Dr. Jha: I'm going to try to talk about why we spend so much more than other countries. This is a question that may seem obvious. Most health policy people in Washington feel like they know the answer to this. I would argue that it hasn't been so obvious, and so I'm going to spend quite a bit of time talking about that.

I'm going to talk a little bit about tradeoffs, because the one thing that policy makers in Washington love is telling you that there's a free lunch. That we just do X and everything will get better and nothing will get worse, and there are never any tradeoffs.

Turns out that health policy, like health care, is full of tradeoffs. I often talk about this from a clinical point of view. I don't have a treatment that doesn't have side effects—I just don't know any. Right? Even highly effective ones have side effects. There are no policy prescriptions that are without side effects.

Here's the other thing that you all know, because most of you are clinicians, or have been, is that often the stronger the medicine, the stronger the side effects. We're often trying to balance that. How do I do enough to make a real difference in something without harming the patient?
I'm going to spend a little bit of time talking about quality and outcomes. The talk is primarily about cost, but I don't think you can do justice to cost without talking about quality and outcomes. I'm going to talk about how we think about value in the international context. That's my goal.

Oh, and then, I'm sorry, the last point—which I am going to finish with, probably spend five minutes on—is talking about states. All of the action in health policy over the next two years, if you drown out the politics of what's going to be happening in Washington, and everybody running for president, all the action—the intellectual action, the real movement—is going to be at the state level. That's my hypothesis, and then again, I'd love it if you guys either want to question that or disagree.

As I said, the rules of the road are this is going to be interactive, and I want disagreements—I want people to push back. I am going to show you a whole bunch of data. The nice thing about data is you all are going to interpret it differently from each other and from me. Let's start with a slide that everybody knows: health care spending. This is 2016, it's America compared to 10 other countries. This is proportion of the economy, we're at 17.8%, just as an orientation because you're going to see these letters over and over again.

The 10 countries we have up here—I'll tell you why we picked those—are UK, Germany, Sweden, France, Netherlands, Switzerland, Denmark, Canada, Japan and Australia. They are 10 big countries, they're wealthy countries. We want to compare America to the wealthiest of countries, and we know that health care spending is high in the United States compared to other countries.

If you actually take out America for a second, what you'll see is there's a good amount of variation across other countries. Switzerland is about 25% higher than the UK, for instance. There's quite a bit of variation in spending across European countries, other high-income countries. America is a bit of an outlier, or a lot of an outlier.

The talk, the next 30–40 minutes, is going to focus on why. Not, “Why are we at 17.6%, or 18%, or more like 19% now?” Why are we so much more than other countries? That's the question I want to track.

Why do we spend so much more on health care than other countries? Again, my suspicion is many of you feel like you know the answer to this question already, but I'm going to try to show you some data that will hopefully, at least, get you to think a little bit differently about it.

This is a paper that was mentioned. This was published last March in the *Journal of the American Medical Association* called, “Health Care Spending in the U.S. and Other High-Income Countries.” Very simple, descriptive title. I want to talk to you about our approach, because, as you might imagine, we had about 90 metrics that we compared these 11 countries—America and 10 countries.
Almost every one of those data points somebody has written to us and contested, “I don’t agree with this.” That’s fine, great. I want to talk to you about how we collected the data, how we did this, because we really spent a good year, year and a half, trying to get this right.

Our approach was pretty straightforward. We first wanted to compare America to 10 other high-income countries. We weren't interested in sort of low or middle, high-middle. We said, “Let's pick the big countries, the wealthy countries, the systems that people often point to whether you're on the left or the right, and say, hey, if we just did that.”

Let's pick those countries. The data sources mostly OECD. I'm assuming that some of you know but not everybody knows what the OECD is. OECD stands for the Organization for Economic Cooperation and Development. It's a multilateral organization.

Think of it like it's the U.N., except it has a very much smaller mission, which is, it's primarily about collecting data and working on social policy and it focuses primarily on high-income countries. It's a club of about 29 countries, almost all high income, and they focus on getting standardized data collected on social policy issues, education, health care, social spending, et cetera. That's what OECD does—it works with governments.

Then what we did was, when we would get data from OECD and some from the Commonwealth Fund, which does surveys across countries, we went back to national statistics offices. We often, very often, especially when we got data that we were a little surprised by, went to experts in those countries and said, “Is this right? Could it be right?”

We did a lot of triangulation and I would say, every data point, especially the more controversial ones that I'll show you, we verified it, spending dozens of hours looking at national data, talking to experts, really trying … to make sure that we were comparing apples to apples.

The question I'm going to focus on is, why do we spend so much more on health care? Let me just get going with a little bit of data, and then I'll take the first set of questions.

Here's the only equation of the day: Total spending is quantity times price. This is not meant to be all that complicated, right? If you say, “Boy, Ashish, you sure spend a lot of money on doughnuts. You spent twice as much on doughnuts last year as Jack did.” I'm pointing to Jack Resnick in the front. It may be that I spent twice as much on doughnuts as he did. There are two ways that I could have spent twice as much on doughnuts. I could have bought twice as many doughnuts as he did. There are two ways that I could have spent twice as much on doughnuts. I could have bought twice as many doughnuts—I could have bought the same number of doughnuts but got really fancy ones and paid twice as much, or some combination thereof. Right?

If we're spending twice as much as other high-income countries, we're achieving that by either doing twice as much health care, paying twice as much for the same amount of health care, or some
combination. Everybody with me? That's the only equation you've got to know. Total spending is quantity times price. …

This notion that we're overusing health care, that we're doing so much to our patients, we're delivering so much health care, that's why we spend so much. All the policy stuff is about trying to reduce that overuse, our culture of overuse. I would say that much of the policy focus has been on the quantity side of things. You'll still see it in a lot of the state activities that are happening. Let's take a look at the data.

One hypothesis I often hear is, as an American culture, we are quick to go the doctor—at the drop of the hat, I get a little pain, Americans are off to see the doctor. We first ask the question, let's look at doctor visits per capita. Here's what it looks like across these 11 countries, America and 10 other countries.

This is physician visits per capita in a given year: The mean is about 6.6, and the United States is about four. By the way, in Japan, the mean is 13. The average Japanese sees their doctor more than once a month. For every 24-year-old who hasn't gone in four years, there are people who are going every other week. A lot of doctor visits, but the average is about 6.6 and we're a good bit below that. We're not seeing the doctor as much as these other countries.

Then people look at that and say, “Ah, maybe the problem is not enough. Not enough prevention, not enough primary care, and it's all leading to too many hospitalizations. The problem is overuse of hospitals. Not doctors, but hospitals.” We're spending way too much time in the hospitals, that's been the other part of the hypothesis. We said, let's look at hospital discharges per population. And here is the mean, right, 149 per thousand population. And here is the United States: a little bit below average. Interestingly, Germany seems like a bit of the outlier, where hospitalizations per population are much, much higher.

The other thing—so this is just hospitalizations, right? Hospital discharges per population—anybody have a sense of how our lengths of stay compare to those of other countries, these other countries?

We're way shorter, way shorter. Anybody have a sense of what the average length of stay for a pneumonia patient in the U.S. is?

Yeah, three. In the Medicare population it's like four, four and a half, because they're a little bit older, but in the three to four days.

In Japan, about 14. Right?

I was in Japan a few years ago visiting a community hospital. It was remarkable to me. There were patients sitting around playing cards around a table. I realized, some of them had finished their oral


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antibiotics three days earlier and they were still being observed. Right? It's like they got the four days of IV, then they switched to the oral, and now we're just observing them two days post-oral antibiotics, just making sure they're fine.

It's interesting in terms of, if you think about it: fewer hospitalizations, shorter lengths of stay. And what you realize is we spend far fewer days in the hospital than any other high-income country. So, fewer days in the hospital, fewer doctor visits.

The third, on this overutilization bit is that, the problem is we do too many tests and procedures. I put a little asterisk in there to remind myself to make a point, which is, of course, when you talk about we do too many tests and procedures, a big part of that hypothesis—a big part of the driving factor in the policy world, and I'm happy to get into more on this—is the sense that the problem is that the doctors in America—we're just out there overtesting, overprocedurizing, fee for service. It motivates us to do more as opposed to doing better, and that's a big part of the underlying problem.

So, let's look at some empirical data, and there's a little bit of support for some of this and not so much for others, but let's look at the data.

MRIs. MRIs, we are high. … Sure, we have more MRIs per population than average, but not some crazy outlier.

Knee replacements, here we really are number one. Number one cause, from a clinical point of view of people needing knee replacements: obesity leading to osteoarthritis, DJD. We have more obesity than almost all of these countries, actually, than any of these countries, so it's not a total surprise that we're going to get more knee replacements.

Hip replacements, I expected comparable numbers on hip replacements. I said, “Oh, our knee replacements are high, our hip replacements are going to be high.” Surprisingly, not so much. We’re actually just a little below average on hip replacements, with Switzerland, Germany and Denmark being the top three. Meaning, again, we see Germany showing up near the top, but we're actually slightly below average.

Coronary angioplasty, a procedure that has gotten a lot of attention for concerns about overuse. … Sure enough, we’re a little bit on the high side, and here's Germany again. …

Again, what we see is we're a little high on some things but not necessarily others, and here's Germany on coronary angioplasty.

Here is how I update my hypothesis on overutilization, which is, I'm having a hard time seeing how high U.S. health care cost is primarily about providing too much care, about overutilization. Right? I don't see it. We have fewer hospitalizations, fewer doctor visits. Tests and procedures, I see as a...
mixed bag. Right? We do more MRIs, and knee replacements, and angioplasties. We do fewer hip replacements.

The way I think about it is, when it comes to utilization of health care services, we're above average on some things, we're below average on other things, and on average, we're pretty average—on utilization. I don't see big differences in utilization of health care as the explanation for why we're spending so much more.

Another quick one, I'm going to just show you this data and then keep going. Actually, this is one I've even said publicly—without data and it turns out I was wrong—the one notion that has come up over and over again is that all these countries are mostly primary care, we're primarily specialists, and that the specialist-primary care physician mix is off.

That was my expectation going into the study, that we were going to find our mix was very different than the mix in other countries. Then the first time my colleagues—I remember they came into my office and they said here's the data on specialty mix—and the data was that here was the mean across these countries, and here was the U.S., right in the middle. I didn't believe it. I just thought this can't be right. This goes against everything I've always said, I've always believed, and a lot of primary groups who look at this data say, "That's not right."

This single data point, we've probably spent more time on—not probably, we have definitely spent more time on this than any other … let me just show you what the data says, and then let me tell you how we've verified it.

The proportion of doctors who are primary care, and on the right is Sweden and Denmark, where it's only 22–33%—in France, 54% of doctors are primary care—the biggest challenge with this statistic is everybody calls it all different terms. Is it general practitioners? Is it generalists? Is it primary care doctors?

What we did was we said, we don't care what you call it, let's talk about what people are actually doing in the office. Right? Are you the first point of contact? What kinds of services are you providing? What are you doing? We did a functionality-based approach.

And then we went to both national statistics offices of each of these countries as well as three to five experts from each country, and we showed them their data.

I remember talking to the guys from Switzerland and saying, "Hey, we find that 48% of your doctors are primary care, based on this definition. Is that right? Could that be right?" And [we] eventually triangulated on these numbers. The 43% for the U.S. comes from the Kaiser Family Foundation, which is an excellent source of data, using the AMA Masterfile national service.

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There are other surveys and data from the U.S. that put the number a little lower. We can have a debate about which number is best, but this is our best at doing an apples-to-apples comparison. It seems to me that maybe we’re a little bit below the median, but we’re not some crazy outlier on primary care specialty mix. That hypothesis, to me, has been surprising—that it doesn’t seem to be primarily about primary care versus specialty mix. …

So, if it doesn’t seem to be about utilization, it doesn't seem to be about a mix of primary care and specialty, we know it’s something. We know we’re spending more, so what is it? Let's start looking at some data that tells us what it is. Again, the question is why are we spending so much more?

One issue that comes up a lot is administrative waste. Administrative costs, it turns out, are hard to measure because different people have different definitions. We spent quite a bit of time, and OECD has a very narrow definition of administrative spending, which is really the administration of insurance and billing, and what they find—this is the OECD data, they call it governance administrative spending—is the mean across countries is about 3% of total health care spending, and here is the U.S. at 8%, a real outlier.

There are several points I want to make on this. One is, there’s no doubt that we’re higher. The second is people quickly want to say that private insurance is administratively wasteful, and government programs are efficient. Both the Netherlands and Switzerland, which are at 4%—not that different from the 3% mean—are primarily private insurance.

So, we have a particularly complex way that we do administration. A lot of it, I think is administrative, a lot of it is wasteful. I haven’t met a clinician, by the way, who thinks we have a super-streamlined way of doing administrative stuff. This is primarily around insurance and billing.

If you take a more expansive view of administrative spending and you start throwing in things like amount of time doctors spend doing quality measurement and all of the costs associated with all the other stuff, all the numbers go up in all the countries, but America remains an outlier.

So, administrative spending is clearly a place where we're doing it differently than everybody else, and I believe there's a lot of administrative simplification—things that we can do—that can lower health care spending without harming care.

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