DATA BRIEF
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Crashing through the Windshield:
Massachusetts Health Care in the Downturn

Health Care Will Consume
18 Percent of Personal Income in 2002

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Health Care Will Consume 18 Percent of Personal Income in Massachusetts in 2002, New Estimates Show

Rising costs and stagnant incomes are likely to boost health spending's share of Massachusetts personal income to 18.1 percent this year, the highest in at least a decade and up from 15.8 percent in 2000.

Although slightly over 17 percent of personal income here went for health care from 1993 through 1995, health care's share dipped steadily to 16.4 percent in 1999 and to 15.8 percent in 2000. (See the following text table and Exhibit A.) But according to new estimates from Alan Sager and Deborah Socolar, directors of the Health Reform Program at the Boston University School of Public Health, the reductions of the previous eight years have been more than erased in 2001 and 2002 alone.

"Health care spending this year will impose the biggest burden in at least a decade on the pocketbooks of all who pay for care in Massachusetts—patients and their families, employers, and government," said Sager.

Massachusetts Health Spending, Personal Income, and Health's Share of Personal Income, 1993 - 2002

year	Health Spending ($billion)	Personal Income ($billion)	Health % of Income
1993	$26.7	$154.3	17.3%
1994	$28.1	$161.9	17.4%
1995	$29.2	$170.1	17.2%
1996	$30.4	$180.2	16.9%
1997	$32.0	$191.6	16.7%
1998	$33.8	$205.2	16.5%
1999	$35.7	$217.9	16.4%
2000	$37.8	$239.7	15.8%
2001	$41.5	$247.8	16.7%
2002	$44.7	$247.9	18.1%

This year, health spending in Massachusetts is expected to total $44.7 billion, the researchers estimate. Health spending per capita in Massachusetts in 2002 is likely to reach $6,990—almost $7,000 per person. By contrast, this year's U.S. average health spending per person is projected at $5,377.[1]

Health spending's proportion of personal income is one good measure of the burden of health care on families and businesses in Massachusetts. [2] While some health care costs are covered by the federal Medicare program and the federal-state Medicaid program, higher health spending in Massachusetts has also meant soaring health insurance premiums here. Many employers have responded by asking their employees to pay greater shares of the premiums, and by increasing co-payments for prescription

drugs or doctor visits. "Today's popular strategies offer no solution. Besides putting many patients at risk of going without needed care, higher patient cost-sharing requirements only shift the cost—they do not save money," Socolar observed.

There is reason to worry that these estimates of health care's burden are conservative. They reflect government data showing no growth in personal income in Massachusetts between the first quarters of 2001 and 2002.[3] (See Exhibit B.) But new figures indicate that the economy nationwide has grown even more slowly than previously thought in 2001 and 2002, which may portend downward revisions in estimated personal income.[4]

The health spending estimates used here also conservatively assume that, despite another year of double-digit premium increases, health spending is rising less rapidly this year than last.

Work by researchers elsewhere has suggested that health spending lags behind economic changes by some four years, growing or slowing after the economy does.[5] "Health spending often continues to rise even as the economy stagnates or moves into recession," Sager said. "This makes the present period precarious for patients, employees and employers, and hospitals, physicians, and other caregivers."

Recent federal government data[6] have confirmed long-standing Health Reform Program estimates[7] that Massachusetts already has the world's costliest health care—the highest per person health spending of any state, in the nation with the highest spending.

So the challenge before us all is to contain cost, cover everyone, and protect all needed caregivers without resorting to financially and politically explosive spending increases. More money for business as usual is not affordable.

We face two competing realities: spending here is highest in the world, but many hospitals, physicians, nursing homes, and other caregivers are not doing well financially. Many caregivers insist that they need higher payments from Medicare, Medicaid, HMOs, insurers, and other payors. But those payors can only get more money by increasing their burdens on employers, workers, taxpayers, and patients. With Massachusetts health care close to the breaking point, we must find ways to better spend the money that is already available, and to make do with modest annual increases.

That means reform—cutting administrative and clinical waste, winning lower drug and medical equipment prices from manufacturers, and streamlining the delivery of care. The market has not been able to do these things well. New approaches involving partnerships among public and private payors, caregivers, and patient advocacy groups will be essential.

Each of the main parties in health care—caregivers, payers, and patients—should think like the crew of old sailing ships: "One hand for yourself and one hand for the ship." Each stakeholder should help craft solutions that protect its needs but also respect the key interests of the other parties.

* * *

See Exhibits A and B, attached.

Exhibit A

MASSACHUSETTS HEALTH CARE'S SHARE OF PERSONAL INCOME, 1993 - 2002

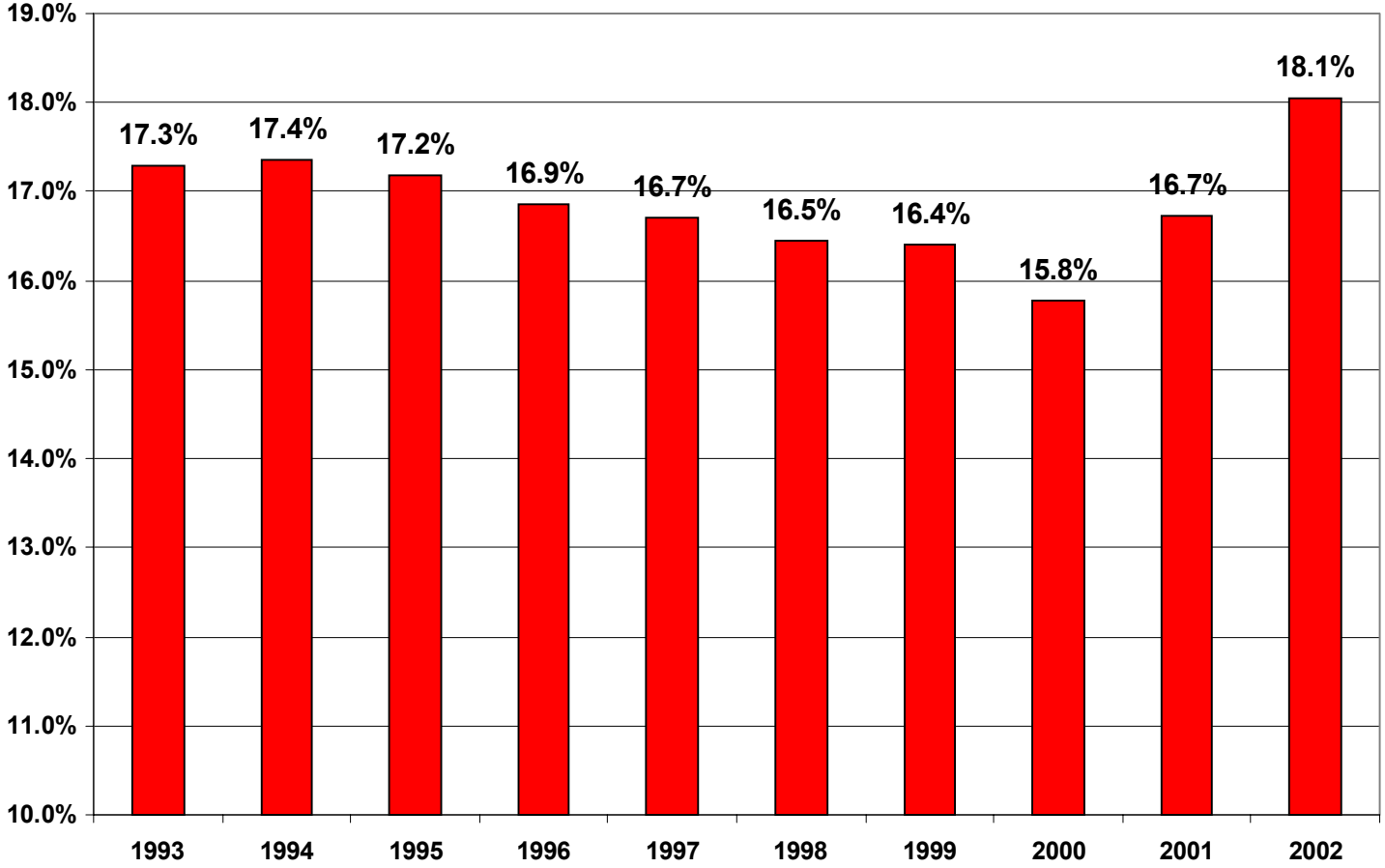
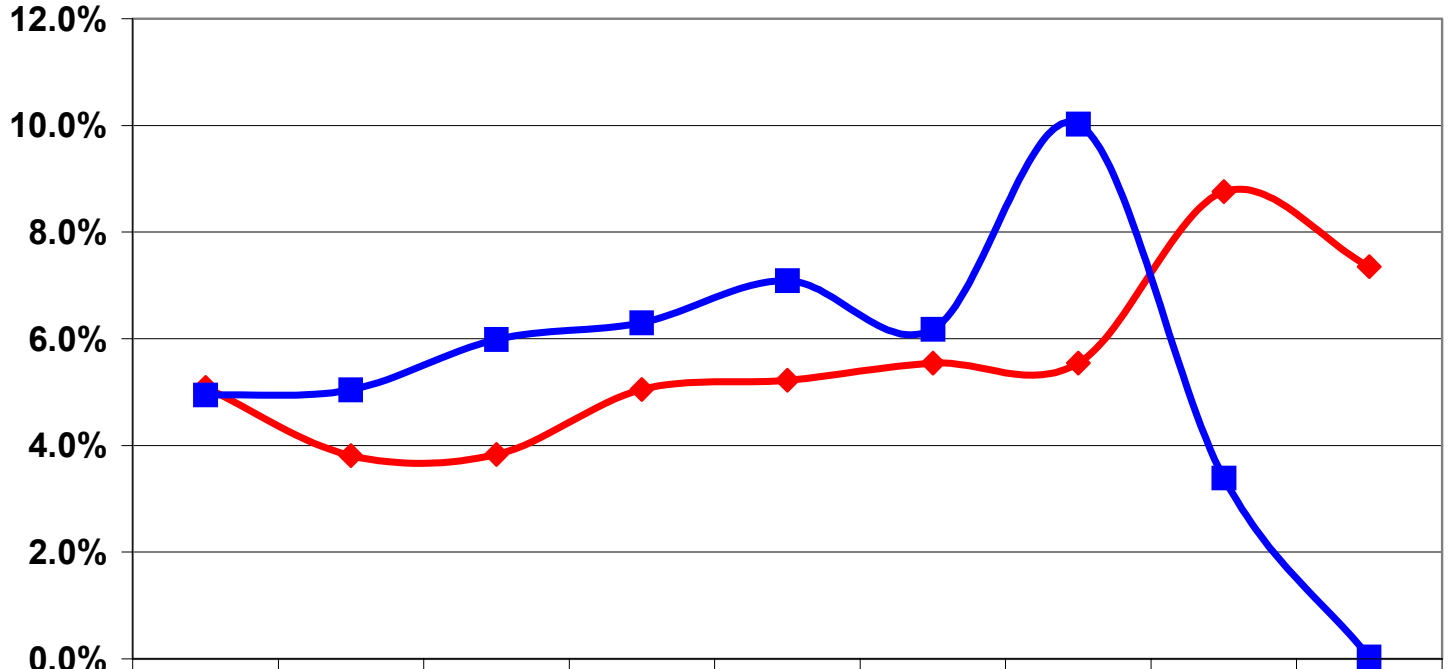


Exhibit B

HEALTH COSTS AND PERSONAL INCOME IN MASSACHUSETTS, ANNUAL PERCENT CHANGE, 1993-2002



	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
Total health spending	5.1%	3.8%	3.8%	5.1%	5.2%	5.5%	5.5%	8.8%	7.3%
Personal Income	4.9%	5.0%	6.0%	6.3%	7.1%	6.2%	10.0%	3.4%	0.0%

NOTES

[1] These are the authors' projections forward from federal estimates of state health care spending for 1998. See Centers for Medicare and Medicaid Services data posted at http://www.cms.hhs.gov/statistics/nhe/default.asp.

[2] Personal income in Massachusetts averages close to 5/6 of gross state product. Personal income generally equals gross state product minus depreciation, corporate savings, and corporate income taxes. Transfer payments are included. Health care's share of personal income is therefore a useful measure of its financial burden on all who live, work, or do business in the Commonwealth.

[3] Bureau of Economic Analysis, U.S. Department of Commerce, "State Personal Income: 1st Quarter 2002," 24 July 2002, http://www.bea.gov/bea/newsrel/spi0702.pdf, Table 1.

[4] Kenneth N. Gilpin, "Economic Growth Slowed Sharply in the 2nd Quarter," *New York Times*, 31 July 2002, http://www.nytimes.com/2002/07/31/business/31CND-ECON.html, and Bureau of Economic Analysis, U.S. Department of Commerce, "National Income and Product Accounts: 2nd Quarter GDP (Advance) -- Revised Estimates 1999 through 1st Quarter 2002," 31 July 2002, http://www.bea.gov/bea/newsrel/gdp202a.pdf.

[5] See, for example, Thomas E. Getzen, "Reducing Healthcare Costs: Is Being Poorer Better," *Healthcare Financial Management,* Vol. 39, No. 3 (March 1985), pp. 34-36; and Richard A. Cooper and Thomas E. Getzen, "Health Care Spending in One Chart," letter, *Health Affairs*, May-June 2002, http://www.healthaffairs.org/freecontent/v21n3/s36.htm#Cooper

[6] Anne Martin and others, in "Health Care Spending During 1991-1998: A Fifty-State Review," *Health Affairs*, July-August 2002, report estimates by state of patient residence. Data are posted at http://www.cms.hhs.gov/statistics/nhe/state-estimates-residence/phc-percap-1998.asp. See also estimates based on state of health care provider, Health Care Financing Administration, U.S. Department of Health and Human Services, 1980-1998 State Health Care Expenditures Estimates, 29 September 2000, posted online at http://www.cms.hhs.gov/statistics/nhe/state-trends/.

[7] Alan Sager and Deborah Socolar, *The World's Most Expensive Health Care: Massachusetts Health Care Costs, 1980 – 1998*, Boston: Health Reform Program, Boston University School of Public Health, 2 October 2000, www.healthreformprogram.org. See also, for example, Alan Sager, Deborah Socolar, and Peter Hiam, *Promise and Performance*: *First Monitoring Report on "An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing" (Chapter 23 of the Acts of 1988)*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 9 April 1989, www.healthreformprogram.org.