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Escalating Health Care Spending: Is It Desirable Or Inevitable?

No single stakeholder should be asked to bear the burden of curbing excess health spending; anything less than a coordinated effort is doomed to failure.

by Stuart H. Altman, Christopher P. Tompkins, Efrat Eilat, and Mitchell P.V. Glavin

ABSTRACT: This study analyzes changing trends in U.S. health spending and concludes that although the long-term growth trend has been a good predictor of future spending, periodic differences in the growth trend are important. Of particular concern is the rapid acceleration in health spending beginning in 1998. If left unchecked, the current growth rate will result in almost 24 percent of GDP spent on health by 2011. The authors question whether such unconstrained spending levels are either desirable or inevitable, and they offer a guide to how the United States might develop a long-term cost-containment strategy that is both effective and sustainable.

Spending for health care in the United States has resumed its upward growth, and it now exceeds the growth trend rate of the late 1980s and early 1990s.¹ Annual growth in national health spending per capita accelerated from 4.3 percent in 1997 to 6.0 percent in 2000.² The Centers for Medicare and Medicaid Services (CMS) now anticipates that health spending will increase much faster than growth in gross domestic product (GDP) and will exceed 17 percent of GDP by 2011.³

Some have reacted to the resurgence in health spending growth with resigned pessimism. In a recent commentary, Drew Altman and Larry Levitt identified as short-lived the impact of the cost containment strategies employed in the past three decades; they conclude that future decades will not look different than recent ones in terms of national health spending growth.⁴ Some economists maintain that Americans do not seem to want things any other way and suggest that escalating health care spending is therefore desirable.⁵ Still others report that the growth in health spending is primarily determined by changes in the country’s na-
“The health sector is big enough to cause sizable, painful economic ripples when its growth rate sharply accelerates or decelerates.”

The long-term trend. Per capita health spending in the United States has grown almost continuously over the 1966–2000 period (Exhibit 1). This underlying growth trend has led some analysts to conclude that any attempt to control health care spending can be successful only for short periods. Ultimately, they believe that the country will return to its long-term growth rate, which is primarily determined by the growth in real national income.8

There are other reasons to support this conclusion. Over time, the presence of private insurance and other forms of coverage has shielded patients from much of the cost at the point of service. The result has been largely unrestrained demand for any available services consumers or their physicians believe could be useful. Victor Fuchs has termed this behavior as “flat of the curve” medicine, whereby...
services are consumed up to the point that they have no value and significance. This consistent availability of funds has encouraged innovation, adoption, and use of increasingly expensive services and escalating health care spending.

Fuchs developed his concept prior to the “managed care revolution” of the 1990s. One result of this revolution was to move the United States to a point where medical interventions and the use of new technologies and procedures generated greater value relative to their costs. The widespread approach was to restrain consumers’ and providers’ high expectations with utilization controls and financial risk arrangements for providers. But, as is well known, such actions were not popular, and in the face of the backlash against managed care, many utilization controls were discontinued. How close we are again to the “flat of the curve” position today is unclear, but if unfettered growth in spending continues, we are clearly moving in that direction. If the past decades have taught us anything, it is that the pressure to use medical technologies up to the point that they have no marginal value is very strong, and as a result, the long-term spending growth trend may appear to be inevitable.

**Short-term trends.** The long-term spending trend, however, masks major year-to-year or period-to-period variations. We believe that these variations can provide some important lessons about the forces affecting the growth rate of health

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**EXHIBIT 1**

**Annual Growth In Per Capita National Health Spending, 1966–2001**

<table>
<thead>
<tr>
<th>Year</th>
<th>Dollars</th>
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<tbody>
<tr>
<td>1966</td>
<td>0</td>
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<tr>
<td>1970</td>
<td>800</td>
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<tr>
<td>1980</td>
<td>1,600</td>
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<td>1990</td>
<td>2,400</td>
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<td>2001</td>
<td>4,000</td>
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**Notes:** Adjusted for inflation, with 1996 as the reference year. We used the gross domestic product (GDP) deflator to adjust for inflation. Figures are computed based on the figures reported by the Bureau of Economic Analysis, www.bea.gov/bea/dn/gdpdef.xls (15 October 2002). The GDP deflator was calculated as follows: annual GDP in billions of current dollars, divided by annual GDP in billions of chained 1996 dollars, multiplied by 100. The ordinary least squares regression equation is as follows: \( y = 106.5x - 208748 \), \( R^2 = 0.9756 \).
care spending. Although in most years the annual growth rate in real terms was positive, there have been certain periods when the rate was substantial and other periods when it was close to zero.

This can be seen more clearly by focusing on deviations from the mean growth rate for the entire period (Exhibit 2). This series reveals that 1991–2000 represents the longest sustained period when spending was below the long-term trend. Exhibit 2 also shows that annual spending grew the fastest in the 1960s and 1980s.

To highlight these period differences, we calculated year-to-year growth rate regression equations separately for each decade using the data shown in Exhibit 1. As one might guess from examining that exhibit carefully, the growth coefficients for the 1970s and the 1990s are much smaller than they are for the 1980s: 1960s: 72.2, 1970s: 69.1, 1980s: 133.4, 1990s: 101.4 and post-1997, 179.2. The 1970s were marked by a number of cost containment efforts by the federal government—the Economic Stabilization Program in 1971–1974, National Health Planning in 1975–1979, and various types of state rate-setting programs—whereas the 1990s were dominated by spending limitations effected through private managed care

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**EXHIBIT 2**

**Rate Of Growth In Per Capita National Health Spending, Deviation From The Mean, 1966–2001**

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<tbody>
<tr>
<td>Percent deviation from the mean</td>
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**NOTES:** Adjusted for inflation, with 1996 as the reference year. We used the gross domestic product (GDP) deflator to adjust for inflation. Figures are computed based on the figures reported by the Bureau of Economic Analysis, www.bea.gov/bea/dn/gdpilev.xls (15 October 2002). The GDP deflator was calculated as follows: annual GDP in billions of current dollars, divided by annual GDP in billions of chained 1996 dollars, multiplied by 100.
plans. In contrast, by the early 1980s most of the governmental regulatory apparatus had been dismantled, and by the late 1980s the few remaining state rate-setting efforts were ended and the market approach of the 1990s had not yet been assembled. One of the authors of this paper has called the 1980s “the decade of halfway competitive markets and ineffective regulation.”¹¹ The years following 1997 indicate a growth rate that is close to what we experienced in the 1980s. In fact, if the current trend continues, growth in health care spending in the first decade of the twenty-first century could exceed that of the 1980s.

Thus, to various degrees at differing times, market forces or governmental actions or both have dampened growth rates in health care spending. This is partly good news: In any given year, the growth rate is neither inevitable nor impervious to influences from the market or from government. The bad news, or perhaps a hard lesson from the past, is that the United States historically has relied on one component of the system at a time for the means of controlling costs. This approach may have been effective for a limited period but was not sustainable.

- **Time-limited successes.** When something works to control spending, is the success inevitably time-limited, with a return to the long-term trend? U.S. history suggests that might be true, and surely any limitation on spending will be met by strong resistance from groups negatively affected. In the 1970s health care providers fought the various constraints imposed on them by government. Many of these constraints were invisible to patients, and while provider groups attempted to make the case that payment limitations or certificate-of-need restrictions negatively affected quality of care and access for patients, consumer groups and employers generally supported these governmental efforts.

This was not true in the 1990s. In that decade patients and consumer groups were at the vanguard of those protesting the limitations imposed by managed care plans. What was similar in both decades was the ultimate reaction of the political system. In the late 1970s and 1980s the federal government and most state governments unraveled their health planning systems and eliminated most health care price control systems. In the latter part of the 1990s governments imposed substantial regulatory and legal restrictions on the behavior of managed care plans. It seems like we are again facing a decade of halfway competitive markets and ineffective regulation.

The reactions of the political system to constrained growth in health care spending suggest that it has lacked the will to stay in the background when the negative consequences of reduced growth become apparent. Certainly, there are always negative consequences to one group or another from reduced spending, but there are also positive consequences. The lessons of history point in the direction that the groups feeling the negative consequences win the political battle and push government to intervene to restrict the use of those elements that have been most effective in curtailing spending growth.

Is this outcome inevitable? To the extent that the actions of the political system
correctly reflect the “will of the people,” and if their will is to continue having the political system intervene to stop the limitations on spending, then the experience of the past thirty-five years will be repeated in the next thirty-five years. We have also learned that the growth rate is critically important. Thirteen percent of GDP spent on health care was judged to be excessive in the early 1990s, when the spending growth rate exceeded double-digit levels for several years. In 1996 the percentage of GDP spent on health was also about 13 percent, but with an annual growth rate below 5 percent for several years, the opposite “political” conclusion seemed to prevail: “We need more spending!” But could we possibly reach a level of spending (as a proportion of national income) that is judged to be too high, when the will of the people will say, “Slow down!” and mean it?

**The Downside Of Large Cyclical Swings In Spending**

The wide range and sharp periodic cycles in spending growth produce disproportionate strains that contribute to the perception of a health system in constant crisis. In the midst of the swirling, there is inherent confusion and frequent incidences where segments of the provider system or individuals are on the verge of bankruptcy, and at other times accusations of excessive profit taking.

This instability is often exacerbated by government actions, whose cyclical fluctuations in health spending are highly episodic. For example, per beneficiary Medicare spending grew at an annual rate of 8.4 percent from 1992 to 1996 and fell to a low of 2.1 percent from 1997 to 2000. In contrast, private per enrollee premiums rose at an annual rate of 5.5 percent during 1992–1996 and 5.1 percent from 1997 to 2000 (calculations based on data from Exhibit 3). The problem is compounded when a periodic change in government spending is matched with a similar directional change in private spending. This is what happened in 1999 and 2000, and it is still a factor for some types of services today.

**Are Government Payment Controls The Answer?**

Government plays a variety of roles vis-à-vis our health system. Most importantly, it administers two major health care financing programs that, in total, account for more than 40 percent of health care spending. Thomas Bodenheimer commented on the Altman/Levitt analysis mentioned above by pointing out that they ignored the general downward trend in Medicare program spending per enrollee. However, a comparison of changes in private versus public spending reveals a different picture: While in some years government was more successful than the private sector was in controlling health spending, in other years the private sector did a better job. Actually, the coefficient explaining the decline in yearly private per enrollee spending growth is slightly larger (that is, there is a steeper decline in private spending) (Exhibit 3). Thus, the federal government has not found the magic bullet, either. In essence, the same forces appear to be influencing both trends with differences in timing.
Future Trends

The upward spending trend that began in 1998 is likely to continue without some outside intervention, by market forces or government or both. As this paper is written in mid-2002, the forces for continued upward growth seem strong. As in similar past cycles, the first phase was dominated by health insurance premiums rising faster than underlying health service costs. We have now entered the second phase, where underlying health care service costs are growing more rapidly. For much of the 1990s reduced spending for inpatient hospital care was a key factor in keeping overall health care spending growth low. The direction of this trend has now changed. Led by an increase in admissions and higher factor costs, inpatient hospital spending is now showing an upward growth trend. Changes in spending for inpatient hospital care reached a low of –5.0 percent in 1997. The trend has turned upward since then, and in 2001 inpatient spending grew by 3.5 percent. The renewed growth in spending for hospital care was highlighted in 2001 by Paul Ginsburg, who showed that hospital spending constituted the largest proportion of health spending growth in 2000 (43 percent). In 1999 increased spending for prescription drugs was the largest factor (35 percent).

Adding to the concern of higher spending for hospital care is the assessment of a leading health care consulting firm that this country will need to increase its hospital capacity by 40 percent over the next decade. The cost implications of this prediction are staggering. Even if such predictions are excessive, they do suggest that the era of declining hospital inpatient spending is over, and with prescription drugs, outpatient care, and other health sectors continuing to grow, ac-
Accelerated growth in overall costs seems to be a likely outcome.

To see where the current upward trend might lead, we projected its continuation through the end of the decade based on the growth rate trend during 1997–2000 (data not shown). While straight-line growth projections are highly suspect, they do have the advantage of highlighting where current trends will lead us without the intervention of new forces. This projection suggests that by the year 2011 the proportion of U.S. GDP spent on health care will grow to more than 23 percent, up from its 2000 level of 13.2 percent. Absurd as these numbers appear, even using the slower spending growth rate projected by the CMS, the GDP percentage will still grow to 17 percent.

At present, there seems to be little political will or general inclination to constrain spending. Adding to these spending increases are consumers who are more willing to select higher-spending preferred provider organizations (PPOs) than lower-spending, tighter forms of managed care. This suggests that the ultimate spending level in 2011 could be higher than the CMS predicted. In either case, can we really be confident that the public will view the prospect of such growth rates as desirable?

**A Guide For Achieving Sustainable Growth**

Unfortunately, in the past the nation has let one group bear the full brunt of slowing the growth in spending, with the other stakeholders retreating to the sidelines or, worse, working at cross-purposes. In the 1970s we had some success in holding down spending with the help of governmental regulations. In the 1990s we again saw some success, resulting from efforts by managed health plans. Current developments suggest that consumers will be asked next to hold down health care spending. Consumers alone, we believe, cannot appreciably slow the growth in health spending. Rather, consumers, employers, insurers, providers, and government must undertake complementary actions to restrain costs and thereby guide the rate of increase in spending. In the following section we briefly explain our rationale for such an approach.

As in other sectors of the economy, the general aim is to use resources to produce goods and services that benefit consumers more than would alternative uses of those resources. This requires actions directed at three related objectives. First, the adoption and use of new technologies should be more carefully considered, based on their health care benefits and costs. Second, improved health of the population and avoidance of illnesses should be encouraged, to help reduce demand for intensive treatment services. Third, the structure and process of health care delivery need incremental, if not major, reforms, to reduce systemic waste and inefficiencies. These objectives relate to the major cost drivers in health care, as depicted in Exhibit 4.

- **Role of activated purchasers (consumers and employers).** Increasing consumer sensitivity to costs is critical if the use of health care resources is to be ratio-
nalized. Patients need to understand and take into account the cost implications of the care they request. The burden of selecting the most appropriate care plan in terms of costs and benefits should not be left totally to health professionals. A financially motivated patient can help guide this process. By paying a higher percentage of the premium and larger coinsurance rates, employees will have more of a financial incentive to choose more tightly managed care plans that have in place mechanisms to select more cost-effective delivery of health services.17

Although we support some increases in patient cost sharing, if these increases become too large, many individuals and families could stand in harm’s way. They could be forced to drop coverage, restrict their use of needed medical services, and reduce the use of important non–health care services. The situation is similar for employers; escalating health care spending may result in fewer employers’ offering coverage to workers. Employers cannot finance health care benefits indefinitely through reduced profits (which can be low or nonexistent) or lower wages (which must be sufficient to retain workers and in some industries are already near the minimum). Where possible, it is desirable for employers to offer comprehensive benefits, not only to limit workers’ financial exposure but also to encourage proactive management of health conditions and avoid needless and expensive progression of illness. Acting individually and collectively, employers can contribute by actively pursuing indicators that make the health care system accountable to purchasers. These include requiring quality standards, such as report cards and improvement programs, and more consistent and reliable premium pricing, to help dampen the insurance cycle.

In the end, we believe, consumers and their employers alone will not be able to turn back the forces of medical inflation. They will need help, and plenty of it, from the other stakeholders if they are to contribute on a sustainable basis to dampening current spending growth rates.

Role of care managers (providers and insurers). If the advantages of comprehensive insurance are to be retained, we will continue to face its disadvantages as
well. At the point of service, consumers will face prices lower than the cost of producing the service and will want to consume a greater volume and intensity of services than the health benefits would warrant. As discussed above, we support the inclusion of more consumer cost sharing to partially mitigate such factors. But physicians and other providers are important agents for recommending and delivering services, and they too should be part of the effort to use expensive resources wisely. Insurers must be part of the process as well, to be “care managers” and not just payers of services. Unfortunately, the return of more traditional fee-for-service financing arrangements pushes the system in the other direction, as providers are rewarded for delivering more services, some of which may be of questionable value. In spite of this, we believe that providers should want to contribute to a strategy that supports moderate spending growth. So, too, should insurance companies want to do more than just pay bills. While the current environment is still quite hostile to most forms of “managing care” by insurance companies and many companies have moved to eliminate such behavior, we suggest that developing effective managed care techniques is important for the long-term survival of private insurance.

Absent such a strategy, the health care sector could suffer badly. Larger segments of the population will lose private insurance and either become uninsured or be displaced to publicly funded programs, resulting in a smaller private insurance market. With continued reliance on sporadic cost control measures, government programs will likely reduce provider payment rates, and overall revenues to many provider units could either be reduced or not grow as fast as the cost of providing services. This problem will be exacerbated by increases in uncompensated care expenses. Further, it is likely that government will step up its efforts to monitor and regulate providers’ practice patterns. At the extreme, government may be pressured by an enraged public into controlling all medical care prices.

Thus, to a degree, the outlook for providers resembles the outlook for consumers. Some could fare well under higher spending, but many would experience disproportionate pressures and a heavy burden. A more desirable future would involve better management of resources by providers and insurers, to help limit demands by consumers for new and increasingly expensive technologies and services that do not bring sufficient medical benefits.

To assure more appropriate use of health care resources, the financial incentives of providers need to be better aligned with those of the patient. Thus, cost sharing by consumers should be mirrored by cost sensitivity on the part of providers. Capitation has been the method used for this in the past and could be used again. But it must be designed to avoid past pitfalls, particularly capitation rates that physicians and hospitals knew to be totally inadequate to pay for needed (as op-
posed to questionable) services. Also, the process of decision making, including
the delineation of the relevant alternatives and the quantifying of benefits versus
costs, should be based on the best empirical science available, not just the personal
experiences of providers and patients. This implies a more formal and science-
based process, not only for the formulation of clinical innovations but also for the
adoption, diffusion, and routine use of medical technologies and treatments.

There are limits on how much to restrain the pressures for patients to want the
newest technologies and for health plans to restrict the income and independence
of providers. If we learned anything from the late 1990s, it is that we crossed the
line. To restrain spending in a more balanced way, in addition to providing finan-
cial incentives to providers who use resources more efficiently, insurers can help
by covering and providing preventive services and early treatment interventions
that help to avoid progression to higher severity conditions. Care managers also
can perfect and expand their use of “disease management” programs for the chron-
ically ill.19 There is growing evidence that such interventions can lower costs over
the long run, by producing a healthier population with less need for health care
services and reducing the use of expensive services by those who do become ill.20

By learning how to manage populations better and allocating resources to best
meet the needs of the population, insurers and providers can contribute to re-
engineering the structure and process of care. The U.S. health care system has tra-
ditionally been organized around delivering medical services to treat acute illness
episodes by means of capital-intensive institutions. Unfortunately, this orienta-
tion results in a delivery system that is ill suited for addressing the ongoing needs
of people with chronic illnesses.21 Such people need services and supports that
will enable them to live in community settings, promote their physical and mental
functioning, and limit the progression of disease and disability. Therefore, better
serving the care needs of people with chronic illnesses requires a shift in focus to-
ward a more preventive, coordinated, and community-based orientation.

■ Role of government. Although there is ample evidence that many of the new
procedures and technologies have improved the health status of the U.S. population,
their high costs make it more imperative than ever to use these resources wisely.22 A
major deficit in the current U.S. system is a pervasive lack of knowledge regarding
the incremental effectiveness of various types of services. For example, with hospital
services often costing thousands of dollars per day, it is becoming increasingly im-
portant to have information about the incremental costs and benefits of services
available in other settings. Similarly, new prescription drugs are often positioned to
replace existing drugs that are much cheaper. Some people clearly benefit from the
most expensive drug; however, in the judgment of many, there are too many patients
consuming too many units of the more expensive alternatives, whose incremental
benefits are not sufficient to justify the higher costs.23

The responsibilities of government in health care are manifold, including pro-
viding coverage for poor and other disadvantaged groups. Government also needs
to help provide the information base for better use of health care services. Government has an indispensable role of sponsoring or conducting technology assessments (including cost-effectiveness analyses) that can inform payers regarding their coverage and reimbursement policies. Payers need to know which new technologies to cover, what value to expect in terms of benefits, and consequently what amounts would be worth paying.

The U.S. health care system has a formal and careful process for determining the safety and efficacy of new products, but more of an ad hoc process for making coverage and reimbursement policies for emerging products. Accordingly, there is a need to greatly increase the funding for studies that assess the outputs of research in terms of their contribution to improving health status, relative to their costs. Given that the potential overuse of new technologies coincides with the rate of innovation, perhaps the federal government should earmark a certain percentage of basic research funding levels (for example, 5–10 percent) for investigating the incremental effectiveness and costs of alternative treatments in actual delivery systems. This would be in addition to the efficacy studies using controlled conditions and comparing new services to placebo or existing treatments.

Important determinants of total spending include the increased availability of hospital beds and other major capital resources. During the 1990s managed care plans put pressure on providers to limit the availability and use of expensive and underused services. Some of these efforts were probably too severe or poorly implemented, but if these pressures are simply eliminated with nothing to take their place, a spending cycle that is equally harmful could be set in motion.

As an alternative, we believe that the activities of private insurers should be supplemented with some form of government regulation to limit the growth in new and expensive capital expenditures. Several studies have shown that one of the most effective tools used in other countries to limit health spending growth has been their use of capital expenditure limitations. Although the United States has had less success with such controls in the past, we may need to reintroduce them, particularly if health inflation continues at or near current levels.

Over the longer term, the amount of capital investment should be gauged in relation to the expected medical benefits of the new technologies and procedures. Where there is clear evidence that a new innovation has sufficient benefit, it should not necessarily be constrained because it is expensive. On the other hand, we should not ignore the added costs of these new activities, and we should be mindful of the need to be sure of the medical benefits before undertaking a massive investment program.

The United States is poised for sizable increases in health care spending for the next decade. The CMS projects that within the next decade this country will use more than 17 percent of its GDP for health care services, a 30 percent increase from the levels in 2000! And these projections could
be quite conservative. Given that current spending growth rates project an even higher level of spending by the end of the decade, some (unspecified) efforts by government, consumers, and the private sector will be needed to reduce spending in the near future. Without such efforts, we might see spending reach levels closer to 24 percent of GDP by 2011. Of concern in addition is the expected amplitude of the cyclical oscillations in the spending growth rate. We are again witnessing spending growth rates of more than twice the rate of inflation, as measured by the Consumer Price Index; for the CMS projections to turn out to be accurate, we would likely have to see some years when spending levels barely keep up with inflation. Such a scenario has the potential to cause great harm to many groups in the population through reduced access to services, fiscal problems for employers and government, uncertainty for insurers, instability for providers, and an increase in the number of uninsured people.

We reject the presumption that traveling down this road is desirable or inevitable, and we believe that a national strategy must be developed to reduce the magnitude of the cyclical swings and produce a stable long-term spending growth rate, which is judged acceptable by the various health system stakeholders. The past has taught us that we allow the long-term cost drivers to go unchecked for too long and then revert to one form of cost containment or another, relying primarily on one group to put the system into reverse. This strategy leads to excessive swings in the growth rate, an attack on the group that is asked to reverse the upward spending trend, and continuous upward pressure on the health care spending level. To change this cycle requires the active involvement of consumers, employers, and providers, as well as government and private insurance plans. The most important aspect of our recommended approach is a focus on developing techniques and sustainable incentives to better manage the use of services, particularly new and expensive technologies.

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NOTES
2. Levit et al., “Inflation Spurs Health Spending in 2000.”
6. One analyst has shown that changes in GDP growth lagged four years are an excellent predictor in ex-
plaining changes in the growth rate of real (inflation-adjusted) health expenditures. Although this is true, such an explanatory model ignores the importance of major changes in the health system. See R.A. Cooper and T.E. Getzen, “Health Care Spending in One Chart” (Letter), *Health Affairs* (May/June 2002): 279.

7. For example, Stephen Stamas, president of the American Assembly at Columbia University, wrote in 1987 in the preface to a book on rising health care costs, “Most agree that future health care cost increases must be moderated and related to our other societal priorities, but there is no agreement on how to do so.” C.J. Schramm, ed., *Health Care and Its Costs* (New York: WW. Norton, 1987).


18. One of the authors of this paper has outlined one possible alternative payment system in another manuscript. See S. Wallack and C. Tompkins, “Achieving Medicare Reform through Fee-for-Service” (Unpublished manuscript, Brandeis University, 2002).


