


Why Did Cross-National Divergences in Life Expectancy and Health Care Expenditures Both Appear in the 1980s?

 See also Magnan and Teutsch, p. 1731, and the *AJPH* Wasteful Medical Care Spending section, pp. 1730–1759.

In this issue of *AJPH*, McCullough et al. (p. 1735) examine US health care expenditures. They report that to reach the Institute of Medicine's (IOM's) recommended median health care expenditures equivalent to those of other high-resource nations by 2030 or 2040, annual declines of 7.0% or 3.3% would be required, respectively. They also show that such trends do not have historical precedent among either states within the United States or Organisation for Economic Co-operation and Development (OECD) nations.

Their account identifies cross-national trends in health care expenditures since 1970, at which time growth in spending began to escalate worldwide. It was not until 1980, however, that the growth in US spending diverged from other nations. In 1980, the United States spent about 75% more than the OECD median, but by 1995, that figure had almost doubled to 145%. But more than two decades later, it remained mostly steady at 155%. The post-1995 period was therefore not as central a contributor to the overall divergence as the critical 1979 to

1993 period (J. M. McCullough, PhD, MPH, written communication, 2020).

WHAT ABOUT LIFE EXPECTANCY TRENDS?

The IOM also offered recommendations on achieving parity among comparable nations in life expectancy. An analysis in these pages showed that a divergence in life expectancy also began in the same period.¹ Was this merely coincidence? Or could related forces be responsible for both?

In 2011, a National Research Council panel concluded that a host of nonbiomedical factors were “playing a substantial role” in reducing life expectancy. It also noted, however, that what appeared to be behavioral patterns were anchored more fundamentally in social contexts, including entrenched automobile culture, low gasoline taxes, residential sprawl, and obesogenic environments.²

These factors existed within larger political and economic shifts. Beginning in 1973, economists have noted persistent

wage stagnation and diminishing purchasing power of the modal American, limiting access to resources critical to betterment of health. Alongside this trend was a decline in organized labor, best exemplified by former President Ronald Reagan's infamous breaking of an air traffic controller strike in 1981. The period also saw historically unprecedented levels of incarceration whose consequences carried serious health effects for those with especially long sentences.

Meanwhile, at the local level, several metropolitan areas underwent sustained fiscal crisis—most famously, New York City in 1975—and they emerged with radically different commitments to social service spending. Overall, what social welfare experts once called the “The New Deal Order”—the generous safety net erected during the

Great Depression—frayed in the 1980s, as the Reagan era gave way to increased military spending, a decline in social services investment, tax cuts, and reduced regulation. This period was characterized by much more friendliness toward private solutions for public problems. Stagnant incomes and growing economic inequality created stress for millions of Americans in the bottom quintiles of the economy.

From a population health perspective, one can easily see how these developments could influence the widening gap between the United States and other countries in life expectancy. They also may explain why the ratio of social services expenditures, relative to health care expenditures, is much lower in the United States compared with other OECD nations.³

WHY DID HEALTH SPENDING DIVERGE?

However, were these same social and economic forces responsible for the uniquely American divergence in health care expenditures? It is well documented that the growth of such post-World War II health care expenditures stemmed from

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expanded technology, increased use of hospital services, and the development of public and private health insurance to pay for them.⁴ Expansion of Medicare and Medicaid fueled even more concerns about rising costs. Regulatory (price controls, health planning) and market force efforts (capitation, managed care) proved to be only a modest constraint on expenditure growth. Fox has shown that many states “abandoned their policy initiatives” in cost control because Medicaid and Medicare “sharply reduced what they could regulate” but also because of lobbying by hospitals.^{5(p194)} As he noted, “by the 1990s only 2 states, Maryland and West Virginia, continued to regulate hospital reimbursement.”^{5(p194)} Similarly, Altman and Levitt observed that “in sum, neither regulation, voluntary action by the health care industry, nor managed care and market competition have had a lasting impact on our nation’s health care cost.”⁶ Homer et al., using models from 1960 to 2010, rooted “rapid growth in costs” in “income-maintaining adaptations by providers, who have been able to raise prices in service volumes for a given quality of care.”^{7(p336–337)}

An often-underappreciated fact is that health care expenditures reflect both price and volume of services. Untangling these relative contributions is not easy, but most research has indicated, contrary to popular thinking, higher prices rather than higher volumes are chiefly responsible for the higher expenditures in the United States. In a tribute to Uwe Reinhardt, Anderson et al.⁸ affirmed his conclusion that pricing—and, by implication, unwillingness or inability to restrain it through governmental controls—is the main

explanation for the United States’ peculiar patterns of spending.⁸ Papanicolas et al. used more recent 2013 to 2016 data and found that

the United States spent approximately twice as much as other high-income countries on medical care, yet utilization rates in the United States were largely similar to those in other nations. Prices of labor and goods, including pharmaceuticals, and administrative costs appeared to be the major drivers of the difference.^{9(p1024)}

A TEMPORAL LINKAGE IS PLAUSIBLE

If escalating prices are responsible for the US divergence in health care expenditures, then this uniqueness requires further explanation. The most likely reason is the growing power of the private sector and the lack of restraints on it. As Paul Starr pointed out, medical expansion without control is a major feature of the American “triumph of accommodation” with professional forces and power.⁴ Fox also has observed that “neoliberalism, as an ideology that captured policy, led to looser regulation almost everywhere.” The exception was countries with single-payer systems, where “politicians needed to defend their decisions about spending taxpayers’ money” (Daniel Fox, personal written communication, 2020). Frakt has written recently that “periods of rapid growth in US health care spending coincide with rapid growth in markups of health care prices. This is what one would expect in markets with low levels of competition.”¹⁰ The impediments for achieving the IOM recommendation are daunting. But some good news might come

from an insight of MacCullough et al. To the extent that prices rather than volume contribute to US spending levels, they argue, “price reductions should encounter less resistance to rationing concerns than volume restrictions often encounter” (p. 1739).

In the end, the connection between the larger historical milieu and the two trends we have examined is necessarily speculative and invites more investigation. Life expectancy divergence, for example, began in the 1980s, but many social factors affecting it take long latent periods to manifest in health outcomes. However, both occurred amid an indisputable transition to a new epoch of diminished regulatory power and withering social safety net. We find it plausible that the divergence in health care expenditures from continuously increasing prices might have crowded out public funds for social spending on critical sectors long known to affect population health, such as education,¹¹ and thus further accelerated the divergence in life expectancy.

The nation’s multiple crises have now compelled a reexamination of the status quo across sectors. Unsustainable health care costs and declining population health have been a norm. But they need not be part of a new normal. *AJPH*

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

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