# PERSPECTIVE

## Don't Break Out The Champagne: Continued Slowing Of Health Care Spending Growth Unlikely To Last

The long-term gap between health spending growth and income growth is likely to continue.

**by Paul B. Ginsburg**

**ABSTRACT:** Aaron Catlin and colleagues report a fourth year of slowing of the rate of growth of personal health care spending. But many factors indicate that relief for purchasers and consumers will be short-lived. Research on local health care markets suggests that rapid expansion of provider capacity and incentives to increase volume of care are continuing. Increasing incidence of obesity is a major factor behind rising costs. The influence of the economic cycle on health spending, which has lowered the trend in recent years, is likely to reverse its impact shortly. [*Health Affairs* 27, no. 1 (2008): 30–32; 10.1377/hlthaff.27.1.30]

In their paper, Aaron Catlin and colleagues report that increases in personal health care (PHC) spending slowed from 6.8 percent in 2005 to 6.6 percent in 2006.[1] About half of the growth in 2006 reflects health care price growth, a sixth reflects population growth, and the remainder—about one-third—reflects real per capita growth in spending.

Although the early portion of the spending trend decline since 2002 likely reflected the completion of the transition away from tightly managed care, the fact that 2006 was the fourth year of a declining spending trend raises a new question: Is this slowing of the trend likely to continue, providing respite from health spending rising faster than incomes, or is it more likely to be the end of a brief period of declining spending growth at a time of faster-than-average gross domestic product (GDP) growth?

In this Perspective I discuss this question, drawing on ongoing qualitative work at the Center for Studying Health System Change (HSC), as well as what others have learned about the determinants of cost trends. HSC conducted the sixth round of its Community Tracking Study (CTS) site visits in 2007 and recently published the initial results.[2] For the most part, we have not seen qualitative evidence to suggest that the slowing of cost trends will continue. Indeed, some developments in local health markets signal concern about accelerating cost trends in the future.

■ **Hospital activity.** Hospitals have been expanding capacity, not predominantly by adding new beds but by expanding specialized facilities (such as operating rooms and imaging facilities) needed to serve patients with the latest technology. When hospitals do

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DOI 10.1377/hlthaff.27.1.30 ©2008 *Project HOPE–The People-to-People Health Foundation, Inc.*

increase inpatient beds, the new construction typically occurs in rapidly growing suburbs, where well-insured patients live. Competing hospital systems also have expanded into some communities where hospital systems have already established dominance, raising concerns about overcapacity.

HSC researchers have documented the hospital "specialty-service line" strategy, and such strategies are continuing.[3] Hospitals have identified the types of services that are most profitable—under a mix of diagnosis-related group (DRG), per diem, and discounted charge reimbursement—and are expanding capacity to provide those services. Interviews with hospital executives suggest that the profitability of the services is the key to developing a service line, with cardiac procedures often topping the list. As one hospital chief executive officer (CEO) told me in response to a question about capital spending priorities: "We just list the specialty lines by profitability and go down the list." We found no hospitals developing a mental health service line; such admissions generally are considered money losers. It may have been too early, but we did not obtain indications of adjustments to these service-line strategies in response to the major revamping of the DRG system started in 2006. The changes appear to have reduced the variation in relative profitability of different DRGs but probably did not eliminate that variation.

■ **Physician activity.** More entrepreneurial physicians have recognized the opportunities for particularly high returns from facility, as opposed to professional, payments for procedures such as imaging, endoscopies, and cardiac tests, which are performed in outpatient settings, as well as outpatient surgery. They have formed ventures to open facilities to perform these services, either jointly with hospitals or to compete with hospitals. Physicians also have brought capabilities to perform profitable ancillary services into their offices, sometimes forming larger single-specialty group practices to achieve the scale needed. Hospitals view these developments as a serious competitive threat.

■ **"Medical arms race."** Before the managed care era, many health policy researchers concluded that increased capacity led to greater use of services. With extensive authorization requirements and use of capitation in the early 1990s, concerns about the "medical arms race" receded. But with the loosening of managed care restrictions, the medical arms race has resurfaced.[4] The literature on this topic has long been subject to controversy—were the facilities expanded to respond to increased demand? But whether supply is inducing or responding to demand, building booms lead to more spending on health services.

■ **Self-referral incentives.** Today, as more physicians have an increased financial stake in the provision of services, self-referral incentives apply to a much larger portion of health care spending than in the past. In contrast to the literature on the medical arms race, the literature on self-referral incentives is very clear, showing much higher referral rates for procedures when physicians have an ownership stake in the facilities.[5]

■ **Health insurance.** Increased patient cost sharing through higher deductibles, coinsurance, and copayments has helped restrain spending trends since early in the decade. Some site-visit respondents this year commented that the cost-sharing trend has slowed recently, partly in response to slower growth in premium trends. With the gap between premium growth and earnings growth diminishing somewhat, employers have felt less urgency about further steps to "buy down" premium increases. Indeed, reports by some Wall Street analysts confirm that the rate of "benefit buydowns" has slowed, at least for large employers. The growth in consumer-directed health plans is still too small to have much impact on the aggregate degree of patient cost sharing in private insurance and overall spending trends.

■ **Health promotion.** Employers' interest in wellness and health promotion has increased sharply, but the search for effective tools to turn this interest into results appears to be at an early stage, and whether employers will pursue programs that may be distasteful to employees has not yet been tested.

**Two other macro factors.** Two macro factors tend to discourage optimism about continued slowing in cost growth. Research by the CMS National Health Expenditures group and by outside economists and actuaries has established the role of the economic cycle in health spending trends. As mentioned in last year's paper on spending trends, a portion of the slowing in trends over the past few years may in fact be the lagged impact of the 2001 recession, indicating that the impact of recent years of economic recovery and rapid growth on health spending trends is likely to be ahead of us.[6] This cycle has often led to difficult periods for those who pay for health care, when general economic distress and rapid increases in health care spending coincide, such as in the early years of this decade and the early 1990s.

The other factor is trends in obesity prevalence. The work of Kenneth Thorpe and colleagues has demonstrated the importance of increasing obesity prevalence to health care spending—not only directly but also through its effects on the incidence of diabetes, hyperlipidemia, and heart disease.[7] Presumably, this relationship has a substantial lag, so the absence so far (based on 2006 data) of a reversal of the obesity trend implies that for many years in the future, obesity will contribute to health spending trends.[8]

**Offsetting factors.** Not all factors point to rising spending trends. Probably the most important is the combination of patent expirations for "blockbuster" drugs and a relative paucity of new drugs with large enough sales to be considered blockbusters. However, the impact on spending of lower prices from greater availability of generic drugs will be increasingly offset by the rapidly growing use of specialty pharmaceuticals that reflect the achievements of biotechnology research.

The reduction in the trend of spending has been a welcome development to those who pay for health care. But it would be a stretch to conclude that the corner has been turned in dealing with the long-term gap between growth in health spending and growth in income and the resulting financial pressures. This diminishing trend has already led to a reduced intensity in efforts to address costs on the part of employers and may be contributing to more-aggressive activities by providers to boost their revenues. With GDP growth starting to slow and most forecasters predicting further slowing, concerns about cost trends are likely to only increase.

*The author acknowledges the financial support of the Robert Wood Johnson Foundation and valuable discussions with Stephen Heffler.*

## NOTES


1. A. Catlin et al., "National Health Spending in 2006: A Year of Change for Prescription Drugs," *Health Affairs* 27, no. 1 (2008): 14–29.
2. D.A. Draper and P.B. Ginsburg, "Health Care Cost and Access Challenges Persist: Initial Findings from HSC's 2007 Site Visits," Issue Brief no. 114, October 2007, http://www.hschange.org/CONTENT/947 (accessed 6 November 2007).
3. R.A. Berenson, T. Bodenheimer, and H.H. Pham, "Specialty-Service Lines: Salvos in the New Medical Arms Race," *Health Affairs* 25 (2006): w337–w343 (published online 25 July 2006; 10.1377/hlthaff.25.w337).
4. K.J. Devers, L.R. Brewster, and L.P. Casalino, "Changes in Hospital Competitive Strategy: A New Medical Arms Race?" *Health Services Research* 38, no. 1, Part 2 (2003): 447–469.
5. J.M. Mitchell, "Physician Joint Ventures and Self-Referral: An Empirical Perspective," in *Conflicts of Interest in Clinical Practice and Research*, ed. R.G. Spece, D.H. Shimm, and A. Buchanan (New York: Oxford University Press, 1996), 299–317.
6. A. Catlin et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs* 26, no. 1 (2007): 142–153.
7. K.E. Thorpe et al., "The Impact of Obesity on Rising Medical Spending," *Health Affairs* 23 (2004): w480–w486 (published online 20 October 2004; 10.1377/hlthaff.w4.480).
8. Centers for Disease Control and Prevention, "Behavioral Risk Factor Surveillance System, Obesity Trends among U.S. Adults, 2006," PowerPoint presentation, http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps (accessed 14 November 2007).