The longer-term picture is, as always, cloudier. Perhaps President Obama will pursue recess appointments. A new president and Congress could, in 2017 and beyond, unshackle the IPAB in response to deficit pressures and the search for Medicare savings. And if Medicare spending growth accelerates, the IPAB’s role could expand. Yet a new president could also refuse to appoint any members or enforce the spending targets, and Congress could repeal the IPAB in 2017. The IPAB’s demise would, in that scenario, deal a symbolic blow to health care reform and cost containment. But the impact on Medicare expenditures and national health spending would be negligible. For all the hype, the Congressional Budget Office currently forecasts no savings from the IPAB over the next decade.

Regardless of the IPAB’s future, one thing is clear: rather than removing politics from Medicare, the board’s difficult early journey has underscored just how entrenched politics are in health care policy.

The Gross Domestic Product and Health Care Spending

Victor R. Fuchs, Ph.D.

How much will the United States spend on health care during the next decade or two? The answer matters greatly to physicians, federal and state governments, businesses, and the general public. The answer will determine the type and extent of care that physicians can provide to their patients, as well as the amount of physicians’ take-home pay. It will also determine how much everyone else can consume or invest in other goods and services. Unfortunately, forecasting health care spending is extremely difficult. Future spending depends in part on developments within the health care sector and in part on developments in the economy as a whole. The former include changes in the prevalence of health problems such as obesity, infectious diseases, and dementia, as well as changes in medical technology such as new drugs, imaging devices, and surgical procedures. The economy as a whole includes variables such as the unemployment rate, trends in average wages, and prices of securities and housing.

The 2013 Economic Report of the President takes an optimistic view of future national health care expenditures, which is based on the slowdown in the rate of growth of those expenditures in recent years. Like most commentators, the report notes that one possible explanation is the recent recession, but it argues that this was not a major factor relative to improved efficiency in hospitals and physician groups, payment reforms, and early responses to the Affordable Care Act. If the United States is entering a new era of modest growth in health care spending, the current pressure for radical changes in funding, modes of payment, organization, and delivery of care would abate. On the other hand, if the current slowdown is primarily attributable to the most severe recession since the...
1930s, or to one-time changes that are not relevant to future trends, then rapid growth in health care expenditures is likely to return when the economy becomes more robust. In that case, the heavy lifting to control cost growth remains to be done.

An examination of data from the past 60 years for the economy as a whole and for health care expenditures indicates that there has been a robust relationship between the two. It seems premature to dismiss the sluggish economy as the major explanation for the spending slowdown of recent years. In the line graph, the economy is represented by the gross domestic product (GDP), which is the total value of all goods and services produced in a given year or its equivalent, the total income received by all contributors to production (e.g., labor, management, and capital). The GDP and national health care expenditures are adjusted for population growth and general inflation. Between 1950 and 2011, real GDP per capita grew at an average of 2.0% per year, while real national health care expenditures per capita grew at 4.4% per year. The gap between the two rates of growth — 2.4% per year — resulted in the share of the GDP related to health care spending increasing from 4.4% in 1950 to 17.9% in 2011. Most experts believe that a gap of close to this magnitude over many future years would have catastrophic consequences for the federal government and the U.S. economy.

In order to observe whether fluctuations in national health care expenditures are related to fluctuations in the GDP, annual data for each series are smoothed with a 5-year moving average (to increase reliability), and the GDP value for each year is increased by 2.4% (the average gap) to facilitate visual comparison of short-term movements in the two series. The correlation is not perfect, but over a period of 60 years, most sharp increases (and decreases) in the GDP have been accompanied by similar movements in health care expenditures. Note the long acceleration in both series in the 1960s, the slowdown around 1980, the subsequent acceleration in the late 1980s, and the recent sharp deceleration when both national health care expenditures and GDP rates of growth fell by more than 2.0% annually in just a few years.

The one big exception to the correlation is the mid-1990s, when growth of real national health care expenditures per capita was below 3% per year even though real GDP per capita was accelerating. This was precisely the period during which managed care became widespread. Prior to the 1990s, most insured patients could choose freely among providers, physicians were paid on a fee-for-service basis, and their decisions were rarely questioned by insurers. Under managed care, insurance companies selectively contracted with hospitals and physicians, fees and prices were negotiated in advance, physician decisions were subject to outside review, patients faced financial penalties if they obtained care “out of plan,” and providers sometimes shared in the insurance risk. A backlash from patients and providers followed, accompanied by a large increase in health care spending.

The spread of managed care in the 1990s, however, seems to have had an effect on long-term trends in expenditures as well as on short-term changes. Between 1950 and 1995, real health care expenditures per capita grew at an average annual rate of 4.7%, while real GDP per capita grew at 2.1%. Between 1995 and 2011, the average rates were 3.1% for real health care expenditures per capita and 1.4% for real GDP per capita. Thus, the average gap fell from 2.6% in the pre-1995 period to 1.7% in the post-1995 period. Resumption of the 60-year gap of 2.4% per year until 2040 would result in health care’s absorbing 30% of the GDP, as compared with the current 18%. Continuation of a 1.7% gap until 2040...
In conclusion, the rate of growth of national health care expenditures in the past appears to have been substantially related to the growth of the GDP. There has been some slowing of the growth of health care spending relative to the GDP, but it began not just a few years ago, but in the 1990s, for reasons that remain to be determined. One possibility is that the movement to managed care in the 1990s resulted in long-term slowing of health care spending, an effect temporarily obscured by the increase in spending during the backlash.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Departments of Economics and Health Research and Policy, Stanford University, Stanford, CA.

This article was published on May 22, 2013, at NEJM.org.


DOI: 10.1056/NEJMp1305298
Copyright © 2013 Massachusetts Medical Society.