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Why Americans want to spend more on health care

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The economic fact is that the amount we spend on health care as a percentage of national income will continue to rise over the next 50 years.

Last week, the Supreme Court upheld the Affordable Care Act (ACA). Now, the battle moves from the courts to electoral politics, with arguments about whether or not the ACA will reduce health care costs compared to what they would have been without it, or whether repealing the ACA and substituting alternatives such as health care vouchers would encourage increased efficiency and lower costs.

However, such debates are fundamentally flawed. The economic fact is that the amount we spend on health care as a percentage of national income will continue to rise over the next 50 years.

Health care spending as a percentage of GDP rose in all industrialized countries over the past 50
years. (See, for example, the graphs here.) This indicates that factors common across countries, rather than differences in delivery systems, drive this trend. For instance, some argue that U.S. health-care spending rose from 5 percent of GDP in 1960 to 18 percent in 2010 because of problems unique to the United States. But this doesn’t explain why all other countries experienced similar increases in their spending shares.

**Joseph Newhouse** of Harvard University first addressed this problem 20 years ago in an article in The Journal of Economics Perspectives. He wrote, “Suppose that some magic wand could almost costlessly get rid of medical services whose marginal benefits were less than their marginal cost.” That is, imagine no unnecessary procedures, no ineffective treatments and all waste was wrung out of the system. He went on to argue that what he called “the march of science” would inevitably push up the share of our national income going to health care.

**March of science**

Why? Because the march of science increases health care spending in two ways. First, medical science advances through expensive new types of physical capital such as CAT scanners, MRI machines and surgical robots. Second, medical science marches on through new procedures that may not require much expensive capital but do require increasingly specialized (and pricey) physicians, nurses and other medical professionals.

But Newhouse’s argument is incomplete. **Charles I. (Chad) Jones**, an economist at Stanford University, pointed out: “People do not have to purchase the new medical technologies if they don’t want to, and, in fact, people do not have to invent them in the first place if they are not valuable. Given that, it must be the case, at some level, that the increasing share of GDP expended on health care reflects people’s preferences.”

In particular, Jones made a distinction between goods and services (such as cars, televisions, clothing,
movies, concerts) and years of life. Goods and services are subject to something economists call “diminishing marginal utility;” in plain English, more stuff is better, but the extra satisfaction that we get from every additional car, TV, shirt or concert gets smaller and smaller.

**Income elasticity**

This can be measured using something economists call income elasticity. Income elasticity measures how much more of a good or service a person will buy if their income goes up by 1 percent. For most goods and services this number is less than 1; that is, if income rises then people will buy more of most goods but they will increase their purchases by less than 1 percent.

Years of life are different. If you have a medical procedure that extends your life, then the first, second, third and however many extra years you receive are all equally valuable. So if your income rises by 1 percent, you will increase your spending on medical care by at least 1 percent, and possibly more.

Jones, along with Robert E. Hall (also of Stanford) embedded this idea in an economic model and found that it does a good job predicting the path of health care expenditures from 1950 to 2000. Further, they show that if this is true, then the share of GDP we devote to health care could easily rise to 30 percent or more over the next 50 years as people choose to spend more on health care to obtain more years of life.

Thinking about the rise in medical spending this way puts health care policy in a different light. People want to live longer, better lives, and they are willing to pay for it. They don’t want more stuff, they want more life.

Thus it might be the case that in economic terms, Americans want a larger percentage of their spending to be devoted to health care, and as long as the extra benefits of greater medical spending exceed the costs people will be willing to pay for more care. This could be true both in their private spending decisions as well as in terms of government spending.
Louis D. Johnston writes Macro, Micro, Minnesota for MinnPost, reporting on economic developments in the news and what those developments mean to Minnesota. He is Joseph P. Farry professor in the Eugene J. McCarthy Center for Public Policy and Civic Engagement at Saint John’s University. He is also a professor of economics at the university.

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