In the United States, we spend more on health care than we do on food. In fact, we significantly outspend peer Organization for Economic Cooperation and Development (OECD) countries, with $650 billion more health care spending than expected in 2006. Several major factors drive U.S. health care spending, most prominently technological advances, utilization and misaligned incentives.

To slow the growth of health care costs, Aetna believes we must take a number of steps including advancing payment reform, incentives for primary care, health information technology, transparency and investments in population health.

What drives health care costs?

If U.S. health care spending continues along current trends, our total spending will reach $4.3 trillion by 2018. The McKinsey Global Institute (MGI) estimates that about 68% of U.S. excess health care spending (as compared to peer OECD countries) results from outpatient care. Other key drivers include drug costs, inpatient care, health administration, higher physician compensation and investments in health, although collectively these factors do not reach two-thirds of the level of outpatient care. Interestingly, while administrative costs are often highlighted as a major cost driver, health insurance and administration represent only 14% of excess U.S. spending.

For further detail, please see reverse.
A number of factors play a critical role in driving U.S. health care costs.

**Technological innovation** is a significant cost driver and is reflected, in part, in our high level of spending on outpatient care. Unlike other industries where technology typically lowers costs, technological innovation in health care usually takes place at the higher end of the market, where new technology can generate higher income.\(^vii\) While innovation can be important in improving health outcomes, it should also be targeted at those who will benefit from it.

**Utilization** is another major factor in U.S. health care costs. The supply of high-cost care (e.g., specialists, new technology) can fuel demand for this care. For example, the 60% higher utilization of health care in high-cost regions than in low-cost regions can be explained by higher frequency of physician visits, tests and minor procedures, and increased use of specialists and hospitals.\(^vii\) But higher utilization does not necessarily result in better quality. States with a higher proportion of specialists actually tend to have higher spending and lower quality.\(^ix\) Expanded use of certain treatments also fuels cost growth, as outcomes improve and non-economic costs (e.g., pain) associated with these treatments decrease.\(^x\)

**Misaligned incentives** within the health care system also raise costs. The widespread fee-for-service reimbursement system for outpatient care encourages the delivery of both more services and more expensive services. In addition, higher utilization is driven in part by physician ownership of technology, with higher referral rates for procedures when physicians own the facilities in which those procedures take place.\(^xi\)

**Lack of transparency** is reflected in the disconnection between the price of care and patients’ demand for it, yielding little price competition among providers. The insured are largely insulated from the true cost of care; in fact, out-of-pocket expenses for outpatient care reach only about 15% of total spending.\(^xii\)

**High prices** for drugs, technology and physicians also drive U.S. health care costs. Drug prices are 50% higher in the U.S. than they are for comparable products in peer OECD countries.\(^xiii\) For the top five inpatient medical devices, the U.S. spends 54% more than OECD countries.\(^xiv\) Physician compensation is also higher in the United States.

**Population health** is an important factor in health care costs, although, in 2006, the U.S. did save $57 billion to $70 billion in medical costs as compared to peer countries because of lower disease prevalence.\(^xv\) Even so, the most common chronic diseases cost our economy over $1 trillion annually in direct and indirect costs.\(^xvi\)

### Health expenditures are expected to reach $4.3 trillion by 2018

To learn more, please visit www.aetna.com/about/america

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\(^vi\)McKinsey Global Institute.


\(^viii\)Katherine Baicker and Amitabh Chandra, “Medicare Spending, the Physician Workforce, and Beneficiaries’ Quality of Care,” Health Affairs, April 7, 2004.

\(^ix\)Ginsburg, October 2008.

\(^x\)Ginsburg, October 2008.


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\(^xii\)Ginsburg, October 2008.