

Public Attitudes Toward Health Care Spending Aren't The Problem; Prices Are

Regulating prices and lowering administrative costs are central to curbing cost growth—and the public agrees.

by Jonathan Oberlander and Joseph White

ABSTRACT: Does the United States spend more on medical care than other nations because Americans desire more medical care than other populations do and dislike constraints on health spending? We argue that the public is not the main barrier to successful cost control in the United States. The preoccupation with excessive demand as the cause of and rationing as the cure for U.S. health spending overlooks an alternative explanation for that spending: higher prices. There is evidence that price regulation can constrain spending and that the public will support that cost-control approach. [Health Aff (Millwood). 2009; 28(5):1285–93; 10.1377/hlthaff.28.5.1285]

THE UNITED STATES IS SINGULARLY UNSUCCESSFUL in controlling medical care costs. Other nations spend much less on medical care while attaining universal coverage and better health outcomes. Many policy analysts agree that the American health care system does not generate sufficient value for the extra money it spends relative to peer countries.^{1–3} Moreover, rising costs erode Americans' access to health insurance, reduce workers' wages, and strain federal and state budgets.

Why, then, has the United States not adopted effective cost controls? One possible explanation is that Americans actually have the health care system they want. In this view, U.S. spending on medical care is higher than in other nations because the American public desires more medical care and dislikes health spending constraints. As *Washington Post* columnist Robert Samuelson summarizes, “We have a health-care system that reflects our national values. It’s highly individualistic, entrepreneurial, and suspicious of centralized supervision. In practice, Medicare and private insurers impose few effective controls on doctors’ and patients’ choices. That’s the way most Americans want it.”⁴

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Peter Neumann similarly stresses cultural explanations for the limited use of cost-effectiveness analysis (CEA) in U.S. health policy. He concludes that “at its roots, resistance to CEA in the United States is grounded, not in methodological or legal barriers, but in Americans’ penchant for medical innovation and our distaste for limits—and in our deep-rooted suspicion of governments or corporations that impose them.”⁵ Henry Aaron and William Schwartz famously argued that to control spending, the United States had to confront those limits and take a “painful prescription.” That meant adopting policies to explicitly ration potentially beneficial medical services.⁶

Health economics provides another explanation for Americans’ ostensibly unlimited taste for medical care: insurance creates “moral hazard,” which leads to overuse of medical services.⁷ In this view, American workers, shielded by the tax exclusion for employer-based health insurance, seek lavish “Cadillac coverage.”⁸ The implication is that excessive use drives the high costs of care.

Can the United States adopt meaningful measures to slow health care spending, given Americans’ supposed resistance to limits? We argue here that the public is not the main obstacle to successful cost control. The preoccupation with excessive demand as the cause of and rationing as the cure for U.S. health care spending leads health policy analysts to overlook an alternative explanation for that spending: higher prices. There is, in fact, evidence both that controlling price levels can constrain spending and that the public supports such constraints.

The remainder of the article proceeds as follows. We first review public opinion data and critically examine claims that Americans’ cultural preferences for more medical care explain the high level of U.S. spending. We then address the roles of prices and rationing in cost control. Finally, we analyze the political barriers to cost control and implications for the current health reform debate.

The Public And Cost Control

The argument that the United States spends more on medical care than other countries because Americans want more medical care and less control is problematic in two key respects.

■ **Relationship with use of services.** Despite our higher spending, for a broad scope of services Americans actually receive less medical care than citizens of other rich democracies. “Lower utilization,” as Bruce Vladeck has written, “doesn’t always equate to lower costs.”⁹

Use of services and prescription drugs. Other nations in the Organization for Economic Cooperation and Development (OECD) have, on average, more hospital beds and physicians than the United States has. The United States does have a comparatively high level of imaging units and inpatient surgeries. Yet patients in OECD countries average more hospital days, more physician visits, and greater consumption of prescription drugs than American patients do. Higher U.S. spending is not primarily explained by greater volume of services.¹⁰

Attitudes toward rationing. If we are inferring cultural predispositions from utilization data, then we have as much reason to ask why Americans are more comfortable with rationing of hospital days and physician visits as we do to assert that Canadians and Europeans are more comfortable with rationing of high-technology services. And if Americans object so much to limits on medical care, those objections are not very effective. American insurance plans commonly have benefit limitations, restrictions on provider choice, and cost-sharing requirements that would be immensely controversial in other nations.

Out-of-pocket spending and coverage. Indeed, out-of-pocket spending in the United States is roughly twice the OECD median.² If some Americans have “Cadillac coverage,” then most workers in Germany or France must have “Mercedes coverage”—and they would likely view many American insurance policies as “Yugo coverage.” Yet Germany and France and all other countries spend much less on medical care than the United States does.^{2, 10–13}

We consequently cannot infer from high U.S. health spending that Americans want more medical care and more comprehensive insurance than citizens of other countries want. American insurers are, by international standards, generous in their payments to medical care providers. That should not, however, be confused with generous insurance coverage.

■ **Attitudes toward cost control.** There is a second problem with the argument that U.S. health spending is high because the public won't abide cost control. Public opinion data suggest that Americans favor some types of cost control. “Polls have long shown,” Drew Altman notes, “that the American people support regulatory action in health.”¹⁴ Even during the Reagan administration, write Mark Schlesinger and Taeku Lee, “the vast majority of Americans favored increasing government regulation of both the prices and the delivery of health services.”¹⁵ Seventy-seven percent of Americans polled in a 1984 survey supported “government price controls and regulations on what hospitals and doctors can charge.”¹⁶

These results persist today, according to a 2009 Kaiser Family Foundation/Harvard School of Public Health poll. Large percentages of Americans favor federal regulatory limits on health insurance companies' profits (62 percent) and administrative expenses (65 percent), as well as requiring insurers to cover all applicants regardless of health status (78 percent).¹⁷ There is also strong public support for increasing government regulation of prescription drug prices (52 percent of respondents said that there was not enough of such regulation, compared with 23 percent who said that there was too much).¹⁷ Sixty-two percent of respondents in a 2006 survey believed that government regulation would be an effective strategy to control health care spending.¹⁸

To be sure, Americans register support for a variety of other cost-control strategies, including competition. The public is divided on the merits of different health reforms—just as experts are. Still, judging by these polls, Americans' cultural aversion to regulating health care is overstated. Despite their contrasting health

care systems, Americans do not differ much from Canadians in their views on the importance of access to advanced medical treatments. Nor do they differ much on the question of whether governments or other insurers can possibly pay for all new treatments. There are larger differences, however, between the United States and some European nations on these questions.¹⁹

Limits Of Public Opinion

This does not mean that the public will endorse all forms of cost control. Public opinion is complex, divided, and at times contradictory.^{20, 21} The public wants its costs controlled, for example, while in some surveys it favors more government spending on medical care.

There is also good evidence that many Americans oppose reform if it means reduced access to medical care. The public is eager for cost controls that limit their rising medical bills, not for restrictions on the availability of services. That makes any reform proposal vulnerable, as the Clinton administration discovered during 1993–94, to arguments that it will worsen access to care for insured people. Health reform plans are similarly susceptible to attacks on big government. Many Americans remain “suspicious of direct, massive government intervention.”²⁰

Echoes of these earlier attacks can be heard in the current health reform debate. Some conservative activists and congressional Republicans argue that federally funded comparative effectiveness research could “ruin your health”²² and “lead to government rationing of health care.”²³ Although many policy analysts object to those descriptions, public opinion experts view this as a winning line of attack on health reform precisely because it arouses the public’s suspicions.

As the Republican pollster Frank Luntz explains in a memo, the killer argument against reform is, “In countries with government run healthcare, politicians make YOUR healthcare decisions. THEY decide if you’ll get the procedure you need, or if you are disqualified because the treatment is too expensive or because you are too old. We can’t have that in America” (emphasis in original).²⁴

Cost-control approaches that emphasize the need to ration and reduce consumption of medical care are politically vulnerable. Reformers can insist that they want to limit only inappropriate care in line with evidence-based medicine. The intent, in other words, is to rationalize medical care rather than to ration it. Opponents, however, will still deride any government policies to substantially change medical practice or reduce medical services as a “one-size-fits-all” bureaucratic nightmare that threatens the doctor-patient relationship.²⁴

Limiting Volume Versus Limiting Prices

If the choice, as Aaron and colleagues put it, were between paying “for all beneficial medical care whatever the cost” or rationing,²⁵ then the public would indeed be an obstacle to cost control. Americans’ collective inability to accept rationing and say “no” to more medical care is, from this perspective, responsible for our fail-

ure to control spending.

Yet rationing services is not the only—or most effective—way to control spending.²⁶ We noted earlier that greater use of medical services is not the primary explanation for the higher level of U.S. health care spending relative to other rich democracies. As Gerard Anderson and colleagues summarize, the major reason is “the prices, stupid!”¹² An extensive analysis by the McKinsey Global Institute emphasized prices, administrative overhead, and excess capacity for some services, while concluding that competing explanations—such as that the U.S. population is particularly unhealthy or that Americans use many more medical services than other people do—do not hold water.¹⁰

■ **How other nations achieve lower prices.** Other nations achieve lower prices by paying for health services through either a single-payer or coordinated, multi-payer systems that set or negotiate fees with all providers.¹¹ Analysts who seek greater productivity in medical care should recognize that productivity can be increased simply by paying less per service.²⁷ Other OECD health systems also spend much less on administration, both because insurance is simpler and because providers do not face the burden of dealing with myriad payers and payment rules.

Our excessive payment rates generate excessive supply of some equipment and thereby inefficient use. “U.S. costs in outpatient settings,” Paul Ginsburg explains, “are higher because of subscale operation of facilities. With prices very high, outpatient facilities in the United States can earn a profit despite underutilizing capacity.”²⁸ Moreover, the Medicare Payment Advisory Commission (MedPAC) argues that high prices may explain, in part, recent growth in imaging services.²⁹ In other words, given provider-induced demand, high prices can result in increased volume of services. Hence, the effect of high prices extends beyond the price per service.

■ **Providers’ responses to price controls.** Some analysts may believe that price restraints are not effective because of providers’ behavioral responses. Doctors, for example, could raise the reported volume and intensity of services when their fees are reduced. There is good evidence that this happens for physician services. Nonetheless, the impact of such volume and intensity offsets is limited. The Congressional Budget Office (CBO) concludes that physicians’ responses to Medicare payment reductions offset only about 25 percent of the “reduction in spending that would otherwise occur.”³⁰

■ **Constrained prices and access to care.** Others, including the health care industry, will argue that constraining prices limits patients’ access to medical care. Doctors, for example, might refuse to take new Medicare patients if Medicare pays much less than private insurers do. A solution to this problem is to adopt all-payer rate regulation in which public and private insurers use standard fee schedules to pay hospitals, doctors, and other providers.³¹ Because all insurers are paying the same fees and prices are constrained across the board, all-payer systems eliminate the problem of price discrimination (as well as that of cost shifting).

U.S. Experience With Price Restraints

The United States has extensive experience with price regulation. That Americans are ostensibly individualistic and suspicious of government power has not stopped U.S. policymakers from adopting policies that strengthen federal regulatory power over prices.

■ **Medicare.** In the face of rising federal deficits, Medicare initiated new payment regulations during the 1980s.³² Since then, Medicare has relied on price restraints and (in the late 1990s) an antifraud campaign to successfully moderate its spending growth. Medicare has, during the past two decades, performed better than private insurers in controlling spending for similar benefits, perhaps because of its greater purchasing power.³³

■ **Managed care.** Private insurers, of course, also seek lower prices or “discounts.” Many providers are paid by private insurers on the basis of the Medicare fee schedule. Moreover, the success of managed care during the mid-1990s in restraining medical care spending was largely attributable to price restraints rather than care management.³⁴ For example, analyzing data from Massachusetts, David Cutler and colleagues found, for example, that virtually all of the savings that managed care plans achieved for heart disease treatment, relative to indemnity insurance, came from price reductions.²⁷ During this period, health maintenance organizations (HMOs) and other insurers leveraged “purchasing power to negotiate price discounts with providers” who believed they had to make contract concessions “to ensure they did not lose patients or revenue as beneficiaries moved into managed care.”³⁵ Managed care declined (and cost trends reversed) largely because consolidation of providers made it more difficult for insurers to extract price concessions.³⁴

The public backlash against managed care was not an objection to controlling prices. Rather, discontent was based on perceived restrictions on services, as well as real limits on choice of providers. Limiting patients’ choice of providers to obtain price concessions—through selective contracting—is a particularly American strategy. Single-payer and multipayer systems outside the United States commonly restrain prices through all-payer negotiation or government fee setting without restricting choice of providers.¹¹

Political Barriers To Cost Control

Experience in the United States and around the world demonstrates that price regulation is the key to controlling health care costs. And though many Americans fear rationing of medical services or limits on their choice of doctors, public opinion data suggest that the public is supportive of price regulation.

Why, then, hasn’t the United States adopted more effective, systemwide policies to regulate medical care prices? One answer lies in the political economy of health care. National health spending amounts to income for medical care providers, insurers, pharmaceutical companies, medical device manufacturers, and a

host of health care–related industries that profit from the status quo. Efforts to control health care spending consequently threaten the medical care industry’s income and trigger fierce political resistance.^{1, 36, 37} The fragmented nature of U.S. political institutions gives these stakeholders numerous opportunities during the legislative process to block cost-control measures.³⁸ Thus, both the Carter administration’s proposal to cap hospitals’ rate increases and the Clinton administration’s proposal to cap the growth of insurance premiums were defeated in Congress after predictably drawing the industry’s ire.

Yet we should not underestimate the effect of another aspect of U.S. health care politics: U.S. health policy analysts’ excessive preoccupation with excessive utilization. Vladeck suggests that the interest-group and policy-community explanations may complement each other because, “if we focus our discussions on utilization, we don’t talk directly about prices—or incomes—and thus won’t directly threaten existing structures of power and prestige within the health care system or the political system.”⁹

The failure to confront the issue of providers’ and insurers’ incomes head-on encourages the misleading view that the public is to blame for our spending predicament. That view is doubly wrong: it overlooks the importance of higher prices in explaining American levels of spending on medical care, and it ignores evidence that the American public supports regulatory controls on those prices. The focus on rationing makes public opinion seem like more of an obstacle than it really is by assuming away effective cost-control methods that are more popular.

The focus on utilization has taken new form in the current emphasis on improving “value,” ironically defined as anything other than paying less per service. Thus, the health policy community promotes initiatives, from disease management to pay-for-performance and health information technology, for which evidence of potential savings is extremely scant.^{30, 36}

Political Feasibility

We have no illusions that adopting systemwide price regulation is politically easy. Most health reform plans under debate in 2009, with the exception of proposals to create a new public insurance option, embrace delivery system reforms and avoid explicit discussion of price regulation. Given the health care industry’s response to the Clinton administration’s proposed spending limits and the persistent stigma of “price controls,” that omission is politically understandable. Yet we believe that there is greater public support than many assume for regulatory strategies if they focus on prices and administration rather than on the current reframing of “managed care.”

If Congress enacts a health reform bill that greatly expands insurance coverage, then fiscal pressures could, as has happened in Medicare, lead federal officials to turn to regulation. Perhaps the health care industry’s promise to cut health care spending will enable policymakers to adopt systemwide spending-control mea-

suers with teeth—including price limits—if the industry does not live up to that pledge.

We are not claiming that regulation of prices will solve all health care cost problems. We do think that the evidence is overwhelming that payment rates are primary; that without good control of payment rates, spending control will fail; that the United States can do much better on limiting rates of payment; that systems that control spending better do so mainly by better control of payment rates and that is even true within American experience; and that payment rates are also a major factor in other sources of spending, such as excessive dissemination of equipment that can then lead to excessive volume.

In short, regulating prices is a good place to start rationalizing American health care spending.

NOTES

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