

# Understanding Health Care Cost Drivers

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February 2003

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## I. Introduction

It is hard to miss the news—health care costs are soaring—and there is a general consensus in the academic as well as popular press that costs will continue to grow indefinitely if unchecked. An annual government report on health care spending showed that costs grew 8.7% in 2002, and *The New York Times* reported that spending in the past two years has risen faster than any time since 1993. Overall, health expenditures are predicted to rise from \$5,043 per capita in 2001 to \$8,708 per capita in 2010 (1), and consume 17.7% of the gross domestic product. (2)

Employers have already felt the burden of rising health care costs with an average increase of 11% in premiums in 2001 and 13% in 2002. (1) The competitive labor market in 2000-01 forced employers to absorb the increases, passing very little on to employees. The past year, however, has been different. Employee health premium contributions rose as much as 30% in some cases as employers began to pass on more costs. {1,2}

Health care costs represent a vast array of complex economic factors. Though there is no consensus on how to control costs, there is agreement about what is making health care so expensive. Topping the list are: Hospital costs, especially outpatient services; physician costs; technology—pharmaceuticals and medical devices; a loosening of managed care restraints; changing demographics; and, an increasing demand from consumers for goods and services. Also considered significant drivers are insurance plan administration, government mandates and regulations, and fraud and abuse.

### *Understanding the Cost Drivers*

Hundreds of health economists, researchers, policy analysts, and others have spent a tremendous amount of energy on the issue of the rising cost of health care and the equally challenging issue of how to pay for it. The National Institute of Health Policy (NIHP) is involved in an ongoing effort to understand the root causes and to translate these findings into action for reform.

We learned first and foremost that it is impossible to consider individual cost drivers in isolation. Many factors impact each component of the health care delivery system and a shift in one area necessitates variation in another. Our research uncovered a range of possible influences on rising costs. All of them fit into three major categories:

- The **price of the goods and services** being delivered;
- The **quantity of the goods and services** being delivered/consumed; and,
- The **construct of the delivery system** itself.

Instead of a traditional linear approach that dissects each component alone, the Health Care Costs Cause and Effect Diagram also in the conference packet shows how all health care cost drivers are interrelated and what might be their common root causes. One important thing to note is that some root causes have an impact at multiple points in the system. Opportunities for the most significant system redesign and improvement will lie with these. In the interest of brevity, this analysis of likely cost drivers will only briefly touch on selected elements, giving the reader a cursory overview of some of the issues. A more comprehensive analysis will be forthcoming on the NIHP website at [www.NIHP.org](http://www.NIHP.org).

## II. Health Care Cost Drivers

When considering the rising cost of health care, it is important to consider the distinction between **growth in costs** and **total dollars spent** in a particular health care segment. Figure 1 shows where 2001 health care dollars come from and how they are spent in Minnesota. Figure 2 shows the same comparison for the United States.

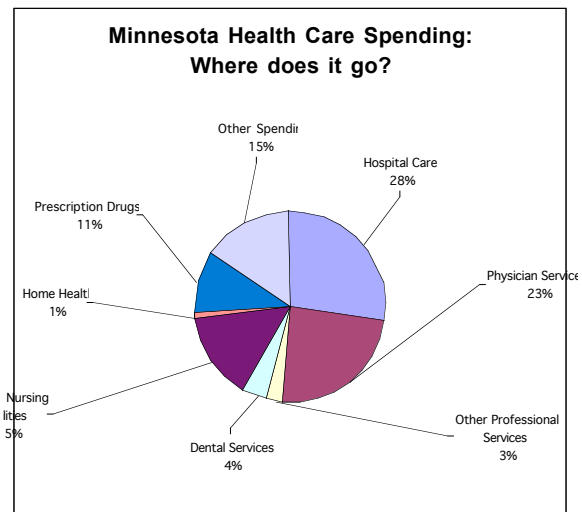
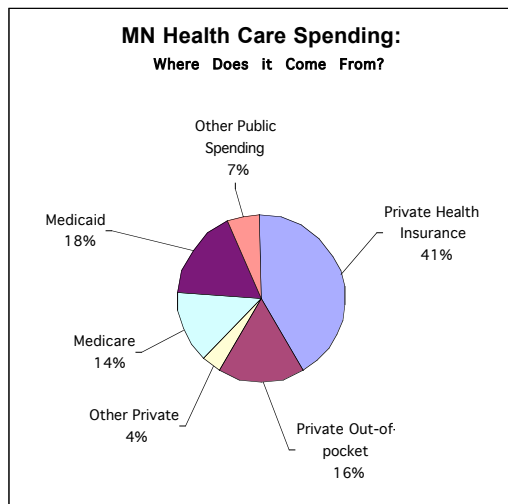


Figure 1

Source: Minnesota Department of Health. Health Economics Program

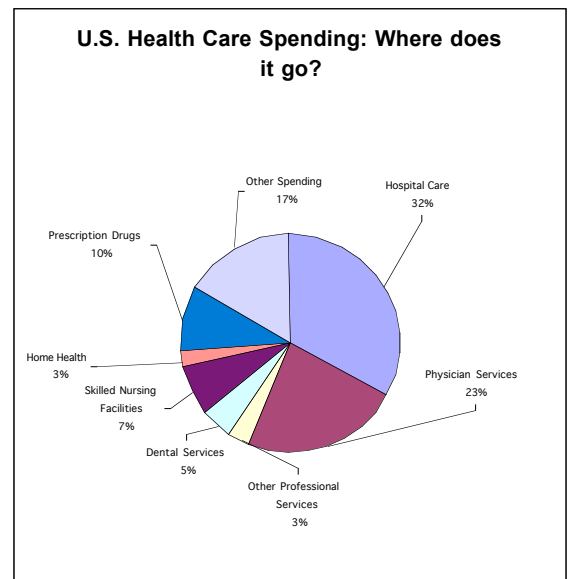
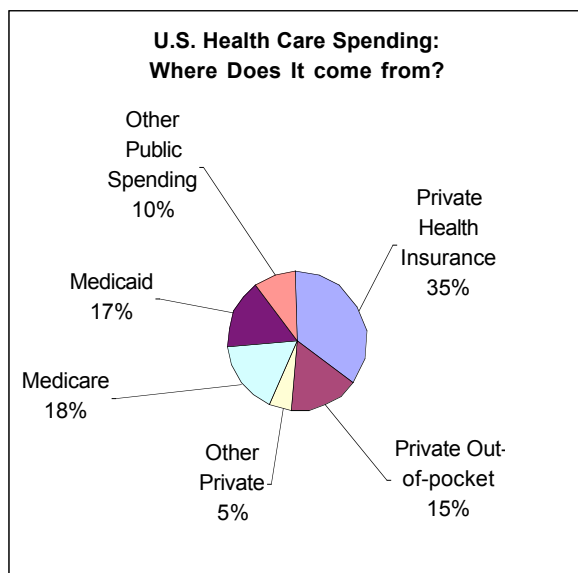
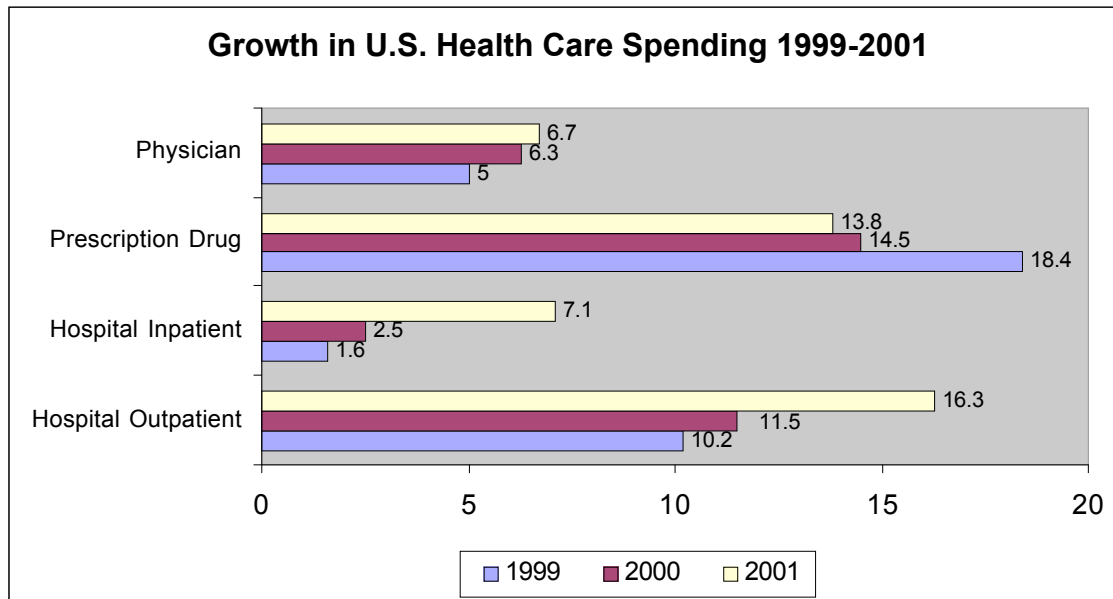


Figure 2

Source: Centers for Medicare and Medicaid Services

Growth trends have changed fairly dramatically in recent years for some segments of the health care system, as depicted in **Figure 3**. There are numerous possible causes for accelerated growth

in each segment, as reflected in the Cause and Effect Chart, and this section will highlight some of the dominant themes in the literature.



**Figure 3 Source: Minnesota Department of Public Health. Health Economics Program**

### A. Provider Costs

In 2001 physician services consumed 36% of private insurance spending in Minnesota (3) and most reports indicate that physician costs have risen at the same rate as overall health care spending during the past two decades. A recent Blue Cross Blue Shield report places growth in expenditures for physician services as a leading driver of health care costs. Minnesota ranks first with an annual growth rate of 7.2% for physician costs between 1990 and 1998 (4). The average annual rate of growth for this same time period nationally was 4.1%. A brief slow down in growth was noted in 1999 but the upward trend continued in 2000 (6.3% growth) and 2001 (6.7%).

Three major factors contribute to rising physician costs:

#### 1. Physician compensation

- **Compensation packages are leveling for primary care providers, increasing for some specialists.**

Several compensation surveys found that there are some specialists who are in high demand and who command significant compensation, but overall, compensation for specialists and primary care physicians combined increased just 4% in 2001 (1.5% more than rate of inflation), compared to 3.7% in 2000 (5). This increase compares to an 8.1% increase in health care costs overall the same year.

- **Productivity is up and compensation increases are recouping “lost” wages**  
Primary care providers (PCP) are seeing on average 2,300 patients annually, up from 2,000 in 1996, and charges have increased 10-11% annually. As the need for the primary care gatekeeper disappears, PCPs are working harder to make the same amount. (6). Recent compensation increases for specialists have been widely critiqued but many in the provider community claim that these increases are just making up for underpayment in the mid-nineties. For example, in 1996 orthopedists increased production by 18.2% but got only a 2.4% pay increase (7). Family practitioners got a 3% pay increase for an 11% boost in production.

## 2. Malpractice premiums

- **Malpractice insurance creates compensation challenge**  
In addition to productivity pressures, providers are also facing increasing malpractice insurance premiums that have forced some to consider leaving the profession altogether. In many cases providers are forgoing compensation increases for higher premium subsidies from their employers.
- In addition, many physicians suggest that the threat of litigation forces them to practice **defensive medicine**—prescribing unnecessary tests and treatments largely to protect themselves from possible adverse outcomes from doing too little. (8)

## 3. Supply and demand

- **More physician supply sometimes leads to higher demand and utilization**  
*“The American system developed under the shaping influence of incentives for private decision makers to expand and intensify medical services.” Paul Starr, 1994*

Research suggests that the more providers there are in a given area, the higher the use of medical services and technology. Some authors tie the increasing supply and use of specialists in particular to the growth in the GDP and economic vitality of the nation. Economic influences also have been tied to increasing physician supply. In one study, researchers found that each 1 percent of increase in GDP per capita results in a .75 increase in physicians per capita. "Virtually all of the growth in US physician supply per capita in last 50 years has been in supply of specialists and those specialists represent a luxury good that is affordable in vital economic times (9). Another author suggests that an expanding economy redefines what warrants attention. Economic expansion fuels innovation, increases expectations, and "reorders personal priorities." "Growth of the economy propels both the utilization of health care and the specialization of health care." (10)

- **Physician practice patterns impact demand and use of services**  
Another important factor is the impact that physician practice patterns have on utilization of all health care services and ultimately on the dollars spent. Though there has been a significant growth in the number of non-clinical providers, (10) physicians are still considered the “gatekeeper” to service and treatment utilization. As such, it is important to consider not just how much physicians are being paid for their services, but what impact their decisions are having on health care utilization overall.

Physicians continually update their clinical training through a variety of measures including professional journals, new clinical information websites, meetings and conferences, and interaction with their peers. Given the vast amount of information that is available, many providers complain that it is difficult to keep up with the latest recommendations regarding every clinical issue. In addition to new data, new technology, and new treatment findings, there is a growing body of information that promotes “best practices,” also known as evidence-based medicine (EBM). EBM evaluates both new and time-tested diagnostic and treatment protocols in terms of quality of care and cost-effectiveness.

Practice variation results as individuals and groups of physician make clinical choices whether or not to pursue and then incorporate EBM and other clinical guidelines. Instead, diagnostic and treatment decisions are made based on the physician’s own clinical training and preference, the recommendations of his or her peer groups—practice group, hospital staff, local physician association—also called “consensus-based medicine,” and the patient’s demands for service.

John Wennberg, M.D., M.P.H., editor of *The Dartmouth Atlas of Health Care* has done extensive research on the financial impact of practice variation. Wennberg found that, for Medicare spending, for example, there was a two-fold variation among regions, and the variations persist even after differences in health are corrected for. The study found that “higher levels of Medicare spending are due largely to increased use of supply-sensitive services—physician visits, specialist consultations, and hospitalizations, particularly for those with chronic illness or in their last six months of life (11).” One striking comparison Wennberg makes is between the lifetime care delivered to a Medicare recipient in Miami vs. Minnesota. The cost difference—\$50,000 more spent in Miami—could buy a Lexus sedan for the patient treated in Minnesota.

- **Better, earlier diagnostics fostering greater use of physician services**  
Technology too, is included on the list of factors impacting use of specialists. Modern technology is enabling better and earlier diagnoses of medical issues, which in turn leads to an increase in visits to specialists for follow-up consultation and care. In addition to better diagnosis, more effective treatment is also extending the lives of patients with chronic or acute illnesses such as cancer, thus requiring a longer-term relationship with their provider (10).

## **B. Hospital Costs**

The cost of health care always reflects a combination of price and quantity. Hospital costs continue to rise—a 23.4% increase in 2001—as a result of increasing use of inpatient, outpatient, and Emergency Department services, as well as the higher price of doing business. Hospital costs absorbed nearly 30% of total private insurance spending in Minnesota in 2001. More than 17% of those costs were dedicated to inpatient services, compared to 21.1% of costs in 1994. Outpatient services consumed 11.2% of dollars spent in Minnesota in 2001, compared to 10.6% in 1994.

Among the most significant factors contributing to higher hospital costs include:

- Wage pressure and physician charges;
- The 3 C's: Consolidation, Competition, and Construction;
- Technology acquisition and use;
- Pharmaceuticals;
- Government payment levels for Medicare and Medicaid; and,
- Hospital support systems

### 1. Wage pressure and the workforce shortage

- **Nursing shortage spurred significant increase in wages**

The nursing shortage in the past few years has been widely recognized as a major force in increasing wages for hospitals. With more than 2,000 nursing vacancies to fill, hospital administrators got creative offering signing bonuses, hiring more temporary staff, and allowing more flextime. Wages paid to workers in hospitals increased 4.1% in 2000, compared with a 2.3% increase in 1995 (12). Other shortages exist as well in allied health professions—especially laboratory and x-ray technicians and recruitment and retention increased expenses.

### 2. Technology and pharmaceutical costs

- **Growing use and supply of technology and pharmaceuticals**

There is a widespread consensus that the growing supply and use of technology and pharmaceuticals is a leading cause of increasing hospital charges. The Agency for Health Research and Quality (AHRQ), a division of the Department of Health and Human Services, reports that “New technologies and rising medication costs explain much of the increase in average hospital charges, while economic pressures have contributed to shortening the average patient stay for most conditions.”

- **Outliers consume much of technology resources**

“Outlier” patients incur a significant portion of inpatient hospital costs. “Outliers actually hold the key to the primary force that drives much of costs in acute and critical care.” Outliers are patients who are small in number but use a disproportionate share of resources—usually for intensive or end-of-life care. They represent 5-20% of patient population but consume 25-50% of resources (13). In addition, “resource consumption is the most intense” in the early stages of the inpatient stay. Cost control measures might have the most impact if they are focused on these early days rather than on reducing the overall length of stay (LOS). In fact, “reducing the LOS by as much as one full day reduces the total cost of care on average by 3% or less.” (14) “Not all hospital days are economically equivalent,” states another study. “The early stages of care are very technology intensive while the final days [for those patients who will be discharged] are more recuperative.” (14)

Overall, the use of technology—MRIs, catheterization labs, etc.—led to 19% of the rise in inpatient spending and 18% of the increase in outpatient spending. (5)

Another author agrees: "Preventative care [for acute illness] doesn't necessarily lower costs in short run, but may actually drive up costs with earlier case finding," and the switch from one technology to newer, presumably more advanced technique can greatly impact costs. Using the colonoscopy vs. the sigmoidoscopy as an example, the author explains that the former would be administered in an outpatient setting by a specialist, using anesthesia, high-cost equipment, and skilled staff vs. sigmoidoscopy which can be administered in a primary care physician's office, producing no facility fee, no high cost personnel nor equipment—the latter clearly being the cheaper alternative. (15)

### 3. Hospital Competition: Price Control or Medical Arms Race?

- **Competition fosters spending**

Competition in most industries typically results in cost control and a reduction in prices or the consumer. In health care, however, competition does not always prove to be the price control panacea it is thought to be. One study by Smet, et al found that in order to gain market share and attract patients "in a competitive market, hospitals will employ more capital and equipment, produce more expensive medical care and incur higher costs than hospitals operating in monopolistic markets. This type of competition is sometimes referred to as a medical arms race." (16)

Enhancing its service menu, however, does not always result in more revenue for a hospital in a competitive market. Hadley et al. found that "competition appears to have had a bigger negative impact on revenue growth than on expense growth, with the result that profits grew significantly less in more competitive hospital markets." (17) While another study found the same was true for revenue growth but that competition in a given market also slowed expense growth (18).

- **Consolidations don't always save money**

Hospital proponents of mergers and consolidations point to such positive outcomes as gains in efficiency, reduction in excess capacity, and a reduction in transaction costs. Opponents suggest that merged institutions in a concentrated health care market could create greater market power for the institution and no incentive to control costs in the name of competition (19).

### 4. Facility Expansion and Technology Acquisition

- **Capital improvements: aging buildings, aging bodies**

A recent report by the Blue Cross Blue Shield Association raised some issues about hospital capital improvements underway in Minnesota as a potential contributor to higher hospital costs.

In Minnesota "health systems are spending more than \$1.45 billion on new or remodeled facilities over the next few years. Four times the more than \$396 million spent on hospital construction from 1992 to 1996 (20).

While the authors of the study question whether some of the expansion is creating duplicative services, hospital executives argue that the expansion is being dictated by

need. An aging population will require expanded services for such specialties as cardiology and orthopedics. During the next 10 years, the number of Minnesotans age 45 and older is expected to balloon 25%, said a health plan spokesperson. “Add to the fact that 91% of cardiology patients and 75% of orthopedic patients are over 45, and you get tremendous future demand (20).”

In contrast, the BCBS report says that from 2000-2001, inpatient days “per thousand for cardiovascular services increased by 7%; inpatient days for mental health and substance abuse treatment rose by 32%; days for musculoskeletal services rose 12%, and digestive services by 10%. Such numbers raise the question about the need for so many new heart and orthopedic facilities. Eight of the 53 building projects statewide are categorized as heart facilities--15% of total overall building.

Whether predictions of future demand for specialty services are realized or not, the need for upgraded facilities is a current reality for Minnesota’s rural hospitals. According to a recent report (21), 58 of 73 of Minnesota’s rural hospitals are in the American Hospital Association’s “struggling” or “distressed” category in terms of its physical plant. “Health care delivery is highly dependent on a wide range of diagnostic and therapeutic technologies.” The equipment needs to be continually updated and replaced. In addition, “hospitals are no longer exclusively defined by their acute care mission, but the hospital facility and physical plant was designed and built to provide only acute care services.” Today, “rural hospitals are no longer in the hospital business, they are in the health care business.”

#### 5. Shifting the balance to outpatient care

A huge shift in spending from inpatient to outpatient services is largely due to better use of technology in outpatient settings and the expansion of the ambulatory care center model. The number of these freestanding centers has grown 31% since 1996 and the volume of procedures has increased from 12,000 to 101,000 annually (4)

#### **C. Technology: Pharmaceuticals**

*“The federal government makes investments [in the development of pharmaceuticals] in order to assure that patients have access to new medical therapies. A strong pharmaceutical industry is also an important source of jobs, productivity, and overall national economic health. The cost of those therapies, however, is an important determinant of whether patients and insurers have access to them.” (22)*

Minnesota ranks 23rd in the nation for total number of retail prescriptions written in 2001; 19th in total prescription sales (\$2.8m); 6th in average price of prescriptions (\$55.79; US is \$49.84); and, 34th in prescriptions per capita (10.2/capita, US is 10.9). The number of prescriptions written increased 8.2% from 2000-2001, compared with a 6.9% average increase nationally. Retail sales of prescriptions in Minnesota rose 19.1% from 2000-2001, compared with 17.3% nationally. The average price increased 10% in Minnesota, compared with 9.7% in the U.S. (23)

Rising technology costs—highlighted by double-digit increases in pharmaceutical spending—is clearly a significant cost driver and one that deserves careful consideration in any debate about

cost control or reform measures. In a recent Blue Cross Blue Shield Association survey of 500 corporate health care purchasers, 64% of respondents cite prescription drugs spending as the most significant factor in rising health care costs.

The challenge of cost control and reform efforts is to assure access to needed drug therapies while at the same time managing rising costs. Between 1995 and 2000, spending on prescription drugs in the US doubled, reaching \$122 billion. The 37 million seniors and 6 million disabled Americans on Medicare do not have a drug benefit. Their average out of pocket spending increased from \$813 in 2000 to \$1,051 in 2002. Pharmaceutical costs are one factor that is making health insurance more expensive and resulting in much higher out-of-pocket expenditures for those who do not have coverage (22)

The cost of pharmaceuticals is dictated by a combination of private industry investment of time and talent and government regulations and policies. As indicated above, however, it is the quantity increase more than the price increase that is the dominant upward trend in the pharmaceutical segment.

#### 1. New and better drugs might benefit health and cost more too

Some researchers contend that “new, more effective drugs might lower overall spending by reducing the use of costly services (24).” Several studies by Lichtenberg, et al. found that the replacement of drugs developed more than 15 years ago with newer, “priority” drugs recently approved (within the last 5.5 years) by the FDA reduce non-drug medical costs by as much as the cost of the new drug (22). The research supports “the hypothesis that the replacement of older by newer drugs generally results in reductions of total medical expenditures as well as mortality [in both the general and Medicare populations] (22).”

In addition to an often positive health impact, the pharmaceutical research and development (R&D) function has a significant impact on our economy as well (Lichtenberg, 2001). R&D in any industry promotes technological development. In turn, technological progress is an essential component of continued economic growth.

Critics of the industry, however, offer a different perspective. A National Institute for Health Care Management 2002 report suggested that a “growing percentage of newly approved drugs are only incremental modifications of existing drugs.” Further, drugs given priority approval by the FDA because of their purported therapeutic efficacy only increased 10% from 1995-2000, compared to an 81% increase in “incrementally modified drugs that did not offer significant advances in efficacy or safety (22).”

#### 2. Pharmaceutical market growth

“The financial success of the pharmaceutical industry requires patients who can purchase their products. Without purchasers, there is no revenue. Between 1990 and 2000, third party reimbursements (private insurers and Medicaid) increased from 37% of retail pharmaceutical sales in the US to 84% (22). And rebates to insurers from pharmaceutical companies encourages the promotion of brand name drugs and subsequent higher costs. Brand names accounted for 91% of U.S. sales in 1999 (Health Affairs, 2002). The introduction of “blockbuster” drugs contributes significantly to rising costs. In 1999, two such drugs were responsible for driving

growth 19.2%. With no blockbusters in the pipeline, spending growth slowed to 17.2% in 2000. (Health Affairs, 2002)

### 3. Direct-to-consumer advertising

In 1997, the FDA approved guidelines for drug ads on television and radio that did not require the same stringent “warning labels” as in print ads, allowing advertisers more freedom in communicating their messages. The final FDA rule regarding TV/radio advertising was issued in 1999. The next year, the pharmaceutical industry spent \$1.6 billion for television drug ads, and \$2.5 billion overall for advertising directed to consumers (Trude, 2002)

## **D. Consumer Behavior and the impact on price, quantity and delivery**

Interwoven through this paper is the implied influence of the consumer on health care consumption and costs. Provider supply, hospital expansion and technology acquisition, growth in sales of “blockbuster” drugs—cannot exist without demand. Numerous authors postulate that consumer demand has a significant impact on the volume of medical care that is used. For example, one author states that the "historical trends in physician supply reflect the historical demand for physician services," and that it is individual health status that is a more significant predictor of a "physician-initiated visit." The public has been increasingly demanding specialty care and that demand is the main reason why managed care failed (10).

Patient demands for the latest technology (driven in large part by web-based information and direct-to-consumer advertising), along with more advanced diagnostics, more costly drugs, new and higher cost vaccines, and regulations and mandates are some of the real causes of rising costs of medical care. Medical costs will continue to rise because of new cohort of aging patients, but also because of the new generations of sophisticated, Internet-capable patients placing demands on the system (15)."

The author continues: "More than the personnel costs, it is patient demand for care that moves costs upward. The technological imperative of new treatment modalities fosters increased demand for preventive, curative, and rehabilitative services. Furthermore, the Internet, with its speed and access to professional literature...also fosters demand. These demands, if not met, could be answered with a malpractice suit or appeal to the health plan or regulations mandating the inclusions of service within a health plan (15)."

Another study by the Lewin Group found that increasing consumer demand for pharmaceuticals has “contributed to increasing physician services because consumers generally require physician visits to obtain prescriptions (AHA, 2002)."

It is widely believed that consumer demand for access to a range of providers, coupled with the provider’s desire to regain a sense of autonomy, led to the loosening of managed care restrictions and ultimately cost control measures.

Traditionally, it is the providers of health care and the manufacturers of technology products who have been under close scrutiny for productivity and cost effective quality measures. With health care costs spiraling out of control, however, it is consumers—their behavior, their spending patterns, their age, and their demographics—who are receiving some of the attention. Providers, insurers, and employers are confident that consumers are having a major impact on health care costs and that new measures to change consumer behavior may halt cost growth.

While many cost control measures have been implemented during the past decade, consumer out of pocket spending is still just 15% of national health care spending—a number that is unchanged since 1994. Consumers have been encouraged to enroll in one plan or another by low co-payments and small deductibles (24).

In 2000, consumers spent 20% of their out-of-pocket health care dollars on pharmaceuticals, 17% on provider fees; and, 15% on over-the-counter and other sundries. Seniors 65 years of age and older have the highest rate of out-of-pocket spending—likely due to high prescription drug utilization. (24)

## **E. Insurance Costs**

### 1. How we pay for health care

Much of our focus has been on what we are paying for in health care. Some attention must be paid as well to “how” we are paying for it. Insurance expenses are also on an upward trend and it is important to understand how premiums prices and health care costs are interrelated.

- **Insurance cycle creates unstable premium market**

The first concept to consider is called the “insurance cycle.” Insurers create a planned pricing cycle that allows them to under price premiums relative to true health care costs in order to gain market share, or more subscribers at a given time. When the desired market share has been achieved and economic conditions may have changed, premium prices are increased to both reflect the true costs of health care as well as to recoup any losses that might have been incurred during the under pricing period. The mid- to late-90’s saw a significant effort on the part of insurers to gain market share and thus premiums were under priced—premium growth was modest for several years. Premiums rose an average of 11% in 2002 and are expected to rise 13% in 2003 (1). Some economists suggest that the current rate of premium growth will level off in the short term as this cycle comes to an end.

- **Administrative costs may contribute to higher premiums**

Premium increases also reflect administrative costs increases within the health plans and insurance companies. Government regulations and mandates also impact how insurance companies do business and what services they are required to cover, and can contribute to price increases.

- **Cost shifting: Government vs. Private payers**

A third element that impacts premium costs is “cost shifting.” Cost shifting occurs when government payment levels for Medicare and Medicaid patients do not fully cover the hospital’s stated costs for delivering care. The impact of serving the uninsured also increases the need for hospitals to cost shift. To recoup the loss from serving these patients, the hospital will negotiate higher rates with health plans that in turn reflect those higher prices in insurance premiums. In essence, the private insurance market is subsidizing the hospital’s stated cost of delivering medical care for the Medicare and Medicaid populations.

- **Risk pool instability affects premium costs**

Finally, the “risk pool” must be taken into consideration. A rise in health care costs sets in motion a challenging conundrum for insurers. Higher prices are reflected in higher premiums, which are absorbed by employer and employees. Higher premiums also coupled with higher co-pays and deductibles for employees. In some cases, cost of health care coverage may become burdensome for employee and he/she may opt out of insurance program. Many who opt out are young and healthy and don’t anticipate needing any expensive health care services. This action negatively impacts the health care system in two significant ways. First, the employee will almost invariably become ill at some time, access the system through the emergency department—a most inefficient and often costly mode. Second, a relatively young, healthy participant contributes some stability to the insurance risk pool. Without their participation, the pool becomes unstable, premium costs rise in anticipation of a sicker insured population, and those who remain in the pool have to pay even higher premiums.

In closing, significant attention is once again being paid to the construct of the health insurance market. Dozens of proposals have been introduced to better organize the financing of health insurance. A discussion of their merits and drawbacks is a massive policy undertaking and cannot be adequately addressed in this paper. It is important to acknowledge, though, the role that the nation’s insurance infrastructure--federal and state government, employers, individuals, insurance companies themselves, the investment community, and others—plays in the cost of care and access to health care.

## **F. Conclusion**

This paper offers a range of possible factors that are contributing to rising health care costs. The list is by no means conclusive. Other significant factors that will be addressed in future work include: the rising cost and increasing use of medical devices; hospital operations and the overall system of health care delivery; the aging population; health system capacity; and, the impact of prevention on costs.

What is clear from the range of ideas presented here is that no one should suggest that one party is to blame for the rapid rise in health care costs. As one reporter said, “Hospitals are marketing to consumers, consumers are demanding services, physicians are prescribing the drugs, and insurers are paying for it. No one party is solely to blame (20).” Instead, it is crucial that all elements of the health care system—its structure, financing mechanisms, the role of government, consumers, providers technology companies, hospital administrators—are taken into

consideration in any reform or cost control discussion. A recent Health Affairs article put it well. “Health care is not purchased by an individual consumer market. Forty percent is purchased with public funds; 40% with private insurance. The 20% of patients who generate 80% of health expenditures each year are for the most part, spending someone else’s money... Collective financing of health care calls for collective decisions about how much to spend (24).”

Fortunately, the Upper Midwest has had a history of innovation in health policy. Working together, all of the system’s stakeholders can identify and implement feasible and lasting solutions.

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