THE AMERICAN HEALTH CARE SYSTEM

Expenditures

JOHN K. IGLEHART

THE AMERICAN HEALTH CARE SYSTEM OPERATES A HEALTH CARE SYSTEM THAT IS UNIQUE AMONG NATIONS. IT IS THE MOST EXPENSIVE OF SYSTEMS, OUTSTRIPPING BY OVER HALF AGAIN THE HEALTH CARE EXPENDITURES OF ANY OTHER COUNTRY.1 THE NUMBER OF PEOPLE WITHOUT INSURANCE CONTINUES TO INCREASE, HOWEVER, REACHING 43.4 MILLION, OR 16.1 PERCENT OF THE POPULATION, IN 1997 — THE HIGHEST LEVEL IN A DECADE.2 BY MANY TECHNICAL STANDARDS, U.S. MEDICAL CARE IS THE BEST IN THE WORLD,3 BUT LEADERS IN THE FIELD DECLARED RECENTLY AT A NATIONAL ROUND TABLE THAT THERE IS AN “URGENT NEED TO IMPROVE HEALTH CARE QUALITY.”4 THE STRINGENCY OF MANAGED CARE AND A LOW INFLATION RATE HAVE SLOWED THE GROWTH OF MEDICAL SPENDING APPRECIABLY, BUT A NEW GOVERNMENT STUDY PROJECTS THAT HEALTH CARE EXPENDITURES WILL SOON BEGIN ESCALATING AGAIN AND WILL DOUBLE OVER THE NEXT DECADE.5 IN SHORT, THE AMERICAN SYSTEM IS A WORK IN PROGRESS, DRIVEN BY A DISPARATE ARRAY OF INTERESTS WITH TWO GOALS THAT ARE OFTEN IN CONFLICT: PROVIDING HEALTH CARE TO THE SICK, AND GENERATING INCOME FOR THE PERSONS AND ORGANIZATIONS THAT ASSUME THE FINANCIAL RISK. IN THIS REPORT, I WILL TAKE STOCK OF THIS DYNAMIC SECTOR, WHICH NOW REPRESENTS ONE SEVENTH OF THE ECONOMY, BY TRACKING IT IN THE MOST AMERICAN OF WAYS — FOLLOWING THE MONEY FROM ITS COLLECTION TO ITS EXPENDITURE.

Almost five years have elapsed since the ambitious efforts of the Clinton administration to reform the health care system fell to defeat without even reaching the floor of the House or Senate for a vote. Since then, with the enthusiastic approval of the Republican-controlled Congress and the acceptance of the Clinton administration, large numbers of private-sector employees and beneficiaries of publicly financed insurance programs have enrolled in managed-care plans. Those covered by such plans now make up an estimated 75 percent of all persons with private health insurance.

In strictly monetary terms, two trends dominate. One is the decline in the growth of health care expenditures in the past five years. In 1997, the growth rate was the slowest in the more than 35 years for which there are data on medical spending.6 The second trend is the growth in the government’s share of the nation’s health care bill. Spending by federal, state, and local governments rose in 1997 to $507 billion, or 46 percent of the total, an increase from 40 percent in 1990. Private resources financed 54 percent of personal health services ($585 billion) in 1997, down from 60 percent in 1990.6

The magnitude of public expenditures in any health care system is important because it indicates the amount of attention governments are likely to pay to the system and thus the influence they bring to bear on its configuration. Rhetoric notwithstanding, the government’s role in the financing and regulation of health care has grown inexorably under both Republicans and Democrats ever since the enactment of Medicare and Medicaid in 1965. As the health economist Victor Fuchs puts it, “No matter how committed the country is in general to the idea of free markets and capitalism, government plays a substantial role in health care.”7

THE ROLE OF ECONOMIC SYSTEMS

Nevertheless, the U.S. economy is driven primarily by market-based capitalism. A market-based system consists of a collection of decision-making units called households and another collection of businesses and other larger organizations. This structure is important to recognize because, as Fuchs asserts, “The households own all the productive resources in the society.”8 Thus, although funds for personal health services flow from three basic sources — employers, governments, and individuals — all of these resources are initially extracted from households as payroll deductions from the wages of working adults, as taxes and other surcharges, and as direct payments to providers and suppliers. In reality, government and employers are only intermediaries in the process. A fourth source is, as Uwe Reinhardt has described it, “an informal, albeit unreliable, catastrophic health insurance program operated by hospitals and many physicians . . . who extract the premium for that insurance through higher charges to paying patients.”9

THE ROLE OF EMPLOYERS

Collectively, private employers and employees are the most important purchasers of health care through the insurance premiums they pay together for coverage. Of the $585 billion that private payers expended for medical services in 1997, about 60 percent ($348 billion) was spent by employers and employees to purchase health insurance.6 The premiums that finance coverage are paid in part by the employee through the explicit deduction of regular (usually weekly or monthly) amounts from the gross wages stated on the employee’s paycheck. The remainder (usually 80 percent or more) is ostensibly paid by employers and not deducted from the employee’s pay. There is a sharp division of opinion

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over who actually foots the bill for the employer-
paid portion. The question is important because as
employers steer their workers into insurance arrange-
ments that employers select, very few employees (17
percent in the most recent estimate\textsuperscript{10}) have a choice
of plans.

Most employees have long believed that the em-
ployer’s portion comes out of the employer’s prof-
its. Most employers share that view, believing that
their premium payments are a cost of doing busi-
ness and, as such, cut into the profitability of the
firm. Economists and the Congressional Budget
Office, on the other hand, are convinced by theory
and empirical evidence that this portion, too, is ac-
tually shifted back to employees in the form of low-
er take-home pay.\textsuperscript{11,12} In a recent book, the econo-
mist Mark Pauly asserted that “higher medical costs
do not harm employers or owners but do reduce
money wages for workers . . . Lower costs bene-
fit workers, not employers; they add to take-home
pay, not profits.”\textsuperscript{13}

By exempting from federal and state taxes the in-
come earned by employees that is used to pay insur-
ance premiums, the government encourages em-
ployers to provide coverage to workers. Employers’
costs are treated as a deductible business expense.
The exclusion from income taxes and Social Security
payroll deductions creates a substantial tax subsidy
for employment-based insurance. In 1999, accord-
ing to the Clinton administration, this exemption
will reduce federal revenues by an estimated $76 bil-
lion. If this were a federal health program, it would
be the third most expensive one after Medicare and
Medicaid.\textsuperscript{14} Families with higher incomes benefit
disproportionately because they are in higher tax
brackets. This subsidy provides little or no benefit to
people who are uninsured or who purchase their
own health insurance. This regressive tax structure
was an unintended consequence of the policy, but
employers strongly oppose its elimination. Recently,
Congress extended the tax benefit to self-employed
people in a phased-in provision that will take full ef-
fect in 2003.

\textbf{THE ROLE OF GOVERNMENT}

One of the key characteristics of all modern econ-
omies is that as they prosper, they spend more money
for health care. For example, high-income countries
(those with per capita annual incomes above $8,500)
accounted for 89 percent of global health expendi-
tures in 1994, even though they comprised only 16
percent of the global population and represented
just 7 percent of the estimated number of disability-
adjusted years of life worldwide (1.4 trillion) that
were lost to disease.\textsuperscript{15} Although all nations purchase
more health care as they prosper — so that about 80
percent of the variation among countries in per cap-
ita health care spending is explained by the per cap-
ita income of a country — the United States is once
again an exception. Its annual bill for personal
health services ($3,925 per person in 1997) is about
$1,000 per person above the level that its per capita
income would seemingly predict. Three reasons are
that physicians in the United States are paid more
than those in other countries for each unit of serv-
ICE,\textsuperscript{16} a day in the hospital for similar patients is con-
siderably more expensive in the United States, and
medical technology diffuses more rapidly and is gen-
erally used to treat more patients than in other
countries. In a survey of 50 health economists in
1995, 81 percent agreed with the following state-
ment: “The primary reason for the increase in the
health sector’s share of [the gross domestic product]
over the past 30 years is technological change in
medicine.”\textsuperscript{17}

Federal and state expenditures for medical care are
collected as taxes of one type or another and redis-
tributed as income to providers and suppliers, who
bill for services rendered and goods delivered. The
dynamics of this system have begun to change, how-
ever, as more payments for health care are fixed and
set prospectively. The federal government pays the
physicians it employs and other employees of publicly
operated health care facilities. States also employ
physicians directly and operate public health care fa-
cilities. Public monies are allocated for health care
through a variety of agencies after being appropriat-
ed by federal and state legislative bodies or collected
carried funds such as social-insurance trust
funds (e.g., Medicare).

One important component of national health care
spending is the transfer of money from the federal
to the state governments. Such transfers evolved af-
after World War II, and their total value tripled during
the 1960s. By 1995, the number of intergovernment-
ral grants for education, health, transportation, and
other purposes had risen to 633, with outlays total-
ing $226 billion.\textsuperscript{18} Democrats and Republicans dif-
fer about how federal aid to states should be struc-
tured. In general, Republicans favor block grants to
states — that is, grants with few strings attached —
because their party supports shifting power from
Washington, D.C., to the states. Democrats generally
prefer categorical grants — that is, those that stip-
ulate with greater specificity how the money should
be spent.

The largest program involving the intergovernment-
tal transfer of funds is Medicaid, which account-
ed for 39 percent of all federal grant outlays in 1995.
In 1997, Medicaid financed acute care and long-
term care services for 41.3 million aged, blind, and
disabled people with low incomes, as well as poor
mothers and children, at a cost of $160 billion.\textsuperscript{19} Of
that amount, the federal share was $95 billion and
the state and local share $65 billion. The federal
funds are appropriated annually, with the amounts
funded from four different sources: mandatory contributions by employers and employees, general tax revenues, beneficiaries’ premiums, and deductibles and copayments paid by patients (or supplemental health insurance). Medicare beneficiaries include people over 65 years of age, the disabled, and those with end-stage renal disease. Medicare’s Hospital Insurance Trust Fund (Part A of the program) is grounded in the principle of social insurance. That is, workers make mandatory contributions to a dedicated trust fund during their working years, with the promise of receiving benefits after they retire. By law, the nation’s employers and some 151 million employees are required to pay equal amounts of a payroll tax that totals 2.9 percent of earned income. Self-employed workers pay the entire 2.9 percent of their net income into the trust fund. In 1997, these payroll taxes totaled $115 billion and made up 88 percent of the income of the trust fund; the remainder came from interest earned on the monies in the trust fund and miscellaneous sources. Approximately 22 percent of the 38 million people who are eligible for Medicare hospital insurance received hospital services in 1997.

Medicare Part B finances care by physicians and outpatient, home health, and other services; it is called the Supplementary Medical Insurance Program. The funds come largely from general tax revenues appropriated by Congress ($60 billion, or about 73 percent of the total Part B income, in 1997), rather than from a mandatory tax collected for that specific purpose. Part B funds are often erroneously called a “trust fund.” Medicare beneficiaries who enroll in Part B are required to pay monthly premiums (in 1998, the premium was $43.80). Enrollment is voluntary, but virtually all people who are eligible sign up. Premiums are not related to income. Thus, in Medicare, unlike Medicaid, the rich and the poor are treated the same. In 1997, premiums accounted for $19 billion, or about 24 percent of Part B income. The remainder of its funding came from interest income on revenues.

Medicare has low administrative costs, as compared with those of managed-care companies or private insurers. Benefit payments represent 99 percent of outlays for Medicare Part A; administrative expenses, including funds to support fiscal intermediaries (generally private insurance companies), make up only 1 percent of the total. More than 98 percent of the Part B outlays are for benefit payments; less than 2 percent are for administration.

THE CONTRIBUTIONS OF INDIVIDUAL CITIZENS

The share of national health expenditures paid for directly by individual citizens declined for 11 straight years until 1997, when it grew markedly faster than private health insurance premiums. Out-of-pocket spending is generally defined as including expenditures for coinsurance and deductibles required by insurers, as well as direct payments for services not covered by a third party. Premium amounts contributed by employees are generally not considered as out-of-pocket expenditures. Out-of-pocket spending amounted to $188 billion in 1997, or 17.2 percent of all national health expenditures. The general decline in direct consumer spending has been attributed in large part to the growth in health maintenance organizations (HMOs), which traditionally offer broad benefits with only modest out-of-pocket payments. In the past few years, however, most HMO enrollees have had increased cost-sharing requirements, as employers and health plan managers have sought to constrain spending even further. In general, out-of-pocket payments are still considerably less in an HMO than with indemnity insurance.

The overall declines in per capita out-of-pocket spending mask the financial difficulties of many poor people and families. A recent study estimated that Medicare beneficiaries over 65 years of age with incomes below the federal poverty level (in 1997 the level was $7,755 for individuals and $9,780 for couples) who were also eligible for Medicaid assistance (which usually covers the monthly Part B premium) still spent 35 percent of their incomes on out-of-pocket health care costs.

THE FLOW OF HEALTH CARE EXPENDITURES

In 1997, national health expenditures totaled $1,092 billion, according to the Health Care Financing Administration (HCFA), which tracks expenditures (Table 1). Health care spending consumed 13.5 percent of the gross domestic product in 1997, which was a slight drop from the previous year. Health care spending increased only 4.8 percent in 1997 — the slowest annual growth rate in more than 35 years. Personal health expenditures accounted for 89 percent of health care spending, or $969 billion. HCFA’s analysts recently projected that, beginning in 1998, national health spending would again begin to grow faster than the rest of the
By 2002, the agency projected that national health expenditures would total $2.1 trillion (Table 2) — an estimated 16.6 percent of the gross domestic product. This analysis was based on two assumptions that are certain to be challenged by employers and the managed-care industry: that “the higher anticipated growth in real per capita national health spending will be driven almost entirely by rising expenditures in the private rather than the public sector,” and that savings from managed care will be a one-time phenomenon, rather than a long-term trend.

Before the emergence of managed care, it was largely physicians, acting individually on behalf of their patients, who decided how much health care dollars were spent. They billed for their services, and third-party insurers usually reimbursed them without asking any questions, because the ultimate payers — employers — demanded no greater accounting. Now, many employers have changed from passive payers to aggressive purchasers and are exerting more influence on payment rates, on where patients are cared for, and on the content of care. Through selective contracting with physicians, stringent review of the use of services, practice protocols, and payment on a fixed, per capita basis, managed-care plans have pressured doctors to furnish fewer services and to improve the coordination and management of care, thereby altering the way in which many physicians treat patients. In striving to balance the conflicts that arise in caring for patients and in striving to balance the conflicts that arise in caring for patients, physicians and private executives — a “double agents.” The ideological tie that long linked many physicians and private executives — a “double agents.” The ideological tie that long linked many physicians and private executives has been weakened by the aggressive intervention of business into the practice of medicine through managed care.

### Table 1. National Health Expenditures for Selected Years from 1960 through 1997.*

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<tr>
<td>Total national expenditures (billions of dollars)</td>
<td>26.9</td>
<td>73.2</td>
<td>247.3</td>
<td>669.4</td>
<td>947.7</td>
<td>993.7</td>
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<td>67.9</td>
<td>235.6</td>
<td>674.8</td>
<td>917.2</td>
<td>963.1</td>
<td>1,010.6</td>
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<td>63.8</td>
<td>217.0</td>
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<td>879.3</td>
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<td>969.0</td>
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<td>9.3</td>
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<td>102.7</td>
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<td>347.2</td>
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<td>371.1</td>
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<td>5.3</td>
<td>13.6</td>
<td>45.2</td>
<td>146.3</td>
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<td>201.9</td>
<td>208.5</td>
<td>217.6</td>
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<td>Dental services</td>
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<td>13.3</td>
<td>31.6</td>
<td>42.4</td>
<td>45.0</td>
<td>47.5</td>
<td>50.6</td>
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<td>Other professional services</td>
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<td>6.4</td>
<td>24.7</td>
<td>49.6</td>
<td>53.6</td>
<td>57.5</td>
<td>61.9</td>
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<td>26.2</td>
<td>29.1</td>
<td>31.2</td>
<td>32.3</td>
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<td>Drugs and other nondurable medical products</td>
<td>4.2</td>
<td>8.8</td>
<td>21.6</td>
<td>59.9</td>
<td>81.6</td>
<td>88.9</td>
<td>98.3</td>
<td>108.9</td>
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<td>Prescription drugs</td>
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<td>69.1</td>
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<td>Vision products and other durable medical products</td>
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<td>13.1</td>
<td>13.4</td>
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<td>Nursing home care</td>
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<td>Other personal health care</td>
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<td>1.3</td>
<td>4.0</td>
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<td>Program administration and net cost of private health insurance</td>
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<td>11.9</td>
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<td>55.1</td>
<td>55.3</td>
<td>52.5</td>
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<td>Government public health activities</td>
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<td>19.6</td>
<td>28.2</td>
<td>30.4</td>
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<td>Expenditures for research and construction (billions of dollars)</td>
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<td>5.3</td>
<td>11.6</td>
<td>24.5</td>
<td>30.5</td>
<td>30.6</td>
<td>32.0</td>
<td>34.9</td>
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<td>Research</td>
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<td>16.7</td>
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<td>18.0</td>
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<td>Construction</td>
<td>1.0</td>
<td>3.4</td>
<td>6.2</td>
<td>12.3</td>
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<td>13.9</td>
<td>14.8</td>
<td>16.9</td>
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<td>National expenditures per capita (dollars)</td>
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<td>341</td>
<td>1,052</td>
<td>2,690</td>
<td>3,500</td>
<td>3,637</td>
<td>3,781</td>
<td>3,925</td>
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<td>Population (millions)</td>
<td>190</td>
<td>215</td>
<td>235</td>
<td>260</td>
<td>271</td>
<td>273</td>
<td>276</td>
<td>278</td>
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<td>GDP (billions of dollars)</td>
<td>527</td>
<td>1,036</td>
<td>2,784</td>
<td>5,744</td>
<td>6,947</td>
<td>7,270</td>
<td>7,662</td>
<td>8,111</td>
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<td>National expenditures as percentage of GDP</td>
<td>5.1</td>
<td>7.1</td>
<td>8.9</td>
<td>12.2</td>
<td>13.6</td>
<td>13.7</td>
<td>13.6</td>
<td>13.5</td>
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*Major revisions were recently introduced into expenditure estimates, including a new data source (IMS) for estimating spending on prescription drugs in 1993 through 1997 and revised Census Bureau Services Annual Survey data for 1993 through 1996 for physician services. Numbers may not add to totals because of rounding. GDP denotes gross domestic product. Data are from the Health Care Financing Administration, Office of the Actuary, National Health Statistics Group; the Department of Commerce, Bureau of Economic Analysis; and the Social Security Administration.

†This category includes free-standing facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

‡Research-and-development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from this category and instead are included in the category in which the product falls.
pressure applied by managed-care plans, growth in such spending has slowed appreciably. The mix of services offered by most hospitals has shifted away from inpatient stays toward greater use of outpatient and postdischarge services (such as home health care and skilled-nursing facilities). Medicare and Medicaid funded half of all hospital expenditures in 1997, private insurance paid for another third, and consumers paid directly for only 3 percent of all hospital care.

According to a new analysis of data collected by the National Institutes of Health (NIH), spending on research and development has increased steadily in recent years, both in absolute terms and as a percentage of total health care spending. In 1995, the total was $35.8 billion. This represented 3.5 percent of total health expenditures, as compared with 3.2 percent in 1986. Over the decade from 1986 through 1995, the share of health-related research and development supported by private industry increased from 42 percent to 52 percent, largely as a consequence of increased spending by pharmaceutical companies.

Recently, Congress has indicated that it is prepared to double the NIH's annual appropriation over the next 5 to 10 years; the only question is how fast. Congress approved an appropriation of $15.6 billion for the NIH for fiscal 1999, an increase of almost $2 billion over the previous year and almost double the increase sought by the Clinton administration. The current situation is a far cry from the

TABLE 2. ACTUAL AND PROJECTED NATIONAL HEALTH EXPENDITURES FOR SELECTED CALENDAR YEARS FROM 1970 THROUGH 2007.*

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<td>billions of dollars (percent)</td>
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<td>Total national expenditures</td>
<td>73.2 (100.0)</td>
<td>247.3 (100.0)</td>
<td>699.5 (100.0)</td>
<td>1,146.8 (100.0)</td>
<td>2,133.3 (100.0)</td>
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<td>Expenditures for health services and supplies</td>
<td>67.9 (92.8)</td>
<td>235.6 (95.3)</td>
<td>775.0 (96.5)</td>
<td>1,113.2 (97.1)</td>
<td>2,085.2 (97.8)</td>
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<td>Personal health care</td>
<td>63.8 (87.2)</td>
<td>217.0 (87.8)</td>
<td>614.7 (87.9)</td>
<td>998.2 (87.0)</td>
<td>1,859.2 (87.2)</td>
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<td>Hospital care</td>
<td>28.0 (38.2)</td>
<td>102.7 (41.5)</td>
<td>256.4 (36.7)</td>
<td>383.2 (33.4)</td>
<td>649.4 (30.4)</td>
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<td>Physicians' services</td>
<td>13.6 (18.6)</td>
<td>45.2 (18.3)</td>
<td>146.3 (20.9)</td>
<td>221.4 (19.3)</td>
<td>427.3 (20.0)</td>
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<td>Dental services</td>
<td>4.7 (6.4)</td>
<td>13.3 (5.4)</td>
<td>51.6 (4.5)</td>
<td>53.7 (4.7)</td>
<td>95.2 (4.5)</td>
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<td>Other professional services</td>
<td>1.4 (1.9)</td>
<td>6.4 (2.6)</td>
<td>34.7 (5.0)</td>
<td>66.8 (5.8)</td>
<td>134.5 (6.3)</td>
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<tr>
<td>Home health care †</td>
<td>0.2 (0.3)</td>
<td>2.4 (1.0)</td>
<td>13.1 (1.9)</td>
<td>33.2 (2.9)</td>
<td>66.1 (3.1)</td>
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<td>Drugs and other nondurable medical products</td>
<td>8.8 (12.0)</td>
<td>21.6 (8.7)</td>
<td>59.9 (8.6)</td>
<td>106.1 (9.3)</td>
<td>223.6 (10.5)</td>
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*Figures for 1998 and 2007 are projections. Numbers may not add to totals because of rounding. Data are from the Health Care Financing Administration, Office of the Actuary, National Health Statistics Group.

†This category includes free-standing facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

‡Research-and-development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from this category and instead are included in the category in which the product falls.
bleak assessment of the agency’s future provided by the NIH director, Dr. Harold Varmus, in his Shattuck Lecture of 1995.\textsuperscript{34}

Congress supports medical research not only because legislators are enthusiastic about its potential, but also because funding research is far less expensive than providing health care coverage for the uninsured.\textsuperscript{35} In addition, NIH research benefits the thriving biotechnology industry by providing its raw material. Congress has taken a far different view of research on health services, as reflected in the budget of the Agency for Health Care Policy and Research (AHCPR). Several years ago, in response to a small but vocal group of spinal surgeons who opposed the results of a study of low-back pain sponsored by the AHCPR, the Republican-controlled Congress flirted with the idea of abolishing the agency.\textsuperscript{36} Having survived that near-death experience, the AHCPR received an appropriation of $171 million in fiscal 1999, an increase of $24 million over the previous year, but considerably less than the funds provided for only one small component of the NIH — the National Human Genome Research Institute, which received $237 million.

Prescription drugs are the fastest-growing component of personal health expenditures, amounting to $78.9 billion in 1997.\textsuperscript{6} This trend is troubling to employers, health plans, physicians, and policy makers alike.\textsuperscript{37,38} In recent years, spending for prescription drugs has increased at double-digit rates: 10.6 percent in 1995, 13.2 percent in 1996, and 14.1 percent in 1997.\textsuperscript{6} The federal Office of Personnel Management announced recently that in 1999 insurance premiums will increase by an average of 10.2 percent for the 8.7 million federal employees, retirees, dependents, and others covered by the Federal Employees Health Benefits Program, the largest premium hike in a decade.\textsuperscript{39} The Office of Personnel Management attributed the increase in part to the rising costs of prescription drugs (which have increased 17 percent annually in recent years). There are several explanations for this acceleration in costs, including broader insurance coverage of prescription drugs, growth in the number of drugs dispensed, more approvals of expensive new drugs by the Food and Drug Administration, and direct advertising of pharmaceutical products to consumers. The use of some new drugs reduces hospital costs, but not enough to offset the increase in expenditures for drugs.

\section*{Conclusions}

America’s trillion-dollar health care system is vast — indeed, larger than the budgets of most nations — and it serves as a perpetual job-creating enterprise, providing employment to some 9 million people. Expenditures for health care are perceived in a variety of ways by different interest groups. Many health care purchasers view them as one of the few uncontrollable costs and have taken unprecedented steps to rein in costs through the constraints imposed by managed-care companies. Patients with employer-sponsored health insurance, who want the best medical care but are fearful of the costs, have sought refuge in managed-care plans, sometimes with mixed results. Physicians may also see health care expenditures as the means to earn a living, or, as Reinhardt has put it, “the allocation of lifestyles to providers.”\textsuperscript{40} But in spite of all the money spent for medical care, education, and research, no one — whether patient, provider, or purchaser — seems satisfied with the status quo.

\section*{References}


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CORRECTION

The American Health Care System — Expenditures

The American Health Care System — Expenditures. On page 71, the sentence that begins on line 2 of the left-hand column should have read, “The question is important because as employers steer their workers into insurance arrangements that employers select, very few employers that offer insurance to their employees provide a choice of plans (17 percent of private employers in the most recent estimate10),” not “very few employees (17 percent in the most recent estimate10) have a choice of plans,” as printed. Also, on page 73, the sentence that begins on the first line of the left-hand column should have read, “By 2007, the agency projected that national health expenditures would total $2.1 trillion,” not “By 2002,” as printed.