend more but do not receive more services or achieve better outcomes.”*

The United States spends considerably more on healthcare than do other industrialized countries, but data suggest that we are not obtaining value for this substantial investment. Outcomes in the United States are not as favorable as those of most other industrialized countries. In

addition, Americans do not receive any greater number of services than do residents of other industrialized countries. Analysis suggests that these higher expenditures are the result of higher prices paid for these services.

### BREAKDOWN OF HEALTHCARE COSTS

Every year the Organization for Economic Cooperation and Development (OECD) releases data that allow researchers and policy makers to compare the health systems of 30 industrialized countries. The OECD collects data on health spending, utilization of medical services, number of doctors, and some limited outcomes data. The data permit a partial answer to the important question: how well does the US healthcare system perform compared to the health systems of other industrialized countries?

### EXPENDITURES

Table 1 shows per capita spending on healthcare in the United States and 9 other industrialized countries in 2001. The United States spent an average of \$4887 for each man, woman, and child in 2001—considerably more than any other country. Germany was second at \$2808.

Table 1 also shows the percentage of the gross domestic product (GDP) that was spent on healthcare in 2001, an important indicator for economists. The higher the percentage of GDP spent on healthcare, the lower the percentage that can be spent on other goods and services. Since 1970, the percentage of GDP spent on healthcare

in the United States rose steadily from 6.9% to reach 13.9% in 2001. The United States spent a higher percentage of its GDP on healthcare than any of the 9 other countries in 2001.

The figure shows how American consumers have spent their money since 1970. Consumer spending is a slightly different measure of spending than GDP. It includes only the amount directly spent by consumers. In 1970, medical care was less than 10% of personal consumption and the fifth largest component after food, housing, transportation, and household operation; in 1970, the American consumer spent roughly the same proportion of dollars on clothing as on medical care. By 2001, however, medical care accounted for 18.2% of personal consumption, and is now the largest component. Since 1970, Americans have allocated more of their personal spending to medical care and less to most other goods and services.

### VALUE FOR DOLLARS

The substantially higher percentage of GDP spent on healthcare and the larger proportion of personal spending on healthcare in the United States raises an important policy question: what is this higher level of spending buying for

Table 1. Total Health Spending, 2001

Country	Total Health Spending per Capita*	Total Health Spending (% GDP)
Australia	2350 <sup>†</sup>	8.9*
Canada	2792	9.7
France	2561	9.5
Germany	2808	10.7
Italy	2212	8.4
Japan	1984 <sup>†</sup>	7.6*
Spain	1600	7.5
Sweden	2270	8.7
United Kingdom	1992	7.6
United States	4887	13.9
OECD Median	2416	9.1

OECD = Organization for Economic Cooperation and Development.

\* Adjusted for purchasing power parities (cost of living).

<sup>†</sup> 2000.

Source: OECD Health Data 2003.

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the US consumer? There are a number of possibilities. For instance, the “quality hypothesis” posits that the United States could be purchasing more health services, which would be reflected in more doctors and doctor visits, more hospitals and/or hospital days, etc, than in other countries. Another possibility is that we could be paying our hospitals, doctors, and other healthcare providers more than they are paid in other countries. The higher expenditures could be the result of higher prices.

The substantially higher spending raises a second policy question: are the higher expenditures yielding better outcomes for patients? For instance, higher spending in the United States could be “buying” longer life expectancies, lower infant mortality rates, better clinical outcomes, higher rates of consumer satisfaction, or some other long- or short-term benefit.

**QUANTITY**

Table 2 is a partial answer to the “quantity hypothesis.” Compared to many other industrialized countries, the United States has fewer doctors and doctor visits per capita, and fewer hospital beds and hospital days per capita. Based on these crude output measures, it appears the United States purchases fewer services than do other countries.

It must be noted that these numbers do not reflect the intensity or the quality of services provided. It is certainly possible that American doctors and American hospitals provide more services per visit or per day than in other countries. It is also possible that the quality provided per physician encounter is better than in other countries. These factors are much more difficult to measure using international data.

**PRICES**

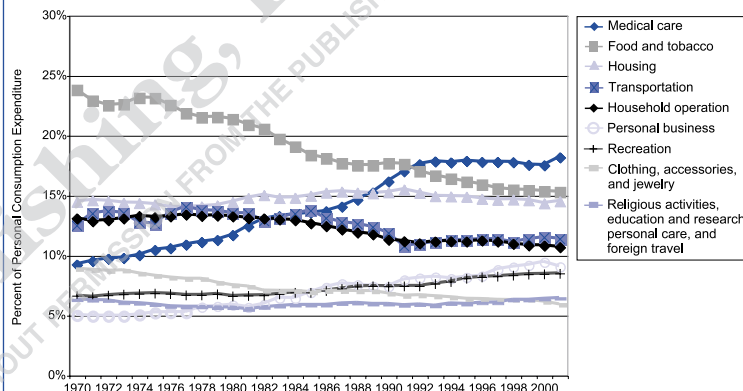
Comparing prices across the board is more difficult than comparing quantities. There are millions of services being provided and there is not one single metric that summarizes all the prices for these services. Table 3 shows 2 measures of price: hospital expenditures and physicians’ take-home income. The data show that hospital expenditures per hospital day and per admission are substantially higher in the United States compared to the other 9 countries. Measuring the prices charged by doctors is even more difficult to accomplish. However, in terms of take-home income, US physicians are paid substantially more than their overseas counterparts. (It should be noted that the physician income data are old and there are comparability problems.)

**OUTCOMES**

Table 4 compares the life expectancy, infant mortality rate, and quality-adjusted life-years in the 10

industrialized countries. According to the data, the United States is in the bottom quartile for outcomes. Many explanations for the poor performance of the United States on these indicators have been offered, including the diversity of the US population, the large percentage of the US population without health insurance coverage, and the obesity problems that are a particular issue for the United States. These indicators, shown in Table 4, are thought to be particularly unresponsive to medical care interventions and quality of care. Nevertheless, the United States ranks near the bottom on these 3 population-based outcome measures.

Figure. Components of US Personal Consumption Expenditure, 1970-2001



Source: US Bureau of Economic Analysis.

Table 2. Hospital and Physician Supply and Utilization, 2001

Country	Hospital Beds per 1000 Population	Hospital Days per Capita	Physicians per 1000 Population	Physician Visits per Capita
Australia	3.8*	1.0*	2.5	6.3
Canada	3.2*	0.9*	2.1	6.3*
France	6.7*	1.9*	3.3	6.9*
Germany	6.3	1.8	3.3	.
Italy	4.3*	1.1*	4.3	6.1*
Japan	.	.	1.9*	14.4*
Spain	3.2†	0.9†	3.1	8.7
Sweden	2.4*	.	3.0*	2.9
United Kingdom	3.9	1.2	2.0*	4.9*
United States	2.9	0.7	2.7†	3.4

Source: OECD Health Data 2003. \*2000; †1998; ‡1999.

## CONCLUSION

Compared to other countries, the United States does not set value for its healthcare spending; we spend more but do not receive more services or achieve better outcomes. Data suggest that the United States can do better and spend less. To find the solution, physicians, policy makers, hospital managers, and others may benefit from looking more often outside of the United States for answers. Some have proposed comparing the healthcare systems and medical practice in other countries with the US system to look for differences in how healthcare is delivered. Others propose a single-payer system to reduce the number of uninsured and reduce administrative costs. Still others have argued that we need to increase the financial incentives for hospitals and physicians to improve quality and lower costs. Finally, many have suggested that a greater investment in prevention is needed. These and other ideas should be explored to improve the care that is provided to our patients and lower the costs associated with providing that care.

Table 3. Price Measures: Hospital Expenditures, Physician Income

Country	Hospital Spending per Day	Hospital Spending per Discharge	Average Physician Income*
Australia	988 <sup>†</sup>	6264 <sup>†</sup>	66,540 <sup>†</sup>
Canada	924	8860	100,781 <sup>§</sup>
France	561	4270	60,161 <sup>  </sup>
Germany	562	5129	104,700 <sup>§</sup>
Italy	826	5988	.
Japan	--	7482 <sup>†</sup>	70,324 <sup>†</sup>
Spain	734	5861	.
Sweden	--	--	40,942 <sup>  </sup>
United Kingdom	--	--	42,826
United States	2263	14,095	199,000 <sup>  </sup>

\*Adjusted for purchasing power parities (cost of living); <sup>†</sup>2000; <sup>‡</sup>1998; <sup>§</sup>1992; <sup>||</sup>1997; <sup>¶</sup>1995.

Source: OECD Health Data 2003.

Table 4. Health Status in Selected Countries: OECD, WHO Data

Country	Life Expectancy at Birth (Years), 2001	Infant Mortality Rate per 1000 Live Births, 2001	Disability-Adjusted Life Expectancy at Birth (Years), 1999
Australia	79.7	5.3	73.2
Canada	79.4*	5.3*	72.0
France	79.3	4.6	73.1
Germany	77.7 <sup>†</sup>	4.5	70.4
Italy	79.8	4.3	72.7
Japan	81.5	3.1	74.5
Spain	79.3	3.9	72.8
Sweden	79.8	3.7	73.0
United Kingdom	78.1	5.5	71.7
United States	76.8*	6.9*	70.0

\*2000; <sup>†</sup>1999.

Source: OECD Health Data 2003 and WHO World Health Report 2000.

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