

Health Costs Absorb One-Quarter of Economic Growth, 2000 – 2005

Recent Federal Report Unintentionally Obscures Massive Rise Physicians' Decisions Key to Controlling Cost

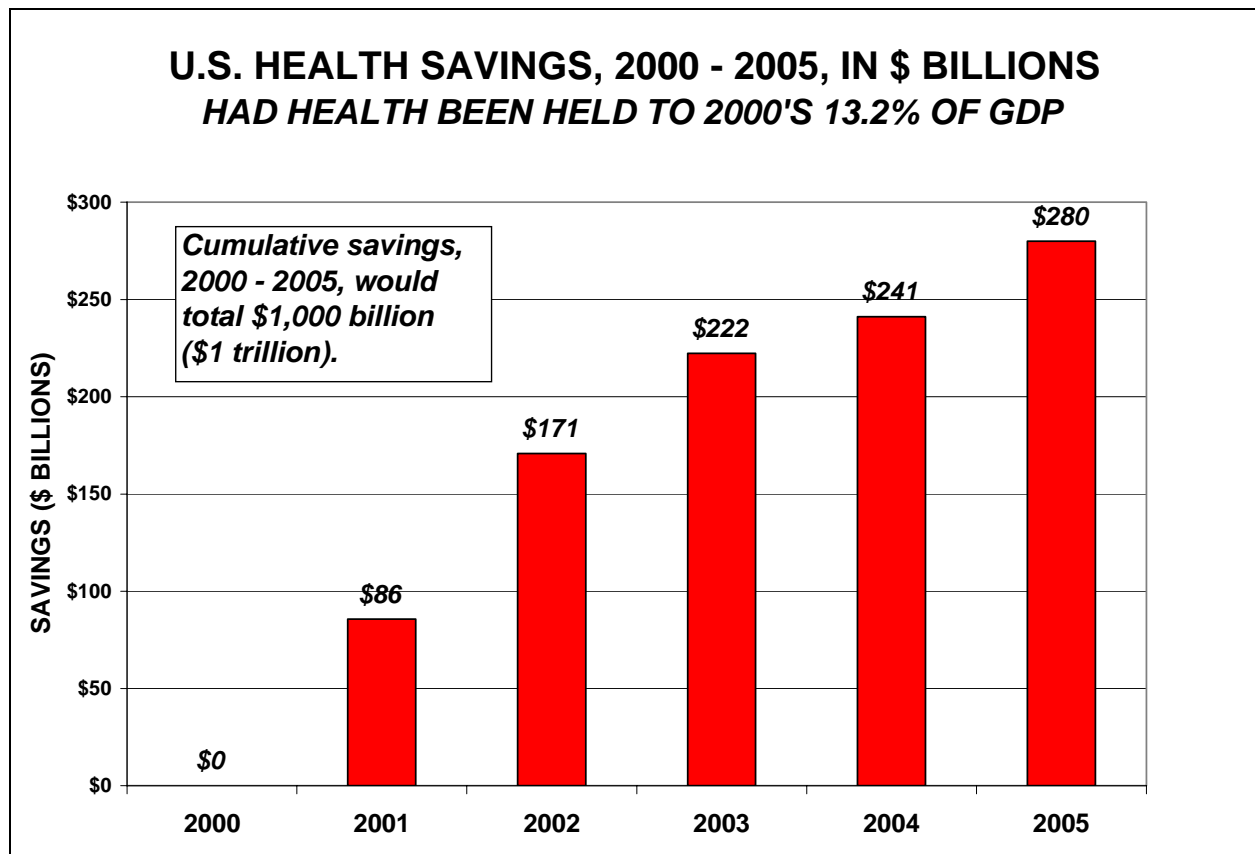
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SUMMARY

I. HEALTH CARE COSTS ARE STILL SOARING UNSUSTAINABLY

- The expected \$621 billion rise in U.S. health care spending from 2000 to 2005, we find, will consume nearly one-quarter of the nation's projected economic growth (rise in GDP) of \$2,579 billion (\$2.6 trillion). [Exhibits 8, 9]
- This rests on a reliable federal projection that 2005 health spending will reach \$1,921 billion (\$1.9 trillion). That is 15.5 percent of the economy, up sharply from 2000's 13.2 percent share. [Ex. 4, 5]
- Had health spending in those five years grown only as fast as GDP, the U.S. would have saved \$280 billion in 2005 (one-seventh of expected health cost), and \$1 trillion in five years. Health spending growth averaged 8.1 percent yearly—more than two-thirds (69 percent) over GDP's 4.8 percent. [Ex. 6]
- If defense spending reaches \$540 billion in 2005, health spending will still be 3.6 times that. Health spending is now twice education spending. [Ex. 7, 8]
- In January 2005, federal researchers published detailed data on 2003 health spending. That report, the press releases, and some news accounts focused on small differences, single-year changes, and other details. They missed the big-picture cost and coverage problems that concern most Americans.
- Administration officials called the findings “good news,” an unduly positive view that stressed 2003's slightly slower rise in costs. Many press reports drew incomplete or incorrect conclusions. The data's main implication is that costs continue rising unaffordably. U.S. health costs suffered the third-largest percentage rise in a decade and the second-largest dollar rise ever. [Ex. 1 ,2]
- The accuracy of federal predictions of health spending permit and oblige the U.S. to now address current costs, not 2003's much lower costs. [Ex. 3, 4]
- Rising health costs force many people to drop insurance and make it harder to cover all Americans. The unsustainable rise in health costs also threatens the stability of hospitals, doctors, nursing homes, drug makers and other caregivers. It burdens all who pay for care, and weakens the U.S. economy.
- Still, many caregivers and access advocates have endorsed spending more to advance their distinct aims—partly because traditional cost controls have offered little to either group. It is essential, instead, to contain cost in ways that squeeze out waste, and mobilize the savings to finance high-quality care for all Americans—while paying all needed caregivers adequately.

(continued)

II. BUT NEW STRATEGIES COULD CONTAIN COST, FINANCE NEEDED CARE FOR ALL PEOPLE, AND STABILIZE CAREGIVERS

- Traditional competitive and regulatory cost controls have failed in health care. The administration urges a new strategy, cost shifting, which it touts as “empowering consumers.” By promoting underinsurance, this strategy pushes patients to deny themselves care. There is no evidence that this is clinically safe or durably contains costs. Patients are the wrong target for cost controls.
- The alternative is to engage physicians in marshaling inevitably finite dollars to care for all Americans. Doctors are key to cutting cost because their decisions control 87 percent of personal health spending. [Ex. 10]
- One-half of health spending goes to clinical and administrative waste, excess prices, and theft. Physicians can identify clinical waste. Careful cost controls should rest on physicians’ decisions about services needed by each patient. Pathology is remorseless but resources are finite, so trade-offs are essential. There are no blank checks. Trustworthy methods of paying doctors should minimize incentives to over- or under-serve. Variations on this approach have been called “bedside rationing” or “professionalism within a budget.”
- It will be hard to engage doctors in this job, but their support is vital to gain backing for effective ways to contain cost and cover all Americans.
- The new Medicare law mandates a “national public debate” on how to make care affordable. But it focuses on the wrong questions, and on one crude cost-cutting tool—asking patients to gamble by excluding certain services from coverage. This process should explore other ways to cut waste and cost, and ways to foster careful physician decisions about appropriate care.
- In 2002, U.S. health spending per person was 2.1 times the average in Canada, France, Germany, Italy, Japan, and the U.K.—nations with greater elderly shares that cover all their people well. Current U.S. spending should be adequate to cover all Americans.
- U.S. health care lives on the hope that more money for business as usual will continue to flow. U.S. caregivers and payers are therefore spectacularly unprepared to economize if a serious recession were to hit. The economy’s fragility makes it vital to forge a contingency plan to live with no growth in real health spending. Caregivers must work with patients and payers to develop such a plan—one that avoids serious damage to both coverage and quality.
- Winning affordable high-quality care for all requires negotiating political deals. An acceptably-functioning free market is impossible in health care, so public action is essential to contain cost and expand coverage. Political deals must offer value to patients, caregivers, and payers. Agreement will be easier to negotiate if each party accepts the principle of “one hand for yourself and one for the ship” to balance private and public interests. [Ex. 11]

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Exhibit 1

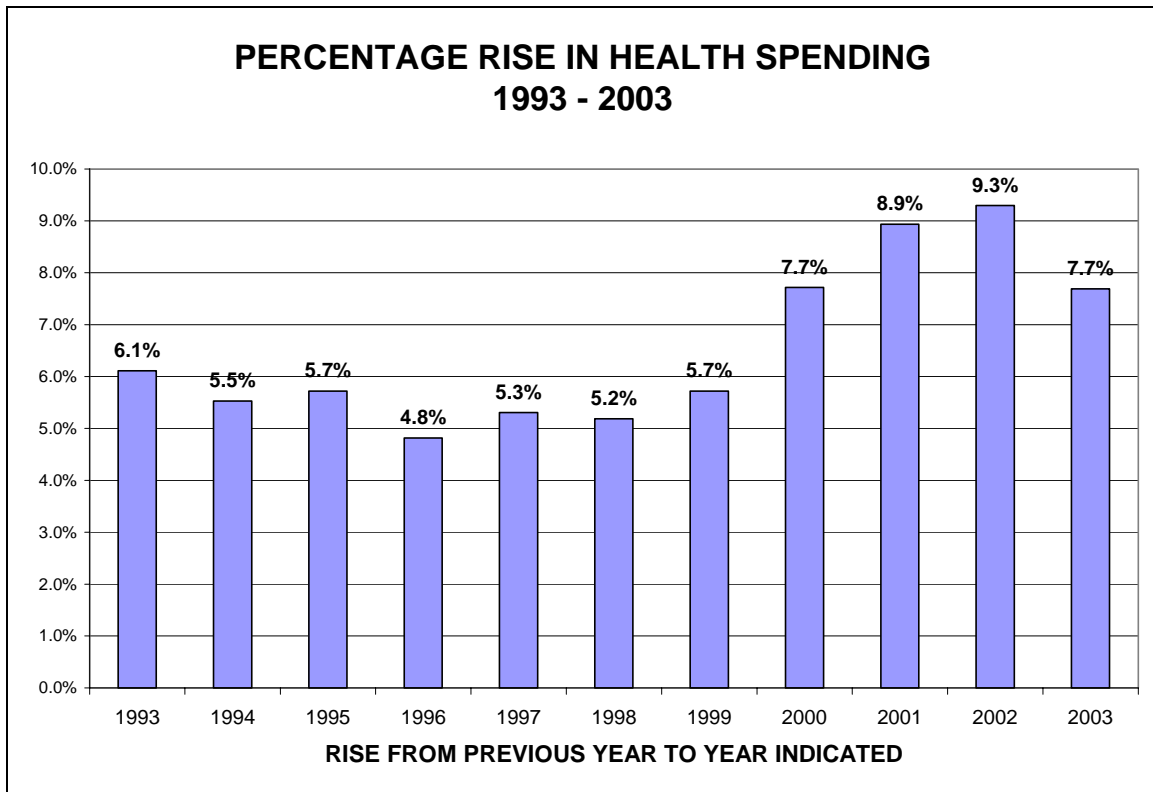


Exhibit 2

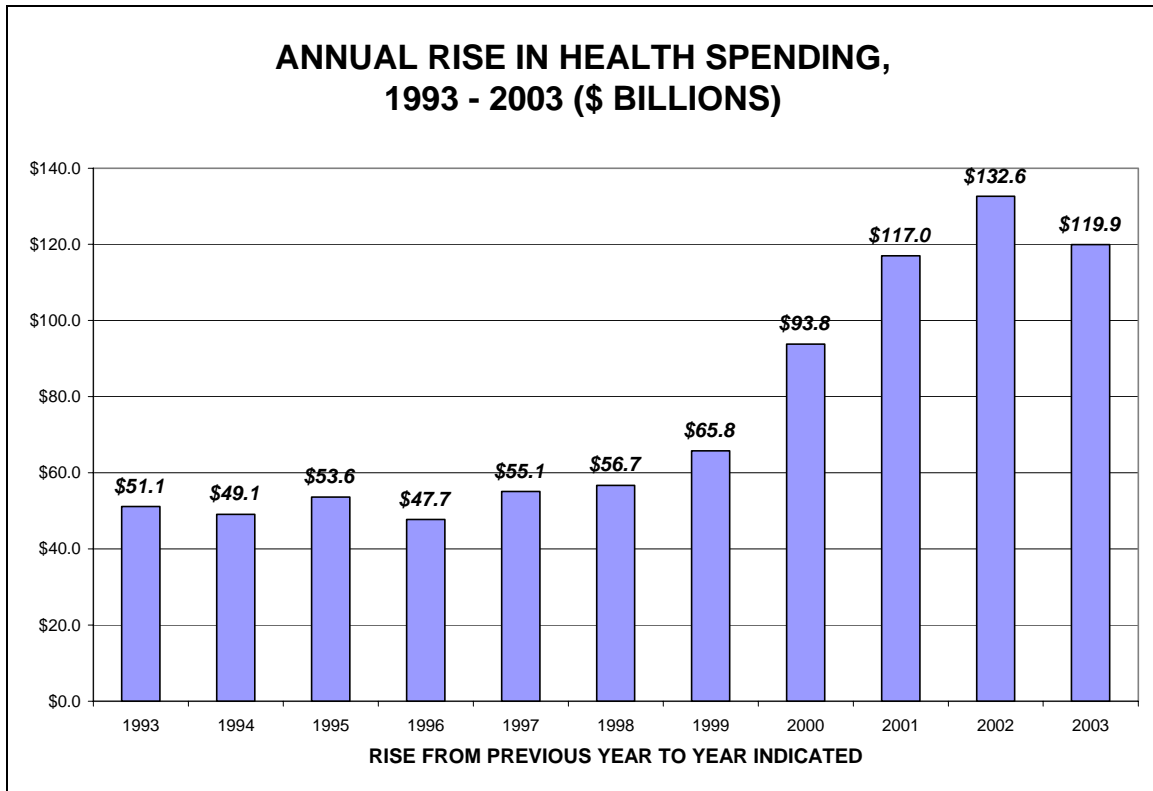


Exhibit 3

**Recent Projections of 2003 Health Spending
versus Actual 2003 Spending (\$ billion)**

	Projections for 2003 Published by CMS in			2003 Actual
	Feb 2002	Feb 2003	Feb 2004	Jan 2005
NHE, 2003	\$1,653.4	\$1,660.5	\$1,673.6	\$1,678.9
% difference from actual 2003	-1.5%	-1.1%	-0.3%	
NHE 2003 % of GDP	15.0%	15.2%	15.3%	15.3%

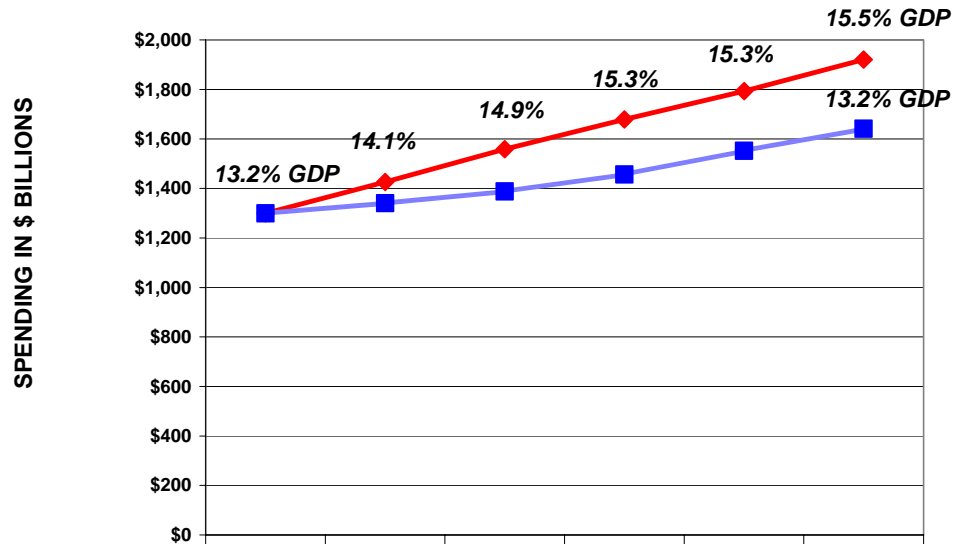
Exhibit 4

Recent Projections of 2005 Health Spending (\$ billion)

	Projections for 2005 Published by CMS in			2002-4 Difference in Projection
	Feb 2002	Feb 2003	Feb 2004	
NHE, 2005	\$1,902.2	\$1,907.3	\$1,920.8	+1%
NHE 2005 % of GDP	15.6%	15.7%	15.7%	+1%

Exhibit 5

U.S. HEALTH SPENDING, 2000 - 2005 ACTUAL SPENDING versus SPENDING HELD TO 13.2% OF GDP



◆ ACTUAL SPENDING	2000	2001	2002	2003	2004	2005
■ SPENDING AT 13.2% GDP	\$1,300	\$1,426	\$1,559	\$1,679	\$1,794	\$1,921
	\$1,300	\$1,341	\$1,388	\$1,457	\$1,552	\$1,641

Exhibit 6

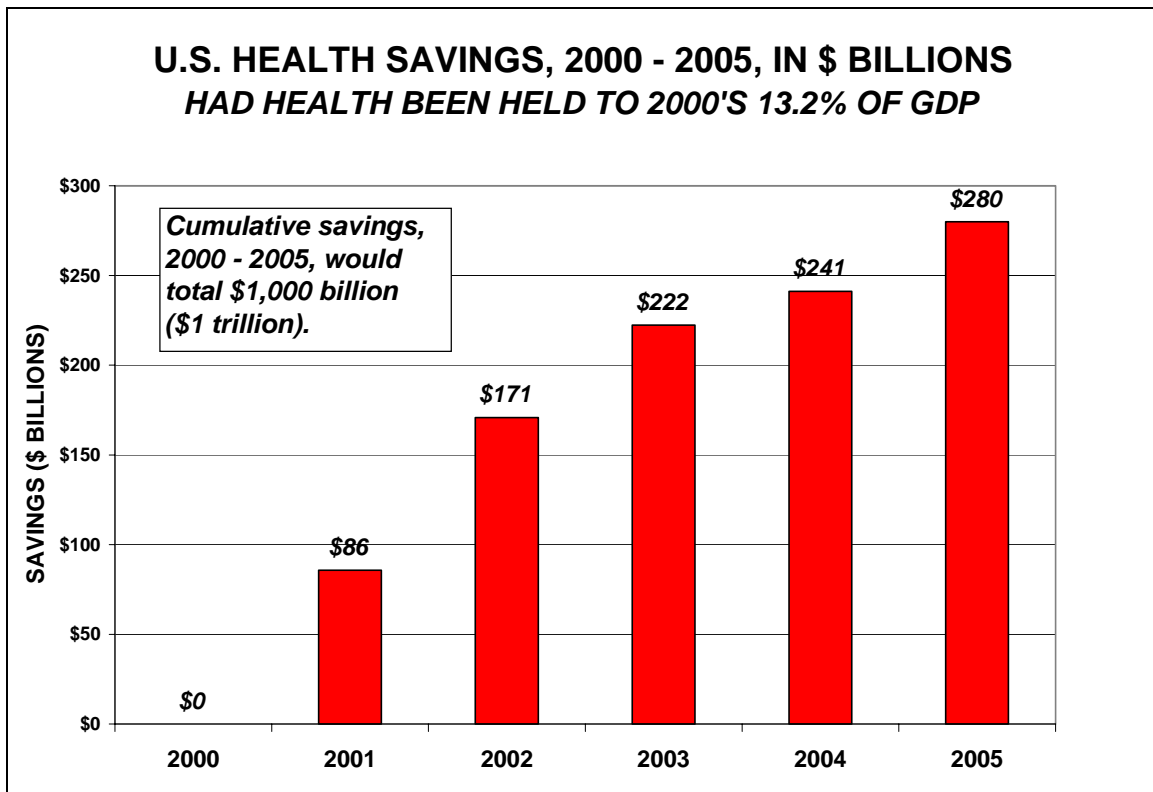


Exhibit 7

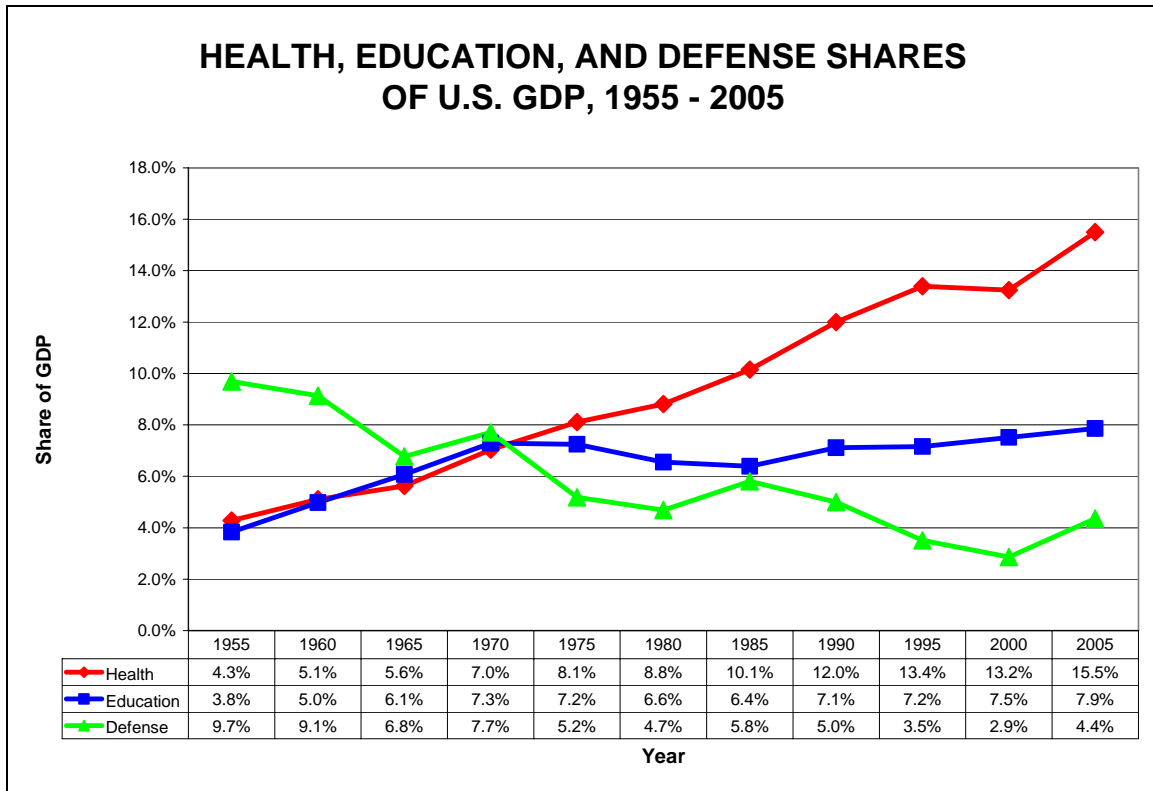


Exhibit 8

**Health and Defense Shares of GDP, 2000 and 2005
(Dollars in Billions)**

	CY	FY	CY	Percent of GDP	
<u>Year</u>	<u>Health</u>	<u>Defense</u>	<u>GDP</u>	<u>Health</u>	<u>Defense</u>
2000	\$1,300	\$281	\$9,817	13.2%	2.9%
expected 2005	\$1,921	\$540	\$12,396	15.5%	4.4%
<u>rise 2000-2005</u>					
Absolute	\$621	\$259	\$2,579	2.3%	1.5%
percentage	47.8%	92.0%	26.3%	17.1%	52.1%
<u>share of GDP rise</u>	24.1%	10.0%			

Exhibit 9

SHARES OF GDP GROWTH, 2000 - 2005

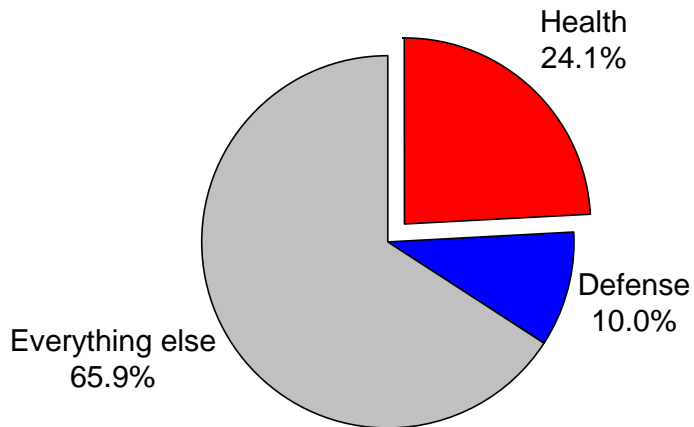


Exhibit 10

**PHYSICIANS RECEIVE OR CONTROL 87% OF
U.S. PERSONAL HEALTH SPENDING, 2003**

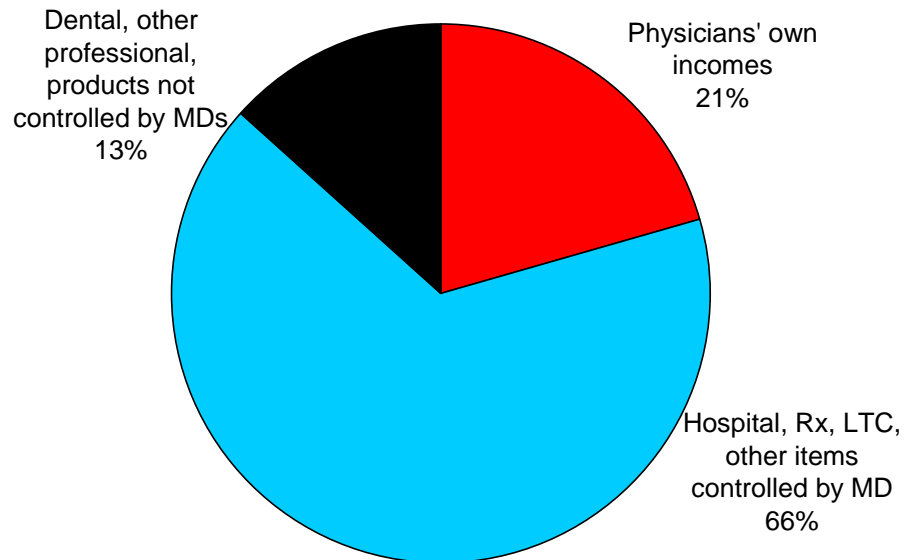


Exhibit 11

“ONE HAND FOR YOURSELF AND ONE FOR THE SHIP.”



The U.S.S. *Constitution*

Appendix Exhibit

SELECTED HEALTH SPENDING ESTIMATES AND PROJECTIONS, 2002-2005

	Actual		Projected
	2002	2003	2005
National Health Expenditures (\$ billion)	\$1559.0	\$1678.9	\$1920.8
Personal Health Care	\$1342.9	\$1440.8	\$1651.5
Prescription Drugs (Retail)	\$161.8	\$179.2	\$233.6
Coverage Administration + Insuror Profit	\$105.7	\$119.7	\$134.7
NHE per person	\$5,414	\$5,774	\$6,477
NHE % of Gross Domestic Product	14.9%	15.3%	15.5%

Sources:

Estimates, 2002-3: Cynthia Smith et al., "Health Spending Growth Slows in 2003," Health Affairs, Vol. 24, No. 1 (Jan.-Feb. 2005), pp. 185-194.

Projections, 2004-5: CMS, "National Health Care Expenditures Projections: 2003-2013," 6 Feb. 2004, www.cms.hhs.gov/statistics/nhe/projections-2003/highlights.asp.

NHE per person: Calculated by Health Reform Program using Census Bureau population data.