

**REMARKS TO THE 2004 ANNUAL MEETING,
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The Rising Cost of Health Care: Is it a Problem?

by
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When Gail Wilensky invited me to participate in this session, I accepted readily for three reasons. First, I was honored—who would not be?—to speak at the annual meetings of the Institute of Medicine? Second, it is hard for me to say “no” to Gail, whom I have known in various capacities since her first job out of graduate school. Third, I know and respect David Cutler. He and I are billed arguing opposite sides on the question. But I don’t think that we disagree sharply on much of anything. Where we do see things differently, the disagreements, I am confident, will be matters of nuance and emphasis.

I

I begin with an economic truism and a fact. The fact is that over the long term, public expenditures cannot much exceed taxes without collapse of the nation’s economy. Yes, outlays can run ahead of revenues for a while. But deficits create debt, and interest on that debt must be paid. If a nation borrows to pay interest, debt explodes, and the currency collapses. The fact is that government expenditures under current law are almost certain to grow much faster than national income. The principal reason is rapid projected growth of government spending on Medicare and Medicaid. Projected increases in health care spending are so large that cuts in other government programs could not possibly close the projected gap between taxes and spending.

The truism and the fact jointly mean that either the proportion of income collected in taxes must be sharply increased, or the growth of outlays—and, more particularly, Medicare and Medicaid spending—must somehow be cut.

This problem is hard enough. But it is only part of the national challenge. The same hospitals and physicians who serve Medicare and Medicaid patients also care for the privately insured. It is neither practicable nor desirable to seek significantly different standards of care for these populations. It is not practicable with current hospitals for patients on one floor to be given all that modern medicine has to offer, while patients one floor down face severe rationing. Nor is it desirable. No developed nation tolerates such distinctions in care. And Medicare and Medicaid were created precisely to reduce or eliminate them. As a practical matter, therefore, lowering Medicare and Medicaid costs *significantly*

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means limiting care for everyone—that is, rationing for all. The alternative—the *only* alternative—will be not only higher taxes but dedication of much—and eventually of all—of the growth in total income to health care.

That is a problem. A *big* problem. Solving it will politically divisive and socially painful.

I

That is my theme. Now, let me justify it. The first line of the slide (slide) shows official estimates of the current budget situation. Taxes are well below their historical average of a bit over 18 percent of GDP. Spending on the two large health programs, Medicare and Medicaid, and Social Security are about the same—just over 4 percent of output. The deficit this year is just under 5 percent of total output. That is high, and it is a problem for the nation's health. But it is more like malaria than e-bola. If it remained that size indefinitely, government borrowing would sap economic growth by absorbing private saving that could instead have financed investment here or abroad. It could eventually become lethal, but it will not quickly precipitate economic collapse.

Looking ahead (click), official projections indicate that Social Security by 2040 will be absorbing a bit over 2 percent of GDP more than it does today. That increase is small. It is spread over thirty-six years. Social Security costs rose by the same amount—2.2 percent of GDP in just the fourteen years before 1983. Political Chicken-littles to the contrary, this isn't close to being a crisis, although the projected long-term deficit in the Social Security trust fund *is* a problem, and it should be addressed soon.

Official projections also assume that *per capita* Medicare spending will grow 1 percentage point faster each year than earnings. A commission chaired by David Cutler recommended use of that assumption. I assume that Medicaid spending will grow at the same rate. Though 1 percent a year sounds small, the implications are troubling (click). By 2040 federal health care spending would grow by 7 percent of GDP, reaching more than 11 percent.

Buried in the category, “rest of government” (click) are offsetting trends. Rising interest payments on a ballooning national debt are slated to more than offset presumed declines in the share of national income spent on defense and all domestic activities other than pensions and health. The tax share (click) is assumed to return to its recent historical average from current levels. Under these assumptions, a huge budget gap would emerge.

Ask yourself how that deficit could be closed. By roughly doubling taxes from current levels? By cutting Social Security, Medicare, and Medicaid? Even if they were cut in half, something that no one deems plausible, nearly half of the gap would remain. By some combination of the two?

This scenario is troubling enough. Unfortunately, it is *unrealistically optimistic*. Medicare spending actually has outpaced wage growth not by 1, but by 2.5, percentage points a year. Total national

health care spending has outpaced income growth by the same amount—for more than forty years. For brief periods excess growth of health care spending has vanished, but it has invariably reasserted itself.

So, let's suppose that historical trends continue. In that event, things would get really ugly (click). Federal spending on Medicare and Medicaid would reach 18.5 percent of GDP—as large as all current government spending other than on interest on the debt is today. Total federal government spending would double. The gap between spending and taxes at historical average levels would reach the truly unthinkable level of more than 20 percent of GDP.

Nor is this all. The same forces operating on Medicare and Medicaid would be pushing up private health care spending. If total per capita health care spending continues to outpace income growth at historical rates, the annual increase in health care spending would claim an ever larger share of total economic growth. A cross-over point would occur in 2049. In that year, growth of health care spending would equal total economic growth.

Such projections should provoke two reactions. The first is that these are mindless extrapolations and that mindless extrapolations are, well, *mindless*. As the late economist, Herb Stein, wryly noted, “if something can't possibly happen, it won't.” The laws of arithmetic decree that nothing can continuously grow materially faster than something of which it is a part. Health care costs cannot continually grow significantly faster than income. So, they won't.

The second reaction should be to wonder just *how* growth of health care spending will be slowed. First, the pace of advance in medical technology might slow. That outcome seems unlikely and undesirable. The revolution of information technology and the breakthroughs in cellular and molecular biology of recent years foretell continued rapid medical advances. Given the promise for betterment of the human condition latent in recent advances, any significant and sustained slowdown in scientific advance would be a catastrophe.

Two benign possibilities come to mind. First, genetic or other medical advances might convert humans into the biological equivalent of William Cullen Bryant's *Wonderful One-Hoss Shay*. That fanciful contraption ran perfectly for 100 years and a day and then collapsed in a heap. A cheap human analogue is an outcome devoutly to be wished. But techniques to bring it about are, alas, hard even to imagine. No one should be deluded by the possibility—confidently forecast by some, derided by others—that cures for some forms of cancer or certain other diseases might soon be found. Solid research has established that cures for some of the principal killer diseases might increase life expectancy over the next few decades a bit, but that the impact of such advances on costs of health care would be small.

Second, advances in medical science might begin to lower health costs, rather than boost them. This outcome *is* conceivable, but it too is unlikely. Scientific advance often lowers prices—what we pay for a single unit of something. It seldom lowers cost, which is price times the quantity of that something that

we buy. The automobile and the airplane, computers, movies, and recorded music all lowered prices—of transportation, of computation, of hearing or seeing musical or staged performances. But all increased cost—the totals spent on these services. There is one exception to this regularity. Hybrid seeds lowered the price—and the cost—of many foods. Unfortunately, we should not take much comfort from this exception. Human food consumption by a given population has certain natural limits—although the current epidemic of obesity seems quite literally to be expanding those limits. No such limits apply to our capacity to invest in delaying physical and mental decline and forestalling death.

We should be clear that if technological fixes are not in the cards, nothing in current institutional arrangements will slow the growth of health care spending. The current payment system is one in which well-insured patients have every incentive to want all care that provides any benefits—however small—at any cost—however large—and most providers have every incentive to give patients what they want. Most health care spending occurs during episodes that are costly enough so that insurance insulates patients from most cost. On the providers' side, professional ethics require providers to act as their patients' agents. Furthermore, most providers are compensated on a fee-for-service basis. And providers are usually paid from many sources so that no buyer has enough leverage to materially retard investments in new technology. Managed care and government regulation have shown that they cannot change this underlying relationship, however skilled they may be at annoying everyone.

Some now suggest that health care spending can be slowed, simply by introducing competition in the purchase of health insurance. The idea is that individuals would be enabled, through refundable tax credits or some other means, to select among insurance plans. Competition, it is alleged, would force insurance vendors to hold down prices as part of their quest to find and retain customers.

I believe that this approach is a chimera. The reason is that the great bulk of spending occurs during episodes when any insurance policy worthy of the name would cover essentially all costs. No incentives would exist for patients not to seek all beneficial care. There would be no reason for providers to deprive themselves of the capacity to provide it.

Effective limits on health care spending require the denial of some beneficial care to some well-insured patients—that is, rationing, and effective enforcement everywhere requires political intervention in some fashion. In some cases, fixed budgets are appropriated to hospitals. In others, large collective groups such as unions or occupational groupings negotiate fees and service standards with providers. Such limits could come to the United States in various ways. None is now on the political horizon. Neither are the grossly higher taxes that would be necessary to provide the services that will be demanded under current institutional arrangements. But, in logic, there is no way to escape one or the other.

That some combination of these alternatives is inevitable and neither seems now to be acceptable to the American public underlie my conviction that rising health care costs pose a formidable problem to the American political system and to American society.

Because this problem is so serious, I believe that it is urgently important for economists and other social scientists to collaborate with physicians and biological scientists in devising ways to ration rationally. That means greatly increased investments not only in developing the evidence for evidence-based medicine, but also in designing ways of enforcing limits that would enjoy political legitimacy. It means careful study of how to blend professional and lay judgments on how limited resources should be used. It means development of new legal doctrine to cope with the spate of bad outcomes that denying some beneficial care would necessitate.

Let me be clear. Nothing in what I have said is inconsistent with allegations that U.S. health care administration is cumbersome and needlessly costly. Nothing in what I have said is inconsistent with claims that a sizeable portion of health care produces little benefit. Nor is anything I have said inconsistent with the solid research—by David Cutler and others—showing that despite such waste, few Americans would trade their current care, with all its red-tape and waste, for the more innocent and less costly system of an earlier year. On the average, the benefits of technological advance have vastly exceeded the costs and are likely to continue to do so.

What I am saying is that even if we can streamline administration, even if we can eliminate wasteful care, even if every single health care dollar is spent so wisely that benefits exceed costs, achieving these meritorious ends will take many, many years. Meanwhile, beneficial interventions will proliferate. Some will reduce price. Nearly all will boost cost. And figuring out how either to pay the bill or to constrain the cost will threaten the stability of U.S. politics, of labor-management relations, and of the legal system—that is, of the nation.