



IS THERE REALLY A CRISIS IN HEALTH CARE SPENDING?

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Health care analysts are fond of saying that one-third of health care spending is unnecessary or wasteful—the problem is finding out which third. As an extension, one can add the problem of whose third. I certainly don't want to see my third eliminated and I suspect neither do most of you. Younger generations and those who have not yet faced a life-threatening illness might be tempted to suggest that significant savings could come from the roughly 25 percent of Medicare expenditures that are incurred in treating those in the last year of their lives (Hogan et al., 2001). End-of-life care has received considerable attention, and national health insurance programs found in other countries have sometimes introduced explicit rationing rules for treating the elderly.¹ Aside from the many moral, ethical and legal issues surrounding such decision rules, especially for end-of-life care, there is one additional major hitch. No one has yet figured out how to accu-

¹ For example, some cardiac care and cardiac rehabilitation units under the United Kingdom's National Health Service have explicit upper age limits. Less formal age limits have been claimed for coronary artery bypass, hip and knee replacement, and kidney

rately predict who is going to live less than one year whether or not costly or heroic measures are taken.

Unfortunately, there are no simple or obvious ways to control health care prices and utilization rates. Despite many innovations and reforms since the 1970s, most notably through the spread of managed care and prospective forms of reimbursement, annual health expenditures currently exceed \$6,000 per-capita. Forecasts by the Centers for Medicare & Medicaid Services project a health economy that will represent nearly 19 percent of GDP by 2014, up from the 15.4 percent expected for 2004 (Heffler, et al., 2005). Although many business and political leaders are alarmed by these trends, the reality is that more spending on health care, whether measured in inflation-adjusted dollars or through its share of GDP, is inevitable. Since the end of World War II, real per capita spending has grown at an average annual rate of about 4 percent, compared with 1.5 percent for real per-capita GDP.

Mathematical extrapolations suggest that a 2.5 percentage point gap cannot be sustained indefinitely or health care would devour most of our incomes well before the end of this century. Even if we were to reduce the annual gap to just one percentage point, a monumental achievement by historical standards, Chernew and colleagues (2003) estimated that expenditures would account for 38 percent of GDP by 2075. But, we do not even have to look that far into the future before the financial implications of a one percentage point gap become apparent. The authors showed that health expenditures would take up nearly 50 percent of the increases in our incomes over the period 2010 to 2050.

As unpalatable as this prognosis seems to be, there are several reasons why health expenditures will rise more rapidly than incomes, and thus leave us with relatively less to spend on other goods and services. The sources go well beyond the aging of the population which, although a major determinant of the level of spending, is not the major factor in its growth rate. Also, contrary to some arguments, the labor intensive nature of health care is not the major cost driver. Barring un-

usual growth of productivity, the prices of labor intensive products tend to rise relative to the prices of other goods. This phenomenon results from the fact that, over the longer term, wages in low productivity growth occupations have to keep up with those elsewhere in order to retain and attract workers. Without large productivity effects to help offset higher wages, members of the OU community should not be surprised to find tuition rising in real (inflation-adjusted) terms, and to find rising real prices for most other services, including medical care.

Even though much higher rates of productivity in health care cannot be ruled out, especially through more widespread and better applications of information technology, the main drivers of rising utilization are new health care services and rising incomes that fuel their demand. Unlike production of many other goods, where technology often leads to new, better and less costly products (electronics and telecommunications are two prominent examples), new technologies in health care have tended to increase costs. Cost-reducing innovations, such as those for cataract surgery which at one time required a lengthy hospital stay, have been overwhelmed by cost-raising technologies where new procedures are often more expensive than the treatments that they have replaced. Even if they are not more expensive, the utilization rates of the new procedures can increase dramatically, driving up overall costs. Cardiac care and prescription drugs illustrate these phenomena. The former includes the development and proliferation since the 1950s of a variety of surgical and imaging procedures (e.g., coronary artery bypass, heart transplantation, angiograms) that were unimaginable to previous generations. Technologies that have more recently come on line include the ventricular assist device at \$150,000 (for patients who are not heart transplant candidates) and the implantable cardioverter defibrillator, which has a potential reach of 2 million patients (Callahan, 2003). As for prescription drugs, the introduction of new, more expensive drugs has certainly been a factor. But it is the rising utilization rates that have made the

prescription drug sector the most rapidly growing component of the health economy.

These developments are closely connected to the second major driver of health expenditures—rising incomes. With higher standards of living, and its unwillingness to support policies that explicitly ration care, Americans appear to value more and better health care and are willing to pay for it including the research infrastructure that produces innovation. Recent scholarly research provides evidence of the relatively high benefits provided through the new medical technologies (Cutler, 2004). Clearly, there are inefficiencies, perhaps substantial, in health care delivery. Clearly, also, there is a continuing need for well-structured programs to reduce inappropriate care and ensure greater value. As such, there is an important role for evidence-based medicine and for other mechanisms that provide both provider and patient with incentives that are consistent with this effort.

As the search for effective and equitable reforms continues, President Bush is using his political influence to support new forms of health savings accounts (HSAs) as part of a market-based, consumer-driven approach to health care delivery. This strategy promotes high deductible insurance and other features that enable consumers to take greater control over their health care dollars and spending decisions. By empowering consumers, the President envisions a more competitive system in which savvy, cost-conscious consumers restrain the power of providers in order to reduce questionable services and keep fees low.

This approach is not without some appeal; nevertheless it will at best enjoy limited success. A decade of experience with medical savings accounts (the forerunner to HSAs) suggests that the number of patients in HSAs is never going to be high enough to have a major impact on national expenditures (state and federal government programs alone account for 46 percent of total spending and they are not impacted by HSAs). Even if larger numbers of households are attracted to these plans, the highly skewed distribution of spending will se-

riously limit their effectiveness. In any year, just 10 percent of the population with more serious illnesses accounts for 70 percent of health expenditures (Berk and Monheit, 2001). These patients are well beyond the point where deductibles or other financial incentives can have a major influence on their decisions.

Finally, and this is a serious concern to some critics, because HSAs are more appealing to younger and healthy employees, their growth can create serious adverse selection problems that leave older and sicker workers in increasingly expensive insurance pools. Thus, if they were to become prevalent, the greatest impact of HSAs would be to shift the burden of financing care rather than to improve the use of health care resources. The bottom line is that, for the foreseeable future, there is no magic bullet that could significantly alter the course of health care spending, even though some policies can shift the burden.

If more and better health care is highly valued, and we seem willing to pay for it, where is the crisis? In particular, are we losing jobs and becoming less competitive on account of rising health care costs, as commonly suggested by the popular press? The answer has to be an emphatic “no.” The United States spends twice as much per capita on health care compared to many other industrially advanced countries, but it has also enjoyed low unemployment rates as well as robust growth of GDP. Employer-provided health benefits are part of compensation and thus of our incomes: health care spending is a reflection of how we decide to use our incomes. It can be misleading, to single out a specific component of total compensation as the villain that needs to be controlled.

If this is the case, what should we make of reports indicating, for example, that health care added about \$1,500 per vehicle for General Motors in 2004, with 70 percent coming from legacy costs? To put this in perspective, Toyota’s figures are about \$200 per vehicle. Is this discrepancy a major factor undermining GM’s competitiveness? As the largest private health care provider in the United States with over 1.1 million

beneficiaries, the competitive disadvantage for GM appears to be especially acute when compared to auto makers in countries with publicly funded national health insurance. In an interview for the Wall Street Journal, Rick Wagoner, GM's CEO, made his position very clear. He stated that while GM was not in a crisis, the "health care cost situation is a crisis. It's by the way, not just a crisis for General Motors . . . it's a crisis for the economy" (Hawkins and White, 2005).

Although Mr. Wagoner's conclusion seems plausible, and has considerable support from the media (e.g., Zakaria, 2005), the underlying issues are anything but obvious or straightforward. Unexpectedly high legacy costs for GM represent a major transfer of income from shareholders to retirees and other recipients. The magnitude of this transfer cannot be sustained indefinitely so that contracts will be renegotiated or other changes affecting worker compensation will have to be made. However, legacy costs are fixed costs which, as every student of basic microeconomics knows, do not influence current pricing decisions. In other words, GM's prices would not go down and GM would not become more competitive were its legacy costs reduced. Auto industry experts (e.g., Flynn and McManus, 2005) have, in fact, stressed that GM's problems are more closely rooted in other factors such as organizational complexity and the deterioration of market share due to questionable product quality and styling. As for the possibility of national health insurance becoming a savior for firms like GM, and leaving aside the formidable political obstacles to its implementation, it is not immediately clear how federally funded health care would affect auto workers and others in high wage occupations. Under progressive tax schemes, high wage workers could ultimately pay more through taxes for health care than they currently pay through their fringe benefits.

In my judgment, the "crisis" is largely one of perception and adjustment to change. Employees have tended to view health care as a free good, even though it is not, paid with employer dollars, even though it is really paid with employee dol-

lars. At lower health cost levels, employers and unions were able to manage the premium increases while still providing reasonable wage increases. At higher premium levels, this balancing act has become much more difficult, especially for firms facing increased global competition, and especially for those with high legacy costs. For example, an 8% premium increase amounts to \$400 when the employer is contributing \$5,000. At \$10,000, or considerably more per employee for some organizations, the same 8% results in a much higher dollar premium increase.

The result is inevitable, whether at GM or at OU: higher employee contributions for health care as well as lower wage increases than would otherwise be the case. In fact, real wages in the United States actually dropped by 0.5 percent over 2004, the first such drop in a decade (Greenhouse, 2005). Although it is not clear whether the rise in health costs was the principal contributor to this drop, it is clear that employers and employees are now in an unaccustomed position with increasingly difficult choices to make because the financial consequences have grown so large. But this process only mirrors the larger decisions that we, as a nation, must make. As health care accounts for a larger share of GDP, any relative increase in spending on health care has a disproportionate adverse impact on what is left over. With so much at stake, it is not surprising to find policymakers, business leaders, and the media as seeing a “crisis” in the system. However, it is how we deal with the trade-offs that drives our concerns and this, in and of itself, is not a crisis.

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