Unconventional Wisdom: Rising Health Costs May not be Attributable to The Graying of America

BY DEXTER W. BRAFF

It is well documented that health care spending in the United States is expected to rise dramatically over the next 25 to 50 years. In the National Health Expenditures report released earlier this year, the Office of the Actuary projected that spending would increase from $1.8 trillion in 2004 to $3.6 trillion in 2014—a compound annual growth rate of 7.1%. Furthermore, over a longer horizon, while total health care expenditures amounted to approximately 13.9% of Gross Domestic Product in 2001, CMS recently projected that health care may consume as much as 38% of GDP by 2075.

As surely as we know that health care expenditures are soaring, we also "know" that this is due, in large part, to a population base that is aging as the baby boomers approach their sunset years. But like so much conventional wisdom, it may be conventional, but it may not be wise—or accurate.

To move beyond convention, we turn to the findings of Uwe Reinhardt, Ph.D., and James Madison Professor of Political Economy at the Woodrow Wilson School of Public and International Affairs, Princeton University, in an extremely thorough and thought-provoking article on the subject entitled, "Does the Aging of the Population Really Drive the Demand for Health Care?"

In simple terms, in order to evaluate the impact of an aging population base on health care spending, it is necessary to hold all other variables constant and project what "per capita health spending would be in specific future years, if the age-specific use of health care were to remain constant at current levels over the entire forecast horizon." By doing so, one can isolate changes in spending related solely to changes in the age composition of the population, excluding other factors that may come into play (more on this later). Several researchers have done just this, and their findings are compelling.

In a 1992 article cited by Reinhardt entitled "National Health Expenditures Projections through 2030" by Sally Burner, D.R. Waldo, and D.R. McKusick, after a period of substantial growth in spending, the authors projected personal health spending would increase from $585 billion in 1990 to $14.8 trillion in 2030, an average compound growth rate of 8.4% (a figure that is higher, but not terribly inconsistent with CMS's recent projections through 2014 as stated above). According to Reinhardt, "after reviewing the various factors that drive this growth rate in spending—medical care price inflation, greater resource intensity of treatments, including the availability of new technology overall, population growth, and so on, Burner and colleagues concluded that the aging of the population adds another 0.5% per year to expenditure growth, which means that the aging of the population explains only a fraction of about 0.06 of the total projected annual spending growth of 8.4%.

He cites several other studies that come to similar conclusions. In one, Bradly Strunk and Paul Ginsburg analyzed historical and projected health care spending from 1991 through 2010 for the population under the age of 65, and concluded that "despite widespread belief to the contrary, aging baby boomers are not a major driver of rapidly rising health care costs for

1 National Health Expenditures Report
3 "Increased Spending on Health Care: How Much can the United States Afford, Michael E. Chernew, Richard A. Horch, and David M. Cutler, Health Affairs, July/August 2003, page 16
4 "Does the Aging of the Population Really Drive the Demand for Health Care?", Uwe E. Reinhardt, Health Affairs, November/December 2003
5 Ibid, page 29
6 Ibid, page 30

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Americans under age 65". Additionally, based on simulations using data drawn from Medical Expenditure Panel Surveys (MEPS), Reinhardt reports that "if only the age structure of the U.S. population changed over the period 2000-2030, then average annual per capita health spending would be projected to grow at an average annual compound rate of only 0.4 percent over this long horizon".

In analyzing these findings, a shrewd observer might suggest that by holding per capita spending for age-specific groups constant, researchers could underestimate the impact of aging demographics if health care spending per capita on the elderly grows disproportionately faster than that of the young. A reasonable, and arguably conventional, assumption to make. But again, the research suggests otherwise. In a recent paper titled "Trends in Medical Spending by Age: 1963-1999" by E. Meara, C. White, and D.M. Cutler, the authors indicate (a) between 1963-1987, the growth in health care spending was the highest for age groups 65-74 and 74 and higher, with the 0-5 age group only slightly behind, and (b) between 1987-1999, these trends seemed to have reversed with the middle population group of 6-64 accounting for the greatest increases in spending. As such, the empirical record belies the widespread notion that relative to health spending for younger Americans, health spending for the elderly in America is 'out of control'.

So if the aging of the population isn't primarily to blame for the rise in health care expenditures, what is? Again we refer to the observations of Uwe Reinhardt and others culled from several of his writings in which, among others, he identifies the following compelling reasons:

Rising Gross Domestic Product. Interestingly, studies have shown that about 90% of the variation in spending across OECD countries is attributable to GDP. Quite simply, the greater a nation's ability to pay for health care, the greater the spending that will be devoted to it.

High Labor Costs. Reinhardt observes that "the distribution of compensation in the United States is wider than in most of the other industrialized countries. The highly trained and highly talented health professionals employed in health care must be recruited from the same talent pool used by other industries offering high compensation, such as law and finance". Accordingly, labor costs are higher in the U.S.

Imbalance of Power Between the Supply and Demand Side of Health Care. Given such a fragmented payment system with numerous, disconnected payers, the supply side of health care wields greater power than that of the demand side - an imbalance that leads to higher prices. The situation is quite different in "other industrialized countries that either endow the demand side of their health systems with strong, monopsonistic (single-buyer) market power…or allow multipayer systems to bargain collectively with the providers of health care".

Administrative Complexity and Costs. The bane of U.S. health care providers. In numeric terms, Reinhardt cites one study that concluded that in 1999, as much as 24% of total health care spending was spent negotiating the paper-laden maze that exists between payers and providers. One item, though, is challenging an aspect of this conventional wisdom: "Commonwealth Fund president Karen Davis observed in her recent testimony before Congress [that] administrative expenses for private insurance in the United States are two-and-one-half times as high as those for public programs".

Availability and Utilization of Expensive Medical Technology. Another frequently cited contributor to rising health care expense, the numbers seem to bear out that the U.S. is indeed a comparatively high user of cutting edge treatments. Based on an analysis of OECD data in 2002 regarding the utilization of sophisticated (i.e. expensive) medical technologies including MRI units, CT scanners, and dialysis, compared to all OECD participants, the U.S. ranked above the median in each category. Moreover, regarding coronary angioplasties for which there was not enough data to calculate a reliable median, the U.S. performed an average of 388 procedures per 100,000 in population, nearly double that of the country that ranked second - Belgium.

Given such a complex interplay between the economy, health care policy, and health care spending, we suspect that others might interpret the financial and numeric metrics and calculations cited above differently than Uwe Reinhardt et al. That said, the arguments raised above are compelling enough to challenge our most firmly held beliefs about the relationship between our aging population and health care expenditures. And in doing so, it also directs our attention to other policy areas - ones in which we arguably have greater control - that can be addressed to constrain these costs in the future.

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7 Ibid, page 30
8 Ibid, page 33
9 Ibid, page 34
10 Organization for Economic Cooperation and Development.
11 "U.S. Health Care Spending in an International Context: Why is U.S. Spending so High, and Can We Afford it?", page 12
12 Ibid, page 13
13 Ibid, page 13-15
14 Ibid, page 14
15 "It's the Prices Stupid: Why the United States is so Different than Other Countries", Gerard F. Anderson, Uwe W. Reinhardt, Peter S. Hussey, Vanduli Pedrosa, Health Affairs, May/June 2003, page 59