

The Best Health Care in the World



By Thomas Lynch
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“American health care is the best in the world.”- John McCain, in an interview with the editorial board of the Washington Post, January, 2008¹

¹ <http://projects.washingtonpost.com/2008-presidential-candidates/issues/candidates/john-mccain/>

Introduction

Although its image may have become tarnished in recent years, the United States is the world's only remaining superpower. When our President opens his mouth, entire tribes of journalists sit up and take notice. Like it or not, ours is a decidedly hegemonic role that we cannot escape. Yet Americans tend to be geographically, culturally and intellectually isolated from most of the rest of the world, and many of them take a good deal of pride in that.

One significant area where this isolationist attitude is manifest is health care.

Over the last 25 years, I've been a close observer of American health care from two distinct angles. First, as the founder of Lynch, Ryan & Associates, a leading workers' compensation consulting company, I've had the chance to work with and get to know many health care professionals, lots of them physicians. Second, like most of us, in my personal life I've been intimately acquainted with a few very sick people.

Regarding the physicians I've come to know, I can say that I have yet to meet one who actually likes our American "system" (if that's the right word) of health care. They work very hard at making the system work for them and their patients, manipulating it when and where they can to produce the best result possible under the circumstances.

Regarding my loved ones who've been very sick, I can say that getting good health care can be a lot of work. I probably don't have to elaborate this.

My general conclusion is that when it works, American health care works in spite of itself, because the people in it, health care professionals and patients alike, work hard at making it work.

Whether it works or not, it's expensive.

Most Americans know that health care costs, particularly group health care costs, have been rising steadily, year after year, like a child's helium balloon that gets released into the air and just keeps going up until you can't see it anymore. What most Americans do not know is that, if group health is the helium balloon, medical costs in workers' compensation are the helium balloon on speed, rising at double the rate of group health.

With this as background, and because this is a presidential election year where candidates say a lot of confusing things as they spout health care platitudes, I decided that I would try to compare our health care system with other developed countries in terms of costs and quality. It's been quite an eye opener for me.

This essay was originally published as a five-part series in Lynch Ryan's blog, workerscompinsider.com. I have edited the series to produce this work.

I have tried to let the facts speak for themselves, although many, including myself, will conclude that, because of my own admitted shortcomings, this effort does not have the breadth of nuance that the subject deserves. Regardless of my inadequacies, I hope that this work is provocative enough to inspire some intelligent and realistic discussion aimed at improving the quality and reducing the cost of American health care, in general, and in the area of workers' compensation, in particular.

One

The Best Health Care Plan in America?

In 1986, US workers' compensation medical costs made up 44% of all of the money allocated to pay injured worker claims. Ten years later, the percentage had grown to 48%. By 2006, medical costs amounted to 58% of total loss costs. And today, nearly a third of the way through 2008, they hover around 60%. The annual workers' comp medical cost rate of growth is nearly double the painfully steep rate of growth in the Group Health arena, and it has been so since 1996.²

And why not? Workers' compensation health care is the best health care plan in America, maybe even the world. Injured employees pay no premiums, co-pays, or deductibles. Prescription drugs are free, and tax-free indemnity payments cover most lost wages. No wonder acute and traumatic injuries cost nearly 50% more than similar injuries in the group health world, according to a National Council on Compensation Insurance (NCCI) Research Brief.³ No wonder chronic, soft tissue, musculo-skeletal injuries cost more than double similar injuries in the group health world. And the disparity is probably even more than that, because NCCI could only examine and compare cost data for the first three months following injuries. Why? Because workers' compensation tracks injuries by claim numbers, attaching all incurred costs to each claim's number, but group health does not, because it views every individual service provided as a separate event. Therefore, in group health, the further one gets from the date of injury, the harder it is to tie rendered medical services to a particular injury.

It's no secret that over-utilization is the biggest reason that workers' comp medical costs are so much higher than costs in group health. True, on the whole and with some notable exceptions, workers' comp medical fee schedules, present in thirty-eight states as of this writing, have caused prices for individual medical services to be only slightly higher than individual services in group health, but in nearly every part of the country workers' comp utilization dwarfs that of group health. Makes you wonder what the workers' comp case management and utilization review companies are actually doing, doesn't it?

The difference here is stark. The group health plans put systemic fences around utilization. Workers' comp does not. If you twist your knee mowing the lawn out in the back forty on a Saturday morning and require arthroscopic knee surgery, your health plan will approve a certain number of visits to a rehab facility after surgery, normally six or seven. After that, you'll need approval for any more. Of

² Source: National Council on Compensation Insurance (NCCI) and the Insurance Information Institute (III)

³ <https://www.ncci.com/NCCI/article.aspx?&articleUrl=/ncci/web/news/research/research-wc-vs-group-health.htm?s=workers%20compensation%20vs%20group%20helath%20comparison%20utilization>

course, you can always choose to self-pay. But in the world of workers' compensation, that's one decision you don't have to make.

Workers' compensation health care is a subset of American health care. To understand the former, one has to examine the latter. This is especially true in this frenzied and seemingly endless Presidential election season that never appears to take a day off and in which health care has become quite the political football.

Consider that at some point in their stump speeches the three remaining candidates, Senators McCain, Obama and Clinton, each forcefully proclaims that, although it might cost too much and although it may have serious flaws that, if elected, his or her health care plan will surely fix, American health care is "the best in the world."

If only that were true.

Two

What does American health care cost?

In 1992 I became a Trustee of a major, tertiary care, teaching hospital in Massachusetts. For Trustee indoctrination, new Trustees spent a week in a classroom learning about every facet of hospital life. One morning we were briefed by the hospital's CFO. I was astonished to learn that the hospital had 27 different billing systems, one for each insurer and HMO with which it did business. To me, this was Kafkaesque. I mention it now, because in the intervening years, the situation has become much worse.

At 31% of total US health care expenditures, the administrative costs of healthcare providers are double those in Canada⁴, and, with the exception of tiny Luxembourg (population 425,000), America's health administration and insurance costs are the highest of any of the world's developed democracies.

We spend more, far more, than any other country in the world on health care. How much more and do we get what we pay for? In Sections Two and Three of this essay, we try to answer those questions. In Section Four we discuss the reliability of the health care statistics, and in Section Five we relate it all to workers' compensation, at 3% - 4% of total spending, a tiny room in the American health care house that Jack built.

The US compared with other developed countries: The cost explosion.

The United States has been a member of the Organization for Economic Cooperation and Development⁵ since the OECD's founding in 1961 (the forerunner of the OECD was the Organization for European Economic Cooperation, set up under the Marshall Plan in 1947). There are 30 member-countries of the OECD, all democracies, most of which are thought to be among the most economically advanced nations in the world.

In September, 2007, the US Congressional Research Service, the best research group you've never heard of, published a report for Congress titled, "U.S. Health Care Spending: Comparison with Other OECD Countries."⁶ This 60-page, well sourced report paints a grim, if occasionally confusing picture.

Until 1980, US spending on health care, as measured as a percentage of gross domestic product (GDP) ranked at the high end of OECD countries, but not excessively so. In 1980, US spending as a share of GDP was 8.8%, which compared favorably to Sweden's 9.0%, Denmark's 8.9%, Ireland's 8.3% and the Netherlands 7.2%. True, spending in the United Kingdom, at 5.6%, France and Norway, at 7.0%, each, and Canada, at 7.1%, was lower, but no one could claim that the US spending was out of control.

⁴ Woolhandler et al, New England Journal of Medicine, August 21, 2003, page 768

⁵ http://www.oecd.org/home/0,3305,en_2649_201185_1_1_1_1_1,00.html

⁶ <http://openrcs.com/document/RL34175/2007-09-17%2000:00:00>

Then something happened. By 1990, our spending as a share of GDP had grown to 11.9%, while the rest of the OECD countries remained fairly static – Sweden’s and Denmark’s declined to 8.3%, the UK’s rose to 6.0%, and so on. And by 2003, the US share had ballooned to 15.3%, nearly three percentage points higher than Switzerland, at the time our closest competitor. In fact, in 2004, the OECD average spending as a percentage share of GDP, excluding the US was 8.6%, nearly half of the US share.

In the average OECD country nearly 74% of healthcare costs are publicly financed; in the US, less than 45 %. Moreover, per capita health care spending in OECD countries, excluding the US is \$2,438; in the US, per capita spending is 250% higher, at \$6,102.

When analyzing why the US spends so much more on health care, one hardly knows where to begin, because in nearly every category we dwarf the field.

Take prescription drugs, for example. Average per capita spending on pharmaceuticals among all OECD countries, including the US is \$383, but in the US it is \$752, which is \$153 dollars per person more than the second largest spender, France. Despite this, because the US spends so much on all of health care, pharmaceuticals account for only 12.3% of total spending, which is near the bottom of the pack among all OECD countries where average spending on pharmaceuticals is 17.8%.

One would think, perhaps, that spending is so much higher in the US because we have more hospitalization, or doctor visits per capita, but one would be wrong. Hospital discharges per 1,000 people in the US are 25% lower than the average for all OECD countries, and doctor visits are 42% lower.

Well, maybe people have significantly more intense and aggressive service while they are hospitalized in the US. One indicator of intensity is the average length of acute care hospital stay. In the US, the length of acute hospital stay is 5.6 days, which is less than all but eight of the other 29 OECD countries. But shorter stays could mean higher efficiency. A better way to look at it is to look at specific causes for hospital stays, like heart attacks, for instance. The US average hospital stay following acute myocardial infarction is 5.5 days, the lowest in the OECD.

Consider childbirth. Here the US has the third-lowest rate of stay, 1.9 days – much shorter than the OECD average of 3.6 days.

Another reason for high costs in the US is our aggressive testing. Only Japan has more CT scanners and MRI units per million people.

And, although doctors will roll their eyes when they read this, still another reason for our higher costs is physician compensation. At an average of \$230,000 and \$161,000 for specialist and general practitioner pay, respectively, each of these groups earns more than double their OECD counterparts.

Clearly then, there is no denying that, for whatever reasons, the US outspends its OECD partners by long a shot. The question that has to be asked is: Are we getting what we are paying so dearly for? And, given the comparative lack of public financing for health care, the correct pronoun is certainly, "we."

Three

What do we get for the money?

To determine whether our extraordinary level of spending is worth it, it seems fair to ask a few questions relative to the other OECD countries:

1. Do we live longer?
2. Are we healthier?
3. What other factors could affect how the health of US citizens compares with OECD citizens?

Do we live longer than people in other OECD countries?

Simply put, we spend a lot more on healthcare than all other OECD countries, but don't live any longer for the money. In fact, we live shorter lives than most.

As of 2004, average life expectancy at birth in the US was 77.5 years, which ranks 22nd out of the 30 OECD countries. This is slightly below the OECD average and four and a half years less than top-ranked Japan. Also, it may surprise readers to learn that life expectancy is two and a half years longer among the people of our neighbor to the north, Canada. And, despite all the editorial bashing of the UK's National Health System, its citizens outlast us by a full year, while people in Spain, France and Italy live, on average, more than two years longer than we do.

Are we healthier?

For all the money we spend on healthcare one would think we enjoy Olympian health, but this does not appear to be the case. Although it pains me to write this, I can find no peer-reviewed studies that conclude that we are a healthier people than our OECD neighbors.

The OECD provides specific disease incidence data in two areas: cancer (malignant neoplasms) and acquired immunodeficiency syndrome (AIDS). In both cases, the US has the highest rates in the OECD. The incidence of cancer in the United States is 34% higher than the average within the OECD (358 cases per 100,000 people versus 266). With respect to AIDS, the US incidence is an astonishing 675% higher than the rest of the OECD (147 cases per 100,000 people versus 19 in the OECD). Our mortality rate due to AIDS ranks second in the OECD (4.2 deaths per 100,000 people, well behind the staggering rate of 8.6 in Portugal). And our mortality rate for cancer ranks only 14th among OECD countries.

What about obesity, reputed by many to be epidemic in the US? With the exception of the UK and the US, which get their obesity statistics by actually measuring people, OECD countries get their results from surveys. So, the only fair comparison is the US versus the UK. In 2004, while the UK's overweight population was 14% higher than that in the US, our obese population was 39% greater.

On the other hand, the US rate of alcohol consumption and incidence of daily smoking were both lower than the average for OECD countries (daily smoking in the US is the third lowest (17%) of all OECD members).

Unfortunately, obesity has been shown to be a greater driver of health care and health care spending than alcohol consumption or smoking – “the effects of obesity are similar to 20 years of aging.”⁷ According to Thorpe, et al, 27% of the per capita increase in US health care spending between 1987 and 2001 was attributable to obesity.⁸ There is a direct correlation between obesity and Type 2 diabetes, obesity and hypertension and obesity and heart disease (the trends in obesity accounted for more than 38% of the increase of diabetes spending and more than 41 % of the increase in spending on heart disease since 1987).⁹ Is it any wonder that in the last thirty years Type 2 diabetes and hypertension have seen explosive growth in the US?

What other factors could affect how the health of US citizens compares with OECD citizens?

There are many other factors that have been identified as influencing how the health of Americans compares with the rest of the OECD. Some of these are:

1. The age of our population – While this will be a concern in the immediate future as baby boomers grow older, currently 12% of the US population is older than 65, which is below the OECD average of 14%.

2. Income and Insurance – The US is unique in the OECD, because it does not have a national insurance program. About 60% of us are covered by some form of employer provided insurance. Another 26% are covered by Medicare and/or Medicaid. That leaves 14% who are uninsured in any way. Among this group, most of whom are poor and many of whom are sick, healthcare often goes a-begging, with harmful results. For example, hypertension is less controlled in this group, “sufficiently so that the annual likelihood of death in that group rose approximately 10%.”¹⁰

Twenty-two OECD countries provide more than 98% of their citizens with public health insurance covering at least hospital and in-patient care. Despite this, Americans spend less out-of-pocket than the people of most other OECD countries – 13.2%. The OECD average is nearly 20%. Studies have shown that when a people pay less out-of-pocket for healthcare, total spending rises.

3. Sophisticated medical procedures – In the movie, Pat and Mike, Spencer Tracy famously said of Katherine Hepburn, “There’s not much meat on her, but what there

⁷ <http://content.healthaffairs.org/cgi/reprint/21/2/245.pdf>

⁸ “The Impact of Obesity on Rising Medical Spending,” Health Affairs, 20 October 2004

⁹ *ibid*

¹⁰ Newhouse et al, *Free for All? Lessons from the RAND Health Insurance Experiment*, Harvard University Press, 1993

is is choice.” (Actually, he said “cherce,” but it means the same thing) The same can be said for hospitalizations in the US. Although hospital stays are fewer and shorter, a lot of high-powered activity goes on.

For example, the US ranks in the top five OECD countries for the rate of caesarean section childbirths as well as all forms of organ transplants with the exception of lung transplants. Moreover, we’re in the top five for all four of the heart procedures on which the OECD collects data. We perform coronary bypass surgery and angioplasties at more than double the rate of the OECD average. Finally, we perform far more coronary revascularization procedures than any other OECD country. **Despite performing substantially more invasive heart procedures than all other OECD countries, death rates for heart disease in the US are the 17th worst in the entire group.**

4. Advertising - Between 1996 and 2003, pharmaceutical advertising quadrupled. Turn on the nightly news and count the ads for prescription drugs. Only two countries in the world allow this, the US and New Zealand. I find it amazing that more than 75% of the brands advertised had ROIs of more than 50%. Clearly, Americans respond to direct-to- consumer drug advertising, which is one reason why we spend double the OECD average on prescription drugs.

Four

Do The Statistics Tell The Whole Truth?

We have seen that America spends more on health care than other developed democracies around the world for outcomes that, on the whole, are no better than those achieved by the average OECD country. Our health care “system” perpetuates ever-increasing spending without delivering results to justify the expense. Moreover, because of our country’s isolation, both geographically and culturally, few Americans actually know about or appreciate this disparity. In the words of that eminent philosopher, Pogo, “We have met the enemy, and he is us.”

But not all the news is gloom and doom. We lead the world in medical technological innovation, and we have chosen to target this expensive technology at some very thorny problems. Further, statistics are black and white, lacking nuance, and nuance is important. Sometimes, one needs to lift up the rug and check what’s lying underneath.

Take infant mortality, for example.

The best place to find infant mortality data is (drum roll): the US Central Intelligence Agency¹¹, which tracks the rate of infant deaths in 241 countries around the world in its World Facts Book.

Currently, the CIA shows Angola, with 184 deaths per 1,000 births, as having the highest infant mortality rate (IMR) in the world, 241st out of 241. That is, more than 18% of Angola’s infants die shortly after birth. In fact, with the exception of Afghanistan, the 24 countries with the world’s highest infant mortality rates are all in Africa.¹² It has long been known that IMR directly correlates with a nation’s per capita GDP.

At the other end of the scale, Singapore, a high-GDP country, ranks first, with the world’s lowest infant mortality rate – 2.3 deaths per 1,000 births, followed by Sweden, Japan, Hong Kong, Iceland and France.

And where in this mix is the United States you may ask. Well, with a rate of 6.37, we rank number 41 in the world.

Or do we? It all depends on how one treats the numbers, because not everyone defines infant mortality the same way. The most common definition is: the number of deaths of infants, one year or younger, per 1,000 live births. The question is – what is a live birth? The World Health Organization (WHO) defines a live birth as “any born human being who demonstrates independent signs of life, including breathing, voluntary muscle movement, or heartbeat.” However, the United States counts all births as live if they show *any* sign of life, regardless

¹¹ <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html>

¹² http://en.wikipedia.org/wiki/Image:World_mort_rate_2007.png

of prematurity or size. This includes what many other countries report as stillbirths.¹³ And the US is far more aggressive and advanced in attacking and treating significant neonatal complications. Visit any major teaching hospital's neonatal ICU and you'll see what I mean. The inference is that the US's actual comparative infant mortality rate may actually be lower, perhaps much lower, than is statistically reported.

But those neonatal ICUs cost a lot of money. It's an investment the US has chosen to make, unlike most other countries, and it is symptomatic of why we spend so much more than the rest of the world on health care.

Of course, if you spend a few minutes talking with a mother and father who have just brought a young child home, healthy and smiling, after six months, or so, in one of those expensive, neonatal ICUs, you might be excused for thinking, as they surely do, that the cost is worth every penny.

Five

Conclusion

A Recap, An Hypothesis And A Modest Proposal

¹³ http://en.wikipedia.org/wiki/Infant_mortality

This essay is meant to paint a realistic, well-sourced and objective portrait of American health care early in the 21st century compared with that of our 29 partners in the Organization for Economic Cooperation and Development (OECD, all of us comprising the most developed democracies in the world, and to examine workers' compensation's fit into that mix. We've done a lot of the former and some of the latter. Now it's time to finish the job.

First, a bullet-point recap. We have seen that:

- American per capita health care spending is two and a half times the average in the (OECD) and 25 % higher than our closest competitor, Switzerland
- American per capita health care spending on pharmaceuticals is double that of the average in the OECD
- We perform more sophisticated testing and surgeries than any other country
- Our physicians earn double the compensation of their OECD counterparts
- Our hospital stays are 25% shorter and our doctor visits 42% fewer than other OECD citizens
- Despite all the spending, we don't live longer and are no healthier than the average among OECD countries
- There has been explosive growth in the incidence of Type 2 Diabetes, much of it caused by an epidemic of obesity, and 27% of the per capita increase in our spending on health care since 1987 is attributable to obesity.
- At nearly 31%, the percentage of obese adults in the US is the highest in the OECD and 25% higher than Mexico, the country that wins obesity's OECD silver medal, yet we have been unable either to halt or reverse the growth of obesity in America
- Thirty-one percent of our total health care expenditures go toward insurance administrative costs, far more than any other OECD country

It is indisputable that health care costs in America far exceed those for any other OECD country and have been sharply and steadily rising over the last 20 years. But every day, medicine practiced within workers' compensation depends entirely on the US healthcare "system," if we want to go so far as to call it that. It's certainly systemic, but perhaps systemic in a lot of the wrong ways. Consider:

- Since 1996, workers' compensation medical treatment costs, representing only 3% - 4% of total US spending on health care, have been rising at twice the rate of those "sharply and steadily rising" group health costs
- We spend significantly more to treat worker injuries than similar injuries in group health, principally because of over-utilization of medical services
- Pharmaceutical costs, representing 18% of total incurred losses at the fifth service year,¹⁴ are a large chunk of the ice beneath the water line, the costs

¹⁴ <https://www.ncci.com/ncci/media/pdf/research-RX-Study-2007.pdf>

that are often hidden and unknowable (When have you ever seen prescription drugs itemized on a loss run?). If you are an employer, ask yourself these questions: Do you have any idea of the prescription drugs your injured workers are taking? Do you have any idea of the extent to which your injured workers are being prescribed narcotics, such as OxyContin, Actiq, Fentora, Duragesic, even Vicodan? If not, you need to have an immediate talk with your insurer and your PBM. It's that important.

There are three more factors to throw into this toxic workers' compensation stew before offering an hypothesis and making a modest proposal.

First, although many in the insurance industry seem to think it inconsequential, the US workforce is getting older. In 2008, the average age of the American worker is 41, up from 35 in 1985. The baby boomers, 77 million of them, are moving inexorably through their careers. Many will retire over the next 20 years, but many will not, because they either don't want to or cannot afford to. Either way, they'll remain in the workforce. These older workers who continue working past normal retirement age will suffer fewer injuries than younger workers, but injuries to older workers cost more to treat, a lot more, and take longer to heal. Some in our industry say that the lower frequency of injury among older workers will cancel out the increase in severity, which would be true, were it not for the fact that there are going to be so many more of them.

A question that should be asked is this: Will workers' compensation become the retirement plan of choice for older workers who have no other choices? If you ask a cross section of claims adjusters they will tell you that this is happening right now and, along with the Medicare Secondary Payer Statute, is an unrecognized cost driver in the increase of medical treatment costs.

Second, the Medicare Secondary Payer Statute is changing the landscape of settlements involving older workers. Case in point - recently I participated in a Lynch Ryan client claims review meeting (at Lynch Ryan, we've always advocated frequent and formal claims reviews to maintain focus). During the meeting, the client's insurer said it was pulling back three settlement offers, because the Centers for Medicare and Medicaid Services (CMS) had increased the cost of each so much that it became more cost effective to simply continue to pay the out-of-work employees. In an insidious way, this will contribute to increased medical costs, and there is nothing employers can do about it at the time of settlement offer.

Third, the steep rise in workers' compensation pharmaceutical costs, which slowed and, to use NCCI's words, "began to level off in 2007," will once again begin to creep up in 2008. Why? Because on 18 January a US District Court gave a big victory to Perdue Pharma by ruling that the firm's patents were enforceable against makers of generic OxyContin. The court ordered that all generic versions

of OxyContin be phased out by May, 2008. This means that the four pharmaceutical drug companies making and selling oxycodone hydrochloride, the generic OxyContin, will no longer be able to do so. The generics cost significantly less than the original, so we can expect costs to rise as doctors once again resort to prescribing the more expensive OxyContin.

Conclusion

None of us can do much about the ridiculous costs of health care in America today. To quote that great Belgian philosopher, Hercule Poirot, the problem is “a many-headed Hydra.” But employers and insurers **can** do something about the ridiculous costs of health care in workers’ compensation.

To end this essay, here is an hypothesis and a modest proposal, which, although to many may seem trite, even pedestrian, emanate from 24 years successfully working with more than 4,000 client employers:

Hypothesis: A minority of injured workers stay out of work much longer than is medically necessary which results in their continuing to receive tax free indemnity wage replacements. Staying out of work longer than is medically necessary requires, ironically, progressively increased usage of what the health care system can offer, including powerful pharmaceuticals, surgeries, psychological and physical evaluations and the most sophisticated and costly medical testing in the world. All of this causes medical and indemnity costs to grow at an alarming rate.

The modest proposal: A caring, aggressive, systemic, performance-oriented and measured program that focuses on bringing injured employees back to work in some medically approved capacity of temporary modified duty as quickly as possible will keep injured workers connected to the workplace and the ingrained routine of getting up, getting dressed and coming to work every day. Absent that, the injured worker will stay at home where he or she will create a new routine of staying out of work and overutilizing the health care system. In an absolutely logical step, the injured worker will make up his or her own, stay-at-home modified duty program. If I were injured and could not go to work because my employer had nothing for me to do, that’s what I would do, and so would you. And that does not have to happen.

It’s a lot of work, but it’s as simple as that.



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