The Economics of Healthcare

Loch Lomond Yacht Club
July 2, 2026

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NEED

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Health Economics is Big Business

- Healthcare is the biggest industry and the largest employer in the U.S.
- We spend **A LOT** on healthcare:
  - In 2024, U.S. national health expenditures were about **$5.3 trillion** -- approximately **18.0% of GDP** ($15,000 per person)

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Markets Studied in Health Economics

- **Markets for:**
  - Physicians
  - Nurses
  - Hospital facilities
  - Nursing homes
  - Pharmaceuticals
  - Medical supplies
    - such as diagnostic and therapeutic equipment
  - **Health Insurance**

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The Three Legs of the Healthcare Stool

ACCESS

QUALITY

COSTS

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Access

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Health Insurance Coverage, 2024 – 92.0%

- **Countries with Less Than Universal Coverage**

Country	% of Persons
Slovakia	94.5
Chile	94.3
UNITED STATES	92.0
Poland	91.5
Mexico	90.2
Algeria	90.9
Jordan	55.0

- **Countries with Universal Coverage**

Countries	% of Persons
Australia	100
Canada	100
Czech Republic	100
Slovenia	100
United Kingdom	100
Greece	100
Hungary	100
And 21 more	**99+**

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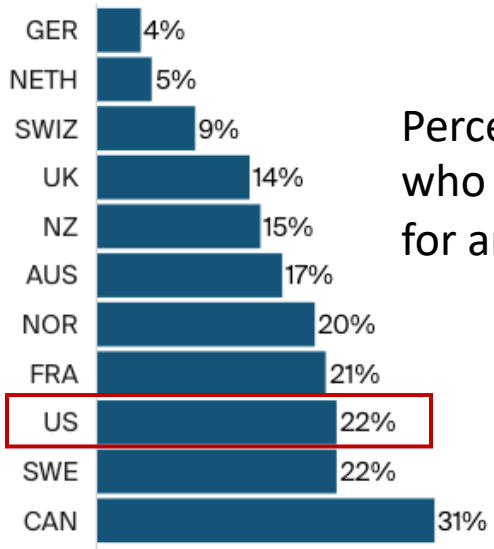
Source: Organization for Economic Cooperation and Development, and https://www.census.gov/content/dam/Census/library/visualizations/2025/demo/p60-288/figure1.pdf

6

But What About Wait Times?



Percentage of adults aged 65+ who waited more than 6 days for an appointment when sick.

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Source: Commonwealth Fund, Comparing Nations on Timeliness and Coordination of Health Care, 2021

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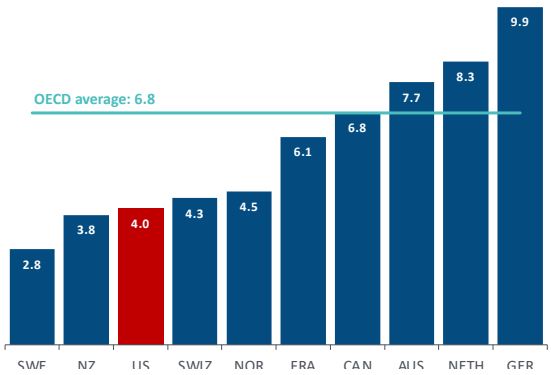
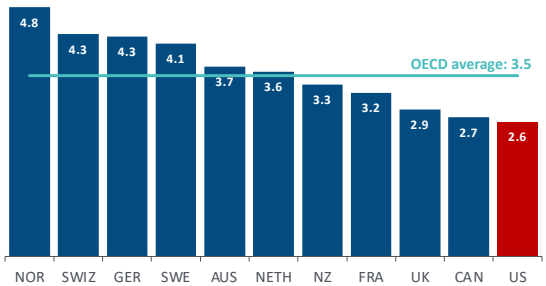
Physician Visits and Physician Supply

Average physician visits per capita, 2017



Practicing physicians per 1,000 population, 2018



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Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

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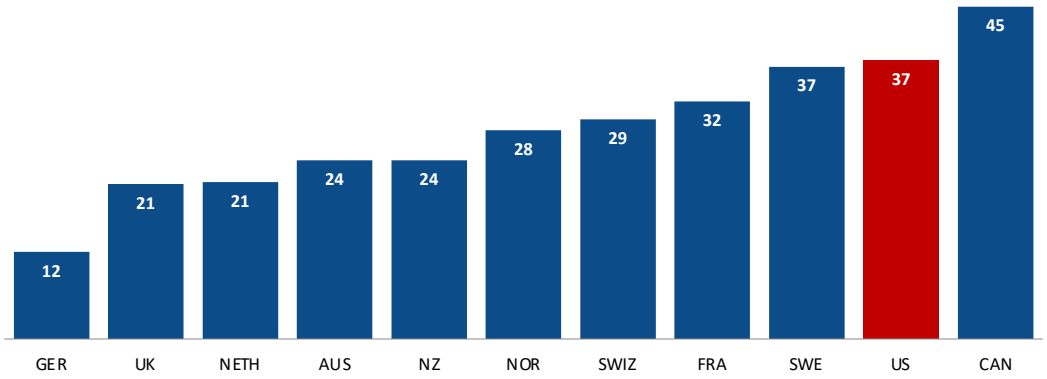
Percent of Women Ages 18–64 Who Reported Going to the Emergency Room in the Past Two Years



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Source: Munira Z. Gunja et al., *What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?* (Commonwealth Fund, Dec. 2018).

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Access Notes

- **Insurance coverage in the U.S. is not universal.**
  - It is universal in every other developed country.
- **Wait times are not necessarily lower in the U.S.**
- **Supply of medical personnel and equipment may be lower than elsewhere.**
- **Emergency room use is higher in the U.S. than elsewhere.**

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What the Affordable Care Act did:

- Created Insurance "exchanges" where individuals could buy insurance
  - Premium could be subsidized by federal government (depends on person's income)
- Significantly expanded Medicaid eligibility, now up to 138% of poverty level.
  - Fed pays 90% of the cost for these people
  - Many Red (21) and Blue (20) states have accepted this expansion
  - Added about 20 million people to Medicaid
- Required insurance companies to cover children up to age 26.
- Required people to have insurance and companies to offer insurance to employees (many exceptions allowed).
- Prevented insurance companies from excluding preexisting conditions.

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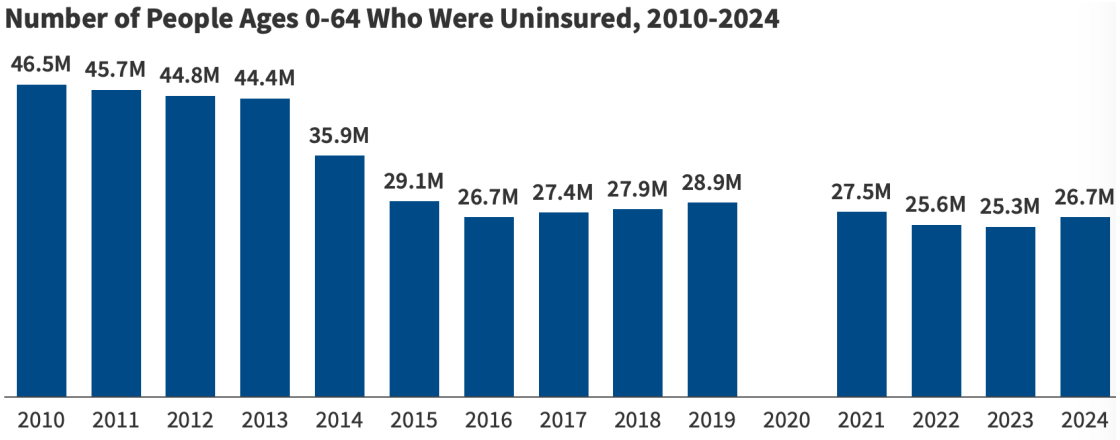
Number of uninsured dropped dramatically after first ACA open enrollment in 2014.



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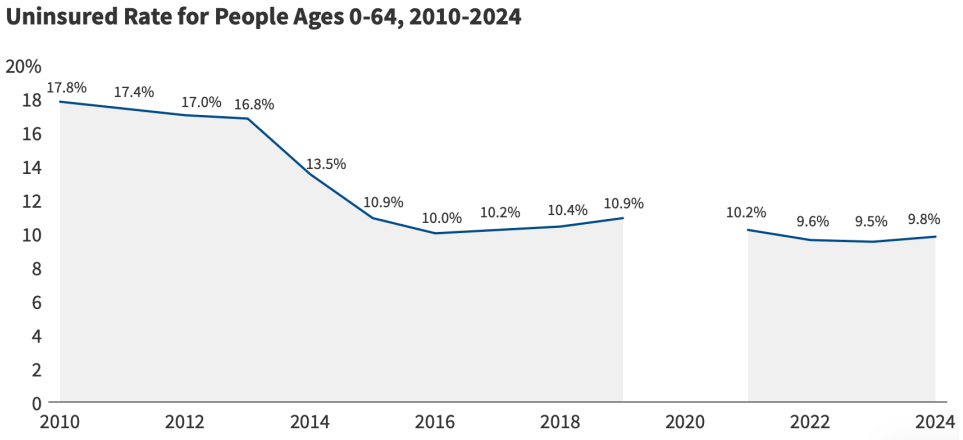
Uninsured rate dropped dramatically after first ACA open enrollment in 2014.



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What the One Big Beautiful Bill did:

Imposed additional requirements for Medicaid-expansion people:

- Tougher work requirements (many participants already working).
- Additional eligibility verifications (2x per year); may be difficult for many recipients to follow.
- Multiple groups estimate about 10 million people will lose Medicaid eligibility and hundreds of rural hospitals will have to close.
- Savings of around $1 trillion expected over next 10 years.

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Quality

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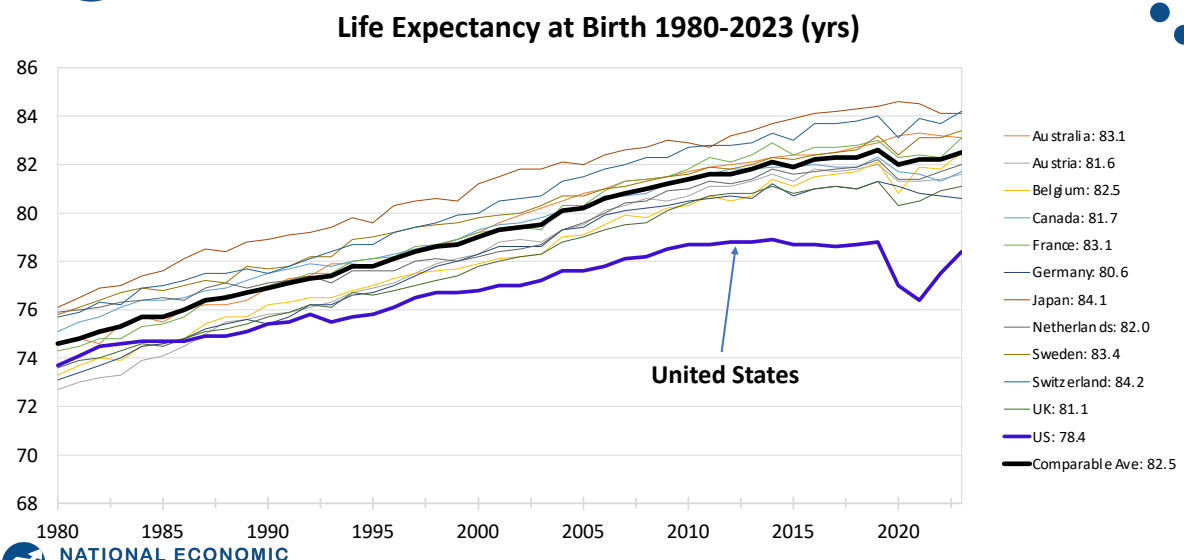
Life Expectancy: How Does the US Compare?



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Source: KFF data collection. https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/

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Life Expectancy at Birth by Race/Ethnicity, 2019

Race/Ethnicity	Life Expectancy (Years)
All Races	78.8
White	78.8
Black	74.8
Hispanic	81.9
Asian	85.6

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Source: KFF, Key Data on Health and Health Care by Race and Ethnicity

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Income Also Matters – Reflecting Access?

Sex	Income Category	Life Expectancy (Years)	Difference High vs Low
Women	**Highest** Incomes (top 1%)	88.9	10.1 years
	Lowest Incomes (bottom 1%)	78.8	
Men	**Highest** Incomes (top 1%)	87.3	14.6 years
	Lowest Incomes (bottom 1%)	72.7	

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Source: https://healthinequality.org/documents/paper/healthineq_summary.pdf

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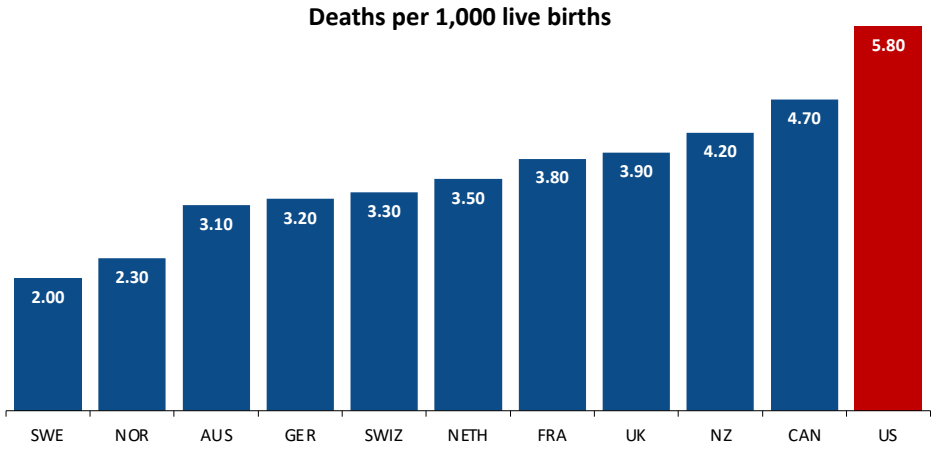
Infant Mortality International Comparison



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Source: NEED from OECD Data

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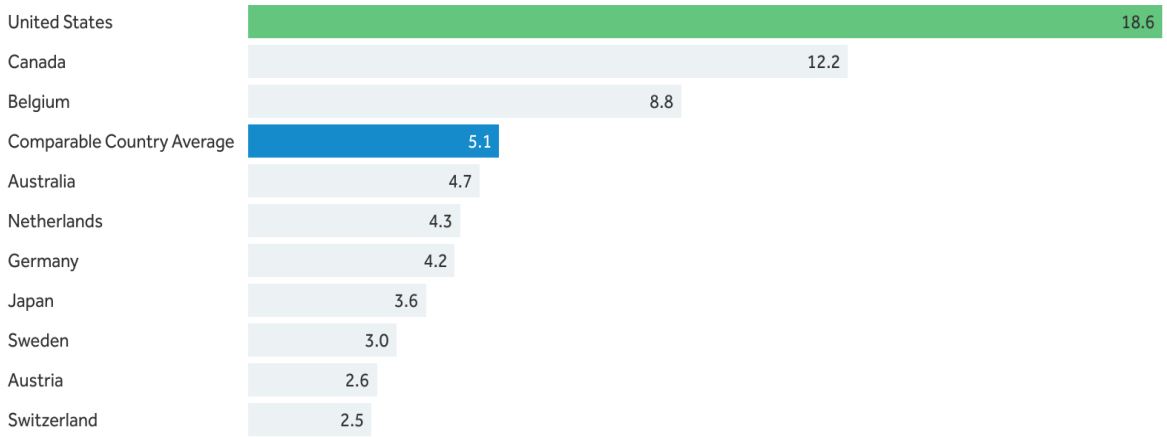
Maternal Mortality Rates per 100,000 live births (2023)



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Source: KFF analysis of OECD data

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Maternal Mortality Rates by Race

Pregnancy-Related Mortality Rate per 100,000 Births and Number of Deaths by Race and Ethnicity, 2023

	Rate	Deaths
White	14.9	265
Hispanic*	12.3	118
Black*	49.4	241
Asian*	10.7	23

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Source: *Pregnancy-Related Deaths by Race-Ethnicity*, 2023, CDC

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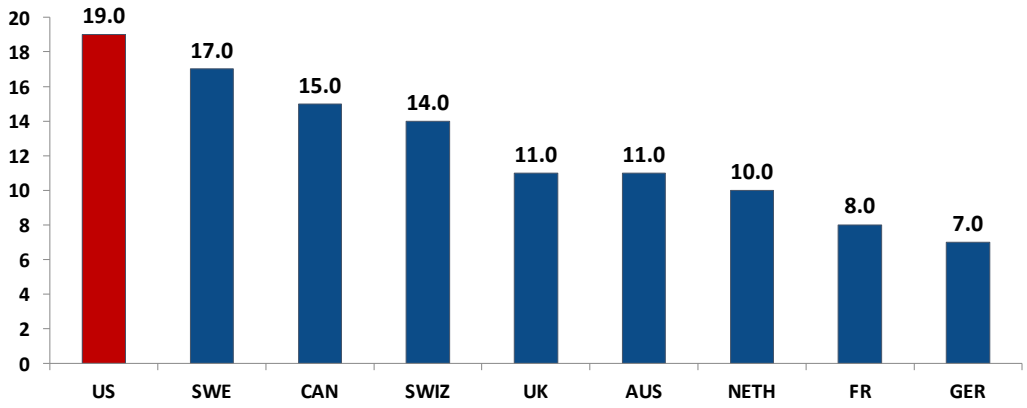
Percent of adults who have experienced medical, medication, or lab errors or delays



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Source: 2016 Commonwealth Fund International Health Policy Survey.

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Prevention and Screening

- The U.S. excels in **some** prevention measures (high ranking):
  - including **flu vaccinations** and **breast cancer screenings**.
- The U.S. has:
  - The highest average five-year survival rate for breast cancer.
  - But the Lowest for cervical cancer.

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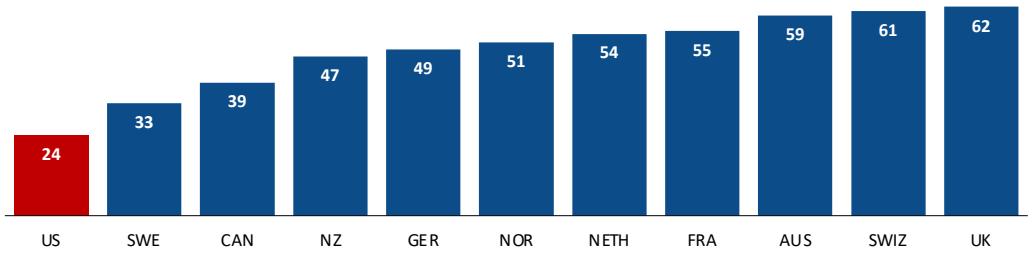
Perception of Quality of Medical Care

*Percent of women ages 18–64 who rated their quality of medical care as **excellent or very good**.*



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Source: Munira Z. Gunja et al., *What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?* (Commonwealth Fund, Dec. 2018).

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Quality of Care Notes

- Metrics of quality in the U.S. are not very good.
- The system has bright spots!
- Quality of care is not considered very good in the U.S.

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Costs

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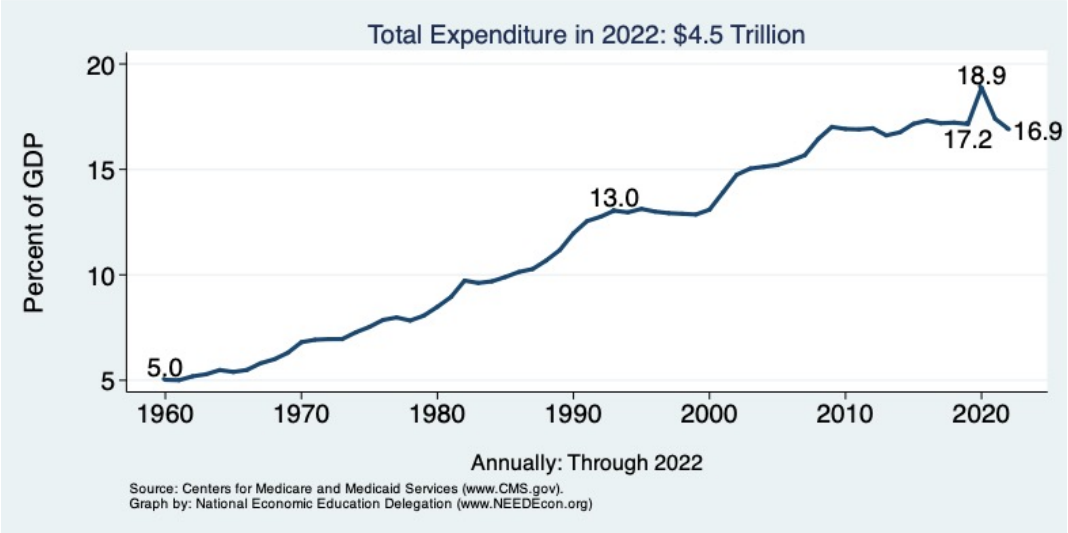
National Health Expenditure as Percent of GDP



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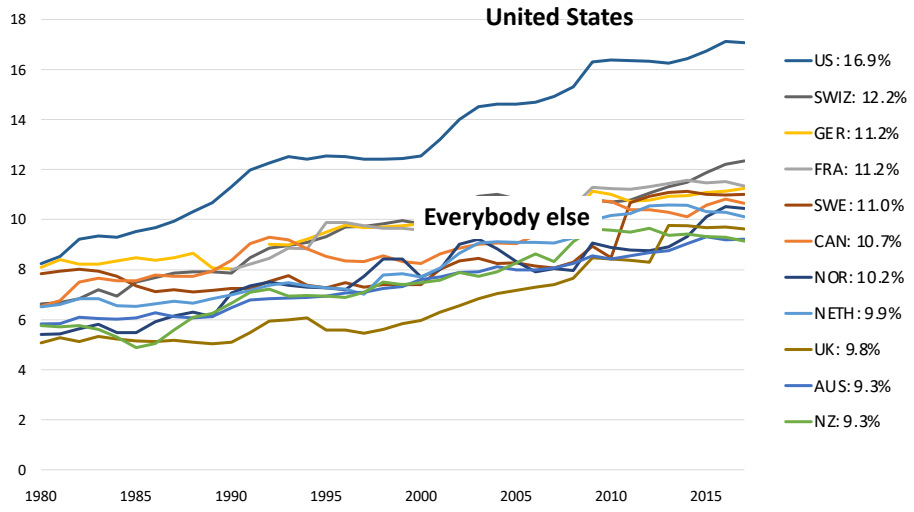
Health Care Spending as % of GDP, 1980–2018



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Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

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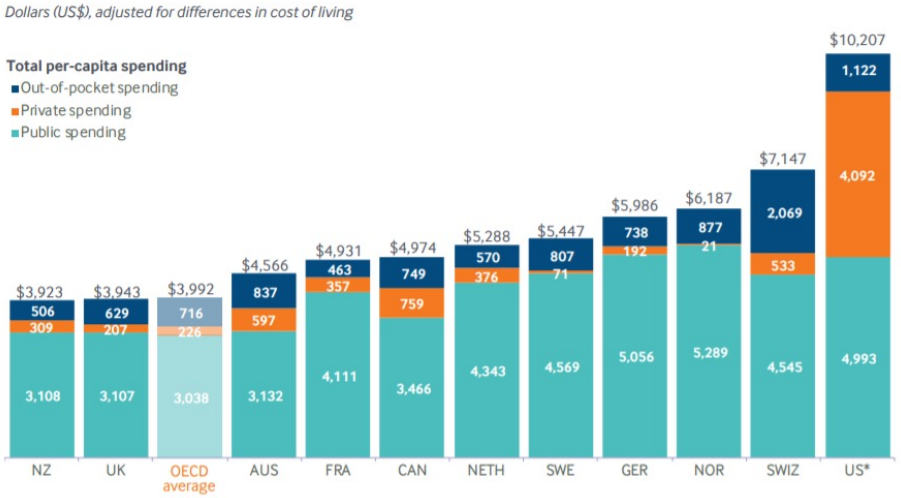
International Per Capita Healthcare Spending



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Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

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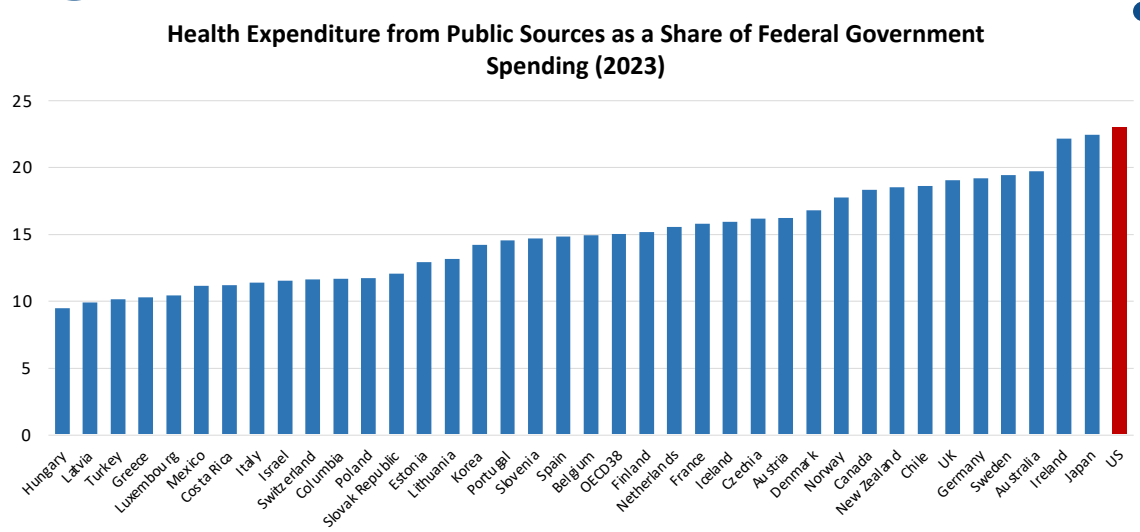
Government Healthcare Spending Share (2023)



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Source: *Health at a Glance 2025* (OECD); graph by NEED

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Why is Healthcare Spending Increasing?

- Costs in the United States, and elsewhere are increasing rapidly.
- The share of economic spending on health care has been steadily increasing for all countries because:
  - Health spending growth has outpaced economic growth.
  - Richer countries demand more services, like attention to health.
- Also because of:
  - Advances in medical technologies.
  - Increased demand for services.
  - Rising prices in the health sector – why?

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Why Are Costs so High in the US?

One Reason:

The United States is the only
profit-motivated healthcare system in the world.

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Why Are Costs so High in the US?

Another Reason:

Our public health system isn't very good.

(We have a health RESTORATION system, NOT a health CARE system.)

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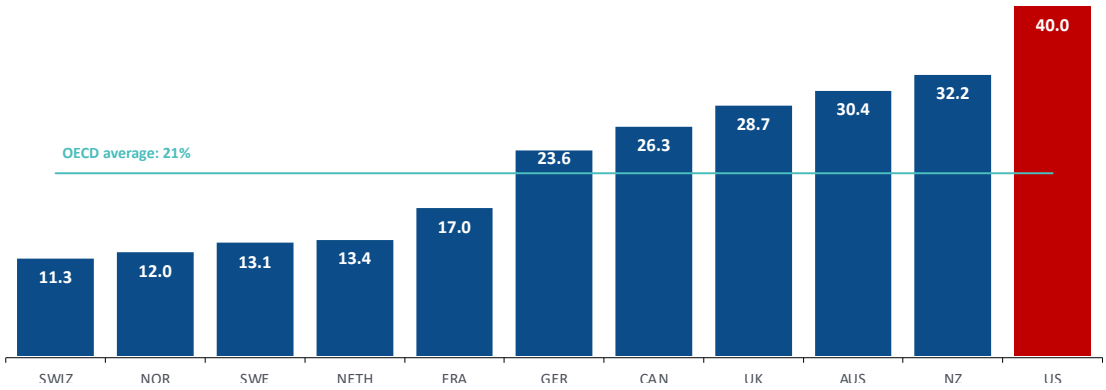
Obesity Rates, 2017

Percent (%)



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Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

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Markets Matter for Costs

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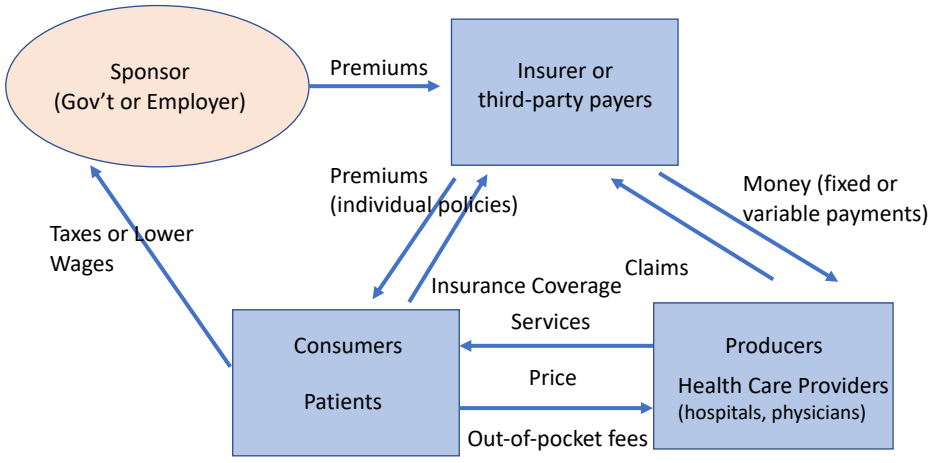
Health Care Markets are Different



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Policy Matters for Costs

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Hospital Monopolization

- Competition in health systems, hospitals, medical groups, and health insurers has DECLINED in recent years.
- Over an 18-month period between July 2016 and January 2018:
  - Hospitals acquired 8,000 more medical practices.
  - 14,000 more physicians left independent practice to become hospital employees.
- Between 1999 and 2018, hospital profit margins soared!
  - From 100% in 1999 to 317% in 2018.

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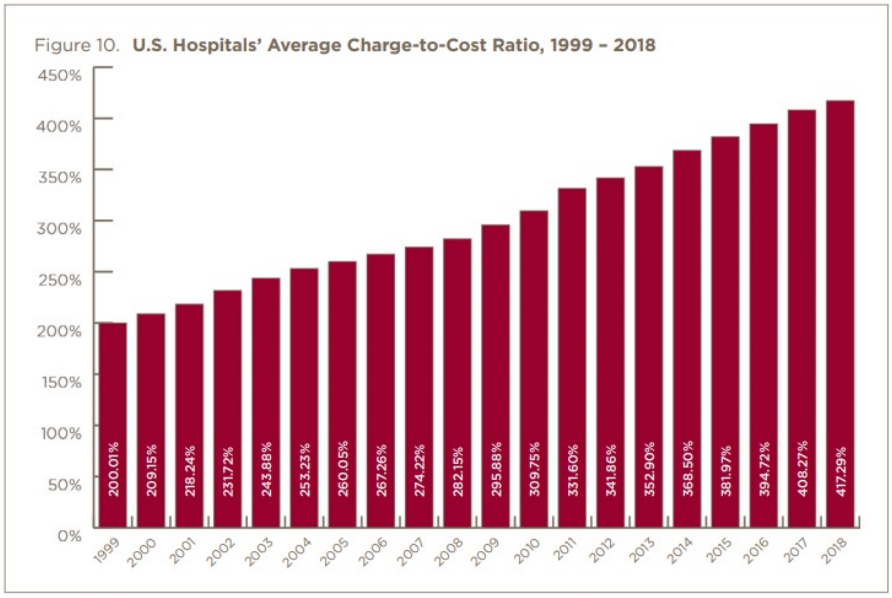

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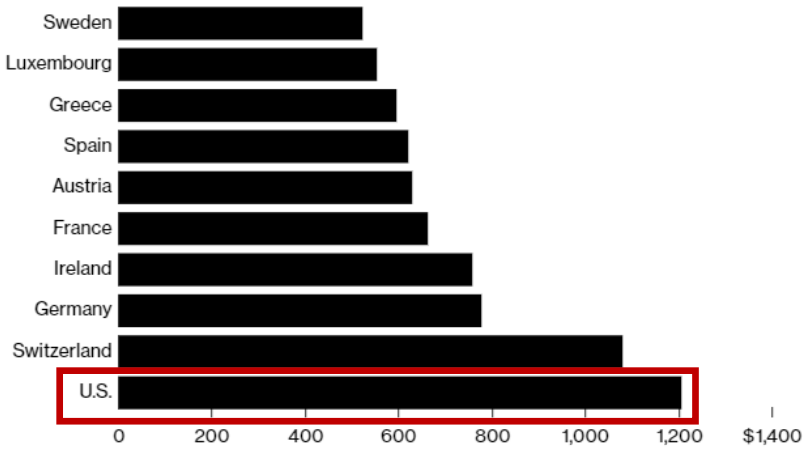
Spending on Pharmaceuticals

Top spenders per capita on drugs in 2016, in U.S. dollars



Source: Organisation for Economic Co-operation and Development

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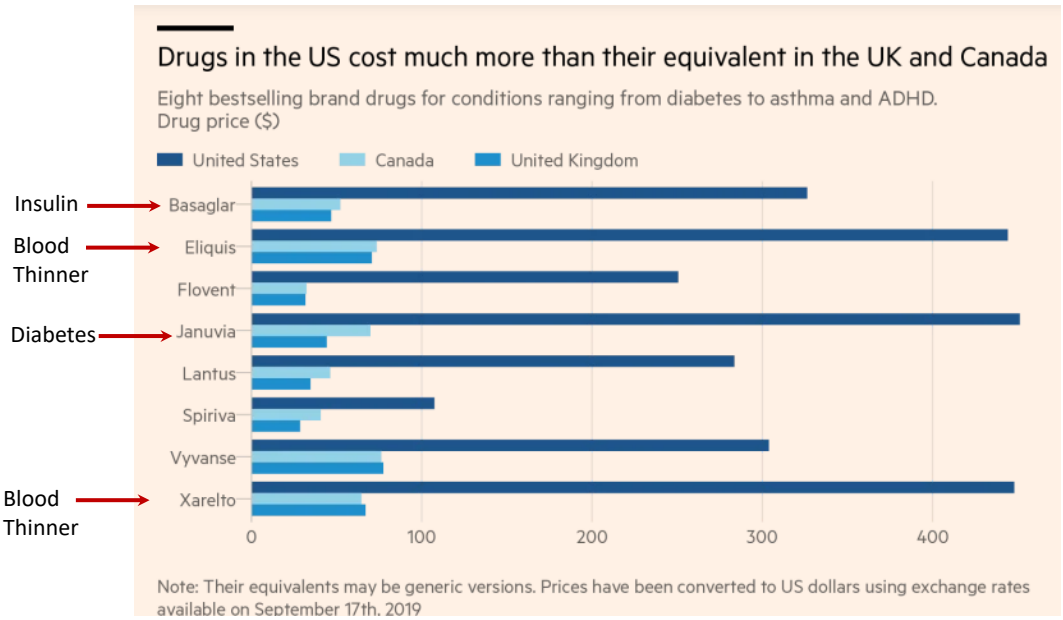

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Reasons for higher drug prices

- **By law**, Medicare Part D was unable to negotiate drug prices like other insurance programs do. The Inflation Reduction Act of 2022 began to change this, starting 1/1/2026
- In 2023, Medicare spent nearly $36 billion on 10 diabetes drugs.
  - Researchers found that if Medicare were allowed to negotiate drug prices like the U.S. Department of Veterans Affairs (VA) can, Medicare could **save about $4.4 billion/year *just* on insulin**.
- Growing concentration of pharmaceutical companies.

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Reducing Medicare Drug Spending

- Under the Inflation Reduction Act (2022), Medicare began negotiating drug prices with manufacturers
  - Beginning January 1, 2026, negotiated prices for 10 drugs were implemented. Estimated savings of:
    - $6 bill/year for Medicare; and,
    - $1.5 billion/year in out-of-pocket savings for participants.
  - Starting 1/1/27, another 15 drugs will see negotiated prices. Then another 15 in 2028 and 20 more drugs per year after that.
- The One Bill Beautiful Bill (2025) included provisions that limit which drugs can be considered for future price negotiations

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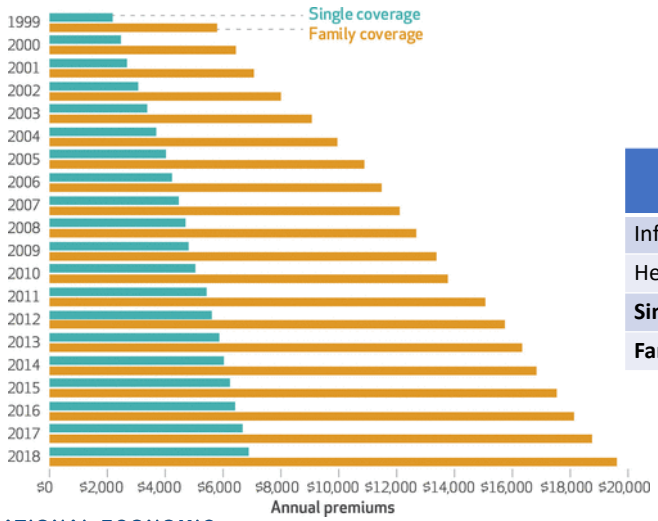
Average Annual Insurance Premiums, 1999-2018

Employer provided, Not Adjusted for Inflation



Single: ~$2,000 to ~$7,000
Family: ~$5,900 to ~$19,500

	Average Annual Rate of Change (%)
Inflation	2.19
Health Care CPI	3.68
Single coverage	**6.51**
Family coverage	**6.52**

Source: The Commonwealth Fund

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Reason for Higher Health Insurance Rates

- Rising prices in the health sector
- Advances in medical technologies
- Increased demand for services
- Decreasing competition in health insurance markets

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Monopolization of Health Insurance Markets

- As of 2011, there were close to **100 insurers** in **Switzerland** competing for consumer health care dollars, **forcing firms to compete** by setting prices to just cover costs.
- In 2019, of the 50 states and the District of Columbia:
  - 21 had only 1 or 2 insurers
  - 14 had 3 or 4, and
  - 16 states had 5 or more. (CA had 11)

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Source: KRR, Number of Issuers Participating in the Individual Health Insurance Marketplaces

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Summary

- US HealthCare system is **not preforming well**.
  - Very expensive with low quality and access.
- One of the main reasons for very high costs is the **monopolization** of healthcare markets.
- **Universal health insurance** would increase access and perhaps also reduce costs.
- Changing the **focus** from maximizing **profits** to maximizing **care** would help.

A Few Simple Solutions Could Reduce Costs

- **Pursue competition in healthcare markets.**
  - Hospitals, pharmaceuticals, insurance.
- **Introduction of a public option in the health insurance market.**
- **Allow the US government to negotiate ALL drug prices**
  - Like most every other nation.
  - Biden administration has started down this path.
  - Trump administration is backtracking.

Health System Classification

- **Developed countries of the world have each taken a different approach for their health care delivery systems.**
- **5 basic models:**
  - Beveridge – socialized medicine (United Kingdom, Spain, New Zealand)
  - Bismarck (France, Germany, Japan, Switzerland)
  - National health insurance (Canada)
  - Out of pocket model – self insurance
  - Mixed (United States)

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US Health Care System

- **Medicare – National Health Insurance**
- **Military Veteran Care – Beveridge model (socialized medicine)**
- **Employer-sponsored insurance – Bismarck model**
- **Individual market health plans – Bismarck model**
- **Uninsured – Out of pocket model**

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Thank you!

Any Questions?

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Health Care Systems and Institutions

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Definition: Universal Coverage

- **Universal coverage –** refers to health care systems in which ***all*** individuals have insurance coverage.
- Generally, this coverage includes:
  - Access to all needed services and benefits.
  - Protects individuals from excessive financial hardships.
    - Medical indebtedness is the #1 cause of bankruptcies in the United States.
- Canada has universal coverage, the United States does not.

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Definition: Single-Payer

- **Single-payer** - refers to financing a health care system by making one entity solely and exclusively responsible for paying for medical goods and services.
  - Not necessarily the government.
- It is only the financing component that is socialized.
  - The money for the payment can be either collected by:
    - Taxes collected by the government.
    - Premiums collected by National or Public Health Insurance.
- **Single-payer systems: 17 countries**
  - Norway, Japan, United Kingdom, Kuwait, Sweden, Bahrain, Brunei, Canada, United Arab Emirates, Denmark, Finland, Slovenia, Italy, Portugal, Cyprus, Spain, and Iceland.

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Definition: Socialized Medicine

- **Socialized medicine** – this model takes the single-payer system one step further.
  - Government not only pays for health care but operates the hospitals and employs the medical staff.
- This has NEVER been a part of the debate in the United States.

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Definition: Third-Party Payer

- A **third-party payer** is an entity that pays medical claims on behalf of the insured. Examples of third-party payers include government agencies, insurance companies, health maintenance organizations (HMOs), and employers.
  - Employer-sponsored health plans
  - Individual market health plans
  - National health insurance

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  - Mixed (United States)

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Model 1: Beveridge

- **In this model, health insurance is paid for through TAXATION.**
  - Everybody has insurance, universal coverage. Everybody receives care at no cost.
  - All providers are public.
  - Supplemental insurance is available in the private market.
  - Similar to public libraries and police forces.

- **Pros:**
  - Universal coverage.
  - Government controls quality of care, so cost of care may be low.
  - No medical bills or co-pays.

- **Cons:**
  - Taxes are high, regardless of use of healthcare.
  - Government controls quality of care, so service availability might be low.
  - Longer waiting times for non-emergency care.
  - Potential for excessive use of the system.

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https://www.ahaap.org/beveridge-model

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Model 2: Bismarck

- **In this model, health insurance is paid for through PREMIUMS.**
  - Everybody must have insurance, only poor don't have to pay premiums.
  - Premiums are paid into the "gov't sickness fund" or directly to private insurers.
  - All insurers are private, but can't make money off the sickness fund.

- **Pros:**
  - Everybody is covered and can avoid expensive healthcare bills.
  - Administrative costs are much lower than in the U.S.
  - Little waiting time to receive basic services.

- **Cons:**
  - Focus on low costs can mean fewer services are available in rural areas.
  - Mandatory premiums are high.
  - Longer waiting times for elective services.

https://www.ahaap.org/bismarck-model

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Model 3: National Health Insurance

- **This model has elements of both Beveridge and Bismarck.**
  - Like Beveridge: government is the single payer and paid for through taxes.
  - Like Bismarck: All health-care providers are in the private sector.

- **Pros:**
  - Lowers the cost of healthcare for the economy – bargaining power.
  - Low administrative costs for care.
    - No incentive to deny claims.
  - Healthier workforce.

- **Cons:**
  - Everybody pays regardless of health care received.
  - May stop people from being careful about their health.
  - Limits payouts to doctors.
  - May affect technology adoption.

https://www.ahaap.org/national-health-insurance-model

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US Health Care System

- **Medicare – National Health Insurance**
- **Military Veteran Care – Beveridge model (socialized medicine)**
- **Employer-sponsored insurance – Bismarck model**
- **Individual market health plans – Bismarck model**
- **Uninsured – Out of pocket model**

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