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How to Decrease the Cost of Healthcare

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ABSTRACT

Healthcare is among the most important issues for Americans since the U.S. healthcase system is the most expensive in the world. Public spending, including governmental spending, social health insurance, and compulsory private insurance constitutes the largest source of healthcare spending. By analyzing the reasons of high healthcare costs the paper contributes to the ongoing policy debates how to improve the current healthcare system.

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Introduction

The U.S. healthcare system is the most expensive in the world. The U.S. spends on healthcare nearly twice as much as the average country of the Organization for Economic Co-operation and Development (OECD). In the U.S., per-capita spending from private sources (for instance, voluntary spending on private health insurance premiums, including employer-sponsored health insurance coverage) is higher than in most of the OECD countries. At $4,092 per capita, U.S. private spending is more than five times higher than Canada, the second-highest spender. In Sweden and Norway, private spending made up less than $100 per capita. As a share of total spending, private spending is much larger in the U.S. (40%) than in any other country (0.3%–15%).

High medical costs may explain why Americans had fewer physician visits than peers in most countries. According to the 2019 OECD Health Statistics, Americans visit the doctor at half the rate as do Germans and the Dutch. Maybe that is why, compared to peer nations, the U.S. has the highest rate of avoidable deaths [4].

Despite high per-capita spending the U.S. has fewer practicing physicians per 1,000 people than almost all comparable large and wealthy countries.

Despite the highest spending, Americans experience worse health outcomes than their international peers. The U.S. has the highest rate of avoidable deaths, preventable with timely access to effective and quality healthcare (from diabetes, hypertensive diseases, and certain cancers). The U.S. rate was two times higher than in Switzerland, France, Norway, and Australia. This poor performance suggests the U.S. has worse access to primary care, prevention, and chronic disease management compared to peer nations [2]. The U.S. has the highest chronic disease burden and an obesity rate that is two times higher than the OECD average (see [1,4]). Analyzing the U.S. rising cost of health care in the 21 century it is impossible not to see that the increase of dental prices exceeds significantly the growth of prices for many other medical services. Regular preventive dental care is essential for good oral health, but many persons don't get the care they need. More people are unable to afford dental care than other types of health care. The research shows that more than 100 million Americans don't attend dentists because they can't afford it. Such situation with dental health is inadmissible. The above material raises doubt about the statements of many politicians that the U.S. healthcare system is the best in the world.

Factors Affecting Physician Compensation

Formally, very high healthcare prices can be explained by high salaries of practicing physicians trying to maximize their profit. The U.S. private healthcare system allows physicians to do that. According to 2018 ZipRecruiter reports, most physicians earn an annual income between $150,000 and $312,000, with the highest salaries in the $397,000 range. The average U.S. primary care physician earns $223,000 annually. The average yearly salary of a doctor in the United States is $248,253/year (see https://www.indeed.com/career/physician/salaries). It is far more than in other industrial countries: in Germany and the United Kingdom it is around $150, 000 and $175,000, respectively. The average yearly salary of family physicians in the U.S. is $209,000; in Germany and the United Kingdom it is around $120, 000 and $85,000, respectively.

The average yearly salary of a dentist in Germany and United Kingdom are $90,000 and $107,000, respectively. This reflects the difference of the health care systems of the considered countries. The U.S. private health care system is significantly more expensive [6].

The existing inability of the United States to meet the needs of the population with primary care physicians contributes to excessive and rising healthcare costs. This fact and the low 2.6 practicing physicians per 1,000 people can be explained by the cost of medical education. The average tuition cost to attend medical school per year in the United States is approximately $55,629, which amounts to $222,516 in tuition debt for four years of school (see https://www.aamc.org/data-reports/reporting-tools/report/tuition-and-student-fees-reports).

Depending on the specialty, it takes 11 to 15 years to train a physician (time in college, medical school, residency, and fellowship). At each step, there are direct and indirect costs; some of them it is it is difficult to anticipate (e.g., for national licensing exams). Students' loans continue to accumulate interest during the following years of training, so that in the end, some physicians may pay two to three times their original amount with interest over multiple decades [3]. As a result, students with increased debt are more likely to give more value to future salary when picking a specialty - and dentistry is not their best choice. That is why there was a period when there was a shortage of dentists and this might be the reason of a sharp rise of dental prices. Although some dentists indicate an average debt between $175,000-$200,000. (see https://www.thegentledentist.com/shelby-dentist-explains-why-dental-care-is-so-expensive/) in reality, it should be lower than for other medical professions. Now, because of high dental prices, some graduates from social science departments, having difficulties to find well paid job in the initially chosen area, take additional courses related to dentistry and in several years become dentists. As a result, number of dentists increased significantly and because of the decreased load some dentists work only 4 days a week. However, even with such workload, high dental prices guarantee satisfactory earnings to dentists. A decrease in the cost of medical education would increase the primary care workforce and diversity of physicians.

Medical specialty boards, the agencies that license medical doctors, investigate complaints, and discipline physicians who violate the medical practice act, contribute to the rise in healthcare costs in the U.S. They are building up substantial assets by charging physicians hefty fees for board certification. In 2017, the average fee for an initial written examination was $1,846 and $5,600 for initial certification (see https://www.abpsus.org/initial-medical-board-certification-fees).

In contrast to prices on many goods and services, healthcare prices do not depend only on the type of medical services and their quality. Healthcare prices are hugely different not only between states but also within the same area. Some researchers believe the reason of an expensive healthcare in the U.S. is that almost all healthcare prices are hidden; this hinders market competition and does not allow patients and their healthcare providers to make fully informed decisions. Of course, the lack of meaningful readily available price information raises costs. However, because of specifics of healthcare insurance, the efforts to produce such data are complicated, and the obtained results are not very helpful.

Health insurance companies are active participants of the healthcare market. They influence healthcare prices by selling insurances to both healthcare providers and their patients. Health insurance companies are suppliers of health related services through health providers who, in turn, buy liability insurances, that is, influence the demand of insurance services. On the one hand, higher costs of liability insurance command higher prices for health provider services. On the other hand, to increase the profit many health providers use unnecessary procedures decreasing the profit of insurance companies. Both sides understand these strategies. The existing healthcare prices are the result of a compromise. Moreover, since the healthcare market doesn't function like the markets for other consumer goods, its quality and prices aren't necessarily correlated.

Doctors and others working in the healthcare industry are not free from possible mistakes. Lawsuits are often costly for doctors and other medical practitioners so that medical professionals protect their businesses through Medical Professional Liability Insurance. The average cost of Medical Professional Liability Insurance is $7,500 annually. However, there are many types of doctors and countless insurance variables. Surgeons pay between $30,000 and $50,000 a year. Other medical personnel can to pay between $4,000 and 12,000 a year. The premium differences between liability insurances in different states are significant. For example, according to the American Medical Association report, in some areas of New York, liability premiums for obstetricians/gynecologists reached $214,999 in 2017 – while liability premiums for obstetricians/gynecologists in some areas of California were $49,804. The federal government may try to remove such disparity that would reduce medical liability costs. However, it is unlikely to expect that it would influence significantly healthcare costs.

Health liability insurers (e.g., large healthcare liability insurance companies as The Doctors Company, Medical Liability Mutual Insurance, Princeton Insurance, Nurses Service, Dentist's Advantage, Med- Pro Group) have a decisive influence on the health market price. Smaller insurers advertise themselves as creators of specific protector plans, innovative liability insurance programs meeting the insurance needs of dentists, optometrists, and other groups in protecting their practices [1]. Usually, they are used as subcontractors of other insurances. In addition, the healthcare market attracts insurers with a wide line of business (fire, water damage, animals, property damage liability, workers' compensation, etc.). To avoid hiring various adjusters such insurance companies use subcontractors, small insurers offering services in several specific areas. Such a pyramidal insurance structure is a reason of rising liability costs. It may look strange that some insurance companies without any experience in the healthcare field try to penetrate in the healthcare liability market which is risky for unexperienced participants because the costs of adjudicating medical malpractice claims can be very high. The average settlement value for a medical malpractice lawsuit in the U.S. is somewhere between $300,000 to $380,000. The median value of a medical malpractice settlement is $250,000. The average jury verdict in a malpractice case is just over $1 million. But the average payment in a dental malpractice suit is $65,000 (according to Medical Protective, the leading provider of malpractice insurance in the United States), which made the dental liability insurance attractive for insurance companies non specialized in the healthcare field.

The Aspen American Insurance Company (AAIC), a tiny company that makes a huge profit is an example of such companies. It insures almost all – from dental to fire, water damage, animals and other indemnities. This is done without having experts in the related fields. As to the dental malpractice insurance, it uses, as a subcontractor, B&B Protector Plans, Inc. and in some cases hires malpractice lawyers to deal with complaints.

Healthcare insurance companies frequently request medical records when evaluating claims. The dental field has its specifics. As a rule, dentists examine a patient and present a treatment

plan; they don't ask previous dental records. This is one of the simplest medical profession, and usually dentists do not require a patient's medical records; some of them have a form with questions a patient should answer. However, it is difficult to believe that companies that deal with animals, fire and water damages, aerospace, dental and wedding insurances have real experts in all these fields. Blindly copying the procedures of healthcare liability insurance companies, Aspen/B&B require claimants to provide their dental records. Moreover, they require "complete dental records," which nobody has. It looks like a trick to deny a claim or the incompetence of these insurers. Maybe this is also the negligence of the state insurance administrations that allow such companies to operate with such requirements. The law that requires "*to treat policyholders and claimants fairly*" is universal for all states. For example, in Maryland it prohibits actions which are "arbitrary and capricious, lacking in good faith." The AAIC operates in many states and its demand for claimants to present "complete dental records" is illegal since dentists don't require previous dental records and, moreover, states allow dentists to destroy their records after a certain period of time. Since nobody can satisfy this requirement, this allows the AAIC to deny claims. There is a small probability to reach a settlement without an experienced lawyer, so that in most cases the amount of money obtained by a claimant (especially, elderly claimants) isn't enough to pay for the required future dental treatment.

The National Association of Insurance Commissioners (NAIC), the National Council of Insurance Legislators (NCOIL), and the National Association of Insurance and Financial Advisors (NAIFA) are the most influential organizations supervising the functioning of the insurance industry. NAIC forms the national system of state-based insurance regulation in the U.S. to protect American consumers supported by the laws obliging insurers to treat policyholders and claimants fairly. NCOIL is the legislative organization, comprised principally of legislators serving on state insurance, that educates state legislators on current and perennial insurance issues. NAIFA promotes professional and ethical conduct among all insurance representatives and financial advisors. The top officials of the mentioned organizations were asked whether the demand of some insurance companies of "complete dental records" is an illegitimate requirement. Unfortunately, all of them refused to answer this question. This has a simple explanation: health insurances are influential companies spending millions in politics and lobbing activity to have favorable conditions for their business.

The above example attracts attention to a serious problem of the insurance industry – the absence of rigorous requirements allowing insurance companies to operate. Traditional specialized insurances (e.g., auto and home insurances, medical liability insurances) demonstrate how insurance company should operate. Only specialized insurances should be allowed to do business in the healthcare area. It is inadmissible to permit insurance companies to operate in the area where they have no experts - technological, medical and legal. The absence of rigorous requirements brings harm to the health care industry. Subcontractors increase liability costs, since both companies try to maximize their profit, and the related health care prices. The above example of the AAIC demonstrates the need of new laws and regulations related to the health insurance industry.

Public and private healthcare in the U.S.

Private medicine in the U.S. is too expensive. Existing channels to maximize physicians' profit are a lure for a possible fraud, which insurance companies would not fight since their profit is the result of a "productive cooperation" with private medicine. Presently it is unrealistic to expect from government any substantial decrease of private healthcare costs. Health insurance companies give healthy donations to political parties.

Parallel with private medicine there exist also two government-sponsored health insurance programs established in 1965: Medicare that provides health coverage for people who are 65 or older and also for certain younger people with disabilities; Medicaid that provides health coverage for people with a very low income. Funding for Medicare is done through payroll taxes and premiums paid by recipients. Medicaid is funded by the federal government and each state. These programs are devouring more and more money from government. They already cost now about one trillion per year.

Medicare and Medicaid fraud is the result of inefficient implementation of these programs. It is difficult to evaluate precisely the level of medical fraud. Only in 2011, the government recovered $4.1 billion from healthcare providers billing for services that never being done: suppliers billing for equipment that never being sent, as well as for services, supplies and equipment obtained by stolen Medicare and Medicaid cards; for misleading diagnostics and unnecessary treatment, etc. With a help of current sophisticated technology, the efficiently managed anti-fraud system can save yearly on average $15–30 billion [5].

The 2010 Affordable Care Act (ACA) was a step to creating universal health system in the United States. Government subsidies enabled to reduce the number of uninsured Americans by 20 million. However, health insurance premiums of many Americans increased.

The ACA contributed to dropping uninsured rates by expanding Medicaid coverage and subsidizing health insurance for low and moderate-income individuals. However, access to health insurance is not sufficient if patients cannot afford all needed services because of high premiums and high out-of-pocket costs of many the ACA plans requiring also to pay a lot in premiums for coverage persons don't use.

How to lower healthcare costs

Without any doubt, all citizens of such a powerful and prosperous country as the United States should have affordable healthcare (right up to a universal, free of charge for all services, healthcare system). But it is also obvious that the modification of the U.S. current health system would require a significant amount of money the government lacks. Having a huge debt the country cannot allow itself such a luxury. It was clear not only to economists (excluding those who decide to make money for fuzzy calculations) but to any educated person based on common sense.

Most European countries have three types (with some variations) of universal healthcare systems; single-payer, socialized, privatized but regulated. In a single-payer system, the government is a health insurance provider, although, in reality, most healthcare's are provided by private entities. In a socialized system, the government usually has control of both health insurance and the providers within the industry. It is essentially the only health insurance provider, and it also runs (and owns) hospitals and employs medical staff. Britain, France, Italy, Norway, Spain, and Sweden use variations of this system. Every citizen is enrolled in the national healthcare system, and a significant portion of medical services are provided free of charge by doctors who are employed by the government. Those who can afford to pay doctors not employed by

the government are allowed to purchase supplemental policies. For example, France has a private system mixed in with the so-called statutory health insurance system. Private health insurance can be purchased as a supplement to the national healthcare system. In a privatized but regulated system (used in Germany), employed citizens with an income below a certain level are required to be enrolled in the public health insurance option (in Germany, as in France, called statutory health insurance). Those making more than that amount are allowed to bypass the public system to purchase private health insurance (although the vast majority of Germans choose to keep the public option; over 90 percent of the population currently receives healthcare through this program). In Netherlands and Switzerland, health insurance is not provided by the government. Citizens are required to purchase insurance. But they are free to do that through whatever company they choose. Insurance premiums are partially funded through subsidies provided by the government so that policies are affordable for everyone.

Any healthcare program and related healthcare system depends upon the available funds to support it. It is easy to declare "Medicare-for-all." But is it possible to realize? Unfortunately, politicians ignore such questions. They do not understand or do not want to understand that healthcare costs are a substantial part of government expenditures. As indicated earlier, total health expenditure per capita in the U.S. is the highest in the world. Any repair costs money. It would be unwise for the country with a high debt to make drastic changes in its healthcare system.

Trying to copy the government-run health systems existing in many industrialized countries that cost government less money than the public health system in the United States Senators Sanders and Warren decided to propose similar systems in the United States under the name a Medicare-for-all. However, their proposals are not supported by rigorous economic estimates. President Biden had openly accused Warren of "fuzzy math" and offered a public option plan—a form of health insurance provided by government that citizens can purchase to pay for their healthcare; this plan does not prohibit people to buy private insurance. A public option health insurance program would be run by the government but could be implemented just like private health insurance. One option is to require a public insurance to be self-sustaining, that is, the system is funded only by the premiums paid in by those who use that program. Formally, the realization of such a program can be done on the federal or state levels. However, a realistic option is with the premiums subsidized by the government. The most difficult problem is how to subsidize the program to make the healthcare affordable. Of course, if such government health system would operate as a non-profit organization then private insurance prices would come down. However, the only realistic way of self-sustaining is higher taxes or/and the increased debt, similar to the above indicated proposals of the universal healthcare.

The Republican Party believes in a patient-centered healthcare system based on the principles of the free market that would foster competition driving healthcare costs down. A consumer-driven model for healthcare works well on paper than in practice, although its practical realization can be a little bit better than under the existing system. Insurance markets in the U.S. are different in various states, and health insurance prices depend on state-specific healthcare laws. Although, because the ACA, it is more transparent than it was earlier, the number of participating insurance companies have decreased significantly (if in 2013 there were 395 insurers participating in exchanges, that number was down to 181 for 2018), so that decisions made based only on the market approach cannot bring real positive results.

Since the health system contributes significantly to the country's debt, the solution of the healthcare problem should start with the admissible amount of money that can be now allocated for healthcare. This should be the starting point. Policies and alternative variants of their realization should be discussed and developed after this amount is established. Unfortunately, politicians start with policies and then ask an appropriate organization to estimate costs in 10–20 years. Such future estimates are unreliable and misleading; in addition, they ignore the fact that under a proper economic policy in the future more money can be allocated and the health system can be improved.

Formally, the two obvious ways to decrease healthcare prices (this would increase the number of insured persons) are: reduce liability costs and reduce doctors' salaries. Lower liability insurance costs can reduce healthcare prices. However, they depend on medical malpractice awards, which are different in various states. A proper legislation concerning malpractice claims could be the first important step to decrease healthcare prices. Now only some states have passed laws that place limitations on the amount of money that can be awarded in a successful medical malpractice lawsuit. As indicated earlier, in their attempts to increase profits some insurances, having no healthcare experts, use subcontractors. Usually, any more complicated insurance structure increases liability costs. That is why liability coverage for healthcare professionals, insurance that financially protects doctors and other medical workers when courts award patients' financial damages in a medical malpractice lawsuit, should be in hands of insurances specialized in the healthcare field.

The efficient societal structures should contain feedforward (regulations, governmental ownership and control) and feedback (market economy) channels [6]. The United States healthcare system is a complex mix of public (government controlled) and private programs (market economy). Most Americans with healthcare insurance have an employer-sponsored plan. But the federal government insures the poor (Medicaid) and elderly (Medicare) as well as veterans, federal employees and Congressmen. State-run programs insure other public employees. Both types of public and private healthcare systems have positive and negative features. The reduction of healthcare prices should be a part of the government economic policy. Such policy should include measures to limit profits of healthcare insurance companies. The obvious solution is to use government as a competitive insurer with zero profit or less than of the existing insurance companies. The earlier mentioned option health insurance programs, to be self-sustaining, cannot be implemented without doctors who are ready to accept lower salaries. Under the current situation, when the government is unable to invest additional money in the healthcare system and doctors would not agree to work for less money than they can get under the current system, such programs are not realizable. However, as a step to decreasing healthcare prices, the states with a help of the federal government can create integrated managed care units, where doctors' salaries are lower than private practice doctors, with a low profit to compensate in the future an initial investment. These units should contain many doctors and related services in one building. Such a structure is used by Kaiser Permanente. Although it is considered as a non-profit, integrated health care delivery organization, seven digit salaries of its top officials, a huge bureaucracy and many customer complaints cannot make it a standard for a cheap healthcare.

Not every doctor wishes to run own business understanding the related additional load and liability; many doctors prefer to

work for a smaller amount of money. A state can use its public universities to create programs for future physicians without tuition fees with their obligation to work in its managed care consortiums (one or several depending on the available investment) for a certain period of time. Such market approach should decrease healthcare prices in the private sector, and this can be a road to extend it in the future.

Politicians like to talk about healthcare of equal quality for all population. Unfortunately, this had never been in the past, and it is unrealistically to expect in the future. Now rich persons, members of the U.S. Congress, and federal government employees have better health insurance than many retirees. Not all doctors accept patients with Medicare or Medicate, since these insurances are not good sources of revenue. For the same reason, old Americans should wait at least a week for office-based medical appointments. That is why the described above possible way to improve the existing healthcare system can be efficient. Many people, especially young, do not need the highest quality physicians to treat them, and they can wait a week to get appointment. If the country has 8.8 percent of people without health insurance coverage and the insurance prices are high, the compromised approach is more realistic that empty proposals of politicians.

The country with the 27 trillion national debts, which exceeds it's GDP, and with spending on healthcare almost 18 percent of its GDP cannot spend on healthcare more. The United States economic health does not allow to do that.

Conclusion

The above analysis of the U.S. healthcare system shows the reasons why it is the most expensive in the world. Because of a huge current national debt, it is not realistic to expect that the universal single-payer healthcare system can be successfully implemented in the United States. Moreover, such a system is not the best solution. The most efficient health system should contain public and private sectors. The measures needed for the modification of the U.S. current health system are discussed.

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