By David M. Cutler

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PERSPECTIVE

What Is The US Health Spending Problem?

ABSTRACT **Is increased spending on medical care harmful to the US economy? The overall share of the gross domestic product spent on medical care is not a problem, provided that the services bought are worth more than their cost. However, high and rising costs expose two often-overlooked problems. First, spending is too high because many dollars are wasted. Estimates suggest that unnecessary medical spending costs the typical American family thousands of dollars each year. Second, high medical costs combined with stagnant incomes for a large share of the population and the inability of governments at all levels to raise tax dollars leads to increased health and economic disparities: fewer people covered by private insurance, the rationing of care in public health programs, and the lack of funds for other social programs. These distribution issues, coupled with the large waste, imply that efforts to address medical spending need to be among our highest priorities.**

David M. Cutler (dcutler@harvard.edu) is the Otto Eckstein Professor of Applied Economics in the Department of Economics at Harvard University and a research associate at the National Bureau of Economic Research, both in Cambridge, Massachusetts.

The latest national health expenditure projections forecast modest but increasing growth in medical spending as a share of the economy over the next decade.[1] The Centers for Medicare and Medicaid Services actuaries suggest that cost increases will be driven by price increases, though to a smaller extent than in the past, and that there will be continued increases in utilization and population aging.

Rising medical spending inevitably leads to political concern, and these forecasts seem destined to do the same. Is there some limit on what is reasonable for a country to spend on health? In this perspective I consider the economics of medical spending and, in particular, whether the US spends too much. I argue that there are harms from spending as much as the US does but that those harms are not what is commonly feared.

Start with the central fear about medical spending: The US economy will suffer if we devote increasing amounts of our income to just one industry. On the contrary, there is no economic law that governs how much money should be spent on any industry. In fact, the shares of different industries in economic output vary greatly. In 1900 one-third of value added was in agriculture. In 1950 one-quarter was in manufacturing. Today those two industries combined account for only 13 percent of the gross domestic product (GDP). At least some of medical care's increasing share of the GDP is a natural response to food and manufactured goods becoming cheaper and thus demand moving elsewhere. There is no obvious harm in this reallocation.

However, noting that high spending on medical care is not prima facie problematic does not imply that we needn't worry about the level of such spending in the United States. There are two reasons why high and rising medical spending is problematic: It is associated with substantial waste, and it makes society more unequal.

A Large Part Of Spending Is Wasteful

A large number of studies have estimated the waste in health care. Estimates suggest that between one-quarter and one-half of medical

spending is not associated with improved health,[2–7]although this view is not without controversy.[8] Waste in medical care comes in many forms. One clear cause is misallocated treatments: spending on care that is not clinically valuable or not spending on preventive services. Examples of overuse include preterm elective induction of childbirth for women at low risk,[9] back surgery for lower back pain,[10] and excessive end-of-life care.[11] Wasteful undertreatment includes recurrent use of emergency departments and hospitalizations for people with inadequately treated congestive heart failure.

High prices are a second form of wasteful spending. Prices for the same services vary greatly across the country and between the US and other countries.[12,13] Pharmaceutical price differences are the most notable international price differences, but physicians and hospitals are paid more in the US as well.[14] Estimates suggest that even very valuable medications are now priced so high in the US that the costs may exceed the clinical benefits.[15]

Excessive administrative costs are a third form of wasteful spending. About one-quarter of US medical spending is estimated to be spent on administrative costs—twice what is spent on cardiovascular disease, and three times what is spent on cancer.[16] Finally, fraud and abuse may account for up to 10 percent of costs for some payers, though the exact amount is difficult to know.[17]

The magnitude of wasteful spending deserves particular attention. If one-third of medical spending is wasteful, the aggregate waste in medical care is about 6 percent of GDP. That is equal to the amount collected in Social Security and Medicare taxes, and it is two-thirds of the amount raised by individual income taxes. It amounts to about $3,500 per person annually.

The fact that there is so much waste in medical care does not mean that spending more is necessarily bad. If a new drug came along that materially slowed the progression of Alzheimer disease, we should not decide to pass up that drug because we are overtreating people with lower back pain. But neither should we assume that all spending increases reflect value, as indicated by the rising prices of established drugs or of services from newly merged hospitals. Most fundamentally, the presence of significant waste argues that we ought to pay at least as much attention to ways of improving efficiency as we do to whether and how people should get covered.

Rising Spending Worsens Inequality

The second problem with medical spending is that it feeds into the already severe harms caused by growing income inequality. The most important fact about the income distribution in the United States is that it is becoming increasingly unequal: Real incomes have soared at the very high end, risen modestly in the next few deciles, and been stagnant or falling at the bottom.[18]

Rising medical costs combined with stagnant incomes for a large share of the population mean that more people will need help paying for medical care. A family at the median income level, whose income is relatively constant, has had no easy way to pay the roughly $10,000 rise in the cost of a family health insurance policy between 1999 and 2017.[19]

At the same time that needs are increasing, however, government resources are being cut. Governments at all levels are loath to raise taxes, and some are even cutting them. Total government revenue as a share of GDP has been relatively constant for several decades and is projected to fall with enactment of the federal tax bill in December 2017.

This combination of increased need for help and fewer resources to spend inevitably creates problems. Three problems are particularly apparent.

FEWER PEOPLE ARE COVERED BY PRIVATE INSURANCE Rising medical costs make private insurance more valuable in some ways and less valuable in others. When medicine can do more for the sick, people naturally want to guarantee access to the medical system. Thus, the desire for insurance rises with spending. It is likely not a coincidence that demand for Medicare to cover prescription drugs rose after expensive new drugs were launched in the 1990s.

However, not everyone wants insurance more when medical costs rise. This is especially the case when the benefits derived from higher spending are concentrated in a small, isolated share of the population. For example, high and rising prices for drugs that treat rare diseases such as hemophilia or multiple sclerosis will have little effect on the value of insurance for people without those conditions and for whom the probability of developing them in the following year is very low. Many medical conditions are predictable, at least in the short run—for example, chronic heart disease, neurological disorders, and mental illness. As costs for treating those conditions increase and insurance premiums as a whole rise, the tendency is for people without those conditions to drop insurance.

A further effect is that for low-income people, the high cost of medical care makes being uninsured relatively more attractive. People bear some liability for medical care when they are uninsured, but this liability is limited by bankruptcy laws. Once people exhaust their income

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and assets, it doesn't matter how much above that limit their medical care costs.[20] In contrast, paying for health insurance means paying for all of the care costs, above or below the person's assets. Thus, being uninsured is relatively more attractive when medical care costs rise.

These latter effects seem to outweigh the coverage-increasing effects, and the result has been a steady decline in private insurance coverage over time. For example, employer-sponsored insurance coverage rates among people with incomes of 100–250 percent of the federal poverty level fell from 53 percent in 1999 to 38 percent in 2014.[21]

Estimating how much private insurance coverage rates would rise if medical costs fell is difficult, because there are many sources of coverage and the residual effect of the mandate in the Affordable Care Act (ACA) to consider. A consensus estimate is that lowering premiums by 25 percent would lead 2–6 percent of the uninsured population to take up nongroup coverage.[22] Therefore, eliminating the one-third of medical care that might be wasteful could be a coverage stimulus somewhat smaller than, but on the order of, the ACA's subsidy for expanded coverage.

PUBLIC PROGRAMS TURN TO RATIONING In the public sector, high medical costs also lead to reduced access, although in a somewhat different fashion. Because of federal eligibility requirements, Medicaid programs are not able to cut enrollment as readily as private companies can when medical costs rise, but they can and do limit access to care.

Consider what occurred with the introduction of new medications to treat hepatitis C. The first of these drugs, introduced in late 2013, originally cost $84,000 for a course of treatment. As more of the drugs have entered the market, costs have fallen, but they remain high—$30,000 or more per treated person. The result has been rationing: The majority of state Medicaid programs restrict use of the new medications to people with very severe liver failure, or at least they did so until lawsuits forced them to cover the treatment for everyone.[23] For example, in 2014 more than 90 percent of state Medicaid programs limited access to the new medications to people with stage 3 or 4 liver disease. Even in 2016, 52 percent of the programs limited access to people with more advanced liver failure. Sobriety requirements are also the norm. More than 40 percent of states require six months of drug and alcohol sobriety before approving treatment for hepatitis C, and 7 percent require abstention for a year. The situation is even worse in prisons: An estimated 10 percent of prisoners have hepatitis C, yet only 1 percent of prisoners with hepatitis C have been treated.[24]

Rationing occurs in more subtle ways as well. As resources become tight, state governments reduce the reimbursement rates for providers.[25] Thus, the more that is spent on some treatments, the lower are reimbursement rates across the board. This creates a situation in which not all providers are willing to treat Medicaid patients. About 30 percent of physicians nationally do not accept Medicaid patients, and many others limit the number they will accept.[26]

High prices for new medications limit access under private insurance as well. It was common for private insurers to impose restrictions such as those in the public sector when hepatitis C medications were new. No studies have examined how these rules have changed with the medications' reduction in prices, and a comparative study of how high prices affect access in public and private insurance plans would be valuable.

There is nothing inherently wrong with people choosing to cut back on care when prices are high. Trade-offs always have to be made when some goods increase in cost. But several points about this trade-off should be noted.

First, we should not necessarily presume that the rationing choices made in the public sector are optimal. One can readily imagine a situation where higher-income taxpayers know they pay more in taxes than they receive in benefits and so push for overall taxes to remain lower than people as a whole would want if they made decisions for everyone in society. Or perhaps health care providers have significant political power and push for greater health care funding, even if that means less spending for other goods and services. Ultimately, how rising medical costs affect the optimality of the coverage decisions made by governments is an empirical question.

Second, even if health care is rationed optimally given the prices that governments face, that is not necessarily socially optimal. The reason is that the marginal cost of many health care services is below the price that is charged. Consider again the medications to treat hepatitis C. In countries where generic versions are available (such as India) or where the brand-name manufacturer has authorized steeply discounted prices, the price of the medication is about $500 per person treated.[27] At that price, many more people in the US would be treated than are now. What deters use is not the high cost of manufacturing pills but rather the combination of high fixed costs for drug development and the drive for profits. Limiting use because of high fixed costs is not efficient.

To put this point another way, a four-tier pharmaceutical pricing system is evolving internationally: Prices are highest in the United States; other rich countries pay high prices, though somewhat lower; middle-income countries pay between what the rich countries pay and the manufacturing cost; and the poorest countries pay the manufacturing cost. Relative to this pricing regime, people with middle and low incomes in the United States are probably comparable to those in Southern Europe or East Asia in their ability to afford medications, yet the prices they face are closer to those paid by high-income insured people in their own country. Not surprisingly, access to care suffers. If pricing in the US could more closely match that in the rest of the world—with high prices for the wealthy and well insured and lower prices for middle- and low-income people—access would improve, and profits might be higher as well.

OTHER SOCIAL PROGRAMS ARE CROWDED OUT

Even with both explicit and implicit rationing, rising costs for medical care translate into higher overall government spending. Given the constraint on raising money, this necessarily means that less money is available for other government services—for example, spending on early childhood education or income subsidies for low-income workers. If US society wants to address issues of income inequality, we need to free up resources invested in health care.

A further difficulty is that even program changes that seem to be neutral between rich and poor may disproportionately harm the poor. For example, one proposed solution to the problem of rising Medicare and Medicaid costs is to raise the ages of eligibility to receive Medicare and Social Security benefits.[28] This proposal has superficial plausibility because life expectancy at age sixty-five is rising, so that today's typical sixty-five-year-old will spend more years receiving benefits than the typical sixty-five-year-old did a few decades ago.

But taking account of the growing disparity in health by socioeconomic status shows that this proposal is highly regressive. Essentially all of the health improvement that occurred in the 1980s and 1990s was realized by people who had higher levels of education (at least some college education, and often a college degree).[29] Life expectancy was stagnant for people who dropped out of or did not go further than high school. Between 2001 and 2014 life expectancy rose by two to three years for people at the top of the income distribution, but by six months or less for people near the bottom.[30] Raising the eligibility ages for Medicare and Social Security in response to high medical spending would thus be a large cut in eligibility years for low-income people and a much smaller one for high-income people. Such regressivity is not desirable.

Conclusion

Additional medical spending brings both benefits and costs to society. For this reason, the question about how much money a country such as the United States can afford to spend on medical care is not well formulated. But that ambiguity does not mean that additional medical spending is innocuous. The United States is being pulled apart as a country, separating into rich and poor. Every dollar that is spent on medical care is one less dollar available for addressing the problems of an unequal society, and one more dollar that is difficult for much of the population to pay. One of the goals for health policy must be to reduce social and economic disparities, not increase them. ■

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NOTES

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