Chapter Three

The Realities of the Growth in Medical Spending

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Introduction

Spending on medical care in the United States has grown in real terms, year in and year out, for as far back as we have data. Although there are brief periods of modest differences, growth has been very similar for private and public sector spending over the long term. The woefully misnamed "health care cost inflation" is usually cited as a major reason for the need to make fundamental changes in the health care system. (It is misnamed because the data do not measure cost and the reason for growth is not inflation.) Is the growth in this category of consumer spending a prima facie reason for concluding that current arrangements are deficient so that changes capable of producing improvement (by some definition) are needed? Are we even sure that it is an improvement to slow spending growth? I will attempt to help answer these questions by undertaking two tasks: first, to explain, at several levels, the reasons why real medical spend-

ing has increased; and second, to offer such evidence as exists on the normative judgment of whether increased spending for those reasons implies that there are feasible reforms that can improve matters. That is, I want to discuss whether the effects of higher real spending are negative for some or all of the population and, if they are, whether there is something that could and should be done about it.

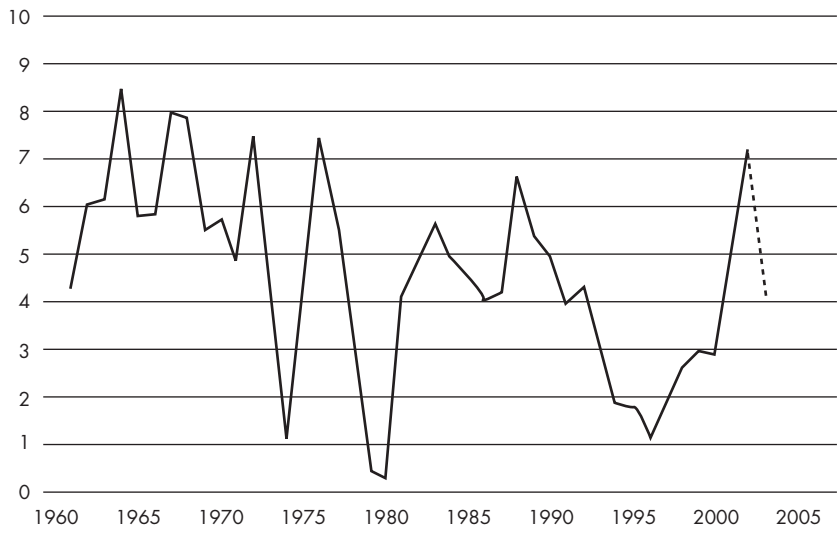
What Do We Measure and What Do the Data Show?

I will rely on the "official" measures of medical spending provided by the Center for Medicare and Medicaid Studies' Division of National Cost [*sic*] Estimates.[1] According to these data, expenditures on per capita personal health care in both nominal and real (deflated by the gross domestic product [GDP] deflator) terms has almost always grown but at varying rates. As figure 3.1 shows, total real spending growth rates have historically fluctuated substantially around a trend of 3 to 4 percent a year. The figure also shows that the upsurge beginning in 1999, far from being atypical, is in the range of previous fluctuations and generally repeats the conventional pattern of high growth. Only the most recent (2002) data are much above trend (although there have been many such observations before) and that is due to some extent to a dramatic drop in the general price index (to 1.1 percent annually). There is nothing in these data to indicate that the current period is unusual, and evidence is starting to accumulate that spending growth is headed down again, judging from the recent results for two large private insurers (Aetna and Cigna) and from the demonstrated slowdown in hospital spending growth beginning in 2003.[2] Even so, real growth at 4 percent gener-

1. K. Levit et al., "Health Spending Rebound Continues in 2002," *Health Affairs* 23 (January/February 2004): 147–159.

2. P. B. Ginsburg, "Hospital Spending," *Health Affairs* 23 (January/February 2004): 273; B. C. Strunk and P. B. Ginsburg, "Tracking Health Care Costs: Trends Slow in First Half of 2003," *Center for Studying Health System Change Data Bulletin* 26 (December 2003).

Figure 3.1 Real Annual Rates of Total National Health Expenditure Growth Per Capita, 1961–2001



2003 data (shown in dashed line) based on the CMS projections; the CPI growth is estimated at 2 percent.

ally exceeds real growth in GDP so that the ratio of medical spending to measured GDP generally rises.

Some policymaker comments on these data: "Personal health care spending" differs from "national health expenditures" mainly in excluding the difference between insurer premiums and benefits, which in turn represents both insurer administrative expense and insurer profit. Spending estimates are based on the estimates of revenue flows gathered from various sources so that there is some error in measurement; although the magnitude of total spending is probably accurate, the estimate of changes in any one pair of years for any specific expenditure item is not totally reliable (and is in fact often revised after the release of data). A blip of 1 percent in the measured growth of spending may not be real. The measure of private insurance benefits (and premiums) is probably one of the least reliable numbers.

Some economist comments on the data: These are the measures of *revenue* received for medical goods and services; they are *not* the measures of cost to the economy. The revenue goes in large part to cover the true (opportunity) costs of the inputs used to produce those products, but it also goes to profits (for firms) and rents (for health personnel). Thus, if spending rises because more smart young people are drawn from doing other useful tasks in the economy into providing medical care, the real opportunity cost that the country as a whole pays is positive and equals the value of those other foregone tasks. In contrast, if spending rises because drug company profits or nurses' wages rise, with no change in the number working, those suppliers gain what consumers lose; the cost does not change, and the only effect is a transfer among Americans. This distinction between costs and transfers will be important later.

Why does spending rise? There are several ways to seek clues to answers to this question. One way is to see to whom the additional money goes, who receives it. Another is to see what (if anything) the additional money buys. A third is to see why people choose to buy those things. I will pursue all three strategies in this paper and then try to put the clues together to yield both explanation and evaluation.

Decomposing the Growth in Spending

It is traditional to try to decompose the growth in spending into two parts: the growth in input prices and returns (including changes in the profit on equity capital and rents on inputs in limited supply) and the residual (which is left over). The residual captures any change in the quantity of care (of various kinds), any change in the quality and kinds of care, demographic changes that influence the quantity of care demanded, and any change in the technical efficiency of production. It also represents payments to added inputs rather than just higher payments for inputs that were already there.

Figure 3.2 shows this decomposition for recent years for total health care; table 3.1 provides the basic data.

Some recent data on hospital spending (in table 3.1 and figure 3.3) may help illustrate what typically goes on and what inferences we can draw about it. There is a little drama here: hospital spending is the largest single share of total medical spending, but for most of the past decade it has grown at rates much lower than total medical spending. Then, suddenly and surprisingly, in the late 1990s hospital spending growth reawakened, at least for a while. What do we know about what happened and who got the money?

One way to view the growth in hospital spending is in terms of the "uses" of the added funds that spending represents. More than 60 percent of hospital spending is for labor, and a substantial fraction of its allocation to other services, such as laundry and prepared foods, represents the labor of workers, although workers not directly employed by the hospital. In contrast, direct capital expense for the plant and equipment is generally less than 10 percent of hospital accounting costs. Finally, payments for profits (for investor-owned

Figure 3.2 Shares of Real NHE Growth

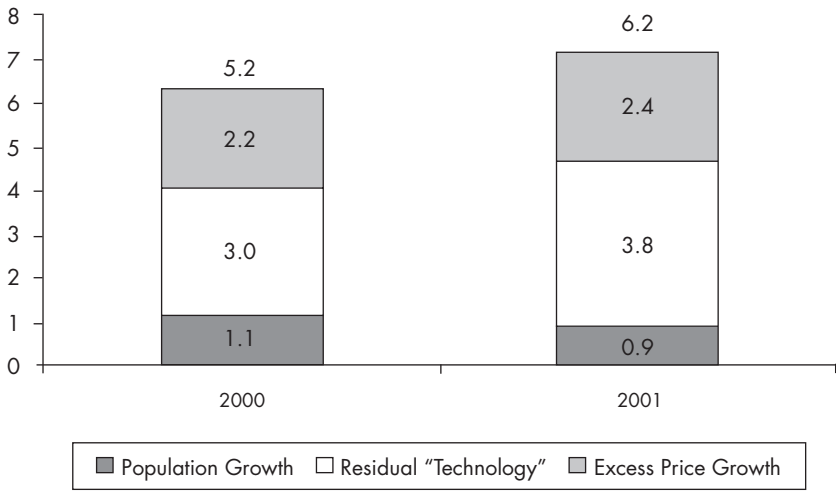


Table 3.1 Health Care Spending and Employment: Annual Rates of Growth

	1999	*2000*	*2001*	*2002*
		ALL NHE		
Nominal NHE	5.7	7.4	8.5	9.3
Nominal PHE	5.2	6.9	8.5	8.8
NHE Deflated by GDP Deflator	4.2	5.2	6.0	8.1
NHE Deflated by HC Price	2.8	3.9	4.8	NA
NHE Deflated by HC wages	2.6	3.0	3.6	NA
Employment (FTE) (Health Services)	0.6	1.9	3.4	2.9
		Private Hospital		
Nominal Spending Rev.	5.8	7.1	10.4	10.0
Nominal Spending Exps.	4.3	6.5	9.7	9.8
Spending Deflated by GDP Def.	3.3	4.9	7.8	7.4
Spending Deflated by ECI	2.6	3.0	4.7	4.6
Adj. Days	1.6	8.1	2.2	1.8
Employment (FTE)	1.1	0.4	2.9	3.3

NHE: National Health Expenditure; PHE: Personal Health Expenditures; GDP: Gross Domestic Product; HC: Health Care; FTE: Full-Time Equivalent; ECI: Employment Cost Index.

Figure 3.3 Shares of Real Hospital Revenue Growth

hospitals) or net revenues (for nonprofits) are only a tiny fraction of the total, never even approaching 5 percent. So, in a rough sense, this change in hospitals' spending can be broken down into three parts: the change in (mostly labor) input prices, the change in the volume of inputs (again, mostly labor), and the change in net income (profit). If we use the average (hours adjusted) change in wage rates as a rough measure of input prices, figure 3.3 shows the decomposition of spending growth into these categories.

What are the normative implications of each? The change in wage rates is easiest to characterize: it represents (in the short run) a transfer to labor that might be related to a change in labor's opportunity cost (wages available elsewhere). This is not necessarily a cost to the economy, or at least not as large an increase in true cost as is the increase in spending. The change in labor quantity definitely has a cost: the cost is the value of the output that new labor could have produced if it were used elsewhere. Finally, the interpretation of the change in net income depends on the kind of hospital ownership. If it is investor-owned, higher profits are a transfer to investors. If it is nonprofit, the questions are what those profits will be used for and what the value of that use is.

A significant fraction (but less than half) of the recent growth in household spending is a transfer from consumers to hospital workers. How this transfer is evaluated depends in large part on who one thinks is more deserving of higher real income. However, if the reason for rising wages is a larger quantity of labor demand pressing on a more or less fixed supply curve, such normative judgments may not matter much; no one would want to deny higher wages to nurses just because there was a shortage of nurses. Higher transfers to stockholders (profits) might be viewed differently in the average person's value judgment, but the net income of hospitals is generally not a large part of rising spending, as it was not in these years. The category of spending most relevant for a normative judgment about effi-

ciency is the approximately 60 percent of spending growth accounted for by hiring more workers.

The main economic question is not one that most people would ask. It is not whether these hospital workers "need" jobs or whether they are getting better jobs (for which the answer is yes on both counts) but whether whatever these new workers will be doing in hospitals is of greater value to all consumers than whatever else the workers would have been doing. Obviously, if the new workers do not enhance either the quantity or the quality of hospital output, this is pure waste: any positive cost for something useless is wasteful. If there is unemployment, or unionization, it may be hard to know what the true opportunity cost of these workers is. If the workers do increase output or quality, the question is one of the value of that output.

For total health care spending, figure 3.2 gives much the same story. Excess (over economy-wide) price growth represents a significant fraction of spending growth but is less than that attributable to the residual "technology."

From the viewpoint of the welfare of all Americans, the changes in wages, prices, or profits are largely zero-sum. Since almost all inputs into health care are produced with American labor (this is true even of many nominally "foreign" drug firms that do the bulk of their research and production in the United States), the only difference transfers make to the economy is whether the donor or receiver saves and invests more, thus fostering growth in total national income. In contrast, the analysis of the desirability of drawing yet more labor into this sector turns on relative valuation, a subject to be discussed in more detail below. Finally, the desirability of higher "nonprofit profits" also depends on the comparison of benefits with opportunity cost, a comparison often to the disadvantage of nonprofit hospitals.[3] The usual resource misallocation that arises when

3. S. Nicholson et al., "Measuring Community Benefits Provided by For-Profit and Nonprofit Hospitals," *Health Affairs* 19 (November/December 2000): 168–177.

prices exceed marginal cost is likely to be relatively small because medical demand is inelastic and insurance is present.

What Kind of Output Do We Get?

So the reality is that the bulk of medical spending growth represents new resources flowing into this sector, associated with a statistical residual that we label (for want of better information) "technology" or "quality." If more inputs are diverted to the medical care sector, what do they do? In the hospital example, we have a rough-and-ready measure of quantity in the form of "adjusted" patient days (in which outpatient visits are converted into inpatient day equivalents based on relative prices[4]). We can then divide the change in spending in a different way: into a change in quantity and (as a residual) a change in what is literally input intensity per unit of output, often called "quality" (but that could also be called "new waste," depending on what the inputs went for). As the table shows, controlling for input prices, this "quality" measure is more important than quantity and quantity and quality together are more important than wages. As luck would have it, however, this quality is hard to measure and even harder to evaluate.

Several categories in this component are possible and are used (often inconsistently) by analysts. First, there may be changes in staffing required by regulation or undertaken in response to a perceived greater malpractice threat. Of course, such regulatory-compulsory sources do not preclude the possibility that the quality change is highly valuable. Indeed, such an assumption would be nearly a necessity if the regulation or liability were itself to be desirable.

Next, there may be "new technologies" in the commonsense

4. For instance, if the average charge for a visit is one-tenth the average charge per day, ten visits equal one day.

view of new patented inventions. Most entries in this category are pharmaceutical, but there can also be new devices (coated stents) or instruments (lasers). Yet if the technology itself is at first embodied in a physical product, or piece of equipment, its contribution to employment growth often depends on its use of complementary labor.

But the use of labor in new ways (without new machines or tools) to produce more effective output may also represent new technology. For example, the hiring of discharge planners whose advice improves patients' postdischarge quality of life represents a change in the way inputs are applied to output.

The real controversy arises with the valuation of this technology. Cost-benefit and cost-effectiveness analyses could establish this value but are presently limited in what they can do and how seriously they are taken. They have an especially hard time if the benefit is positive but small relative to the cost, exactly the "close calls" that might be debated as things that should or should not be done. As before, some of the evaluation will apply to the question of whether to use a new technology at all, and some will apply to how intensively it should be used, in the aggregate, and in patients with specific characteristics. I will further review below what (little) we know about the answer to the valuation question.

A second approach to decomposing spending growth is to attribute it to specific causes. The easiest call to make here concerns the effect of population. Population growth, which occurs these days at annual rates of 1 percent or even a little less, should (one might assume) increase spending by an equal percentage amount. Another commonly cited cause is the change in the age distribution of the population. As the population ages, that would seem to call for higher levels of spending. The actual annual magnitude of this effect at present is small, only about one-half of 1 percent or less. However, if we compare geographic areas (countries, states, counties) with varying proportions of older people, there is no strong evidence that a larger proportion of older people is associated with a higher level

of spending or use. So while the old always use more care than the young do, apparently the system as a whole sometimes makes a downward adjustment in the average spending level at all ages to offset increases in the proportion of older people. The process by which this happens is a mystery.

Even if we adjust for these demographic changes, we can account for at most about 1.5 percent of real medical spending growth. Taking out the 2 percent due to higher input prices, that leaves about 2 to 2.5 percent a year as a residual, representing (definitionally) "more real inputs per capita, age adjusted." What is this, and what is it worth?

The usual explanation, and the one I generally agree with, is that this residual reflects the costly but beneficial new technology already mentioned. But there is no necessity that such technology be invented or, if it is, that it be adopted or, if it is adopted, that it take so costly a form. That is, consumers need not necessarily demand this new technology just because it has been invented. Why do they do so, and why do they do so to the extent that they do? Whatever the value of costly new technology, why do consumers (and insurers on their behalf) demand it and then pay for it?

We have only some crude answers to these questions. At the most fundamental level, it is clear that human beings seek to live longer lives with high physical quality of life. Avoiding death, discomfort, disability, and even disfigurement is a good for which people are willing to pay the cost, that is, to sacrifice other goods that they value. But the fact that there is a high demand for health, broadly defined, only means that people will spend money on medical care, not that they will spend more money every year.

But they may be induced to spend more in the current year if there is a change in technology that allows them to buy additional health at a lower price than was available in the previous year. And if the demand for health is sufficiently price elastic, they may spend more in total at this lower price.

Take the extreme case of a serious disease (e.g., multiple sclerosis or Alzheimer's) that is initially untreatable in any serious way. One could say that the price of improving health is infinite, or nearly so. When the price is so high, people choose to spend nothing. The marginal value benefit or value from prospective improvement in health is quite high, but the price is higher still; there is no point in spending anything. Now let technology invent (as it has) a moderately effective treatment, perhaps one that only slows the progression of the disease. People may prefer to spend for this treatment (rather than for other things), and, if the treatment is a patented product, the price they will be charged will be high if their marginal valuation is high. If the technological change is effective enough, and if there is no patent protection, new technology can help spending fall: this has been the case for infectious diseases like polio and syphilis. But the patented "halfway" technologies (to use the term suggested by Lewis Thomas) that we usually see invented are not of this kind. And if technology cuts the cost per unit of treating a disease but also substantially improves the quality, the effect of higher quality may so increase the quality demanded that total spending rises. We think that is the case for laparoscopic surgery, at least initially.[5]

I think that these ideas help answer a question (and implicit criticism) of technological change in health care that is often posed. "Why is it," critics want to know, "that technological change reduces cost for things like computers and chicken but not for medical services?" One answer is that the demand for the underlying "commodity" people seek is less price elastic for these other things; I do not want that much more food because it is cheaper, but I do want more health if its price falls from infinity. That certainly seems true for the quantity of foodstuffs (as distinct from the quality, which may not always be improved by hybridization or factory farming). The other answer is that some of those changes represent the "full

5. A. P. Legorreta et al, "Increased Cholecystectomy Rate after the Introduction of Laparoscopic Cholecystectomy," *Journal of the America Medical Association* (September 22, 1993); 270 (12): 1429–1432.

way" technology, which reduces the price of doing almost anything to something close to zero, as is the case with the PC-Internet combination.

The economist William Baumol has provided another explanation.[6] He argues that, relative to manufacturing and agriculture, the possibilities for improving productivity in services like health care are more limited. The rising productivity in those other sectors, translated into higher economy-wide wages, means that the relative prices of services will rise. If demand is inelastic, total spending and the share of measured GDP will rise too. We could have a lower rate of growth in medical spending, by this argument, if we could squelch productivity improvements elsewhere in the economy.

So what is the value of new technology? The work of Cutler and McClellan and others is definitive here: for expenses for heart and circulatory disease, the benefit in the money value of improved health dwarfs the increase in real cost.[7] It even exceeds by a substantial margin the increase in total spending. Higher spending is "worth it" in that case.[8] But we do not know the aggregate value of spending increases for all diseases. More important, we do not know whether we would have gotten 80 percent of the benefit for 20 percent of the cost, and then whether the remaining 20 percent of the benefit was worth its cost.

What Will Happen to Spending Growth? Will It Continue to Explode?

The current rate of real growth in medical spending resumes the pattern and level that occurred before the managed care transition in

6. W. J. Baumol, "Macroeconomics of Unbalanced Growth: The Anatomy of Urban Crisis," *The American Economic Review* 57 (June 1967): 415–426.

7. D. Cutler et al., "Pricing Heart Attack Treatments," in *Medical Care Output and Productivity*, ed. D. Cutler and E. Berndt (Chicago: University of Chicago Press, 2001), 305–362.

8. D. Cutler and M. McClellan, "Is Technological Change in Medicine Worth It?" *Health Affairs* (September/October 2001): 11–29.

the mid-1990s. The public sector rate has been lower largely because Medicare does not cover prescription drugs. The overall rate is close to the rate for earlier periods, although there is considerable fluctuation. At least it is in a range that we have often seen before. At this level, there is nothing new. Its slight excess also has a precedent: periods of low growth are usually matched with equally long periods of unusually high growth. In short, at the level of aggregate data, it appears to be business as usual, not the end of the world.

One place with much above-average growth appears to be private health insurance. This insurance (in contrast to Medicare) does cover costs for outpatient prescription drugs, and those costs are growing at a rate that has receded considerably from its 1999 peak but is still above average.

The year 2002 is the last for which we have actual official aggregate data, but some more current data have recently raised sustained concern. One is the answers employers give to surveys asking about their projected health benefits costs. Few employers covered by risk-bearing insurers will pay the premium charged, although experience rating means that there could be reductions or add-ons next year based on what actually happens. But the bulk of employees are covered by self-insured plans, whose insurance costs cannot be known until the year is over and claims have all come in. Employers may change coverage or insurers to reduce actual costs. So I expect actual premiums to rise by less than the 12 to 13 percent that has been forecasted and to continue to slow for the next five years, as does the official estimate provided by the Centers for Medicare and Medicaid Services (CMS).

The most reasonable projection, I believe, is that medical care will continue to take a bite out of increases in the economy's productivity and the citizens' real income that is moderately disproportionate to the growth in income, but surely not so much so that the growth in income spendable on other things will decline.[9] A rough

9. D. Cutler, M. Chernew, and R. Hirth, "Increased Spending on Health Care: How Much Can the United States Afford?" *Health Affairs* 22 (July/August 2003): 15–25.

calculation from relatively recent data is that the "marginal propensity to spend" an increase in total compensation on health care is about 0.2.[10] That is, the average American who gets a 5 percent raise seems to want to spend about 1 percent of that on medical care. At least for the foreseeable future, then, medical care spending will grow in real terms at a moderately rapid rate and the share of GDP (and productive imports) being used for medical care will grow modestly, topping out at around 20 percent. Things won't go on like this forever.

What we do not know, however, is the vehicle by which this slowdown will be brought about (nor do we expect that it will proceed in a tidy fashion). What we do know is that the growth that nevertheless does materialize will be, on balance, a good thing, representing choices by rational people to take a large minority of their increased real income in the form of enhanced quantity and quality of life. Health will be chosen over potatoes, shirts, and even housing because additions to it are valued more than what the same money could buy, or the same resources could do, if applied to something else.

The problem then is not the prospect of this kind of medical spending growth. I believe it is feasible, proper, and rational. It represents, on average, value for money. The problem rather is assuring ourselves that this is true. We would like to believe that real spending growth on medical care is worth it, but how can we get over the nagging doubt that it is not? People have the feeling that the usual test of value for money is lacking. For almost all products, the fact that someone was willing to pay the price means that the product is worth the price. But the presence of health insurance breaks this easy equivalency for health care. If I get an MRI (magnetic resonance imaging) or a bottle of pills for my migraine headaches, which the insurance pays for, there is no basis for concluding that they are

10. M. V. Pauly, "Should We Be Worried about High Real Medical Spending Growth in the United States?" *Health Affairs Web Exclusive*, January 8, 2003, http://www.healthaffairs.org/WebExclusives/2201Pauly.pdf.

worth as much to me as they cost, or indeed that they are worth much *at all*.

Insurers in principle have an alternative way of assuring value for money. If a newly insured product, in total, will cost more to consumers (through higher premiums) than it is worth, the unregulated insurer will refuse to cover.[11] Life is more complex if the new technology provides large benefits to some and unequivocally positive but small benefit to others. It is then much harder for insurers to titrate or ration the product to be consistent with such differences in benefits. The line of least resistance, once the door is open, is to make the technology available to all patients for whom physicians expect a positive benefit. Obviously, it would be ideal to limit this low-value use, and a variety of devices, from patient cost sharing to clinical guidelines, can do so, even if only imperfectly. But if the excess of cost over benefit for the low-benefit people (subject to the best method of constraining this "moral hazard") exceeds the positive net benefit to the high-benefit people, the competitive insurer (unconstrained by state laws or mandates) will again refuse to cover. Thus we get a very strong result.[12] If insurers do choose to cover a new technology (compared with not having it covered at all), that technology must be efficient, in the sense that the benefit from the technology and the risk reduction benefit from insurance coverage (taken together) must exceed the cost or additional premium associated with the technology. *There cannot be an excessively high or excessively costly rate of technical change* in competitive insurance and medical care markets.

But, you may object, how can we afford this new technology? Yogi Berra famously remarked (of a restaurant in which he worked in the off-season), "it's so crowded nobody goes there anymore." In a

11. M. V. Pauly, "Market Insurance, Public Insurance, and the Rate of Technological Change in Medical Care," *The Geneva Papers on Insurance and Risk* 28 (April 2003): 180–193.

12. Pauly, "Market Insurance."

similar logical view, one could complain that drug companies, hospitals, and doctors "are making so much money from health care that nobody can afford to buy it anymore." The pedantic point is that high spending must be made by, and therefore afforded by, at least *some* consumers. Once (or if) consumers decide they can't "afford" the latest new technology, they won't buy it anymore. Then either spending will not occur or (more plausibly, especially for patented drugs) the price will be dropped to a level consumers are willing to pay.

So, to state it simply, one cannot assert that higher spending on new technology is hurting the average consumer, compared with a situation in which the technology did not exist. It should be providing benefits greater than costs by a large amount. Then what is the problem? Why did we instinctively cringe when we heard that real spending growth in 2002 was higher than in 2001? Of course, consumers would rather pay less for what they get, but that would not affect efficiency, only distribution. I think there are two possible problems. One possibility is that, even if the new technology we bought in 2002 for an extra $190 billion was worth it (compared with sticking to the 2001 technology), it could be that we could have gotten 90 percent of that benefit for much less than 90 percent of the cost. That is, there might still be a lot of waste at the margin that somebody should do something about.

The other possibility is that the technology that many can afford may be overpriced for some who react by dropping insurance coverage or quietly going bankrupt. But why should this step be necessary? Usually, the old cheaper technology is still available: you can still obtain aspirin, noncoated stents, and oat bran rather than Imitrex, drug-eluting stents, and statins. It should be possible to keep the old technology in place; its price is less clear but probably need not rise even as much as overall health input prices. And the people for whom the added value of the latest technology is less than the added cost should prefer a "Classic Care Insurance," which covers the old

but not the new, to no insurance at all. The availability of charity care also influences private insurance purchase, but its effect is small and especially so for the growing number of definitely not-poor uninsured. Why then is demand for insurance as sensitive to quality-related spending and premium growth as it appears to be?

I think this is a major puzzle and problem. One can think of excuses. While old technologies may still be available, doctors or lawyers may be uncomfortable about people using them. Consumers may not know how to find insurance that specializes in this care, and insurers may not know how to market coverage that isn't as good as it could be but is cheap. Employers may also not feel comfortable offering intentionally inferior options, and editorial page writers will be bound to jump on anyone who does. But the alternative of the best or nothing at all seems even less attractive.

The relationship of insurance to the valuation of new technology has two dimensions. Let us suppose that the valuation of a technology depends on income and illness severity and each person (at any point in time) will use one unit. If the distribution of illness is independent of income and if the value of the technology rises with income, given severity, then both the value and the rate of use of the technology will differ by income.

A compromise strategy would be to offer insurance with patient cost sharing to low-income people only, since they will ideally use less than high-income people will. This insurance will be a better deal for them than either full-coverage insurance (which they may use at the same rate but value the use less) or insurance pooled with higher-income people where the premium is biased upward by the higher use of higher-income people.

More generally, I would blame a kind of "money illusion." I see the money cost of my insurance rise by $50 a month, but I cannot see so clearly the new technology that money buys. And my employer sees this even less clearly. Price increases are certain; quality in-

creases are contingent and imprecise. Closing this information gap appears to be important.

Where Will It All Go?

The *percentage rate* of spending growth eventually has to be brought down below the levels it has reached in recent years, but the absolute increase in real spending can remain high and the rate of growth can remain above that of real income. The bulk of Americans who are insured and not elderly have been experiencing spending growth, and that group almost surely has been made better-off by spending more on something of great average value. For that group, the worst thing that could happen would be for spending growth to slow down, because this would mean that the opportunities of increasing the length and quality of life had diminished; they would only have more mundane things to spend additional real income on. My own forecast is a modest tailing off of this growth, but no great rejoicing by chief financial officers.

For those of us who are or will soon be eligible for the tax-financed Medicare program, I think that things are more ominous. It is not that the middle class who now predominate among the elderly will value technical change less after their sixty-fifth birthday than they did before; it is rather that the vehicle through which they may express that valuation will become more sluggish and they will be forced to raise money in costly and unpopular ways. Specifically, higher taxes for Medicare mean higher distortion or higher "excess burden" on the economy. Trying to get a frugal government to raise the taxes of a shrinking and skeptical young work force is not a challenge I personally relish; I think it is a recipe for intense political conflict and confusion. Thus the main message here is that what the nonelderly insured can handle with relative equanimity will pose extraordinarily difficult financial problems for the Medicare program, difficulties that will be accentuated if drug coverage is added.

Conversely, the kind of spending growth my cohort will demand when we go on Medicare will seriously discomfort our grandchildren, who will largely need to pay for it. I don't know what will happen, but I am sure that efficiency and rationality will suffer. Medicare suffers more severe financial problems because it is by nature political and because it *raises* revenue through distortive taxes on nonbeneficiaries. This means that it ought efficiently to do less, but politically it cannot admit to doing so.

The other group for which there will potentially be a problem is the near poor and the "near uninsured." For some reasons described above and for more reasons that we do not understand, some people seem to overreact to rising insurance premiums that pay for new technology, by bailing out of private insurance entirely. Some of these dropouts are almost totally irrational: they are workers who take jobs (with lower wages) where coverage is offered, and then they reject coverage because of employee premiums that are only a small fraction of the average value of benefits, and do this even if they are at high risk and very likely to need care.[13] They may say (and do say) that they can't "afford" the premiums, but then how can they afford out-of-pocket payments? Begging for free care or going without cannot be an attractive option.

The most plausible explanation is that the people who drop insurance are making a mistake, underestimating the need for, or the benefits of, insurance, and, most especially, underestimating the increase in the *value* of insurance that accompanies a quality-driven increase in premiums. Methods to communicate this value should be developed; that is, consumers should be informed that insurance benefits are valuable. One way to convey this message would be to describe explicitly why premiums rise and what they buy. People

13. L. J. Blumberg and L. M. Nichols, "The Health Status of Workers Who Decline Employer-Sponsored Insurance," *Health Affairs* 20 (November/December 2001): 180–187.

should be encouraged to purchase coverage; those who fail to do so should be treated as mistaken, not pitiful.

More specifically, what is needed is a clear statement of something individual insurance consumers, who are generally not sick, have a hard time seeing: that the new technologies have improved effects on the quality of life and survival, which consumers could obtain if they needed them. Perceptions probably lag most behind reality when and if both spending growth and improved technology accelerate simultaneously. A similar step would be public service campaigns intended to persuade people not to drop insurance. Rather than spend millions trying to persuade taxpayers to subsidize people who are confused, we should provide the potentially uninsured with information on how inexpensive insurance can be relative to the possible bills they would experience without it or to the benefit they would have to forego without it.

Another positive step would be to design and approve a less costly insurance plan than the low-deductible, low-copayment plans that well-off and well-subsidized consumers obtain. One could begin with a policy with coverage equivalent to today's Medicare: almost no drug, mental health, or preventive care coverage; a large inpatient deductible; and an upper limit on hospital days. Although such limited coverage would violate regulations in many states, Medicare coverage is customarily accepted to be part of a popular program. The Medicare limits would pare a lot off the premium for the average private policy. Moreover, the absence of drug coverage means that Medicare has avoided much of the source of the most rapid increases in private premiums.[14]

Another step that might improve insurance affordability and lower spending growth would be to remove or limit the current $100 billion (and more) subsidy to employment-based insurance. This

14. R. Pear, "Health Spending Rises to 15 Percent of Economy, a Record Level," *The New York Times*, January 8, 2004, sec. A, 15.

would surely produce a one-time but large reduction in spending, probably of about 10 to 15 percent, and that alone would bring back many of those lower-middle-income people who have dropped coverage. More speculatively, but perhaps more importantly, reducing coverage across the board might cause physician practice patterns to become more frugal. In addition, a lower level of coverage might stimulate a reduction in the rate of growth of spending, at least for a while. People with more frugal coverage would also presumably use less of any new technology offered for sale. At least initially, that would lower the rate of growth as well as the absolute amount of growth. The period of lower-growth rates would end when the base level of spending shrank.

A common suggestion to make insurance more affordable is to preclude state-mandated benefit laws that increase the premium for individual and small group insurance. There is some question about how much this would improve insurance take-up rates (since the lower premiums are offset by lower benefits). If there is an increase in take-up, that will provide strong evidence that the mandates are inefficient, adding more to premiums than to value.

Finally, generous subsidies to lower-middle-income people are needed in any case. That they would help those at the margin afford new, as well as old, technology is a point in their favor.

Conclusion

Perhaps most important, health policymakers should level with people. They should admit that it is almost impossible to lower cost without lowering quality, and that new information technology, managed care, malpractice reform, focused factories, medical savings accounts, chronic care management, or continuous quality improvement plans can produce at best little more than a small and temporary slowdown in the rates of spending growth. People should also be told as taxpayers to expect to pay higher premiums if they want to

maintain access to new technology for Medicare or Medicaid that is similar to that of private sector insureds.

The view that, for the great bulk of the American population, higher health spending is worth it should be pressed more strongly. As part of this case, however, we should look seriously at (or for) the waste that many believe, based mainly on anecdote, is rampant in the medical care system. Either find the waste (and find a set of incentives to squeeze it out) or call the current outcome good—as good as it will get. While we may wish that improvement in the quantity and quality of life came more cheaply and easily, we will need to face the fact that, even at high real cost (with adequate protection for the uninsured), we do not want to reject what is still a bargain.