EDITORIAL

Myth Busters
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It takes a certain kind of person to enjoy reading official testimony from the Congressional Budget Office (CBO). I guess I am one of those special people!

A recent CBO report, entitled Growth in Health Care Costs, caught my interest. The report comes from a statement by CBO Director Peter R. Orszag, who testified before the Senate Budget Committee this past winter. I believe that the report could have easily been called “Myth Busters Regarding Spending in Health Care.” I’ll focus on some of the report’s highlights and then outline four myths that the report dispels.

It should come as no surprise to our readers that spending for health care in the U.S. has grown substantially over the past four decades. It more than doubled in real terms (in inflation-adjusted dollars) in the last 20 years. Spending per person has also risen rapidly, with growth averaging about 5% per year in inflation-adjusted dollars over the past 40 years. I think we all know that we as a country spend far more than most other developed Western nations; thus, a critical national policy question emerges: what value accrues from all of this spending? Here are the four key “myths,” as cited in the report.

Myth No. 1: There is a widespread belief, even among some of our clinical colleagues, that the cost of pharmaceuticals and doctors’ fees are driving up health care costs out of proportion to other causes. However, most analysts suggest that the single most important factor behind the long-term increase in health care costs has been the “emergence, adoption, and widespread diffusion” of new medical technologies and services by our health care system. That is, the bulk of the projected increase in spending in Medicare and Medicaid is not a result of demographic changes (such as an increased number of beneficiaries) but of the ongoing increases in costs per beneficiary. In a nutshell, this means “it’s the technology, stupid!” We are doing more and spending more per person than ever before, largely because we have the tools, ability, and resources to do so. There is clearly no national allocation of resources and very little critical evaluation of the evidence to support much of clinical decision-making.

Myth No. 2: Even though the U.S. spends more money per capita for health care than France, Canada, and Germany and almost 2.5 times that of the United Kingdom, Italy, and Japan, the second myth relates to the growth rate of that spending. Even though the level of spending per capita in the U.S. contrasts sharply with that of other wealthy countries, our growth rate of spending is “less unusual.” Most industrialized countries, even those with financing systems that differ from ours, have experienced a substantial increase in real spending on health care. Every developed Western nation is beginning to face the same challenges posed by the rate of spending; the U.S. simply has more actual resources to spend on a per-capita basis.

Myth No. 3: Many believe that one of the critical driving forces that increases costs is the fear of litigation and the fact that doctors practice what we call “defensive medicine.” The CBO report, however, dispels this myth; it notes that factors such as defensive medicine and physician-induced demand do not seem to explain the significant growth in spending, according to published analyses. Yet it is true that because medical care is a greatly desired service, people naturally purchase more of it as their income increases:

As economists are fond of pointing out, this effectively drives down the cost of care from the consumer’s perspective, resulting in a high(er) quantity of services demanded than would otherwise be the case.

Myth No. 4: Contrary to what some would like to believe, any attempt to slow the excess cost growth in health care will not be painless, and it will not occur simply through improved efficiencies, given our current structure. We would still face steadily increasing health care costs. Even though our growth rate might decline, the real level of health care costs would continue to rise—to the point of accounting for all of the increases in productivity. Thus, real average consumption of goods and services, other than health care, would stagnate. Our system is so broken that even productivity increases that might evolve with changes in technology might not be a sufficient fix. We could end up spending so much on a per-capita basis that we could lose whatever productivity gains might have accrued from an improved quality of life and a reduced disease burden.

I do not think that most readers of P&T are searching the Internet looking for information from the budget office on a regular basis, but if you are interested in reading Mr. Orszag’s direct testimony, please visit the following Web site: www.cbo.gov/ftpdocs/89xx/doc8948/01-31-HealthTestimony.pdf.

As always, I am interested in your comments. You can reach me at my e-mail address, david.nash@jefferson.edu. I also hope you’ll visit my blog at http://departmentofhealthpolicy.blogspot.com.

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