The rapid growth of medical expenditures since 1965 is as familiar as the increasing percentage of US gross domestic product (GDP) devoted to medical care. Less known are the reasons for this continual increase. The purpose of this introductory chapter is twofold: to provide a historical perspective on the medical sector and explain the rise of medical expenditures in an economic context.

**Before Medicare and Medicaid**

Until 1965, spending in the medical sector was predominantly private—80 percent of all expenditures were paid by individuals out of pocket or by private health insurance on their behalf. The remaining expenditures (20 percent) were paid by the federal government (8 percent) and the states (12 percent) (see Exhibit 1.1). Personal medical expenditures totaled $35 billion and accounted for approximately 6 percent of GDP—that is, six cents of every dollar spent went to medical services.

**The Increasing Role of Government**

Medicare and Medicaid were enacted in 1965, dramatically increasing the role of government in financing medical care. Medicare, which covers the aged, initially consisted of two of its current four parts, Part A and Part B. Part A is for hospital care and is financed by a separate (Medicare) payroll tax on the working population. Part B covers physicians’ services and is financed by federal taxes (currently 75 percent) and by a premium paid by the aged (25 percent). Medicare Parts C and D have since been added. Part C is a managed care option, and Part D is a prescription drug benefit, financed 75 percent by the federal government and 25 percent by the aged. Medicare Parts B, C, and D are all voluntary programs. Medicaid is for the categorically or medically needy, including the indigent aged and families with dependent children who receive cash assistance. Each state administers its own program, and the federal government pays, on average, more than half of the costs.
Two important trends are the increasing role of government in financing medical services and the declining portion of expenditures paid out of pocket by the public. As shown in Exhibit 1.1, 47.4 percent of total medical expenditures in 2009 were paid by the government; the federal share was 38.3 percent and the states contributed 9.1 percent. The private share declined to 52.6 percent; of that amount, 14.3 percent was paid out of pocket (compared to 52.4 percent out of pocket in 1965).

The rapid increase of total healthcare expenditures is illustrated in Exhibit 1.2, which shows expenditures on the different components of medical services over time. Since 1990, per capita healthcare expenditures have risen from $2,853 to $8,086. The two largest components of medical expenditures, hospital services and physician and clinical services, have increased 303 percent and 318 percent, respectively, during this time frame.

In the United States, $2.486 trillion, or 17.6 percent of GDP, was spent on medical care in 2009. From 2000 to 2009, these expenditures increased by about 8.9 percent per year. Since peaking in the early part of the decade, the annual rate of increase in healthcare expenditures has been declining, although it remains above the rate of inflation. Health expenditures continue to increase as a percentage of GDP.

### Exhibit 1.1
Personal Health Services Expenditures by Source of Funds, 1965 and 2009

<table>
<thead>
<tr>
<th>Source of Funds</th>
<th>1965</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In Billions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>In Billions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>34.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Private</td>
<td>27.6</td>
<td>79.5</td>
</tr>
<tr>
<td>Out-of-pocket</td>
<td>18.2</td>
<td>52.4</td>
</tr>
<tr>
<td>Insurance benefits</td>
<td>8.7</td>
<td>25.1</td>
</tr>
<tr>
<td>All other</td>
<td>0.7</td>
<td>2.0</td>
</tr>
<tr>
<td>Public</td>
<td>7.1</td>
<td>20.5</td>
</tr>
<tr>
<td>Federal</td>
<td>2.8</td>
<td>8.1</td>
</tr>
<tr>
<td>State and local</td>
<td>4.3</td>
<td>12.4</td>
</tr>
</tbody>
</table>

### Exhibit 1.2 National Health Services Expenditures, Selected Calendar Years, 1965–2009  
(in Billions of Dollars)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total national health expenditures</td>
<td>$41.9</td>
<td>$74.8</td>
<td>$255.7</td>
<td>$724.0</td>
<td>$1,378.0</td>
<td>$2,486.3</td>
</tr>
<tr>
<td>Health services and supplies</td>
<td>37.2</td>
<td>67.0</td>
<td>235.6</td>
<td>675.3</td>
<td>1,288.5</td>
<td>2,330.1</td>
</tr>
<tr>
<td>Personal healthcare</td>
<td>34.7</td>
<td>63.1</td>
<td>217.1</td>
<td>616.6</td>
<td>1,164.4</td>
<td>2,089.9</td>
</tr>
<tr>
<td>Hospital care</td>
<td>13.5</td>
<td>27.2</td>
<td>100.5</td>
<td>250.4</td>
<td>415.5</td>
<td>759.1</td>
</tr>
<tr>
<td>Physician and clinical services</td>
<td>8.6</td>
<td>14.3</td>
<td>47.7</td>
<td>158.9</td>
<td>290.0</td>
<td>505.9</td>
</tr>
<tr>
<td>Dental services</td>
<td>2.8</td>
<td>4.7</td>
<td>13.3</td>
<td>31.5</td>
<td>62.0</td>
<td>102.2</td>
</tr>
<tr>
<td>Other professional care</td>
<td>0.5</td>
<td>0.7</td>
<td>3.5</td>
<td>17.4</td>
<td>37.0</td>
<td>66.8</td>
</tr>
<tr>
<td>Home healthcare</td>
<td>0.1</td>
<td>0.2</td>
<td>2.4</td>
<td>12.6</td>
<td>32.4</td>
<td>68.3</td>
</tr>
<tr>
<td>Nursing home care</td>
<td>1.4</td>
<td>4.0</td>
<td>15.3</td>
<td>44.9</td>
<td>85.1</td>
<td>137.0</td>
</tr>
<tr>
<td>Drugs, medical nondurables</td>
<td>5.9</td>
<td>8.8</td>
<td>21.8</td>
<td>62.7</td>
<td>152.5</td>
<td>293.2</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>1.1</td>
<td>1.7</td>
<td>4.1</td>
<td>13.8</td>
<td>25.1</td>
<td>34.9</td>
</tr>
<tr>
<td>Other personal healthcare</td>
<td>0.7</td>
<td>1.3</td>
<td>8.5</td>
<td>24.3</td>
<td>64.7</td>
<td>122.6</td>
</tr>
<tr>
<td>Program administration and net cost of private health insurance</td>
<td>1.8</td>
<td>2.6</td>
<td>12.0</td>
<td>38.7</td>
<td>81.1</td>
<td>163.0</td>
</tr>
<tr>
<td>Government public health activities</td>
<td>0.6</td>
<td>1.4</td>
<td>6.4</td>
<td>20.0</td>
<td>43.0</td>
<td>77.2</td>
</tr>
<tr>
<td>Research and construction</td>
<td>4.9</td>
<td>8.1</td>
<td>20.9</td>
<td>50.7</td>
<td>94.0</td>
<td>157.5</td>
</tr>
<tr>
<td>Research</td>
<td>1.5</td>
<td>2.0</td>
<td>5.4</td>
<td>12.7</td>
<td>25.5</td>
<td>45.3</td>
</tr>
<tr>
<td>Construction</td>
<td>3.2</td>
<td>5.8</td>
<td>14.7</td>
<td>36.0</td>
<td>64.1</td>
<td>110.9</td>
</tr>
<tr>
<td>National health expenditures per capita</td>
<td>$210</td>
<td>$356</td>
<td>$1,110</td>
<td>$2,853</td>
<td>$4,878</td>
<td>$8,086</td>
</tr>
</tbody>
</table>

In the mid-1990s, medical expenditures increased at a slower rate because of the growth of managed care, which emphasized utilization management, and price competition among providers participating in managed care provider networks. By the end of the 1990s, managed care’s cost-containment approaches lost support as a result of public dissatisfaction with managed care, lawsuits against managed care organizations (MCOs) for denial of care, government legislation, and a tight labor market that led employers to offer their employees more health plan choices. As a result, medical expenditures rose at a more rapid rate. The recent decline in the annual rate of increase in expenditures can be attributed to the financial crisis in the United States, the recession, growing unemployment, a larger number of uninsured, and the decline in the number of employers paying for employee health insurance.

National health expenditures are likely to rise at a faster rate this decade as the first of the baby boomers become eligible for Medicare; as new technology that improves quality, but at a higher cost, continues to be introduced; and when President Obama’s 2010 health legislation, with its expansion of Medicaid eligibility and subsidies for low-income employees, becomes effective in 2014. By 2019, national health expenditures are expected to double to $4.5 trillion and consume an even greater portion of GDP.

Exhibit 1.3 shows where healthcare dollars come from and how they are distributed among the different types of healthcare providers.

### Changing Patient and Provider Incentives

Medical expenditures equal the prices of services provided multiplied by the quantity of services provided. The rise of medical expenditures can be explained by looking at the factors that prompt medical prices and quantities to change. In a market system, the prices and output of goods and services are determined by the interaction of buyers (the demand side) and sellers (the supply side). We can analyze price and output changes by examining how various interventions change the behavior of buyers and sellers. One such intervention was Medicare, which lowered the out-of-pocket price the aged had to pay for medical care. The demand for hospital and physician services by the aged increased dramatically after Medicare was enacted, spurring rapid price increases. Similarly, government payments to the poor under Medicaid stimulated demand for medical services among this demographic. Greater demand for services multiplied by higher prices for those services equals greater total expenditures.

Prices also increase when the costs of providing services increase. For example, to attract more nurses to care for the increased number of aged patients, hospitals raised nurses’ wages and then passed this increase to payers in
the form of higher prices for services. Increased demand for care multiplied by higher costs of care equals greater expenditures.

At the same time the government was subsidizing the demands of the aged and poor, the demand for medical services by the employed population also was increasing. The growth of private health insurance during the late 1960s and 1970s was stimulated by income growth, high marginal (federal) income tax rates (up to 70 percent), and the high inflation rate in the economy. The high inflation rate threatened to push many people into higher marginal tax brackets. If an employee were pushed into a 50 percent marginal income tax bracket, half of his salary in that bracket would go to taxes. Instead of having that additional income taxed at 50 percent, employees often chose to have the employer spend those same dollars, before tax, to buy more

**Exhibit 1.3 The Nation’s Health Services Dollar, 2009**

**Where It Came From**
- Other government programs 16.9%
- Medicare 20.2%
- Medicaid 15.0%
- Other private 3.7%
- Out-of-pocket payments 12.0%
- Private health insurance 32.2%

**Where It Went**
- Other personal healthcare* 27.7%
- Physician services 20.3%
- Hospital care 30.5%
- Nursing home care 5.5%
- Other spending** 16.0%
- Other** 16.0%

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**Other personal healthcare** includes dental care, vision care, home healthcare, drugs, medical products, and other professional services.

**Other spending** includes program administration, net cost of private health insurance, government public health, and research and construction.

SOURCE: Data from CMS (2010a).
comprehensive health insurance. Thus, employees could receive the full value of their raise, albeit in healthcare benefits. This tax subsidy for employer-paid health insurance stimulated the demand for medical services in the private sector and further boosted medical prices.

Demand increased most rapidly for medical services covered by government and private health insurance. As of 2009, only 3.2 percent of hospital care and 9.5 percent of physician services were paid out of pocket by the patient; the remainder was paid by some third party (CMS 2010d). Patients had little incentive to be concerned about the price of a service when they were not responsible for paying a significant portion of the price. As the out-of-pocket price declined, the use of services increased.

The aged, who represent 13 percent of the population and use more medical services than any other age group, filled approximately 40 percent of hospital beds as of 2007 (Hall et al. 2010). Use of physician services by the aged (Medicare), the poor (Medicaid), and those covered by tax-exempt employer-paid insurance also increased.

Advances in medical technology were yet another factor stimulating the demand for medical treatment. New methods of diagnosis and treatment were developed; those with previously untreatable diseases gained access to technology that offered hope of recovery. New medical devices, such as imaging equipment, were introduced, and new treatments, such as organ transplants, became available. New diseases, such as acquired immune deficiency syndrome (AIDS), also increased demand on the medical system. Reduced out-of-pocket costs and increased third-party payments (both public and private), on top of an aging population, new technologies, and new diseases, drove up both the prices and quantity of medical services provided.

Providers (hospitals and physicians) responded to the increased demand for care, but the way they responded unnecessarily increased the cost of providing medical services. After Medicare was enacted, hospitals had few incentives to be efficient because the program reimbursed hospitals their costs plus 2 percent for serving Medicare patients. Hospitals, predominantly not for profit, consequently expanded their capacity, invested in the latest technology, and duplicated facilities and services offered in nearby hospitals. Hospital prices rose faster than the prices of any other medical service. Similarly, physicians had little cause for concern over hospital costs. Physicians, who were paid fee-for-service, wanted their hospitals to have the latest equipment so that they would not have to refer their patients elsewhere (and possibly lose them). They would hospitalize patients for diagnostic workups and keep them in the hospital longer because it was less costly for patients covered by hospital insurance and physicians would be sure to receive reimbursement; outpatient services, which were less costly than hospital care, initially were not covered by third-party payers.
In addition to the lack of incentives for patients to be concerned with the cost of their care and the similar lack of incentives for providers to supply that care efficiently, the government imposed restrictions on the delivery of services that increased enrollees’ medical costs. Under Medicare and Medicaid, the government ruled that insurers must give enrollees free choice of provider. Insurers such as health maintenance organizations (HMOs) that preclude their enrollees from choosing any physician in the community were violating the free-choice-of-provider rule and were thus ineligible to receive capitation payments from the government; HMOs were instead paid fee-for-service, reducing their incentive to reduce the total costs of treating a patient. Numerous state restrictions on HMOs, such as prohibiting HMOs from advertising, requiring HMOs to be not for profit (thereby limiting their access to capital), and requiring HMOs to be controlled by physicians, further inhibited their development. By imposing these restrictions on alternative delivery systems, however, the government reduced competition for Medicare and Medicaid patients, forgoing an opportunity to reduce government payments for Medicare and Medicaid.

The effects of increased demand, limited patient and provider incentives to search for lower-cost approaches, and restrictions on the delivery of medical services were escalating prices, increased use of services, and, consequently, greater medical expenditures.

**Government Response to Rising Costs**

As expenditures under Medicare and Medicaid increased, the federal government faced limited options. It could (1) raise the Medicare payroll tax and income taxes on the nonaged to continue funding these programs, (2) require the aged to pay higher premiums for Medicare and increase their deductibles and copayments, or (3) reduce payments to hospitals and physicians. Each of these approaches would cost the administration and Congress political support from some constituency (e.g., employees, the aged, healthcare providers). The least politically costly options appeared to be to increase taxes on the nonaged and to pay hospitals and physicians less.

Federal and state governments used additional regulatory approaches to control these rapidly rising expenditures. Medicare utilization review programs were instituted, and controls were placed on hospital investment in new facilities and equipment. These government controls proved ineffective as hospital expenditures continued to escalate through the 1970s. The government then limited physician fee increases under Medicare and Medicaid; as a consequence, many physicians refused to participate in these programs, reducing access to care for the aged and the poor. As a result of their refusal
to participate in Medicare, many Medicare patients had to pay higher out-of-pocket fees to be seen by physicians.

In 1979, President Carter’s highest domestic priority was to enact expenditure limits on Medicare hospital cost increases; a Congress controlled by his own political party defeated him.

**The 1980s**

By the beginning of the 1980s, political consensus on what should be done to control Medicare hospital and physician expenditures was lacking, and private health expenditures continued to increase rapidly. By the mid-1980s, however, legislative changes and other events imposed heavy cost-containment pressures on Medicare, Medicaid, and the private sector.

Several events in the early 1980s brought major changes to the medical sector. The HMO legislation enacted in 1974 began to have an effect in this decade. In 1974, President Nixon wanted a health program that would not increase federal expenditures. The result was the HMO Act of 1974, which legitimized HMOs and removed restrictive state laws impeding the development of federally approved HMOs. However, many HMOs decided not to seek federal qualification because imposed restrictions, such as having to offer more costly benefits, would have caused their premiums to be too high to be price competitive with traditional health insurers’ premiums. These restrictions were removed by the late 1970s, and the growth of HMOs began in the early 1980s.

To achieve savings in Medicaid, in 1981 the Reagan administration removed the free choice of provider rule, enabling states to enroll their Medicaid populations in closed provider panels. As a result, states were permitted to negotiate capitation payments with HMOs for care of their Medicaid patients. The free-choice rule continued for the aged; however, in the mid-1980s they were permitted to voluntarily join HMOs. The federal government agreed to pay HMOs a capitated amount for enrolling Medicare patients, but less than 10 percent of the aged voluntarily participated (CBO 1995). (As of 2009, of the 40 million aged, 18.4 percent were enrolled in Medicare HMOs, referred to as Medicare Advantage plans [US Census Bureau 2011b; CMS 2011b].)

Federal subsidies were provided to medical schools in 1964 to increase the number of students they could accommodate, and the supply of physicians increased. The number of active physicians increased from 146 per 100,000 civilian population in 1965 to 195 per 100,000 in 1980; it reached 229 per 100,000 in 1990 and 283 per 100,000 in 2008 (AMA Division of Survey and Data Resources 1991, 2010). The increased supply of physicians created excess capacity among physicians, dampened their fee increases, made it easier for HMOs to attract physicians, and, therefore, made it easier for the HMOs to expand.
A new Medicare hospital payment system was phased in during 1983. Hospitals were no longer to be paid according to their costs; fixed prices were established for each diagnostic admission (referred to as diagnosis-related groups [DRGs]), and each year Congress set an annual limit on the amount by which these fixed prices per admission could increase. DRG prices changed hospitals’ incentives. Because hospitals could keep the difference if the costs they incurred from an admission were less than the fixed DRG payment they received for that admission, they were motivated to reduce the cost of caring for Medicare patients and to discharge them earlier. Length of stay per admission fell, and occupancy rates declined. Hospitals also became concerned with inefficient physician practice behaviors that increased the hospitals’ costs of care.

In 1992, the federal government also changed its method of paying physicians under Medicare. A national fee schedule (resource-based relative value system [RBRVS]) was implemented, and volume expenditure limits were established to limit the total rate of increase in physician Medicare payments. The imposition of price controls and expenditure limits on payments to hospitals and physicians for services provided to Medicare patients continues to be the approach the federal government takes to contain Medicare expenditures today.

The RBRVS also prohibited physicians from charging their higher-income patients a higher fee and accepting the Medicare fee only for lower-income patients; they had to accept the fee for all their Medicare patients or none. Medicare patients represent such a significant portion of a physician’s practice that few physicians decided not to participate; consequently, they accepted Medicare fees for all patients.

In addition to the government policy changes of the early 1980s, important events were occurring in the private sector. The new decade started with a recession. To survive the recession and remain competitive internationally, the business sector looked to reduce labor costs. Because employer-paid health insurance was the fastest-growing labor expense, businesses pressured health insurers to better control the use and cost of medical services. Competitive pressures forced insurers to increase the efficiency of their benefit packages by including lower-cost substitutes for inpatient care, such as outpatient surgery. They increased deductibles and copayments, intensifying patients’ price sensitivity. Further, patients had to receive prior authorization from their insurer before being admitted to a hospital, and insurers reviewed patients’ length of stay while patients were in the hospital. These actions greatly reduced hospital admission rates and lengths of stay. The number of admissions in community hospitals in 1975 was 155 per 1,000 population. By 1990 it had fallen to 125 per 1,000, and it continued to decline, dropping to
116 in 2009. The number of inpatient days per 1,000 population fell even more dramatically, from 1,302 in 1977 to 982 in 1990 to 628 in 2009 (AHA 2011; US Census Bureau 2011b).

Due to the implementation of the federal DRG payment system, the changes to private programs, and a shift to the outpatient sector facilitated by technological change (both anesthetic and surgical techniques), hospital occupancy rates declined from 76 percent in 1980 to 65.5 percent in 2009 (AHA 2010).

**Antitrust Laws**

The preconditions for price competition were in place: Hospitals and physicians had excess capacity, and employers wanted to pay less for employee health insurance. The last necessary condition for price competition was set in 1982, when the US Supreme Court upheld the applicability of the antitrust laws to the medical sector. Successful antitrust cases were brought against the American Medical Association for its restrictions on advertising, against a medical society that threatened to boycott an insurer over physician fee increases, against a dental organization that boycotted an insurer’s cost-containment program, against medical staffs that denied hospital privileges to physicians because they belonged to an HMO, and against hospitals whose mergers threatened to reduce price competition in their communities.

The applicability of the antitrust laws, excess capacity among providers, and employer and insurer interest in lowering medical costs brought about profound changes in the medical marketplace. Traditional insurance plans lost market share as managed care plans, which controlled utilization and limited access to hospitals and physicians, grew. Preferred provider organizations (PPOs) were formed and included only physicians and hospitals that were willing to discount their prices. Employees and their families were offered price incentives in the form of lower out-of-pocket payments to use these less expensive providers. Large employers and health insurers began to select PPOs on the basis of their prices, use of services, and outcomes of their treatment.

**Consequences of the 1980s Changes**

The 1980s disrupted the traditional physician–patient relationship. Insurers and HMOs used utilization review to control patient demand, emphasize outcomes and appropriateness of care, and limit patients’ access to higher-priced physicians and hospitals by not including them in their provider networks; they also used case management for catastrophic illnesses, substituted less expensive settings for more costly inpatient care, and affected patients’ choice of drugs through the use of formularies.

The use of cost-containment programs and the shift to outpatient care lowered hospital occupancy rates. The increasing supply of physicians, particularly specialists, created excess capacity. Hospitals in financial trouble closed, and others merged. Hospital consolidation increased. Hospitals’ excess capacity
was not reduced until years later, when the demand for care began to exceed the available supply of hospitals and physicians. Until then, hospitals and physicians continued to be subject to intense competitive pressures.

Employees’ incentive to reduce their insurance premiums also stimulated competition among HMOs and insurers. Employers required employees to pay the additional cost of more expensive health plans, so many employees chose the lowest-priced plan. Health plans competed for enrollees primarily by offering lower premiums and provider networks with better reputations.

**The 1990s**

As managed care spread throughout the United States during the 1990s, the rate of increase of medical expenditures declined. Hospital use decreased dramatically, and hospitals and physicians agreed to large price discounts to be included in an insurer’s provider panel. These cost-containment approaches contributed to the lower annual rate of increase. However, although price competition reduced medical costs, patients were dissatisfied. The public wanted greater access to care, particularly less restriction on referrals to specialists. There was also public backlash against HMOs; HMOs lost several lawsuits for denying access to experimental treatments, and Congress and the states imposed restrictions on MCOs, such as mandating minimum lengths of stay in the hospital for normal deliveries. Cost-containment restrictions weakened as a result of these events, and increases in prices, use of services, and medical expenditures reaccelerated.

**The Decade 2000–2010**

The excess capacity that weakened hospitals in their negotiations with insurers dried up. Financially weak hospitals closed. Because hospital consolidation reduces the number of competing hospitals in an area, thereby increasing a hospital’s bargaining power, the number of hospital mergers increased. As hospital prices increased, so did insurance premiums. It was no longer possible to use past approaches—decreased hospital use and price discounts—to achieve large cost reductions. Instead, insurers tried to develop more innovative, less costly ways of managing patient care.

Several of the newer approaches to cost containment included high-deductible health plans, evidence-based medicine, and disease management programs. Insurers’ method of shifting a larger share of medical costs to consumers is referred to as *consumer-driven healthcare* (CDHC). In return for lower health insurance premiums, consumers pay higher deductibles and copayments. Consumers are then presumed to evaluate the costs and benefits of spending their own funds on healthcare. Instead of relying on consumer incentives to reduce medical costs, other health insurers use evidence-based medicine, which relies on the analysis of large data sets to determine the effect of different physician practice patterns on costs and medical outcomes.
To the same end, insurers are using disease management programs to provide chronically ill patients with preventive and continuous care, which not only improves the quality of care but also reduces costly hospitalizations.

Another development was pay-for-performance (P4P) programs. Insurers pay physicians and other healthcare providers more if they provide high-quality care, which is usually defined on the basis of process measures developed by medical experts. Insurers also made report cards available to their enrollees. Report cards evaluate hospitals and medical groups in the insurer’s provider network according to medical outcomes, preventive services, and patient satisfaction scores to enable enrollees to make more informed choices about the providers they use.

In the latter half of the decade, rising premiums and increased unemployment prompted people to drop their insurance or switch to new types of insurance that charge lower premiums, such as high-deductible plans. Many Americans are concerned that premiums will continue increasing and that insurance will become ever less affordable.

**A Look Ahead**

The forces increasing demand and the costs of providing care have not changed. If anything, these factors promise to increase medical expenditures and insurance premiums more rapidly in coming years. The population is aging (the first of the baby boomers retire in 2011), technological advances enable early diagnosis, and new methods of treatment are emerging, all of which stimulate increased demand for medical services. Of these three developments, new technology is believed to be the most important force behind rising expenditures. For example, the number of people receiving organ transplants has increased dramatically, as have the diffusion of new equipment and the use of imaging tests. The cost of providing medical services is also increasing as more highly trained medical personnel are needed to handle the increased technology and as wage rates increase to attract more nurses and technicians to the medical sector.

There are also increasing concerns that a shortage of physicians is developing. The demand for physician services is increasing faster than the number of physicians is increasing, and physician payment under Medicare and Medicaid has not kept pace with these market changes.

The enactment of President Obama’s new health legislation in 2010 (to take effect in 2014) will further increase the demand for care. More people will become eligible for Medicaid, including more privately insured individuals; as a result, the private insurance market will become smaller. Everyone will be required to have insurance under the legislation’s individual mandate,
and under the employer mandate, employers will be required to provide insurance for their employees or pay a fine. On the basis of financial need, some uninsured individuals will receive new subsidies to buy insurance. Insurance exchanges will become available in each state, promoting greater competition among insurers. In anticipation of the forecasted increase in demand, the legislation includes a few demonstration projects that may over time become potential cost-containment programs. However, the legislation makes no changes to patient or provider incentives to encourage them to be more efficient in their use of medical services. Medical expenditures and premiums will likely increase more rapidly than they are today.

As the cost of financing these expansions of Medicaid eligibility and new subsidies increase, the already large federal deficit will grow even faster than it is growing today. The federal government will be under great pressure to reduce the rising deficit and the burden of increasing premiums faced by the middle class. Will the government rely more on regulatory or competitive approaches to reduce medical expenditures and premium increases?

Innovative approaches to reducing healthcare costs are more likely to be taken in a system that has price incentives to do so (e.g., health insurers compete for enrollees) than in a regulated system. Any regulatory approach that arbitrarily seeks to reduce the rate of increase in medical expenditures will result in reduced access to both medical care and new technology.

**Summary**

Although the United States spends more on healthcare than any other country spends, a scarcity of funds to provide for all of our medical needs and population groups, such as the uninsured and those on Medicaid, still exists. Therefore, choices must be made. The first choice we as a society must make is to determine how much we should spend on medical care. What approach should we use to make this choice? Should individuals decide how much they want to spend on healthcare, or should the government decide the percentage of GDP that goes to healthcare?

The second choice is to identify the best way to provide medical services. Would competition among health plans or government regulation and price controls bring about greater efficiency in providing medical services?

Third, how rapidly should medical innovation be introduced? Should regulatory agencies evaluate each medical advance and determine whether its benefits exceed its costs, or should the evaluation of those costs and benefits be left to the separate health plans competing for enrollees?

Fourth, how much should be spent on those who are medically indigent, and how should their care be provided? Should the medically indigent
be enrolled in a separate medical system, such as Medicaid, or should they be provided with vouchers to enroll in competing health plans?

These choices can be better understood when we are more aware of the consequences of each approach (e.g., which groups benefit and which groups bear the costs). Economics clarifies the implications of different approaches to these decisions.

**Discussion Questions**

1. What are some of the reasons for the increased demand for medical services since 1965?
2. Why has employer-paid health insurance been an important stimulant of demand for health insurance?
3. How did hospital payment methods in the 1960s and 1970s affect hospitals’ investment policies and incentives to improve efficiency?
4. Why were HMOs and managed care not more prevalent in the 1960s and 1970s?
5. What choices has the federal government had to reduce greater-than-projected Medicare expenditures?
6. What events during the 1980s in both the public and private sectors made the delivery of medical services price competitive?