DOES AMERICA SPEND TOO MUCH ON HEALTH CARE?*

RALPH L. ANDREANO, Ph.D.

Department of Economics
University of Wisconsin
Madison, Wisconsin

WE spend about 9% of our gross national product on personal health care. Is this too much? It is, of course, impossible to say whether we spend too much or too little of our national product on health care. I am not aware of any research that tells us what the optimal level of health spending should be in relation to national product. Two international meetings in the 1970s explored the escalation in the shares of national product health care was receiving in western countries.[1,7] And within the past two years the subject has been treated again by an Organization for Economic Cooperation and Development (OECD) study on resource allocation in health.[4]

It is difficult to put together international data which are very recent, but during the mid-1970s proportions of national product spent on medical care were uniformly high in western industrialized countries. For the 24 leading, non-Communist, industrialized developed countries, the average percent of total (public and private) health expenditures to Gross Domestic Product was about 6%; by 1980 the average will be probably 7 to 7½%. The United States, throughout the decade of the 1970s, exceeded the average of total spending to national product of its industrialized sisters, but still health expenditures in Sweden, Germany, Australia, Holland, and Canada took almost as significant a share of national resources as in America.

If one plays around with some of the numbers in these international reports, it does seem that during the decade of the 1970s shares of national product grew in western industrialized countries at 1½ percentage points, on average, for the decade. Insofar as I can tell from published accounts, the growth rate for health exceeds that for almost anything else

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including national defense, other social welfare programs, and education. It is probably not surprising, then, that there should be worldwide concern with the levels of resource commitments countries make toward health care and equally serious concern as to whether or not the benefits of these expenditures outweigh the costs.

Of course, the belief is strong among policymakers that the American health system does cost "too much" and produces "too little" of what society wants. The belief is also strong, again among experts and policy makers, that the system is riddled with inefficiencies, excess capacity, and a financing mechanism for health care which generates these characteristics by removing any restraints on the key actors—consumers, providers, and governments—to economize on the use of resources.

For example, in the Department of Health, Education and Welfare prepared briefing paper on the President's Hospital Cost Containment Bill, a onetime slack in total national expenditures of about $10 billion was detailed. The slack identified ranged from excess hospital beds to energy savings from better energy management control. It is little wonder, then, that policymakers feel a sense of urgency about correcting what they perceive to be such massive market failure, especially in the hospital sector.[6] And that is a perception observed in all non-Communist countries, not just in America.

I want to make it clear that whatever proportion of national product is spent on health by a country can be generated by an efficient or an inefficient industry. Given the nature of demand for medical care, even an efficiently organized industry does not necessarily imply reductions in the share of national product going to medical care. It is generally believed that the American health sector is inefficiently organized and that market behavior presumed under a well functioning price system does not dominate consumption and production decisions. In this sense, the 9% gross national product America spends on medical care probably does not represent the consumption level that would be chosen if prices allocated resources. From this perspective, it is difficult to say that we currently spend in America the amount, all things being equal, that we would choose to spend if consumers had to allocate their consumption levels based on the prices they faced, their own incomes, and the prices of available substitutes.

Belief is also widespread that 9% of gross national product is not what we would choose to spend because of the rate at which expenditures on

health care have grown in recent years, especially when compared to other parts of the economy. We have benefited from innumerable analyses of what seems to cause health care costs to rise faster than general economywide inflation rates and, of course, there are many hypotheses about this. I do not need to recount these stories again.

For whatever comfort it may be, however, health care prices have risen dramatically in all western countries during the past half decade. Some, such as Germany, have been more successful in containing health cost inflation. In America we have not succeeded very well and because of this we have embarked on rather elaborate planning and regulation in the hope that production and consumption decisions can be brought closer to what private market forces might have produced.

As this group well knows, the 1970s have produced a panoply of government regulation and planning in the presumed belief that the rate of growth in health care costs would not be self-correcting and that interference with health markets—regulating the supply of new resources, rationalizing excess capacity, and limiting the prices charged for some big-ticket items (like inpatient hospital care) was required. The classic "market failure" that allegedly exists in health, where "too many" cardiac surgeons, for example, are being produced, but "too few" primary care doctors, invited government regulation and supports the conclusion that the price and market system could not self-correct these apparent disparities between the producers of health care and what consumers wanted. The uneven distribution of access to health care, huge gaps in insurance coverage, uneven distribution of medical care resources, all suggested that the health industry could not be left alone, could not be left unplanned and unregulated.

Indeed, the political climate of the last decade generated by the rising share of national product spent on health has offered two policy alternatives, not mutually exclusive: planning and regulation and national health insurance. The presumption, widespread among policy makers, is that we could and will spend more than 9% of gross national product and still have distributional inequities and endemic inefficiencies in the production of health care.

I think there is a need in the current climate of opinion for some balance and realism. The level of national product in American devoted to health care is large, but our national product is also very large. Compared with other western, developed, and industrialized nations, America is not alone

PHYSICIANS' INCOME IN RELATION TO GROSS DOMESTIC PRODUCT PER HEAD. SELECTED COUNTRIES, AROUND 1974

Country	*Ratio of physicians' incomes to gross domestic product per head*
Belgium	6.3%
Canada	6.8%
Holland	10.2%
United Kingdom	4.5%
United States	6.7%
Average	6.2%

Source: OECD: *Public Expenditures on Health*. Paris, 1977, p. 24.

in being a big spender for health and medical care, nor in having an inefficiently structured medical care industry. Indeed, under a wide variety of health systems—centralized, decentralized, purely public, semi-public/private, and purely public—the size of per capita national product seems to be the principal determinant of levels of spending for health care, regardless of industry efficiency or distributional inequities.[2,3] Newhouse[3] has shown that the implied elasticities of medical care with respect to gross domestic product substantially exceed one. Thus, as per capita national product grows, rich nations tend to spend a higher proportion of those gains on medical care.

Medical care may indeed be, in the technical definition imposed by economists, a luxury good. Prices are not important in rationing production and consumption. As Newhouse and others have pointed out, if medical care is to be viewed, at least for conceptual purposes, as a luxury rather than a necessary good, it raises very serious questions about what a country is getting, at the margin, for the resources it expends on health care. In other words, is an additional dollar spent on health care "worth it?" Or, as we are witnessing in America with the vast increases in producers' payments (doctors, hospitals), does the increased level of expenditure, at the margin, go into the incomes of the factors of production and is, therefore, not buying society measurable health improvements? Another way of putting this question is: as health care expenditures rise, do physicians (it could be other health producers as well) get more than a disproportionate share of these increases? The answer appears to be no. Physicians' incomes, for example, across countries appear to rise proportionately with shares of gross national product spent on health care rather

than disproportionately.[4] It may also come as some surprise to this audience that, compared to the size of one's overall economy, physicians' incomes in America are not out of line with other rich countries (see table). If rising fractions of medical care expenditures, at the margin, are not therefore going into higher factor incomes, what does this additional expenditure produce? If medical care is viewed as a luxury good, rising shares of national product lavished on it may well represent our perception that we want "caring" from our medical system almost as much as we want "curing."

Even for an economist, it is hard to infer what this may mean for current health policy in the United States. But it does seem clear that the problems we think that we face in America over how much we spend on health care and what health care now costs are as much due to the wealth and income of the American economy as they are to structural inefficiencies in the production and distribution of medical care services. Where does this leave us? I started by asking: "Does America Spend Too Much on Health Care?" My answer is: "I do not know." I am not aware of any widespread dissatisfaction among consumers with the quality of medical care. There does seem to be widespread dissatisfaction with the cost of medical care, especially inpatient hospital care. This may, however, be as much a function of the depth of one's insurance coverage (and thus how much out-of-pocket costs are incurred) as it is with the actual cost of the care received.

For example, a recent hospital cost survey done in Wisconsin shows the sort of dilemma people feel they are in. On performance, regarding hospital care, the people of Wisconsin give their hospitals very high marks from both those who recently were in a hospital and those not. On the other hand, almost 92% of those surveyed said they were personally concerned with hospital costs and this concern increased with age, but decreased with educational level. Similarly, despite overwhelming concern with cost, more than half of the survey population rejected government regulation of hospital annual revenues, nearly two thirds rejected government regulation of the type of service a hospital could offer, and nearly 90% supported the view that hospitals should be encouraged voluntarily to cut costs. The Wisconsin Survey also asked respondents to compare changes in hospital costs with changes in food, housing, and utilities' costs. Except for food costs, about half the respondents viewed hospital costs as increasing at about the same rate as housing and utilities' costs.

Finally, nearly two thirds of those surveyed expected to pay more, relative than at present, for hospital care out of their own pockets during the next 10 years.[5]

It seems fitting, given the tone of my presentation, that some comments should be offered regarding the future. It does seem to me that current planning and regulatory efforts are not likely to succeed in *reducing* the level of national product devoted to health even if production efficiency is improved. I think most policymakers would settle for *containment*—i.e., growth at economywide levels of prices and productivity—rather than outright reductions. Similarly, I fail to see national health insurance as a cost containment strategy: it may well improve social equity, and I certainly favor this; but I am not impressed by the arguments that it will improve production efficiency. It is difficult to perceive of a massive structural change in the American health system that could be achieved through any politically acceptable version of national health insurance. I favor it, but not because it is going to restructure the delivery system and taper off the level of national product going to medical care. I favor it almost alone on equity grounds.

So, during the next decade, while the pressures to slow the rate of growth in personal health expenditures will be forceful and more inclusive and encompassing than the panoply of planning and regulation faced in 1979, I just do not think that we can expect any major change in national priorities that would give health and medical care a smaller share of our resources than it has now.

The future of the American economy of the 1980s is far from clear, in any case. We are already in double-digit inflation because of energy and food prices. Productivity gains in the economy are pitifully constant. New technology breakthroughs that could generate high economywide growth rates don't seem to be on the horizon. Energy prices are the key growth variable of the 1980s and it seems that those prices will be extraordinarily high for at least the first half of the decade. However, the capacity of the American economy to adjust is well known and perhaps the pressure that high energy prices will produce on all relative prices will make viable a whole series of technologic changes that will vastly reduce the economy's energy dependence. At least one hopes by the end of the decade to have seen these adjustments work their way through the economy.

Yet another scenario, should energy costs put a more prolonged crunch on the American economy than it has up to now, is vast international

military adventures. One hopes earnestly that we can solve our economic growth problems without war.

In sum, the 1980s may well be a mirror image of the 1970s: modest real growth, high inflation rates, and stagnant or slowly rising productivity. In this state of the world, it is hard to see how we could spend less, proportionately, on health. The change in the population's age structure, the very values of western medicine, and the mixed perceptions of health care as necessity *qua* luxury all suggest rising rather than declining shares of national product for health. But, of course, I do not vouch for this forecast and, it should be noted, I am usually wrong about most things! Forecasting, like medical care itself, is a risky business.

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