

HEALTH CARE

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# Three imperatives for improving US health care

**Making health care more affordable is the key to making the US system sustainable. We can bring three of the largest sources of underlying costs and their growth under control.**

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Reforming the US health care system presents a daunting challenge, and there will be no shortage of proposals as the Obama administration prepares to handle it. Appropriately, the early dialogue has focused on extending coverage to the uninsured. However, any reform also needs to address the underlying problem—the relentless annual growth in the cost of health care—or reform will ultimately be inadequate. Poor affordability contributes directly to the unacceptably high number of uninsured Americans and presents a grave threat to the system’s sustainability.

To stem these high and rising costs, the public and private sectors should cooperate to tackle three underlying problems, starting with the high incidence and cost of treating lifestyle- and behavior-induced diseases, such as obesity. These diseases are responsible not only for a majority of the deaths in the United States but also for the fastest-growing share of health care costs. Second, public and private stakeholders should make health care more affordable and improve its quality by minimizing the economic distortions that now tend to prevent consumers and providers from making value-conscious decisions. Finally, we need to simplify the system’s pervasive and unnecessary administrative complexity to remove the waste that drives up costs, to facilitate the real-time flow of critical information, and to promote the introduction of productivity-enhancing technologies.

Regardless of the mechanism for administering or financing the system, we believe that without addressing these three issues, the sustainability of the system will be threatened. Solving the problems won’t be easy. The weaknesses and considerable strengths of the modern US health care system are the products of an evolution that began nearly seven decades ago, and lasting change will surely take years to achieve. Nevertheless, by addressing the growth of costs and thus making the system more affordable, we can extend its benefits more quickly to larger numbers of people.

### **The state of the system**

The US health care system is the world’s largest. It is also by far the most expensive, consuming 16 percent of GDP. Research by the McKinsey Global Institute indicates that the United States spends about \$650 billion a year more on health care than its wealth would suggest (see accompanying article, “Why Americans pay more for health care,” on [mckinseyquarterly.com](http://mckinseyquarterly.com)).

Even more worrisome are the rapid increase in health care costs and the resulting rise in insurance premiums. Indeed, in recent years the growth of costs has outstripped the growth of both the country’s GDP and of its workers’ per capita income. The premiums of commercial health insurance policies, paid

largely by employers, help subsidize health care for the uninsured and for people in government-sponsored programs (Exhibit 1). Since 1999, the cost of such a policy for a family of four has more than doubled. Today, it equals about one-quarter of the median US household income (\$50,740).

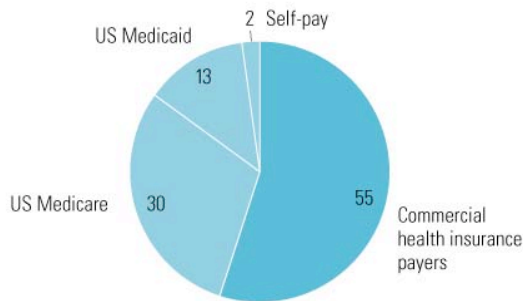
EXHIBIT 1

**A silent subsidy**

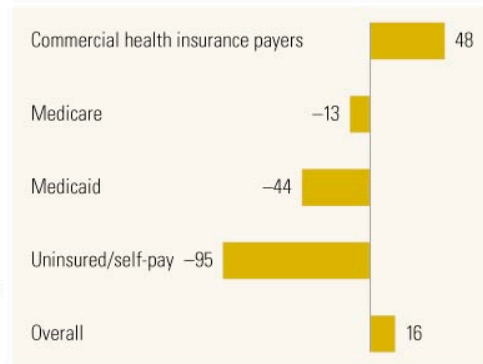
Typical US regional hospital system, FY 2006–08, %

**Distribution of hospital's net revenue<sup>1</sup>**

100% = \$900 million



**Hospital's profitability by type of insurance, EBITDA<sup>2</sup> margin**



<sup>1</sup>Gross charges net of contractual allowances/adjustments and bad debt.

<sup>2</sup>Earnings before interest, taxes, depreciation, and amortization.

Source: Various statistics from representative US hospital; McKinsey analysis

Rising costs threaten the system's sustainability. Washington's estimated total unfunded liability for Medicare (the federal government's health care program for the elderly) is a staggering \$36 trillion.<sup>1</sup> A McKinsey analysis of Medicaid (the government program for the poor) finds that it will soon consume up to three-quarters of any new tax revenues in several US states, in effect crowding out spending on nearly all other social programs.

Nonetheless, the US system is also enviable in several ways. It is the world leader in health care research and innovation: more than two-thirds of all Nobel laureates in medicine over the past decade worked in the United States, and more than 80 percent of venture capital in the global health care sector flowed there in 2007. Publicly traded health care operations remain highly open to new business models and technological innovations.

What's more, health care services and technology are more readily accessible to insured patients in the United States than anywhere else. Wait times for elective surgeries, such as hip replacements, are up to three-quarters shorter than they are in nearly all other countries. About 40 percent of the world's medical travelers—people who go abroad to obtain acute elective care—come to the United States. And observers throughout the world recognize the distinctiveness of the system's treatment of diseases, such as cancer, that respond to technology and inpatient care.

Any proposal for fundamental health reform should seek to preserve and sustain these strengths while tackling the underlying factors that drive up costs—starting with the growing incidence of chronic lifestyle-induced diseases.

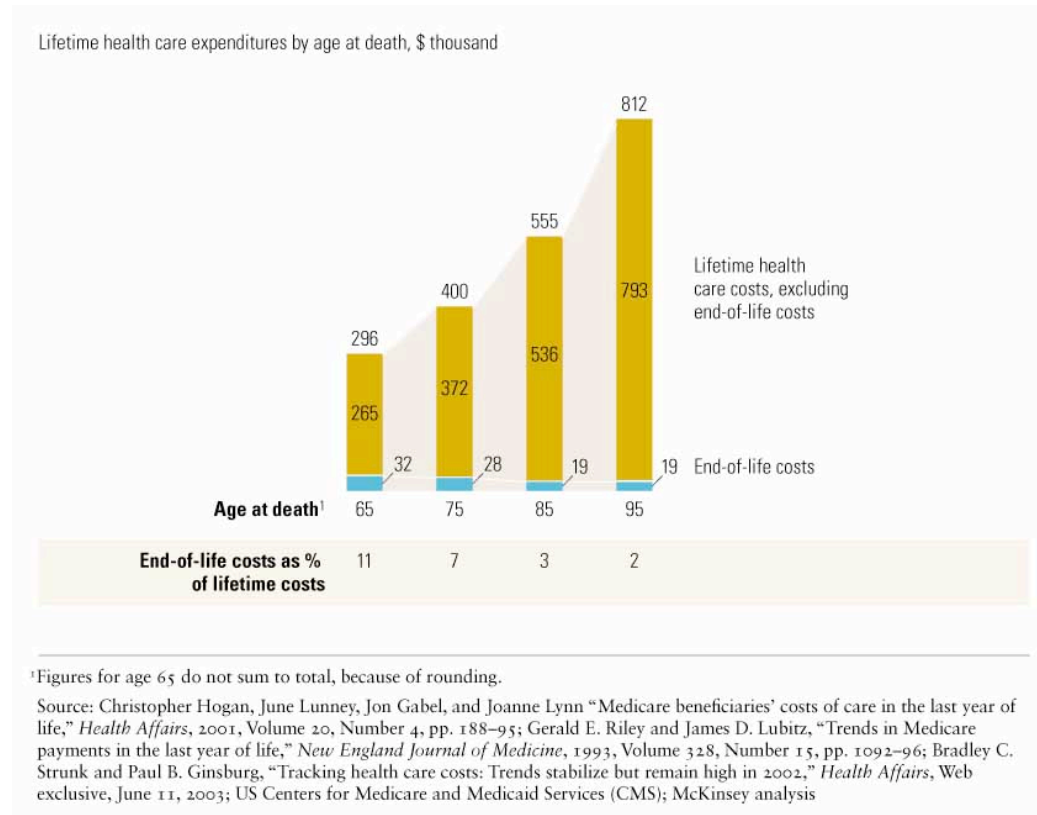
### **Reverse the growing incidence of chronic disease**

In recent decades, the nature of medical risk in the United States has shifted dramatically. About two-thirds of all deaths in the United States now result from chronic diseases most often induced by behavior and lifestyle—for instance, obesity and related chronic conditions, type 2 diabetes and related conditions, smoking-related cancers, and alcohol-related liver disease. By contrast, before the 1940s or thereabouts, medical risk had largely been concentrated in random, infrequent, and catastrophic events such as injuries, congenital conditions, or contagious diseases. Health insurance was designed, at its inception, to address these kinds of events.

The increasing prevalence of chronic disease has significant implications for managing health care costs. For one thing, advances in medical technology and treatments mean that people with such conditions can now live much longer, though at a substantially higher financial cost. In fact, our findings suggest that the management of chronic disease outside of acute-care environments accounts for at least 20 percent of total US health care spending, perhaps more. That level of expenditure, compounded over decades in many cases, dwarfs the cost of end-of-life care—including, for example, the health care associated with the terminal stages of cancer or the last year of nursing-home care (Exhibit 2).<sup>2</sup> This point undercuts the cynical notion that chronically sick people die relatively young and therefore cost society less than people who receive health care services over the course of an extended lifetime.

EXHIBIT 2

Living expenses



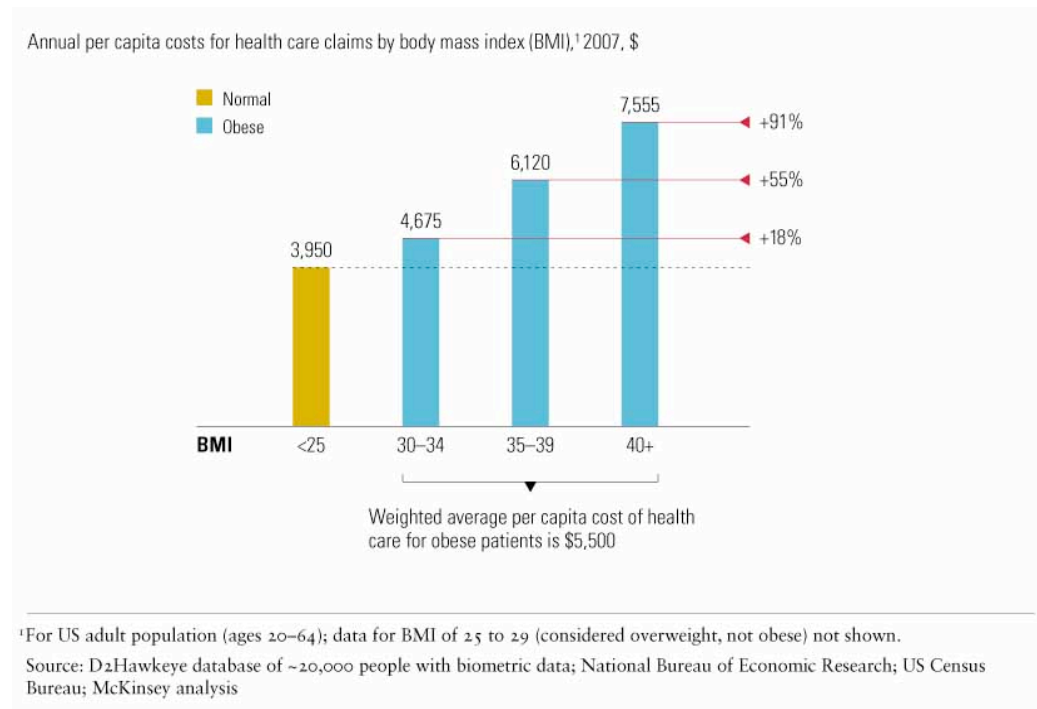
For insurers—and ultimately employers—the changing nature of medical risk has big implications for risk pools. Pooling similar risks to provide protection against them underlies the concept of insurance, but commercial risk pools are becoming more and more asymmetric because they now bring together individuals presenting radically different risks. Meanwhile, employers are transferring more and more benefit costs to employees through premium sharing and other cost-sharing approaches. Healthier patients must therefore subsidize growing numbers of the chronically ill. This cross-subsidy in turn creates incentives for people in better health to forgo insurance, and that raises costs still higher for people remaining in the commercial risk pool. Together, these factors conspire to make health care less affordable and to increase the number of uninsured people in the United States.

Obesity—a widespread chronic condition linked to others, such as diabetes, heart and circulatory maladies, orthopedic problems, and certain cancers—provides a telling example. The incidence of clinically defined obesity in the US adult population has more than doubled, to 34 percent, since 1980. The average annual cost of health care claims associated with morbidly obese

patients (the fastest-growing category of obesity) is more than \$7,500 a year, nearly twice the average for adults who are not obese (Exhibit 3). To put these figures in perspective, we estimate that the medical costs associated with clinically obese patients represent about 10 percent of the sum spent on health care premiums and that reducing obesity to the 1980 level would generate \$60 billion a year in net savings.

EXHIBIT 3

**An expensive condition**



Public and private institutions alike should collaborate to help reduce the overall incidence of obesity to 15 percent of the population over the next decade, as the US Centers for Disease Control and Prevention (CDC) suggests. The public side should mount a broad-based multi-institutional effort, comparable to those in recent decades to reduce tobacco consumption. The secretary of the US Department of Health and Human Services could convene and lead the effort, which should draw as needed on the broader resources of the government. Active participants should include public schools and the US Department of Education (nearly 20 percent of US children and adolescents are obese), the CDC, and the US Department of Agriculture.

A full-scale program to reverse the growing incidence of obesity should start with straightforward initiatives (for instance, to make it easier to bike along US roads) together with direct interventions (such as banning trans fats in

foods). The country should also revive systematic efforts, like the Presidential Physical Fitness Award, to celebrate and encourage athletic activity among children. Comparable programs might then address other prevalent chronic conditions (for example, diabetes).

Meanwhile, the private sector should build upon the early progress it has already made—for instance, by expanding healthy alternatives in fast-food restaurants and improving the nutritional information on food packages. Companies could ultimately have a large, collective impact if they looked for new ways to help change the nutritional and exercise habits of Americans even in minor respects.

The stakeholders evaluating potential initiatives to counter chronic diseases should consider the influence of behavioral biases on decision making and build this understanding into the design of benefit plans and into prevention, wellness, and disease-management programs. In drug compliance efforts, for example, payers might harness the human tendency to overvalue positive short-term outcomes and to undervalue negative long-term ones. Behavioral economists at Carnegie Mellon University and the University of Pennsylvania<sup>3</sup> recently designed an experiment along these lines. Patients requiring drug therapy every day were significantly more likely to take their prescriptions when offered small daily financial rewards (namely, a chance to win a cash prize in a lottery). Meanwhile, noncompliant patients were advised how much they might have won had they complied. The experiment capitalized on the tendency to assign more significance to smaller punishments than to larger rewards.

In a different experiment, these same researchers found that when lower-calorie sandwiches appeared on the front page of a restaurant's menu, so that customers didn't have to hunt for them, an average order had 100 fewer calories than it did when such items were spread throughout the menu.<sup>4</sup>

### **Eliminate economic distortions**

The US health care system is rife with economic distortions that impede value-conscious behavior by the suppliers and the consumers alike. This affects both the cost and quality of care. Any cost reduction initiative that ignores this fundamental disconnect will fail to make the system more sustainable in the long term. Without a more efficient, value-driven market, neither suppliers nor consumers have an incentive to prevent the kinds of decisions that are now undermining the system.

Today, for example, health care consumers—insurers, employers, patients, or others subscribing to insurance plans—find it extraordinarily difficult to discern or even define the benefits available at any given price and from any given provider and therefore cannot compare them. The lack of clear market signals also means that the service levels, practices, and even medical outcomes of the providers often bear little relation to their reimbursements (Exhibit 4). In no other industry are service attributes and prices so opaque.

EXHIBIT 4

**Luck of the draw?**



<sup>1</sup>Based in internal mammary coronary artery bypass graft (CABG) surgery for patients admitted through the emergency room.

<sup>2</sup>US Centers for Medicare and Medicaid Services (CMS) composite quality scores.

Source: DHawkeye database of ~20,000 people with biometric data; CMS; McKinsey analysis

To create a more value-conscious marketplace, it will be necessary to realign the funding of health services with the risks and behavior we wish to influence. On the demand side, consumers will have to become more responsible for their health care spending, for this would help mitigate the agency problem that currently hampers economically rational behavior and drives up costs throughout the system. Insured consumers simply don't understand the economic—and often quality—implications of the purchase decisions made on their behalf.

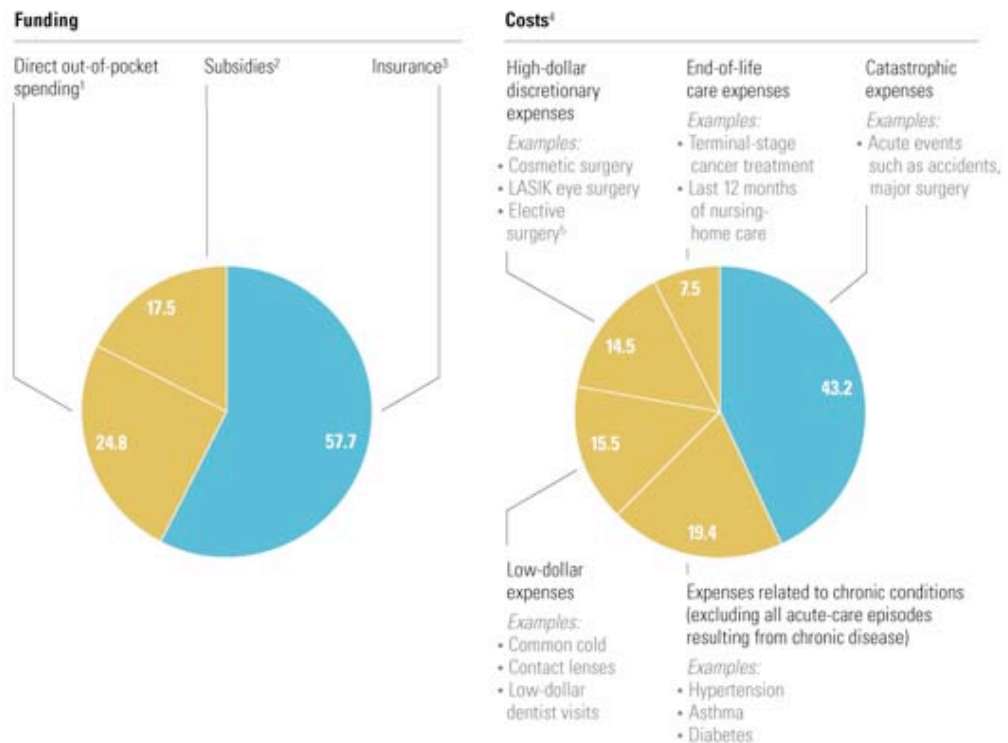
What might a value-conscious system look like in practice? One approach would be to have health insurance cover random, infrequent, and catastrophic risks beyond the control of individuals—for instance, nonelective hospital admissions, major surgery, and expensive therapies for cancer. Personal savings, out-of-pocket funds, or subsidies<sup>5</sup> could then contribute to payments for the more frequent, smaller, and predictable events, such as routine visits to

physicians, certain postoperative visits, selected outpatient pharmaceuticals, and discretionary elective surgery. But strong incentives (for instance, waiving payment altogether) should encourage basic required health maintenance activities (for instance, getting a flu shot or other preventive measure). This approach would help to address a great imbalance: in 2007, nearly 60 percent of all US health care funding came from insurance, but only 43 percent of health care payments covered infrequent, random, or catastrophic events (Exhibit 5).

EXHIBIT 5

**Imbalance in the system**

**US health care funding and costs by risk category, 2006, 100% = \$1,878 billion<sup>2</sup>%**



<sup>1</sup>Includes federal and state subsidy programs, eg, Medicaid and State Children's Health Insurance Program.  
<sup>2</sup>Includes copayment, coinsurance, and deductibles; excludes premiums for employer-sponsored and individually purchased insurance.  
<sup>3</sup>Public and private employer-sponsored and individually purchased insurance, including consumer-paid premiums.  
<sup>4</sup>Excludes government administrative expenses, structures, equipment, and public-health activities; does not include wellness expenses (eg, health club membership). Risk categories defined as: low dollar = \$125 per instance (eg, prescriptions, dental care, vision care); high-dollar discretionary = ~\$3,000 per instance; chronic = \$118 per instance; catastrophic = \$18,851 per instance; end of life = \$32,763 per person per year of continuous care. Figures do not sum to 100%, because of rounding.  
<sup>5</sup>Operations that, according to evidence-based medicine, do not yield better outcomes than other treatment methods (eg, back surgery, joint surgery).

Source: National health expenditure data, 2006, US Centers for Medicare and Medicaid Services (CMS); Medical Expenditure Panel Survey (MEPS), US Department of Health and Human Services; McKinsey analysis

On the supply side, providers and regulators must move more quickly toward greater transparency. Evidence-based standards, such as the Core Measures established by the US Centers for Medicare and Medicaid Services (CMS), are a step in the right direction; to make information transparent to consumers, these standards track and report evidence-based data in areas such as the treatment of heart failure and the prevention of surgical infections. Medical societies or other third parties should intensify their efforts to propagate and enforce new metrics focusing on the appropriateness of care. That would aid the study of usage patterns and might therefore reveal over- or underdependence on certain technologies or services—say, expensive medical-imaging resources, such as CT (computerized tomography) scans, or clinical-laboratory diagnostics.

Moreover, public and private stakeholders must agree upon—and report—standardized outcome metrics for both the effectiveness of clinical care (such as severity-adjusted mortality rates) and the incidence of egregious medical errors (including postsurgical infections and adverse drug reactions). These changes will make it easier to move toward a pricing system based on standardized care and, together with greater transparency, will help consumers compare providers and to judge the value and quality they offer. Transparency is particularly important for inpatient hospital care, which tends to be complex and hard to evaluate.

Ultimately, such moves would promote the widespread adoption of pay-for-performance reimbursement schemes and the further development of “infomediaries”—payers and other groups that help consumers make more informed decisions by providing information on prices, service, and quality. The government must play a central role by establishing reporting standards, specifying metrics, and creating similar reimbursement schemes for providers of care to government beneficiaries.

### **Simplify administrative complexity**

Excessive administrative complexity is the third most important reason US health care is so costly. Research by the McKinsey Global Institute, for example, finds that in 2006, the bill for administrative costs in the United States came to nearly \$500 per capita, nearly five times the average level across 13 other countries<sup>6</sup> in the Organisation for Economic Co-operation and Development (OECD). Further, we estimate that unnecessary administrative expenses currently represent fully 5 percent of total system costs, or about \$100 billion a year.<sup>7</sup> This complexity comes primarily in two forms.

The first is the regulatory complexity imposed on payers in developing, distributing, and managing insurance products. Fifty different US state insurance commissions prescribe everything from basic mandates for minimum coverage to the format of enrollment forms to the language in marketing materials. Payers therefore have only a limited ability to distribute standardized products and thus benefit from economies of scale. Regulatory complexity also drives up costs in the payers' downstream operations by making it more complicated to process claims.

A second form of administrative complexity burdens transactions between payers and providers: the innumerable claims-management systems, IT platforms, reporting requirements, and contracting terms payers use. The average US hospital, for example, may work with 40 to 60 different payers, each with several products sporting unique contracting terms, reimbursement algorithms, and reporting requirements for quality metrics, productivity incentives, and so forth. Indeed, we find that US hospitals spend about 3 percent of their revenues just interacting with payers to deal with the problems created by this array of complexity.

As for payers, they incur unnecessary administrative costs as a result of the vastly different IT systems the thousands of providers they interact with use. Moreover, the providers don't characterize episodes of care in a uniform way and insist on contract terms with lots of reimbursement levels and minor administrative distinctions. This too helps drive up complexity and costs.


To unravel this regulatory and administrative complexity, the public and private sectors must act aggressively to standardize key elements in the development, distribution, and management of insurance products and to make them more portable across states. While some progress has been made—for example, in creating consistent claims forms and codes—most administrative interactions still involve considerable variation. Public and private stakeholders alike should encourage the adoption of standards (akin to the bank-routing numbers that financial institutions use) to make these interactions faster and more efficient.

Both the public and private sectors might learn from the credit card industry, where third-party merchant processors handle both outgoing requests for payment and settlement activities—roles divided in health care. Robust third-party utilities would let payers focus on creating innovative products to differentiate themselves, and providers on offering superior clinical outcomes at reasonable costs. Eventually, third-party utilities might handle a much larger range of activities, including insurance verification, performance

management, contracting protocols, the coordination of benefits, and reconciliation.

Heightened collaboration between the public and private sectors will be crucial not only to curb administrative complexity but also to stem the rise of chronic diseases and ameliorate the pervasive economic distortions that ratchet up costs. Both sides bring important strengths to the table.

Only the government can push all the levers available to increase the impact of the broad-based, multi-institutional programs that might cut the incidence of lifestyle-induced disease. Further, given the role of the government as both the largest purchaser of health services and the possessor of the largest fund of health-related claims data, it is also best placed to improve the transparency and exchange of information, as well as to trim the administrative complexity associated with poorly defined IT and data transfer standards.

The adaptability and nimbleness of the private sector allow it to help patients adopt healthier lifestyles—for example, through new approaches to managing chronic diseases. The private sector could also continue to create innovative financing products and to help patients receive superior care and service. 

#### About the Authors

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#### Notes

<sup>1</sup>According to the 2008 *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, US Centers for Medicare & Medicaid Services (CMS).

<sup>2</sup>These findings reinforce the central role of preventing and managing chronic diseases but don't obviate the need to manage the costs associated with end-of-life care more effectively.

<sup>3</sup>See Kevin G. Volpp, George Loewenstein, Andrea B. Troxel, Jalpa A. Doshi, M. Price, and Stephen E. Kimmel, "A test of financial incentives to improve warfarin adherence," *Biomedical Central: Health Services Research* (forthcoming).

<sup>4</sup>See Kevin G. Volpp, Leslie K. John, Andrea B. Troxel, Laurie Norton, Jennifer Fassbender, and George Loewenstein, "Financial incentive-based approaches for weight loss: A randomized trial," *Journal of the American Medical Association* (forthcoming).

<sup>5</sup>We recognize the need for effective subsidies to cover the costs of people who cannot pay for medical care, but the details of specific subsidy arrangements or schemes lie outside the scope of this article.

<sup>6</sup>Austria, Canada, Czech Republic, Denmark, Finland, France, Germany, Iceland, Korea, Poland, Portugal, Spain, and Switzerland.

<sup>7</sup>This figure is based on our analysis of administrative interactions between payers and providers, including both hospitals and physicians.

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