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V. Delving Into Health Expenditure Trends: Two Approaches

by Katharine R. Levit

The major thrust of the paper by Haiden Huskamp and Joseph Newhouse is to produce a measure of growth in health care costs that will assist policymakers in understanding the future direction of health care spending and the status of the health care “crisis.” To accomplish this task, the authors estimate the “real” costs of health care and compare them to our estimates of “real” costs. Their analysis suggests that only a modest slowing of health care spending growth has occurred, and that this conclusion differs from our analysis.

I agree with Huskamp and Newhouse that health spending has slowed only modestly in real terms, but I disagree with their statement that this conclusion differs from that expressed in our paper. Deflating health care costs by economywide or health sector-specific price indices are two important ways of evaluating health care trends. An additional way of assessing the growth of health care costs is also one of the simplest: assessing it in relation to the productive capacity of the economy, namely gross domestic product (GDP). Assuming that value is received for services, rising health costs are not a problem requiring political intervention if the economy expands fast enough (or almost fast enough) to absorb these costs. In that regard, the results described in the national health expenditures paper for 1993 are in general agreement with the conclusion of Huskamp and Newhouse. In 1993 national health expenditures as a percentage of GDP increased faster than the GDP, at the average rate experienced between 1960 and 1993. This increase (0.3 percent) is down from historically high increases in 1990 and 1991 and are unlikely to prompt a federal policy initiative. Typically, it takes high annual increases in this ratio to cause debate or actual intervention by the federal government. We saw these types of increases prior to the implementation of the Voluntary Effort (1976-1979) and the Medicare prospective payment system (1982-1985), and prior to the current health care reform era.1

Since we agree with the conclusions of Huskamp and Newhouse, why do our measures of “real” spending differ? The difference between the two is that they purposely measure different things. Our measure of real personal health care spending attempts to measure the quantity (real use and intensity) of medical services delivered. The rate of growth in these “real” services appears to have slowed over the past several decades, meaning that our additional expenditures are purchasing fewer real health care goods and services. This measure quantifies the amount of additional services received and allows policymakers to ask whether this additional quantity of health care is worth the added cost to society.

Huskamp and Newhouse’s measurement of the opportunity cost of health care is likewise valid in that they measure the “real” costs of alternative (nonhealth) goods and services that could have been purchased if personal health care purchases had been forgone. Both the opportunity cost and quantity measures are valuable, but each addresses different issues. Both measures add to the discussion and analysis of historical health spending trends. Both are useful analytical tools created for specific purposes; they can produce different results because they answer different questions.

The quality of the price indices we used in deflating personal health care spending per capita varies among services. For hospital care, spending is deflated using a transac-
tion price index developed by the Health Care Financing Administration (HCFA). The main reason for using this alternative price measure rather than the hospital Consumer Price Index (CPI) is because medical CPIs in general measure list prices rather than transaction prices. Transaction prices are lower for insurers that negotiate a less-than-full-charge payment for medical services. We have attempted to approximate changes in transaction prices for hospital care by using an index developed by Charles Fisher. This index alone was used to deflate 43 percent of personal health care expenditures and is a major influence in the personal health care spending fixed-weight price index. For nursing home spending, an input price index was used to deflate expenditures. To the extent that input prices (expenses) faced by nursing homes grow at rates similar to revenues received by nursing homes, the input price index will provide an accurate measure of price changes for nursing homes. This index likely will introduce few distortions because nursing home profit margins are small, varying little from year to year, and productivity changes are likely to be minimal compared with more high-technology service sectors such as hospital care or physician services. Nursing home expenditures represented 9 percent of personal health care spending in the 1987 base year, so the impact of any variation in profit margins should have a negligible influence on the overall fixed-weight price index.

The remaining 49 percent of personal health care spending is deflated using CPIs. While CPIs are subject to problems noted by Huskamp and Newhouse, these problems are minimized in some of the remaining personal health care spending sectors (dentist and other professional service expenditures, expenditures for the purchase of durable medical products) because a higher percentage of these services are not covered by third-party payers. As a result, CPIs are less subject to the distortion caused by measuring changes in list prices rather than transaction prices because these two prices will be identical more often. As stated in our paper, however, growth in managed care and in drug manufacturer rebates to insurers may have introduced further distortions into the CPIs, particularly since 1990.

As Huskamp and Newhouse suggest, the National Income and Product Accounts (NIPA) contain alternative estimates of health care, but in a form that is more difficult for the casual user to extract and combine into aggregate health care totals. The data presented in the NIPA do provide estimates of personal consumption expenditures for health care; other elements of spending are scattered elsewhere throughout the NIPA accounts. Unlike HCFA’s National Health Accounts, however, the NIPA does not possess the richness of information on funding sources for each type of service that allows researchers to thoroughly analyze health care spending levels and trends.

Huskamp and Newhouse provide an additional analysis of health spending growth in deflating personal health spending by a general price deflator that may be useful to policymakers to answer specific questions. Other analyses of spending growth using national health expenditures as a share of GDP and personal health spending deflated using medical prices as presented in our national health spending paper are also useful to address other questions.

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