

HOW MUCH SHOULD WE SPEND ON MEDICAL CARE?

The United States spends more on medical care than does any other country—17.2 percent of its gross domestic product (in 2012)—and this percentage is expected to continue to grow. Can we afford to spend that much of our resources on medical care? Why do we view the growth of expenditures in other areas (such as the automotive industry) more favorably than the growth of expenditures in healthcare? Increased medical expenditures create new healthcare jobs, do not pollute the air, save rather than destroy lives, and alleviate pain and suffering. Why should society not be pleased that more resources are flowing into a sector that cares for the aged, the poor, and the sick? Medical care would seem to be a more appropriate use of a society's resources than cars, electronics, or other consumer products, yet increased expenditures on these goods do not prompt the concern that growth in healthcare spending causes.

Are we concerned about rising medical costs because we believe we are not receiving value for our money—that more medical services and technologies are not worth their costs when compared to other potential uses of those resources? Or is there a fundamental difference of opinion regarding the rate at which medical expenditures should increase?

To answer these questions, we must define what we consider an appropriate or “right” amount of expenditure—only then can we evaluate whether we are spending too much on medical care. If we determine that we are spending too much, how does public policy have to change to achieve the right expenditure level?

Consumer Sovereignty

The appropriate amount of health expenditure is based on a set of values and on the concept of economic efficiency. Resources are limited, so they should be used for what consumers believe to deliver the most value. Consumers decide how much to purchase on the basis of their perception of the value they expect to receive and the price they have to pay, knowing that buying one good or service means forgoing other goods and services. Consumers differ greatly in what value they place on medical care and what

they are willing to forgo. In a competitive market, consumers receive the full benefits of their purchases and in turn pay the full costs of those benefits. If the benefits received from the last unit used (e.g., the last visit to the doctor) equal the cost of that unit, the quantity consumed is said to be optimal. If more or fewer services were consumed, the benefits received are said to be either less or greater than the cost of that service.

Consumer sovereignty is most easily achieved in a competitive market system. Consumers differ in the medical services they value and in their willingness to pay for a given service. Through their purchases, consumers communicate what goods and services they value. In response, producers use their resources to produce the goods and services consumers desire. If producers are to survive and profit in competitive markets, they must use their resources efficiently and produce the goods and services consumers are willing to pay for; otherwise, they will be replaced by producers that are more efficient and in tune with what consumers want.

Some people believe that consumer sovereignty should not determine how much we as a society spend on medical care. Patients lack information and have limited ability to judge their needs for medical treatment, more so than in other areas. Other concerns are the quality of care patients receive and the quantity of care that is appropriate.

Consumer sovereignty may be imperfect, but the alternatives are equally imperfect. If medical care were free to all and physicians (paid on a fee-for-service basis or salaried) decided the quantity of medical care to provide, the result would be the provision of "too much" care. Physicians are likely to prescribe services as long as they perceive the services will benefit their patients—even if only slightly—because the physicians are not responsible for the cost of that care.

The inevitable consequence of a free medical system is a government-imposed expenditure limit to halt the provision of too much care. Although physicians still would be responsible for determining who receives services and for which diagnoses, "too little" care likely would be provided—as is sometimes the case in government-controlled health systems such as those in Canada and Great Britain. Queues would be established to ration available medical care, and waiting times and age would become criteria for allocating medical resources.

No government that funds healthcare spends sufficient resources to provide all the care demanded at the going price. As does an individual making purchases, the government makes trade-offs between the benefits received from additional health expenditures and the cost of those expenditures. However, the benefits and costs to the government are different from those consumers consider in their decision-making processes. To the government, *benefit* means the political support it gains by increasing health expenditures;

cost means the political support it loses when it raises taxes or shifts resources from politically popular programs to fund additional expenditures.

Let us, therefore, assume that consumer sovereignty will continue to guide the amount we spend on medical care. Having consumer sovereignty as a guide, however, does not mean that the United States is spending the right amount on medical services. This judgment is influenced by another factor: economic efficiency.

Economic Efficiency

Efficiency in the Provision of Medical Services

If medical services were produced in an inefficient manner, medical expenditures would be excessive. For example, rather than treating a patient for ten days in the hospital, a physician might be able to achieve the same outcome and same level of patient satisfaction by treating the patient in the hospital over a fewer number of days, sending the patient home, and having a visiting nurse finish the treatment. Similarly, the patient might be able to be treated in an outpatient setting rather than in the hospital. Physicians' practice patterns vary greatly across the country, causing medical expenditures to vary widely with no apparent difference in outcomes. Unless providers have appropriate incentives to be efficient, economic efficiency in providing medical services is unlikely to be achieved.

When hospitals were paid on a cost-plus basis, they had an incentive to raise their costs. Subsequent events changed those incentives, and since the early 1980s, both the government and the private sector have been pressing for better efficiency of the delivery system. Cost-based payment to hospitals under Medicare gave way to fixed payment based on diagnosis-related groups. Price competition has escalated not just among hospitals and physicians but also among insurance companies, as they are themselves competing on the basis of premiums in the sale of group health insurance. PPOs (preferred provider organizations), HMOs, and managed care systems have expanded their market share at the expense of traditional insurers. Hospitalization rates have declined as utilization review mechanisms have increased, and the trend toward implementing case management for catastrophic illness and monitoring providers for appropriateness of care and medical outcomes has grown.

Few would contend that the provision of medical services is as efficient as it could be. Waste exists in the health system, and it is difficult to define (Brook 2011; *Health Affairs* 2012). Is it any medical intervention that provides no medical benefit, or is it a medical intervention in which the potential for a negative outcome exceeds the potential for the patient to

benefit (Fuchs 2009)? Economic waste occurs when the expected benefits of an intervention are less than the expected costs. Remember that waste is also a provider's income.

The current movement by managed care plans, Medicare Advantage, and accountable care organizations away from fee-for-service and toward episode-based payment and capitation is changing provider incentives. Providers now have a financial incentive to become concerned with coordination of care and management of chronic diseases, resulting in less use of costly inpatient settings, greater use of physician extenders, and better outcomes at lower cost. It will take a number of years, however, for these new payment schemes and outcomes to become widespread throughout the medical care system.

However difficult it is to define and reduce waste, the emphasis on cost containment and the growth of managed care are efforts to decrease inefficient use and delivery of medical services. Even if administrative costs for private health plans were reduced by 50 percent (which would have saved almost \$100 billion in 2012), the profits of the pharmaceutical drug companies dropped by 50 percent (saving \$55 billion), and all physician incomes decreased by 25 percent (saving \$40 billion), the combined savings of \$195 billion represent less than two years' annual percentage increase in total medical expenditures.

Inefficiency, although important, is not the main cause for concern about the rise of medical expenditures.

Efficiency in the Use of Medical Services

Inefficiencies in the use of medical services result when individuals do not have to pay the full cost of their choices; they consume too much medical care because their use of services is based on the out-of-pocket price they pay, and that price is less than the cost of providing the service. Consequently, the cost of providing the service exceeds the benefit the patient receives from consuming additional units of the service. The resources devoted to providing these additional services could be better used for other services, such as education, that would provide greater benefits.

The effect of paying less than the full price of a service is easy to understand when the concept is applied to some other consumer product, such as automobiles. If the price of automobiles were greatly lowered for consumers, they would purchase more automobiles (and more expensive ones). To produce these additional automobiles, manufacturers would use resources that could have been used to produce other goods. Similarly, if the price people have to pay for services is decreased, people would use more services. Studies have shown that patients who pay less out of pocket have more hospital admissions, visit physicians more often, and use more outpatient services than

patients who pay higher prices (Feldstein 2011). This relationship between price and use of services also holds for patients classified by health status.

Inefficient use is an important concept in healthcare because the price of medical services has been artificially lowered for many consumers. The government subsidizes medical care for the poor and the aged under Medicaid and Medicare. Those eligible for these programs use more services than they would if they had to pay the full price. Although the purpose of these programs is to increase the use of medical services by the poor and the aged, the artificially low prices also promote inefficient use—for example, when a patient uses the more expensive emergency department rather than a physician's office in a non-emergent situation.

A greater concern is that the working population contributes to use inefficiency. An employer-purchased health plan is not considered taxable income for employees. If an employer gave the same amount of funds to an employee in the form of higher wages, the employee would have to pay federal and state income taxes as well as Social Security tax on that additional income. Because employer-purchased health insurance is not subject to these taxes, in effect the government subsidizes the purchase of health insurance and—when the employee uses that insurance—the purchase of medical services. Employees do not pay the full cost of health insurance; it is bought with before-tax dollars, as opposed to all other purchases, which are made with after-tax dollars.

The greatest beneficiaries of this tax subsidy are employees in higher income tax brackets. As discussed in Chapter 1, rather than receive additional income as cash, which is then subject to high taxes (in the 1970s, the highest federal income tax bracket was 70 percent), these employees choose to receive more of their additional wages in the form of more health insurance coverage. Instead of spending after-tax dollars on vision and dental services, they can purchase these services more cheaply with before-tax dollars. The price of insurance is reduced by employees' tax bracket; as a result, they purchase more coverage than they otherwise would because they did not have to pay the full cost of coverage, and the additional coverage is worth less to employees than its full cost.

With the purchase of additional coverage, the out-of-pocket price paid for medical services declined, prompting the increased use of all medical services covered by health insurance. As employees and their families became less concerned with the real cost of medical services, few constraints limited the growth in medical expenditures. Had the inefficient use of medical services (resulting from the tax subsidy for the purchase of health insurance) been less prevalent, medical expenditures would have risen more slowly.

Inefficiencies in the provision and use of medical services are legitimate reasons for concern about how much is spent on medical care. Public

policy should attempt to eliminate these government-caused inefficiencies. However, other, less valid reasons for concern exist.

Government and Employer Concerns over Rising Medical Expenditures

As payers of medical expenditures, federal and state governments and employers are concerned about growing medical costs. State governments pay half the costs of caring for the medically indigent in their state, while the federal government pays the remaining half. Medicaid expenditures have gone up more rapidly than any other state expenditure and have caused states to reduce funding for other politically popular programs so that they do not have to raise taxes. At the federal level, the government is also responsible for Medicare (acute medical services for the aged). The hospital portion of Medicare (Part A) is financed by a specific payroll tax that has been raised numerous times, and the physician and prescription drug portions (Parts B and D) are financed with general income taxes. Medicare expenditures have also risen rapidly. As a result of the Affordable Care Act (ACA), starting in 2014 government subsidies will greatly increase to pay for expanded Medicaid eligibility and for those whose income is between 133 percent to 400 percent of the federal poverty level and who buy health insurance on state healthcare exchanges.

As shown in Exhibit 2.1, federal health spending as a proportion of total federal spending is skyrocketing—from 12 percent in 1985 to 20 percent in 1995 to 26 percent in 2012 and to a projected 30 percent in 2018. The oldest of the baby boomers started to retire in 2011 and became eligible for Medicare, which will dramatically boost Medicare expenditures over the coming years. Unless the federal government can reform Medicare and reduce its growth rate, the Medicare payroll tax on the working population will be sharply raised to prevent the Medicare trust fund from going bankrupt. Funding Part B, Part D, and the subsidies under the ACA will require raising income taxes, adding to an already large federal deficit, or reducing funding for other federal programs.

Thus, even if inefficiencies did not exist in the use or provision of medical services, large increases in Medicare and Medicaid enrollments and expenses—together with the additional costs to finance the subsidies included in the ACA—will lead to federal expenditures that exceed the government's ability to finance. The consumer products comparison presented earlier can be applied here as well: If the government were the purchaser of 50 percent of all automobiles, it would become concerned with the price and use of automobiles and the associated expenditures. The pressure to continue

EXHIBIT 2.1
Federal
Spending on
Health, Fiscal
Years 1965–
2018 (in Billions
of Dollars)

	1965	1975	1985	1995	2005	2012	2018*
Total federal spending	118.2	332.3	946.3	1,515.7	2,472.0	3,537.1	4,449.2
Federal health spending	3.1	29.5	117.1	307.1	614.0	922.6	1,328.4
Medicare	n/a	12.9	65.8	159.9	298.7	471.8	614.8
Medicaid	0.3	6.8	22.7	89.1	181.7	250.5	390.6
Veterans Administration	1.3	3.7	9.5	16.4	28.8	50.6	60.3
Other	1.5	6.1	19.1	41.7	105.0	149.7	262.8
Federal health spending as a percentage of total federal spending	2.6%	8.9%	12.4%	20.3%	24.8%	26.1%	29.9%

* Projected data; n/a: not applicable

SOURCE: Data from Office of Management and Budget (2014), tables 1.1 and 16.1.

funding Medicaid, Medicare, and the new healthcare entitlements through higher taxes or greater budget deficits is driving the federal government to seek ways to limit medical spending increases.

Similarly, unions and employers are concerned with the rise in employee medical expenditures for reasons other than the inefficiencies in the provision or use of services. The business sector's spending on health insurance premiums has gone up over time, both as a percentage of total employee compensation and as a percentage of business profits. Health insurance, when offered, is part of an employee's total compensation. Employers are interested only in the total cost (income) of an employee, not in the form the employee takes that income (i.e., wages or health benefits). Thus, the employee bears the cost of rising health insurance premiums because higher premiums mean lower cash wages. Large unions, whose members receive generous health benefits, want to slow the rate of growth of medical expenditures because they have seen more of their compensation gains spent on health insurance than paid out as wages.

Large employers were seriously affected by the Financial Accounting Standards Board ruling: Starting in 1993, employers that promised medical benefits to their retirees are required to list these unfunded liabilities on their balance sheets. Employers previously paid their retirees' medical expenses only as they occurred and did not set aside funds (as is done with pensions). By having to acknowledge these liabilities on their balance sheets, many large corporations, such as automobile companies, have seen their net worth decline by billions of dollars. Furthermore, because these companies have to expense a portion of these future liabilities each year (not only for

their present but also future retirees), they have to report lower earnings per share. If employers were to reduce the rate of increase in their employees' medical expenditures, the net worth of companies with large unfunded retiree liabilities would rise, as would their earnings per share.

These differing reasons for concern over rising medical expenditures are important to recognize. Which concern should drive public policy—the government's desire not to raise revenues to fund its share of medical services, unions' and employers' interest in lowering employee and retiree medical expenses, or society's desire to achieve the appropriate rate of increase in medical expenditures? The interests of government, unions, and large employers have little to do with achieving an appropriate rate of growth. Instead, their particular political and economic burdens drive their proposals for limiting increases in medical expenditures.

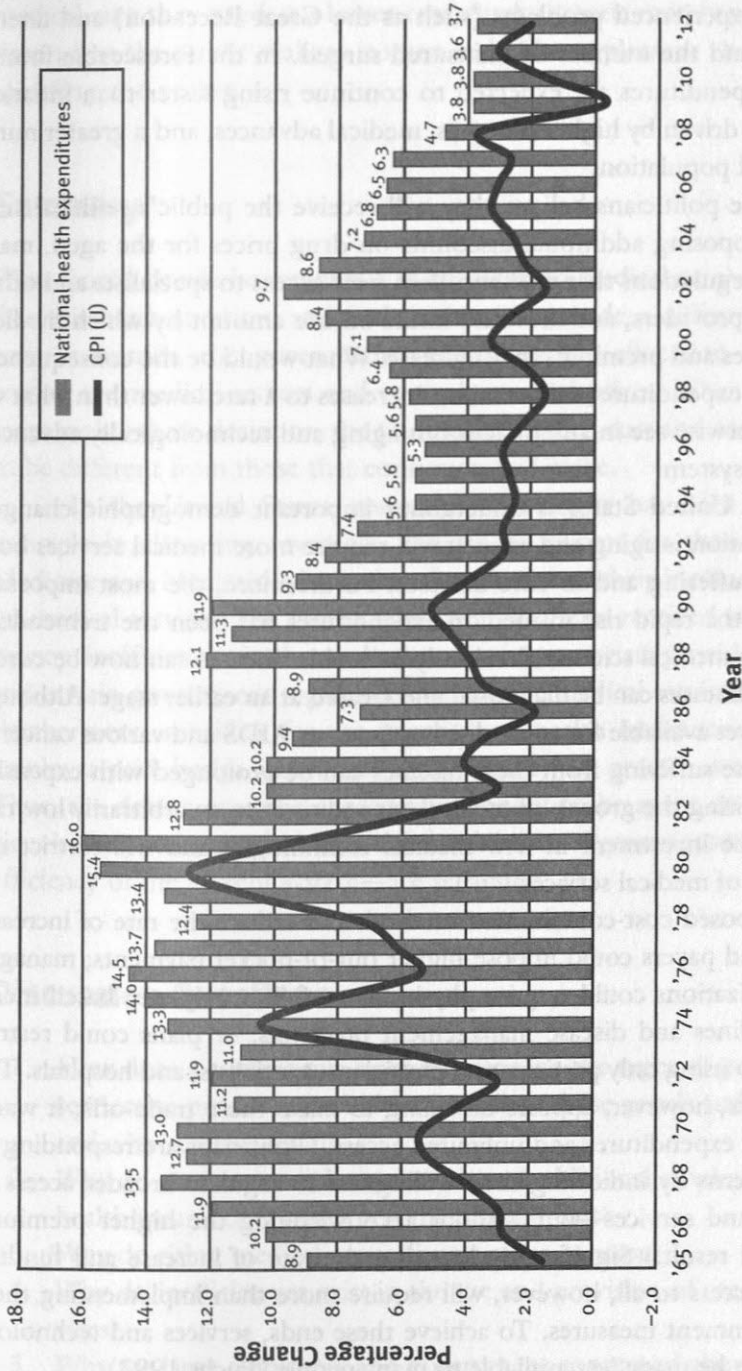
Approaches to Limiting Increases in Medical Expenditures

The United States should strive to reduce inefficiencies in both the provision and the use of medical services. Inefficiencies in provision, however, are decreasing as managed care plans are forced to compete for enrollees on the basis of price. The large variations that exist in physicians' treatment patterns should decrease as more information on outcomes becomes available through the analysis of large insurer data sets. Vigilant application of the antitrust laws is needed to ensure that healthcare markets remain competitive and that providers, such as hospitals, do not monopolize their markets. Inefficiencies in use are also declining as managed care plans control use of services through utilization management and patient cost sharing. As these inefficiencies are reduced, the growth rate of medical expenditures will approximate the "correct" rate of increase.

Naturally, the public would like to pay lower insurance premiums and out-of-pocket costs and still have unlimited access to healthcare and to the latest medical technology. As in other sectors of the economy, however, choices must be made.

Medical expenditures have consistently grown faster than inflation, sometimes several times faster and sometimes by just several percentage points. Exhibit 2.2 shows the annual percentage change in national health expenditures and the consumer price index since 1965. During the mid-1990s, expenditures moderated as managed care enrollment rose. By the late 1990s, however, they increased more rapidly as a result of the backlash against managed care and the consequent relaxation of managed care's cost-containment methods. In the past decade, they have moderated as the

EXHIBIT 2.2
Annual
Percentage
Changes in
National Health
Expenditures
and the
Consumer Price
Index, 1965–
2012



CPI (U): consumer price index for all urban consumers
 SOURCES: Data from BLS (2014); CMS (2014).

economy experienced problems (such as the Great Recession) and unemployment and the number of uninsured surged. In the foreseeable future, medical expenditures are expected to continue rising faster than inflation and will be driven by higher incomes, medical advances, and a greater number of aged population.

Some politicians believe they will receive the public's political support by proposing additional discounts on drug prices for the aged, managed care regulations that give enrollees freer access to specialists and other healthcare providers, and arbitrary limits on the amount by which medical expenditures and premiums may increase. What would be the consequences of limiting expenditure and premium increases to a rate lower than what we would otherwise see in an efficient but aging and technologically advanced healthcare system?

The United States is undergoing important demographic changes. The population is aging and as such will require more medical services both to relieve suffering and to cure illnesses. Furthermore, the most important reason for the rapid rise in medical expenditures has been the tremendous advances in medical science. Previously incurable diseases can now be cured, and other illnesses can be diagnosed and treated at an earlier stage. Although no cure is yet available for some diseases (such as AIDS and various cancers), life for those suffering from these diseases can be prolonged with expensive drugs. Limiting the growth of medical expenditures to an arbitrarily low rate will decrease investment in new medical technologies and will restrict the availability of medical services.

Proposed cost-containment methods can reduce the rate of increase. Insurers and payers could impose higher out-of-pocket payments; managed care organizations could require physicians to follow evidence-based medicine guidelines and disease management protocols; or plans could restrict enrollees to using only participating physicians, specialists, and hospitals. The middle class, however, appears unwilling to make these trade-offs; it wants both lower expenditures and unlimited access. (Politicians are responding to these concerns by indicating their willingness to regulate broader access to providers and services—but without acknowledging the higher premiums that would result.) Significantly lowering the rate of increase and funding universal access to all, however, will require more than implementing these cost-containment measures. To achieve these ends, services and technology will have to be made less available to many people (Fuchs 1993).

Some politicians have led the public to believe these trade-offs are not necessary; they claim that by eliminating waste in the healthcare system, universal coverage can be achieved and everyone can have all the

medical care they need at a lower cost. Such rhetoric merely postpones the time when the public realizes it must make the unpleasant choice between spending and access.

Summary

Who should decide how much is to be spent on medical care? All countries face this basic question, and each country has made a different choice. In some countries, the government determines the allocation of resources among the medical sectors and controls medical prices. When the government makes these decisions, the trade-offs between cost and access are likely to be different from those that consumers will make.

In the United States, consumer sovereignty has been the guiding principle in allocating resources; consumers (except for those enrolled in Medicare and Medicaid) determine the amount of their income to be spent on medical services. Yet, consumers have not always received value for their money. Inefficiencies in the medical sector, inappropriate provider incentives, and certain government regulations have made medical services more costly. Furthermore, subsidies for the purchase of health insurance (tax-exempt, employer-paid health insurance) have resulted in greater use of services. Thus, the debate over the appropriate amount to be spent on medical services is likely to be clarified once these two issues—consumer sovereignty and efficiency of the current system—are separated.

Discussion Questions

1. How does a competitive market determine the types of goods and services to produce, the costs to produce those goods and services, and who receives them?
2. Why do economists believe the value of additional employer-paid health insurance is worth less than its full cost?
3. Why do rising medical expenditures cause concern?
4. Why do inefficiencies exist in the use and provision of medical services?
5. Why are large employers and government concerned about rising medical expenditures?

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