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Health care spending in 1994: slowest in decades
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Prologue: Spending for personal health care services in the United States has surpassed that of any other industrialized nation for many years. In the past two years, however, aggregate spending growth has begun to ease. This paper contains the latest health spending estimates, which confirm this welcome new direction. However, as its authors point out, a two-year observation does not necessarily constitute the beginning of a long-run trend. The estimates were prepared, as they are annually, by the Office of National Health Statistics in the Health care Financing Administration’s Office of the Actuary. A National Health Accounts team led by Katharine Levit prepared them. The National Health Accounts are composed of all of the services rendered and sources of funding—private and public—for each type of service. As such, they represent the most comprehensive snapshot available of health care expenditures in relation to the national economy. The paper also discusses one of the contentious issues on which the Clinton administration and Republicans differ: whether Medicare spending is growing more rapidly than that of private insurance and the reasons that account for the measurable difference. The trends in health care spending are the subject of endless fascination for analysts because they indicate the directions in which the system is moving. In a Perspective that follows, economist Uwe Reinhardt underscores the notion that the system, viewed in toto, is like a balloon—squeeze it in one spot and it is likely to bulge out at another. Here he discusses the implications of the declining length of hospital inpatient stays. Reinhardt is the James Madison Professor of Political Economy at Princeton University’s Woodrow Wilson School of Public and International Affairs and is a long-time observer of the U.S. health care scene.
Abstract: Falling medical prices and slowing growth in private health insurance premiums diverted the spotlight from large-scale reform of the health care system in 1994. In aggregate, growth in health expenditures dropped to its lowest rate in more than thirty years. Even at this low rate, health spending grew faster than gross domestic product (GDP), but the economy easily absorbed these modest increases. In this picture of moderation, there was one disconcerting note: Medicare spending continued to increase at double-digit rates. Although Medicare’s more rapid spending growth seems out of sync with the current modest health spending growth trends in the private sector, closer examination of factors accounting for growth in 1994 suggests that some difference is warranted.

National health expenditures (NHE) in the United States amounted to $949.4 billion in 1994 (Exhibit 1). After five years of double-digit and near double-digit growth in aggregate health care spending between 1988 and 1992, health expenditure growth decelerated to 7 percent in 1993 and 6.4 percent in 1994 (Exhibit 2). The 6.4 percent growth rate

Exhibit 1
National Health Expenditures, Aggregate Amounts, Billions Of Dollars, Selected Calendar Years 1960-1994

<table>
<thead>
<tr>
<th></th>
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<td>Personal health care</td>
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<td>63.8</td>
<td>217.0</td>
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<td>676.2</td>
<td>739.8</td>
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<td>831.7</td>
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<td>Hospital care</td>
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<td>102.7</td>
<td>256.4</td>
<td>282.3</td>
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<td>21.6</td>
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<tr>
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<td>3.8</td>
<td>10.5</td>
<td>11.2</td>
<td>11.9</td>
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<td>62.3</td>
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<td>Other personal health care</td>
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<td>4.0</td>
<td>11.2</td>
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<td>21.8</td>
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<td>Program administration and net cost of private health insurance</td>
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<td>11.8</td>
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<td>38.7</td>
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<tr>
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<td>12.0</td>
<td>13.4</td>
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<td>National health expenditures per capita</td>
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<td>$341</td>
<td>$1,052</td>
<td>$2,688</td>
<td>$2,902</td>
<td>$3,144</td>
<td>$3,331</td>
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<td>GDP (billions of dollars)</td>
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<td>$1,036</td>
<td>$2,784</td>
<td>$5,744</td>
<td>$5,917</td>
<td>$6,244</td>
<td>$6,550</td>
<td>$6,931</td>
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<tr>
<td>National health expenditures as percent of GDP</td>
<td>5.1%</td>
<td>7.1%</td>
<td>8.9%</td>
<td>12.1%</td>
<td>12.9%</td>
<td>13.3%</td>
<td>13.6%</td>
<td>13.7%</td>
</tr>
</tbody>
</table>

Source: Health Care Financing Administration, Office of the Actuary, data from the Office of National Health Statistics.

Notes: Numbers may not add to totals because of rounding. GDP is gross domestic product.

*Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from “research” expenditures but are included in the expenditure class in which the product falls.
### Exhibit 2
National Health Expenditures, Average Annual Growth From Prior Year Shown, Selected Calendar Years 1960-1994

<table>
<thead>
<tr>
<th></th>
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<td>12.9%</td>
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<td>9.1%</td>
<td>9.5%</td>
<td>7.0%</td>
<td>4.4%</td>
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<td>Health services and supplies</td>
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<td>13.2</td>
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<td>9.5</td>
<td>7.1</td>
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<tr>
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<td>–</td>
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<td>11.0</td>
<td>10.0</td>
<td>9.4</td>
<td>6.3</td>
<td>5.7</td>
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<tr>
<td>Hospital care</td>
<td>–</td>
<td>11.7</td>
<td>13.9</td>
<td>9.6</td>
<td>10.1</td>
<td>8.1</td>
<td>4.4</td>
<td>4.4</td>
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<td>Physician services</td>
<td>–</td>
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<td>12.8</td>
<td>12.5</td>
<td>8.4</td>
<td>10.1</td>
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<tr>
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<td>16.3</td>
<td>18.5</td>
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<td>10.0</td>
<td>10.0</td>
<td>7.1</td>
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<tr>
<td>Home health care</td>
<td>–</td>
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<td>22.3</td>
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<td>13.8</td>
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<tr>
<td>Drugs and other medical nondurables</td>
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<td>9.4</td>
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<td>8.6</td>
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<td>4.5</td>
</tr>
<tr>
<td>Vision products and other medical durables</td>
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<td>8.8</td>
<td>10.7</td>
<td>6.8</td>
<td>6.9</td>
<td>5.1</td>
<td>4.6</td>
</tr>
<tr>
<td>Other personal health care</td>
<td>–</td>
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<td>15.4</td>
<td>11.2</td>
<td>12.2</td>
<td>9.0</td>
<td>7.6</td>
<td>7.8</td>
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<tr>
<td>Program administration and net cost of private health insurance</td>
<td>–</td>
<td>8.9</td>
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<td>12.6</td>
<td>0.2</td>
<td>10.5</td>
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<td>15.2</td>
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<tr>
<td>Government public health activities</td>
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<td>17.5</td>
<td>11.3</td>
<td>9.1</td>
<td>9.4</td>
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<tr>
<td>Research and construction</td>
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<td>8.1</td>
<td>7.7</td>
<td>1.7</td>
<td>10.5</td>
<td>5.9</td>
<td>3.5</td>
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<td>7.1</td>
<td>-2.4</td>
<td>11.4</td>
<td>9.7</td>
<td>-2.8</td>
</tr>
<tr>
<td>National health expenditures per capita</td>
<td>–</td>
<td>9.2</td>
<td>11.9</td>
<td>9.8</td>
<td>8.0</td>
<td>8.3</td>
<td>5.9</td>
<td>5.4</td>
</tr>
<tr>
<td>GDP</td>
<td>–</td>
<td>7.0</td>
<td>10.4</td>
<td>7.5</td>
<td>3.0</td>
<td>5.5</td>
<td>4.9</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Source: Health Care Financing Administration, Office of the Actuary, data from the Office of National Health Statistics.

Notes: Numbers may not add to totals because of rounding. GDP is gross domestic product.

* Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from “research” expenditures but are included in the expenditure class in which the product falls.

in 1994 was the slowest recorded in more than three decades.

Two key statistics help to interpret the meaning of this slow growth in health care spending. The first, national health expenditures as a share of gross domestic product (GDP), measures the proportion of national resources devoted to health care. From 1960 to 1994 this measure grew from 5.1 percent to 13.7 percent, increasing, on average, 0.2-0.3 percentage points per year. From 1988 to 1992 health care spending as a share of GDP grew at an average rate of more than half a percentage point annually. The enormous pressure that health care exerted on the nation’s economic resources during this period provided a backdrop for the health care reform debate. By late 1993 this pressure had begun to subside as the increase in NHE share of GDP slowed to 0.3 percentage points. In 1994 the share increased only 0.1 percentage point to 13.7 percent—the direct result of slowing growth in health care spending and accelerating growth in GDP.
Although resources allocated to the provision of health care in the United States continued to rise in 1994, the rate at which additional resources were consumed had slowed substantially.

The second set of statistics that help to interpret the spending slowdown is real or inflation-adjusted national health expenditures. When economy-wide inflation is removed from national health expenditures, the results measure the value of health care purchases in terms of the forgone opportunity to purchase other goods and services. To adjust for inflation, we used the new GDP chain-type annual-weighted price index as the deflator. The question of appropriate deflators to adjust for inflation has sparked a great deal of controversy among health services researchers. A more correct measure for interpreting health spending in terms of constant purchasing power would be to use the price index for GDP less health care. However, in its absence, we believe that using the new GDP index is a close approximation.

Using the GDP index, we found that real national health expenditures grew 4 percent in 1994, as additional purchases of health care were substituted for the purchase of other goods and services. However, this rate also matched the slowest real growth rates for health care spending recorded over the past three decades (Exhibit 3). The trend for 1993-1994 shows that the runaway health care expenditures of the 1988-1992 period have subsided. However, history warns that a two-year observation does not necessarily constitute the beginning of a long-run trend. Real growth rates identical to those measured for 1993 and 1994 also were recorded for 1978 and 1979, when the threat of explicit government cost controls provided

<table>
<thead>
<tr>
<th>Exhibit 3</th>
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<tbody>
<tr>
<td>Annual Growth In Real National Health Expenditures, Calendar Years 1961-1994</td>
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<table>
<thead>
<tr>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>0</td>
<td>2</td>
<td>4</td>
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</tbody>
</table>

Source: Health Care Financing Administration, Office of the Actuary, data from the Office of National Health Statistics.

Note: Deflated by the gross domestic product (GDP) chain-type annual-weighted price index (1992 = 100).
enough uncertainty for the private sector to voluntarily hold down increases in hospital costs and physician fees. As the threat subsided, real growth escalated. The prospect of health care reform during 1993-1994 may be having a similar, possibly short-lived, effect.\(^5\)

Medicare And Private Health Insurance: A Comparison

The National Health Accounts contain information on overall financing of health care services by Medicare and private health insurance. The temptation is to use these aggregate figures to imply that Medicare is less able than private health insurance to control costs. However, aggregate figures mask important underlying differences.\(^6\)

Comparing unadjusted growth rates. Figures for 1994 show a striking break in the traditional relationship between growth in Medicare and private health insurance benefits. (Benefits are listed as total personal health care expenditures for each payer. They exclude all administrative costs and out-of-pocket deductibles and copayments made by enrollees.) Both payers encountered rapid aggregate benefit payment increases between 1969 and 1993 (at average annual rates of 13.7 percent for Medicare and 13.4 percent for private health insurance). In 1994 growth patterns diverged: Spending for benefits increased 11.8 percent for Medicare and increased only 4 percent for private health insurance (Exhibit 4).

While benefit growth rates in 1994 appear unusually far apart, certain

<table>
<thead>
<tr>
<th>Exhibit 4</th>
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<tbody>
<tr>
<td>Aggregate Growth In Medicare And Private Health Insurance Benefits, Calendar Years 1970-1994</td>
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</table>

<table>
<thead>
<tr>
<th>Percent growth</th>
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</table>

Source: Health Care Financing Administration, Office of the Actuary, data from the Office of National Health Statistics.
factors tended to exaggerate the growth rate of Medicare benefits, especially in 1994. These factors include enrollment growth, benefit coverage, and government regulatory and policy effects. These have little to do with insurers' performance in providing benefits to enrollees.

**Sources of differential growth.** Part of the difference between aggregate growth in Medicare and private insurance is attributable to enrollment. The number of Medicare beneficiaries increased 1.8 percent in 1994. Net enrollment in private health insurance, including enrollment through employer-sponsored and individual plans (including Medigap), actually declined 0.1 percent. Thus, one would expect Medicare benefits in aggregate to grow more rapidly than private insurance benefits.

However, enrollment growth differentials alone do not explain all of the gap in expenditure growth in 1994. Medicare benefits per enrollee grew more slowly than private health insurance benefits from 1969 to 1993. Medicare increased at average annual rates of 10.9 percent, compared with increases of 12.6 percent for private health insurance. In 1994 Medicare benefit expenditures per enrollee increased 9.8 percent, while those of private health insurance increased only 4.1 percent (Exhibit 5).

Besides enrollment growth, breadth of coverage of services and products also differs, with some rapidly growing coverage concentrated in Medicare. The function of Medicare is to fund health care services for the aged and disabled. Private health insurance primarily covers the working-age population and their families. Because these insurers serve different groups, each insurer pays different amounts of benefits for specific services. Per enrollee,

---

**Exhibit 5**

*Growth in Medicare and Private Health Insurance Benefits Per Enrollee, Calendar Years 1970-1994*

<table>
<thead>
<tr>
<th>Year</th>
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<th>Private Health Insurance</th>
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<td>1975</td>
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<tr>
<td>1980</td>
<td></td>
<td></td>
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<td>1985</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>1994</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Health Care Financing Administration, Office of the Actuary, data from the Office of National Health Statistics.
Medicare funded fourteen times the home health care and thirteen times the nursing home care that private health insurance funded in 1994 (Exhibit 6). Medicare also provides the majority of payments for end-stage renal disease (ESRD) treatments and hospice care. These benefits are basic to serving the health care needs of the aged and disabled population and are needed less routinely by nonaged persons. In contrast, private health insur-

### Exhibit 6

**Medicare And Private Health Insurance Expenditures Per Enrollee For Personal Health Care, 1969-1994**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Medicare expenditures</th>
<th>Hospital care</th>
<th>Physician services</th>
<th>Other professional services</th>
<th>Free-standing home health care</th>
<th>Vision products and other medical durables</th>
<th>Free-standing nursing home care</th>
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<tr>
<td>1969</td>
<td>$388</td>
<td>$241</td>
<td>$79</td>
<td>$2</td>
<td>$4</td>
<td>$2</td>
<td>$11</td>
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<td>1974</td>
<td>535</td>
<td>394</td>
<td>118</td>
<td>5</td>
<td>5</td>
<td>4</td>
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<td>1979</td>
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<td>236</td>
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<td>12</td>
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<td>1984</td>
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<td>484</td>
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<td>51</td>
<td>36</td>
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<td>1989</td>
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<td>1,904</td>
<td>799</td>
<td>76</td>
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<td>62</td>
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<tr>
<td>1991</td>
<td>3,436</td>
<td>2,175</td>
<td>881</td>
<td>117</td>
<td>121</td>
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<td>1993</td>
<td>4,083</td>
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<td>930</td>
<td>159</td>
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<td>1,028</td>
<td>184</td>
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**Average annual percent growth**

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<td>23.0%</td>
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**Private health insurance expenditures**

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<tr>
<td></td>
<td>$82</td>
<td>91</td>
<td>46</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>11</td>
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<td>1</td>
<td>5</td>
<td>11</td>
<td>5</td>
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**Average annual percent growth**

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<tr>
<th></th>
<th>1969-93</th>
<th>1993-94</th>
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<tr>
<td></td>
<td>12.6%</td>
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<tr>
<td></td>
<td>11.0%</td>
<td>2.4%</td>
</tr>
<tr>
<td></td>
<td>12.7%</td>
<td>5.2%</td>
</tr>
<tr>
<td></td>
<td>22.5%</td>
<td>3.7%</td>
</tr>
<tr>
<td></td>
<td>26.7%</td>
<td>9.4</td>
</tr>
<tr>
<td></td>
<td>9.5%</td>
<td>-2.4%</td>
</tr>
<tr>
<td></td>
<td>23.0%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

**Source:** Health Care Financing Administration (HCFA). Office of the Actuary, data from the Office of National Health Statistics.

**Notes:** Annual Medicare enrollment is estimated by HCFA actuaries, and net private health insurance enrollment is estimated by the Office of National Health Statistics, based on data from National Health Interview Surveys, Current Population Surveys, and previously published HCFA estimates. Personal health care expenditures are estimates from the National Health Accounts.

*a* Includes per enrollee private health insurance expenditures for dental services and for prescription drugs and other medical nondurables, which are not shown separately.
ance covered almost two-fifths of all outpatient prescription drug spending and almost half of all spending for dental services, benefits that Medicare does not cover. Although both insurers paid benefits for durable medical equipment, the composition of these benefits differed: Medicare paid for oxygen and oxygen-related equipment, prosthetics and orthotics, and rental and purchase of durable products such as wheelchairs and walkers, while the majority of private insurance benefits paid for vision products.

Medicare’s spending increase in 1994 was affected by the Medicare volume performance standard (MVPS). Physicians and other professionals were paid a bonus in 1994 that was earned in 1992, and penalties incurred in 1994 for excessive volume increases will be reflected in 1996 rates. Government introduced the MVPS in 1990 and incorporated it into Medicare’s physician fee schedule in 1992. These regulations were designed to control growth in the volume of Medicare physician and other professional services. The MVPS penalizes physicians and other professionals for increases in volume of services above a predetermined target. A penalty for overshooting the target is imposed by way of reduced fee increases two years later. Likewise, when the volume of services increases below targeted amounts, bonuses are paid through fee increases in a subsequent year. When bonuses and penalties are associated with the year triggering their implementation, the 1994 growth in Medicare spending more accurately measures the ultimate obligations incurred by the program in 1994.

Comparing adjusted growth rates. More meaningful comparisons between Medicare and private insurance can be obtained by making the two series as comparable as possible. Of the aggregate increase in Medicare benefit spending between 1993 and 1994, enrollment growth accounted for 13 percent. Services not traditionally covered by private insurance (home health and skilled nursing home care, ESRD treatment, durable medical products, and hospice care) accounted for another 29 percent of the increase. MVPS bonuses for 1992, and the 1994 penalty to be imposed in 1996, accounted for 10 percent of the increase. Adjusting for these three factors, which accounted for 52 percent of Medicare’s increase (Exhibit 7), reduces the 1994 growth rate to 5.6 percent per enrollee.

A comparable analysis of private health insurance requires the removal of spending associated with enrollment increases and coverage differences. In 1994 private health insurance benefits grew 4 percent, and enrollment declined 0.1 percent. Creating a benefit package comparable to Medicare’s stripped-down package described above requires the removal of spending for prescription drugs, home health care, skilled nursing home care, dental services, and durable medical products. These changes result in private health insurance benefit growth of 3.6 percent per enrollee.

The use of aggregate estimates of Medicare and private health insurance
spending growth to infer inferior performance by Medicare is misleading at best. From 1969 through 1993 the growth of benefits per enrollee was lower on average for Medicare than for private insurance. The divergence in 1994 can be traced to a number of causes. Although the 1994 unadjusted growth differential was 7.8 percent, growth in “core spending” per enrollee differed by only two percentage points between Medicare and private insurance.

Service Expenditures

The nation’s health care bill totaled $949.4 billion in 1994 for the 271 million persons residing in the United States (Exhibit 8). Spending per person amounted to $3,510 in 1994, 5.4 percent higher than in 1993.

Hospital care. The largest single NHE component is hospital care at $338.5 billion in 1994 (35.7 percent). Eighty-eight percent of all hospital care in 1994 was delivered in short-term, acute care community hospitals, and 63 percent was for inpatient services alone. The remaining hospital services were provided in federal facilities or in nonfederal, noncommunity institutions such as psychiatric hospitals.

Hospital expenditures, which increased only 4.4 percent in 1994, experienced the fourth consecutive year of decelerated growth. Price inflation accounted for 3.6 percentage points of this increase, and one percentage point was attributable to population increases. Removing price and population increases from hospital growth produced a decline in the use and intensity of hospital services per person in 1994 (0.2 percent), the first time since the introduction of Medicare’s prospective payment system (PPS) in 1983 that such declines occurred. Nearly all hospital care was
### Exhibit 8
National Health Expenditures, By Source Of Funds And Type Of Expenditure, Billions Of Dollars, Calendar Year 1994

<table>
<thead>
<tr>
<th>Type of expenditure</th>
<th>Private</th>
<th>Consumer</th>
<th>Government</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>All</td>
<td>Out of Private pocket</td>
</tr>
<tr>
<td>National health expenditures</td>
<td>$949.4</td>
<td>$528.6</td>
<td>$488.1</td>
</tr>
<tr>
<td>Health services and supplies</td>
<td>919.2</td>
<td>517.1</td>
<td>488.1</td>
</tr>
<tr>
<td>Personal health care</td>
<td>831.7</td>
<td>469.9</td>
<td>441.6</td>
</tr>
<tr>
<td>Hospital care</td>
<td>338.5</td>
<td>138.9</td>
<td>125.5</td>
</tr>
<tr>
<td>Physician services</td>
<td>189.4</td>
<td>128.5</td>
<td>125.5</td>
</tr>
<tr>
<td>Dental services</td>
<td>42.2</td>
<td>40.4</td>
<td>40.3</td>
</tr>
<tr>
<td>Other professional services</td>
<td>49.6</td>
<td>34.7</td>
<td>34.7</td>
</tr>
<tr>
<td>Home health care</td>
<td>26.2</td>
<td>13.0</td>
<td>9.5</td>
</tr>
<tr>
<td>Drugs and other medical nondurables</td>
<td>78.6</td>
<td>68.6</td>
<td>68.6</td>
</tr>
<tr>
<td>Vision products and other medical durables</td>
<td>13.1</td>
<td>8.6</td>
<td>7.7</td>
</tr>
<tr>
<td>Nursing home care</td>
<td>72.3</td>
<td>30.4</td>
<td>29.0</td>
</tr>
<tr>
<td>Other personal health care</td>
<td>21.8</td>
<td>3.0</td>
<td>-</td>
</tr>
</tbody>
</table>

Program administration and net cost of private health insurance: 58.7, 47.2, 46.5, -46.5, 0.7, 11.5, 6.6, 4.9
Government public health activities: 28.8, - , - , - , - , 28.8, 3.7, 25.1

Research and construction: 30.2, 11.5, - , - , - , 11.5, 18.7, 13.3, 5.4
Research: 15.9, 1.3, - , - , - , 1.3, 14.7, 12.4, 2.3
Construction: 14.3, 10.3, - , - , - , 10.3, 4.0, 0.9, 3.1

**Source:** Health Care Financing Administration, Office of the Actuary, data from the Office of National Health Statistics.

**Notes:** Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from “research expenditures” but are included in the expenditure class in which the product falls. Numbers may not add to totals because of rounding.

Health spending was $949.4 billion in 1994, accounting for almost 20 percent of national health expenditures. Two-thirds of all funding for physician services came from private sources in 1994. Out-of-pocket spending accounted for 18.9 percent and private health insurance for 47.3 percent. The share of spending from

financed by third parties, with only 2.9 percent paid by consumers out of pocket in 1994. Private health insurance financed 34.2 percent of hospital care, while Medicare paid for 30 percent and Medicaid, 14.6 percent. The remaining 18.3 percent was funded by other government and other private sources.

**Professional services.** Spending for physician services grew to $189.4 billion in 1994, accounting for almost 20 percent of national health expenditures. Two-thirds of all funding for physician services came from private sources in 1994. Out-of-pocket spending accounted for 18.9 percent and private health insurance for 47.3 percent. The share of spending from
out-of-pocket sources continued to fall, as the growth in aggregate copayments and deductibles required by third-party payers failed to keep pace with third-party reimbursement. As more privately insured persons moved from fee-for-service to managed care plans, they faced flat out-of-pocket charges per visit or frequently smaller copayment rates. Similarly, slow growth in cost-sharing liability for Medicare beneficiaries meant that out-of-pocket expenditures accounted for a smaller share of Medicare benefits.

Almost half of all spending for dental services came from out-of-pocket sources. Dental expenditures grew slightly faster than did spending for services predominantly financed by third-party payers. In 1994 spending for dental services increased to $42.2 billion, up 7.5 percent from 1993. Overall, dental services accounted for 4.4 percent of national health expenditures.

Other professional services accounted for 5.2 percent of national health expenditures in 1994. Expenditures in 1994 amounted to $49.6 billion, an increase of 7.1 percent over the 1993 level. Although spending growth in this sector exceeded that of national health expenditures overall, spending for other professional services in 1994 represented the slowest expenditure growth in this sector since 1968.

Expenditures for freestanding home health agencies amounted to $26.2 billion in 1994, a 13.8 percent increase from 1993. Home health care was the second-fastest-growing component of personal health care expenditures in 1994, although the 13.8 percent growth is substantially slower than the 20-30 percent growth rates experienced in the late 1980s and early 1990s. Spending for services and products provided by these agencies amounted to 2.8 percent of national health expenditures. In 1994 Medicare and Medicaid financed more than half of all home health care expenditures. This share continues to rise, despite the deceleration in Medicare spending growth from the 40-50 percent range in 1990-1992 to 22.3 percent in 1994.

Nondurable and durable medical products. Spending for drugs and other nondurable medical products totaled $78.6 billion in 1994. Spending for these products has decelerated steadily since 1990, from a growth rate of 11.5 percent in 1990 to 4.5 percent in 1994.

Two-thirds of spending on nondurable products, $51.9 billion, went for purchases of prescription drugs, and one-third for over-the-counter medicines and medical sundries. Spending for prescription drugs rose 5.1 percent in 1994, having steadily decelerated from a growth of 14.6 percent in 1990. Prescription drug price increases measured by the Consumer Price Index (CPI) tumbled from 10 percent in 1990 to 3.4 percent in 1994. Price competition precipitated by an increase in generic drug availability, the rise of pharmaceutical benefit managers, and the emergence of alternative
pharmacy sites forced consumer prices to fall.\textsuperscript{13}

Spending for durable medical products totaled $13.1 billion in 1994. Spending grew a modest 4.6 percent in 1994 for purchases such as vision products, hearing aids, wheelchairs, crutches, and artificial limbs. Almost two-thirds of all spending for durable products came from private sources: 59 percent out of pocket and 6.5 percent from private health insurance. Medicare paid for 31.2 percent of durable products in 1994.

**Nursing home care.** Spending for nursing home care rose to $72.3 billion in 1994, a 7.8 percent increase from the 1993 level. This estimate covers spending in three facility types: private and state and local government nursing home facilities; Department of Veterans Affairs facilities; and intermediate care facilities for the mentally retarded (ICF/MR).

In 1994 Medicaid funded a slightly smaller share (47.4 percent) of all nursing home care than in 1993 (48.4 percent). This decline was offset by an increased Medicare share (8.2 percent in 1994, compared with 6.8 percent in 1993). Private funding, mostly through out-of-pocket spending, amounted to 42.1 percent of the total nursing home bill.

**Other personal health care.** In this fastest-growing personal health care expenditure category, governments and businesses spent $21.8 billion in 1994 to purchase services from establishments not usually recognized as medical care providers. In that year businesses spent $3.0 billion for worksite health services. Government programs spent $18.8 billion for services in schools, military facilities, and other nonmedical locations. More than half of all purchases for other personal health care came from Medicaid.

**Sources Of Funding**

From 1989 to 1994 the share of health spending funded by the public sector increased from 40.5 percent to 44.3 percent—the highest level ever recorded. This shift in share occurred because Medicare and federal Medicaid spending increased more rapidly than private spending did.

**Medicare.** Medicare spending for personal health care amounted to $166.1 billion in 1994, an increase of 11.8 percent over spending incurred in 1993. Medicare is the largest public payer for total personal health care expenditures. In 1994 Medicare covered 36.9 million enrollees and financed 20 percent of total personal health care spending, 30 percent of spending for hospital care, 20.1 percent for physician services, 13.7 percent for other professional services, 36.5 percent for home health care, 31.2 percent for medical durables, and 8.2 percent for nursing home care. Medicare’s shares have increased each year since 1991 (earlier for some services) except for physician services. Faster growth in the Medicare population compared with the general population and the aging of frail elderly Medi-
care enrollees contribute to the increase.

In 1994 Medicare spending for a broad range of services continued to exhibit strong growth. Medicare spending for hospital care and physician services grew between 10 and 13 percent in 1994. Growth in spending for care provided in freestanding nursing homes and by freestanding home health agencies decelerated from 1993 to 1994 but still exceeded 20 percent. Introduction of the Medicare Catastrophic Coverage Act of 1989, the clarification of skilled nursing home conditions for payment (1988), and the clarification of home health coverage criteria (1988) produced major expansions in eligibility and benefit payments for home health and skilled nursing home services. These actions and their residual effects produced average annual increases in spending per enrollee for home health care and skilled nursing home care of 36 percent and 47 percent, respectively, from 1988 to 1993.

Medicaid, Federal and state Medicaid spending for personal health care amounted to $122.9 billion in 1994 (14.8 percent of total personal health care spending). The program provided benefits to 35.1 million recipients in fiscal 1994. Growth in Medicaid personal health care spending has been decelerating, slowing from 25.7 percent in 1991 to 7.7 percent in 1994. Legislation that set state limits on disproportionate-share payments and recent deceleration in recipient growth seem to have had an effect on controlling spending. The largest share of Medicaid funds goes for institutional services. In 1994 hospital and nursing home care consumed more than two-thirds of Medicaid benefits. Medicaid was the largest third-party payer of nursing home care in 1994, financing 47.4 percent of total spending for care provided in freestanding nursing facilities.

Private health insurance. In 1994 private health insurance premiums equaled $313.3 billion (Exhibit 8), a 5.7 percent increase from 1993. This is the second consecutive year of decelerating growth and the fourth of single-digit growth. The slower growth exhibited by private health insurance resulted in large measure from a shift by employees to lower-cost managed care plans. These plans tended to restrict use to a preapproved list of providers in return for smaller premiums, copayments, and deductibles. An increasingly popular type of managed care plan known as a point-of-service plan offers the option to go outside the plan’s provider list, but larger out-of-pocket costs are incurred by so doing. Within various plan types, surveys note that premiums continued to increase in 1994. This suggests that a portion of the slow growth in private health insurance premiums resulted from the change in mix of plans toward lower-cost plans. It also fuels speculation about the insurance industry’s ability to maintain slow growth in the future once enrollment in managed care plans is maximized.
Private health insurance paid $266.8 billion in benefits in 1994. The breadth of insurance coverage widened as more people enrolled in managed care plans that more fully cover preventive services. The distribution of benefits paid by private insurance for personal health care reflected this change. A smaller share of benefits went for hospital care between 1990 and 1994, offset by larger shares for physician services and prescription drugs.

The net cost of private health insurance rose 16 percent to $46.5 billion. This amount, 14.8 percent of total premiums, includes administrative costs faced by private insurers and self-insurers, insurers’ net additions to reserves, rate credits and dividends, premium taxes, and profits and losses.

**Conclusion**

It may be several years before clear evidence on the long-run trend of health spending growth can be confirmed. For 1995 available indicators on health care use and price trends and on private health insurance premiums reveal little or no change in expected spending growth patterns. For 1996 and beyond the expected trends are more ambiguous. First, anecdotal information suggests that insurers’ profits are being squeezed as insurers attempt to increase market share by offering lower premiums to employers. If true, this could signal an acceleration in premium growth in the near future as insurers attempt to reestablish previous profit margins. Second, surveys of employer-sponsored private health insurance show that part of the slowdown in premium growth in 1994 and 1995 resulted from the switch of employees’ coverage from conventional to managed care plans. Once that switch nears completion, growth in aggregate premiums may accelerate. In sum, it is not yet clear that slower spending growth in 1993 and 1994 signals a new era of moderation in health spending growth trends.

The authors thank Daniel Waldo, Richard Foster, and three anonymous reviewers for their helpful comments on a previous draft. The views expressed in this paper are those of the authors, and no endorsement by the Health Care Financing Administration is intended or should be inferred.

**NOTES**


2. Benchmark revisions to estimates of GDP were introduced in January 1996 and have been included here. For further information, see U.S. Bureau of Economic Analysis, Gross Domestic Product: Third Quarter 1995 (Preliminary); Corporate Profits: Third
Quarter 1995 (Preliminary); and Revised Estimates, 1993-95 (Press release from the U.S. Department of Commerce, 19 January 1996). The substantial upward revision to GDP is the major reason that NHE as a share of GDP fell from the 13.9 percent reported last year for 1993 to 13.6 percent recorded in this set of estimates for the same year.


5. Aaron, “Thinking Straight about Medical Costs.”


8. Net enrollment counts each person who participates in one or more employer-sponsored or individual private health insurance plan. Estimates were developed using data collected in the National Health Interview Survey, conducted by the National Center for Health Statistics, and the Current Population Survey, conducted by the U.S. Bureau of the Census.


11. This category includes services provided by licensed medical professionals such as chiropractors, psychologists, optometrists, podiatrists, and private duty nurses; by kidney dialysis centers and freestanding specialty outpatient clinics such as substance abuse, rehabilitation, and mental health clinics; by ambulances paid under Medicare; and by miscellaneous health and allied services not elsewhere classified.

12. Home health agencies also operate out of hospitals and other medical facilities. In these cases, expenditures for those services are included in the NHE category of the sponsoring establishment.


15. Foster Higgins reported 1994 premium increases of 2.1 percent in preferred provider organization (PPO) plans and 10.5 percent in point-of-service plans, while KPMG Peat Marwick reported premium increases of 3.2 percent in PPO plans and 5.9 percent in point-of-service plans.
