

New Evidence to Explain Rising Healthcare Costs

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Constituting roughly one seventh of the US economy, American healthcare is the most technologically advanced in the world, but also the most costly. Per-capita healthcare costs in 1999 were 53% higher than in any other nation.¹ In the mid-1990s, private healthcare costs slowed dramatically, reaching the lowest level of inflation since the days of wage-price controls of the Nixon administration. After reaching a low point in 1996, medical expenditures have accelerated each year.² In 2001, medical claims expenses increased by 10%, with the cost of outpatient hospital services and pharmaceuticals greatly exceeding this overall figure.³

If double-digit healthcare cost growth continues over a prolonged period of time, a number of adverse forces will be set in motion. Fewer small firms will offer health coverage to their workers, and more workers will decline coverage. Healthcare consumers may be forced to make choices based on their ability to pay rather than their medical needs. To the extent that rising costs are ultimately borne by workers, wages and living standards will suffer. To the extent that American businesses bear much of the cost of rising healthcare costs, healthcare inflation will reduce profits and investment in physical capital, thereby making it more difficult for American firms to compete in the global marketplace and thus reducing long-term economic growth.

In 2002, responding to the rising cost of healthcare, the Blue Cross and Blue Shield Association commissioned studies by respected researchers to elucidate the factors behind recent cost increases. The resulting articles, presented in this supplement, examine factors that contribute to rising costs in inpatient and outpatient hospital settings and the physician sector. An additional article analyzes the cost of poor quality in the inpatient hospital sector.

Taken together, these reports provide a broad overview of the current state of healthcare finance. Most published studies address only one segment of the healthcare system and rely on easily accessible

but old data. These studies address inpatient, outpatient, and physician costs and use data from a large national insurer that covered more than 4 million lives across the nation from 1998 to 2001, when cost pressures heated up.

Goetghebeur and colleagues⁴ provide a comprehensive literature review of underlying factors contributing to inpatient hospital cost growth. They identified 5 major cost drivers: workforce shortages; new technology; the shift from tightly managed care; shifting business directions and market structure (mergers and increased provider strength in negotiating with health plans); and recent state and federal legislation (Balanced Budget Act of 1997 and Health Insurance Portability and Accountability Act of 1996).

Our interpretation is that these individual factors interact with one another to make their collective stimulus much greater than the sum of their individual effects. For example, the greater demand for inpatient services exacerbated the shortage of nurses, pharmacists, and other health professionals, thereby driving up the labor costs throughout the healthcare sector.

In their analysis of the growth of outpatient care services, Hearle and colleagues⁵ examined Medicare cost reports for 93% of the nation's hospitals from 1996 to 1999; to analyze the growth of physician expenditures, Koenig and colleagues⁶ used data from the Center for Medicare and Medicaid Services, State Health Expenditure Accounts from 1990 through 2000. Likewise, a report by Hay⁷ on inpatient hospital cost augments the large national insurance data with nationally representative state data from US government agencies to confirm the validity of

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variables in explaining differences in hospital costs. Spending on hospital care accounts for 32% of the healthcare dollar and inpatient spending increased an average of 5.9% annually from 1998 to 2001. Not surprisingly, multiple factors contributed to inpatient expenditures, including the state of the economy, managed care market share, population demographics, and morbidity characteristics. The 2 factors most amenable to change are hospital technology and market structure.

Hearle and associates⁵ found that, from 1991 to 2002, outpatient care costs (including those associated with ambulatory surgery centers independent of hospitals) escalated at an average rate of 12.1% per year, faster than any category of healthcare spending, except for prescription drugs. Physician expenditures grew at more than double the rate of overall inflation. More important from the perspective of developing an action agenda is the effect of physician and outpatient facility supply, which accounted for 15% of outpatient cost growth.

One significant technical relationship uncovered in the analysis by Hearle and associates was the close relationship between per-capita disposable income and expenditures for physician services. A 1% increase in per capita income raised spending on physician services by 0.76%. Thus, as society becomes more affluent, Americans spend more on physician services.

Through an analysis of hospital discharge abstracts and Medicare cost reports in 10 states, Siegrist and Kane⁸ show the higher cost implications of poor quality. Siegrist and Kane estimated the cost of measurable quality outcomes for 6 types of complications. They reported that these 6 conditions raise the cost of care 35% to 120% on average. Together, these conditions account for 2.8% of hospital spending.

Siegrist and Kane also examined the cost of 16 ambulatory care sensitive conditions, identified by the University of California at San Francisco. With continuous, high-quality care for chronic disease, these hospitalizations should rarely occur. The authors estimate that hospitalizations for ambulatory care sensitive conditions constitute 6.2% of total hospital spending, about \$18 billion nationally.

These articles assess the effect of healthcare cost growth in terms of costs to the payer. Collectively, they provide a comprehensive analysis of the underlying reasons for increased healthcare costs during a recent period. Prescription drugs, which account for

24% of cost increases, were not a focus of the research.

The overall message from these studies is a call to move beyond an examination of how much we are spending on healthcare in the United States, to focus an important national dialogue on how well we are investing our limited financial resources. The researchers have made an important distinction between controllable and relatively uncontrollable healthcare cost drivers to enable us to identify factors contributing to success in initial cost-containment efforts and to set priorities for solutions to keeping healthcare affordable.

Many Americans recognize that the current growth in healthcare costs could threaten access to their care. This same public, however, recoils from traditional strategies to control costs, such as tightly managed care, greater patient cost sharing, or government control of supply and prices. As these studies show, healthcare expenditure growth is complex, and stemming the spiraling costs is not easy. These reports contribute to the existing body of literature by providing an understanding of recent nationwide cost drivers. They also suggest other areas of study, such as the effect of technology on cost and quality. Taken together, these articles convey the challenge Americans face in keeping healthcare affordable and protecting access to healthcare for as many people as possible.

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