



MEDICAL COST CONTAINMENT A Microeconomic Approach

Health care costs, which already consume roughly one-sixth of the US economy, are projected to surge as aging baby boomers begin flooding the medical system. The Affordable Care Act (ACA) does little to stem this tide; it mainly shifts costs among taxpayers, insurance carriers, and medical providers. Further reforms are critical to ease the mounting pressure of health care costs—but what, specifically, can be done?

In a new study for the Mercatus Center at George Mason University, [Marc D. Joffe](#) shows that relaxing legally enforced rigidities in the health care market can unlock competitive forces, driving down prices and empowering individuals in their medical choices. Recognizing there is no silver bullet, the study explores four options for savings: medical tourism (obtaining medical services abroad); greater use of qualified nonphysician providers; medical liability reform; and changes in how prescription drugs are sold. A more open health care market, Joffe argues, would encourage providers to innovate in ways that reduce costs while improving the quality of care.

For the complete study, see [“Medical Cost Containment: A Microeconomic Approach.”](#)

KEY POINTS

Medical Tourism

In his movie *Sicko*, director Michael Moore tried to ridicule US health insurers by escorting a number of Americans to Cuba for services under that country’s single-payer system. In the process, Moore demonstrated a major opportunity for health care savings in America: expanding the use of lower-cost foreign providers.

- Anywhere from 900,000 to 1.6 million Americans travel to other countries annually for cosmetic procedures, dental surgery, and infertility treatments excluded from their insurance policies or subject to high copayments. For more intensive procedures—including coronary bypass surgery, hip and knee replacements, and spinal fusion—patients can obtain savings of 30–70 percent by using services abroad.
- The quality of foreign-provided services often equals or exceeds that of services in the United States, and countries such as India and Thailand have poured billions of dollars into improving their health care systems and are aggressively catering to international patients.

For more information, contact
Angela Kuck, 703-993-9338, akuck@mercatus.gmu.edu
Mercatus Center at George Mason University
3434 Washington Boulevard, 4th Floor, Arlington, VA 22201

- Some commercial US insurers, including WellPoint and Blue Cross and Blue Shield, already cover certain offshore procedures, and even travel expenses in some cases. Hundreds of thousands of California residents save on health costs by using Mexican medical facilities under plans offered by Aetna, Blue Shield of California, and Health Net.
- The government could accelerate the globalization of health care and promote significant savings by removing travel restrictions and offering patients incentives to use less costly services outside the United States. Medicare also could achieve substantial savings by covering medical expenses abroad.

Alternatives to Medical Doctors

Many routine medical services—such as checking heart function, ordering tests, and referring patients to specialists when needed—can be capably provided by trained, nonphysician professionals at lower costs than by physicians. Adjustments in medical licensing laws could expand the use of such practitioners, assuming they are fully qualified and authorized to provide the services, and help compensate for the limited supply of medical doctors.

- Restrictions in medical practices began in the late 19th century, as the American Medical Association (AMA) lobbied state capitols to help professionalize the field. The AMA also succeeded in limiting the number of medical schools, which suppressed the supply of physicians and kept their costs high.
- Similarly, the profession of midwifery had all but vanished in the United States by the early 1970s due to restrictive state laws. Since then, however, 28 states have authorized certified professional midwives, allowing at-home births that are more comfortable for many women and less expensive than hospitalization. Yet only about 1 percent of American women choose to deliver at home. Expanding the practice could yield valuable savings.
- Other groups of medical professionals have also arisen in recent decades, offsetting physician shortages. These include more than 170,000 nurse practitioners who receive advanced training to provide services similar to a doctor's; 69,000 clinical nurse specialists, with training beyond that required to become a registered nurse; and 80,000 physician's assistants who provide specialized care in emergency rooms, operating rooms, and other settings.

Malpractice Reform

Malpractice law accounts for only about 2.4 percent of medical spending, mostly from “defensive medicine,” or unnecessary tests and treatments that merely guard against negligence claims. Nevertheless, tort reform can make a useful contribution to reducing medical cost growth.

- The major reforms fall into four broad categories: caps on punitive damages for medical negligence; caps on noneconomic damages; collateral source reforms, which allow or require courts to reduce a plaintiff's award through payments from other sources such as worker's compensation or the plaintiff's insurance; and “joint and several liability,” which apportions liability when several defendants are sued in a single claim.
- Research on these reforms has yielded mixed results. For instance, after Texas adopted tort reform in 2003—including a \$250,000 cap on noneconomic damages—one study reported an 80 percent reduction in malpractice lawsuits at a San Antonio medical center. Another analysis found that a 10 percent reduction in medical malpractice insurance rates yielded only a 0.7 percent decline in medical care expenses.

- One option would be to replace or supplement tort litigation with a less-expensive administrative law process, as in Sweden, Denmark, and New Zealand. Because these arrangements do not require plaintiffs to prove negligence, they produce more awards, but in considerably smaller amounts.

Prescription Drug Patent and Dispensing Rules

Prescription drug spending totaled \$269 billion in 2011, about 10 percent of total health costs. Drug patents, which give pharmaceutical companies a 20-year monopoly on a drug's sales, eliminate the potential for savings resulting from competition. Removing or limiting patent protections, and reducing the need for pharmacists to dispense drugs, could reduce prices without necessarily sacrificing beneficial pharmaceutical research.

- Evidence suggests that, even without patents, pride of accomplishment or favorable publicity would still promote pharmaceutical research. Further, the most important discoveries in recent decades have come from universities and nonprofit medical facilities, often funded by the National Institutes of Health.
- One option for savings on drug costs is to limit patent protections to only those drugs that offer major benefits over previously approved treatments. Another would be to reduce the duration of patent protections from the current 20 years.
- Prescription dispensing requirements increase the cost of medications and cause patients to arrange otherwise unnecessary medical appointments, just to obtain a prescription. Yet research shows no measurable safety benefits to the prescription regime, and, in at least some cases, prescription drugs and over-the-counter alternatives—for example, Nexium and Prilosec—have similar risks.