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Macroeconomics and Health Care:  
Assessing Long Run Prospects

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# Two Points

## ● US health sector buoys inflation

- “Healthcare price pressure fueled by private sector
- Healthcare reform and new technology could alter this scenario
- “Stress testing” would be prudent

## ● US health sector an under-recognized source of inequality

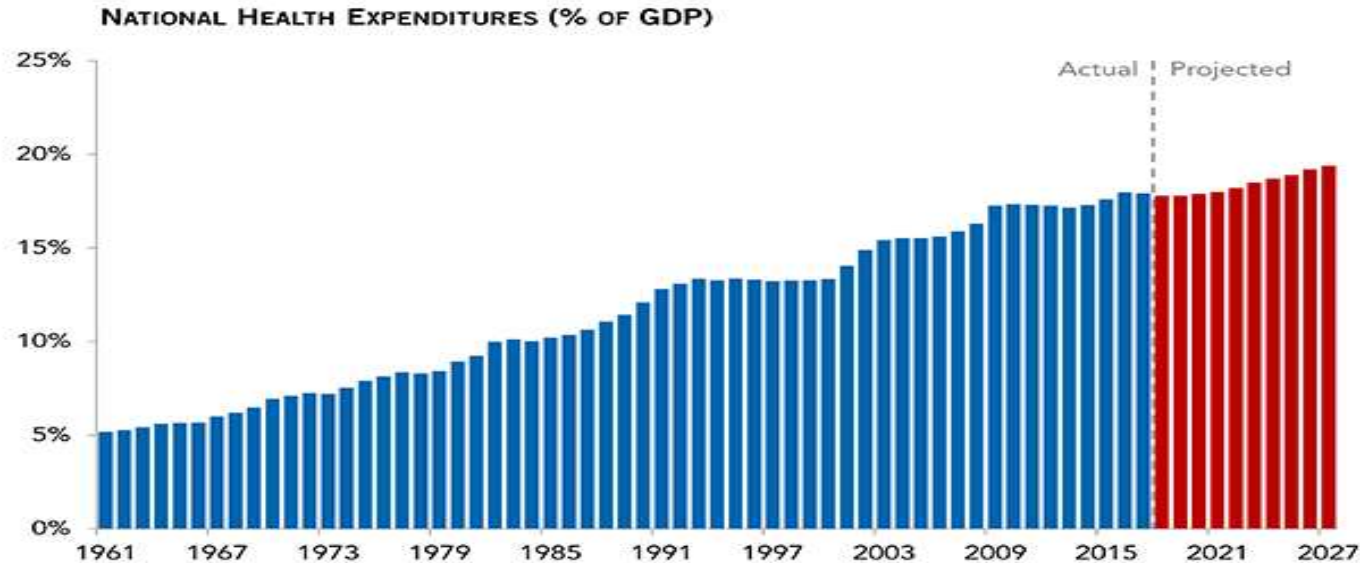
- Fuels popular discontent
- Inequality may ease with healthcare reform

# Healthcare as Share of US GDP



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Healthcare costs in the U.S. have increased drastically over the past several decades



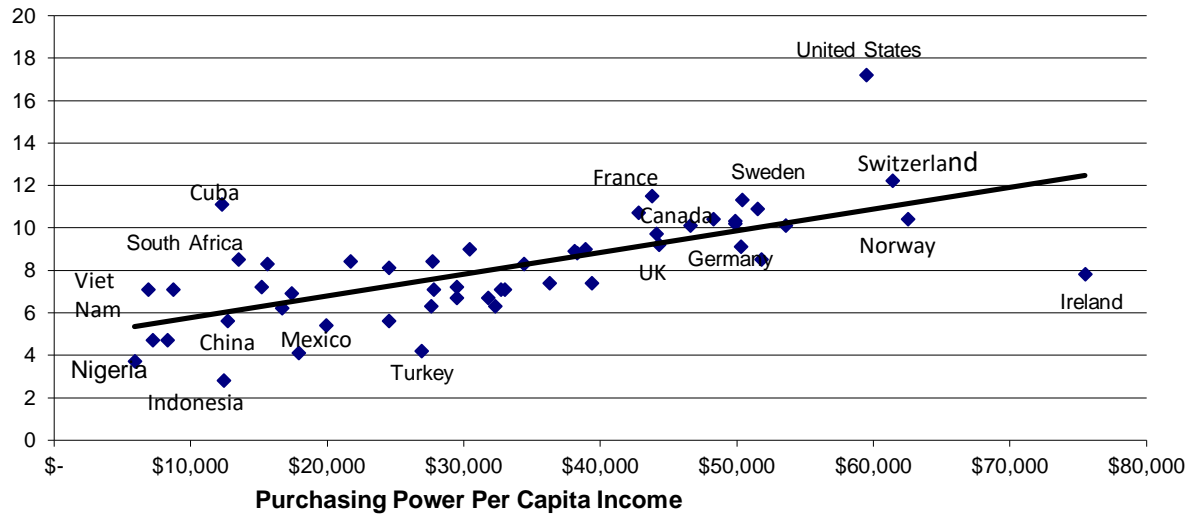
SOURCE: Centers for Medicare and Medicaid Services, *National Health Expenditure Data*, February 2019. Compiled by PGPF.

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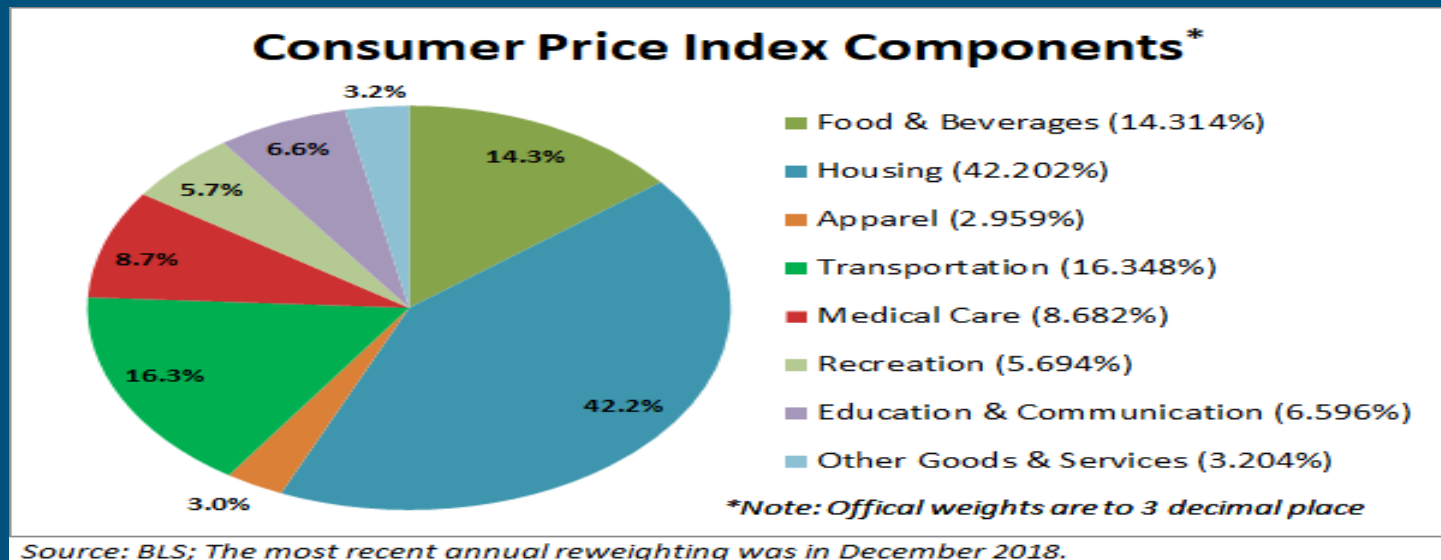
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# United States is an Outlier

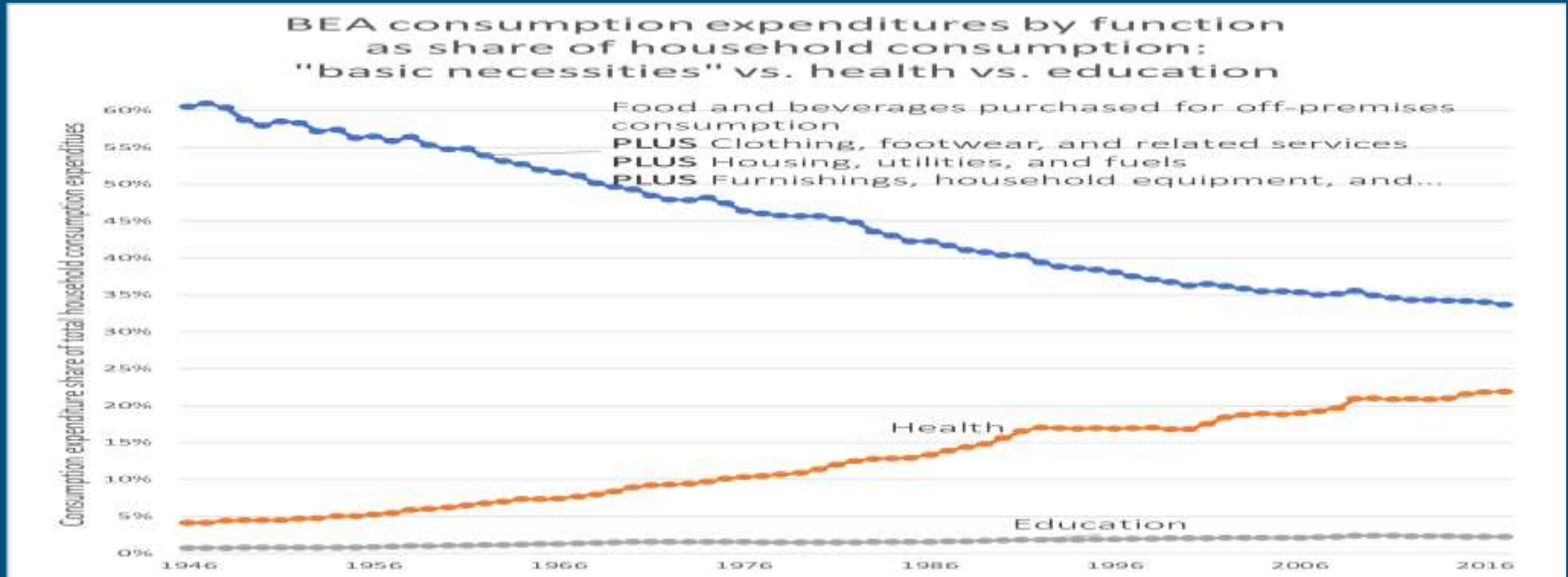
Health Expenditure as Share  
of Gross Domestic  
Product



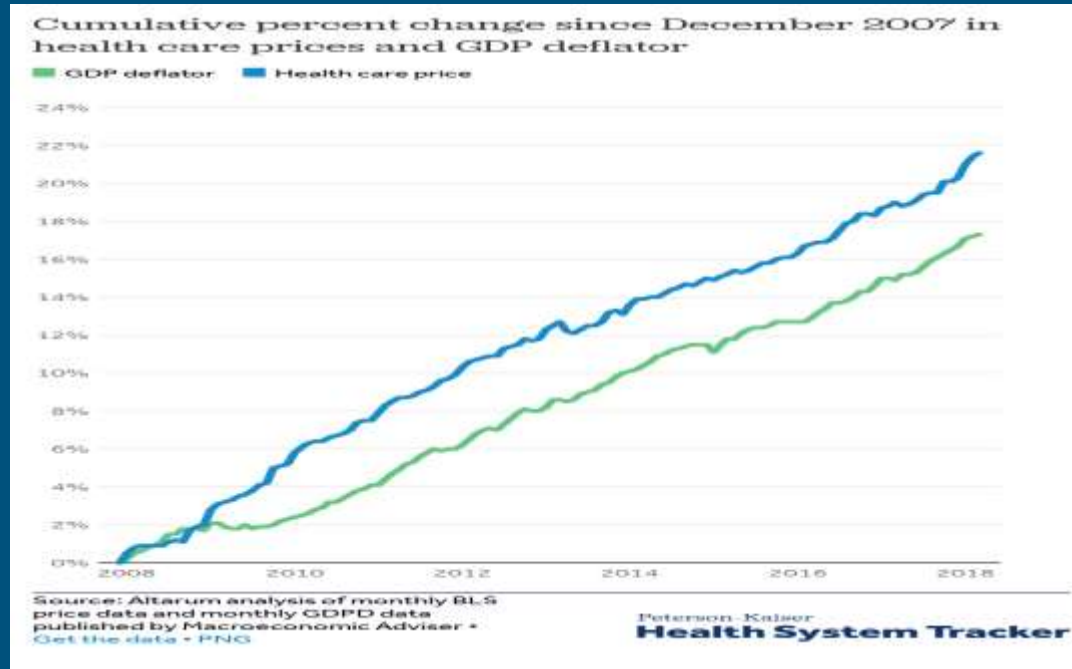
# Components of Consumer Price Index



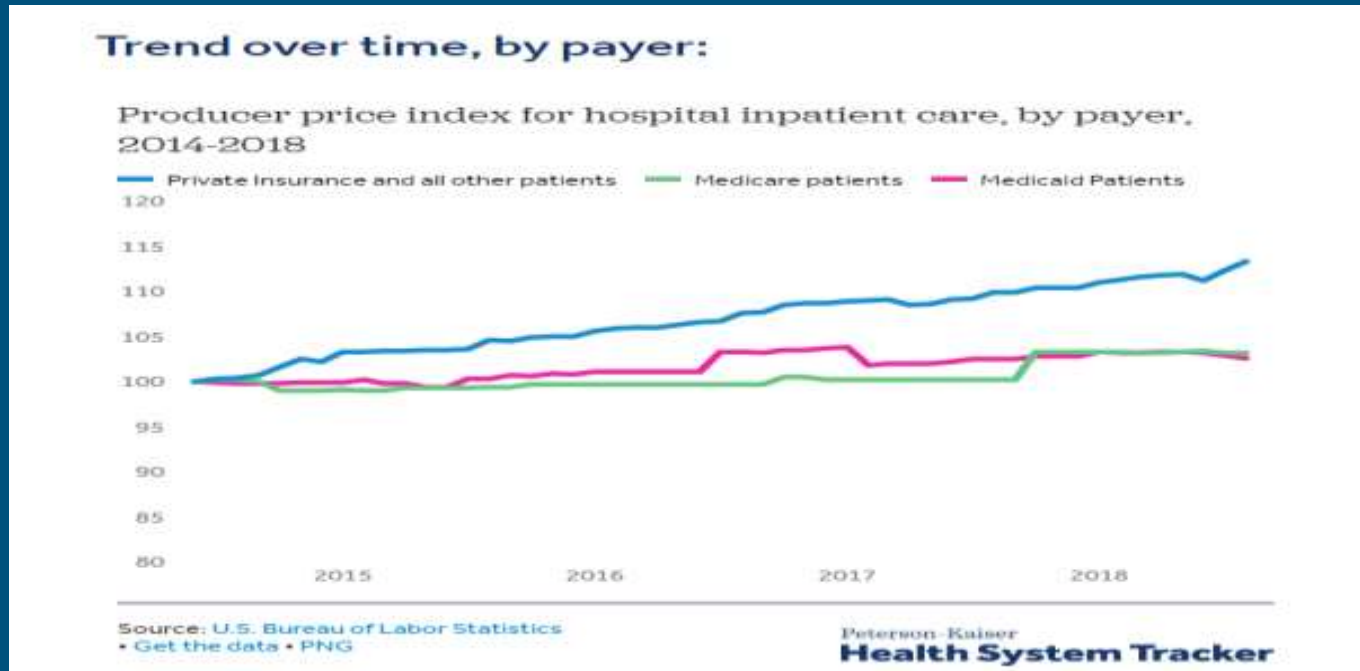
# Role of Health in US Consumption



# Health Care Leads Inflation

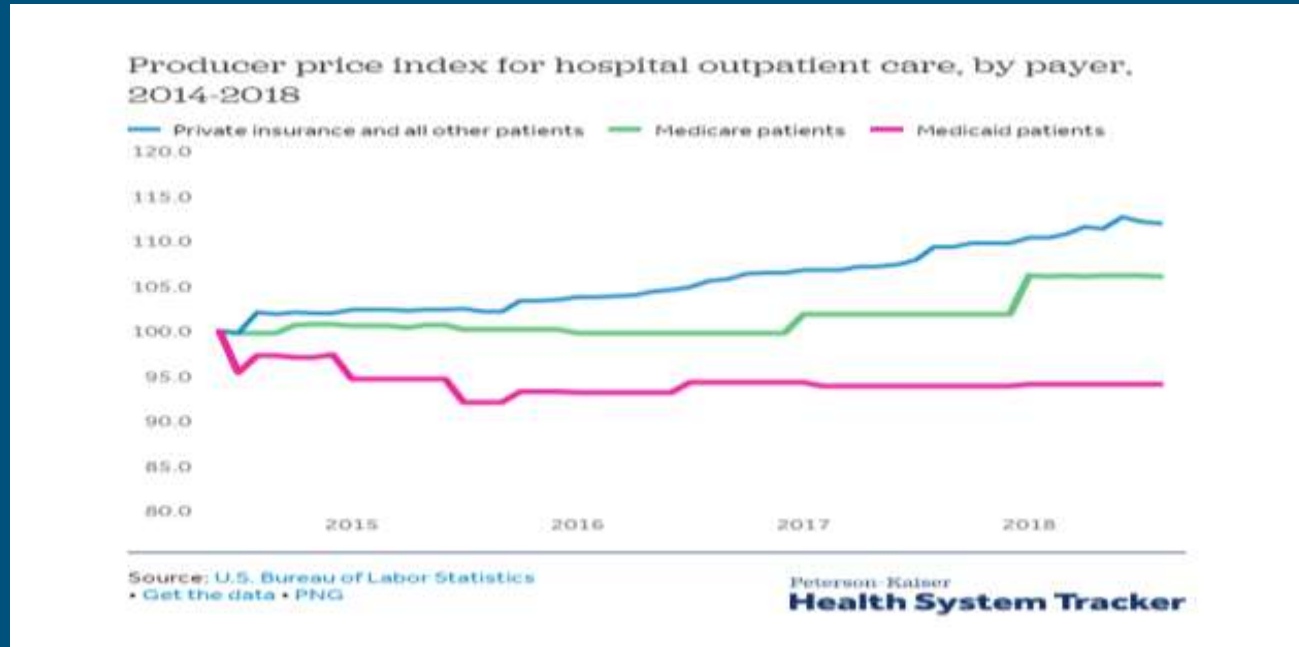


# Hospital Prices Led by Private Sector-Inpatient





# Hospital Prices Led by Private Sector-Outpatient



# Medicare-for-All

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- Reduced role for private insurance
- More oligopsony power for Medicare
- More constrained price trajectory
  - Maybe even deflation in health sector
- Impact on economy-wide inflation could be significant
- Global implications

# Productivity in Health Care

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- Productivity gains in health sector are weak
- Price competition rare
- Product differentiation and monopolistic competition commonplace
- New technology associated with higher, not lower prices
- An engine of innovation, but increasingly costly

# Robert Gordon and US Productivity

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- Gordon believes best years of productivity growth behind for US
- Recognizes modest uptick last four years but hasn't changed view
- But imagine productivity revolution in health sector
- Brought about by constrained prices due to high deductibles, expanded public sector insurance, more competitive labor markets, price transparency and internet

# New Price Decreasing Technologies

- Consider long run impact of following on health sector price appreciation
  - Mobile phone applications
  - Health information systems
  - Sensors
  - Artificial intelligence
  - Medications
    - Including shift to a more competitive generics industry
    - Possible public sector price controls

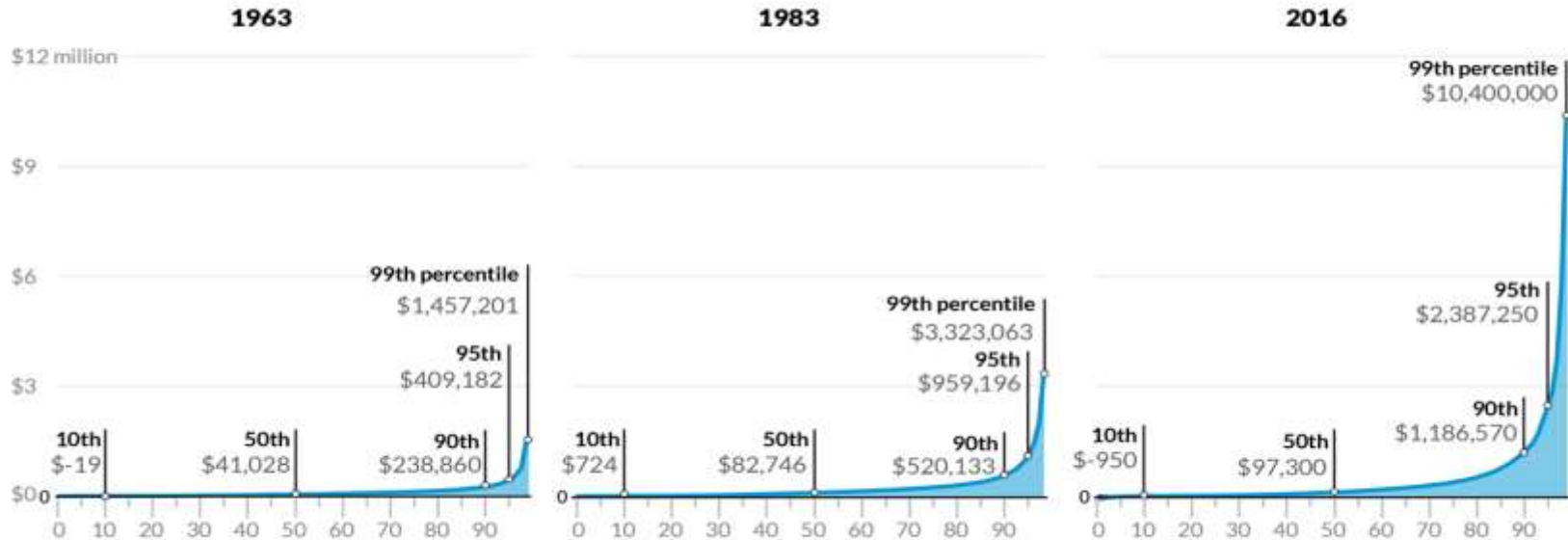
# Implications for Monetary Policy

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- More difficulty achieving 2 percent target
- US may look more like Europe & Japan with negative real interest rates
- Central banks may want to better anticipate such a turn of events with studies and sensitivity and scenario analyses

# Wealth Inequality

## Distribution of Family Wealth, 1963–2016



Source: Urban Institute calculations from Survey of Financial Characteristics of Consumers 1962 (December 31), Survey of Changes in Family Finances 1963, and Survey of Consumer Finances 1983–2016.

Note: 2016 dollars.

# Income Inequality



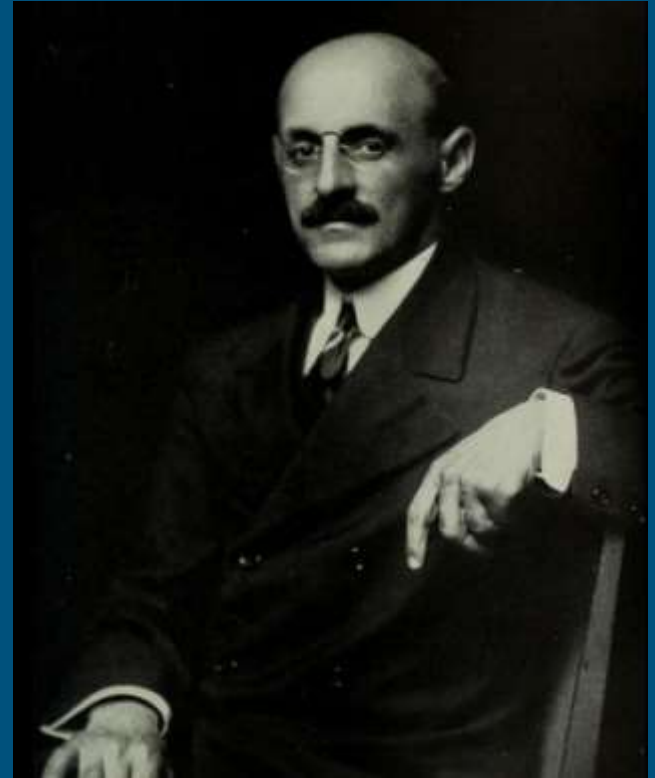
Source: WID.world (2017). See [wii2018.wid.world](#) for data series and notes.



# Flexner Report of 1910

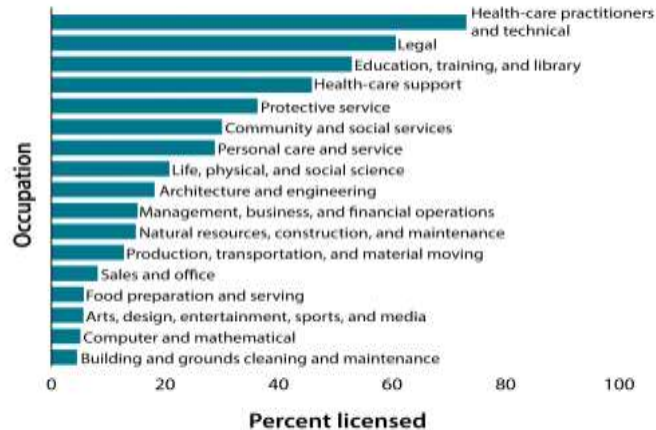
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- John Hopkins Medical school selected as model
- Majority of medical schools eventually shut down
- Adversely effected less wealthy institutions



# Licensure Very Widespread in Healthcare

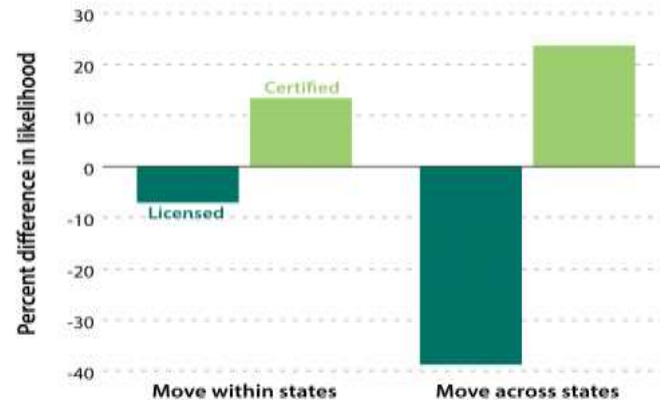
FIGURE 14A.  
Licensed Share of Workers, by Occupation



Source: BLS 2016–17; authors' calculations.

Note: Sample is restricted to employed workers age 25 to 64. We define workers as licensed only if their government-issued credential is required for their job.

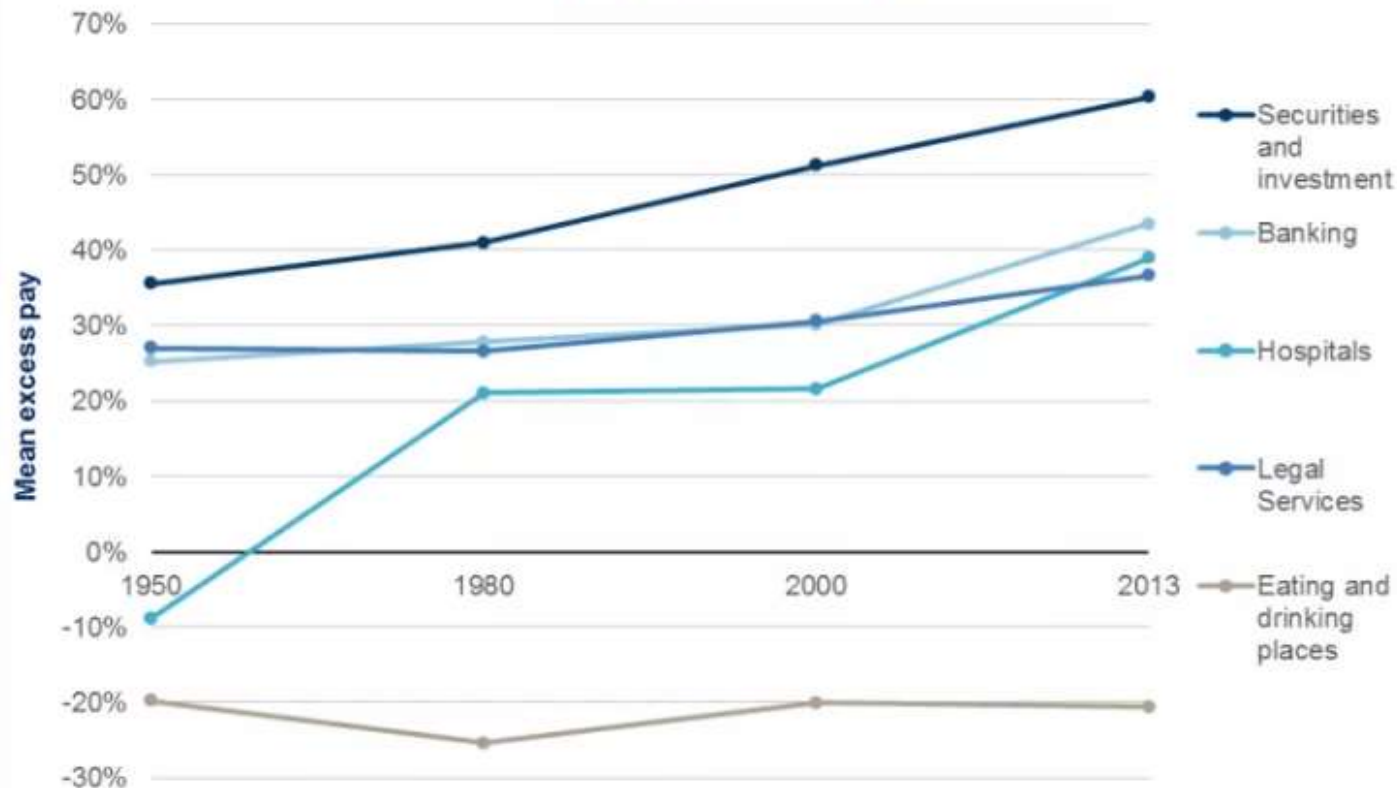
FIGURE 14B.  
Differences in Likelihood of Moving for  
Licensed and Certified Workers



Source: BLS 2016–17; authors' calculations.

Note: Sample is restricted to workers age 25 to 64. We define workers as licensed only if their government-issued credential is required for their job. Estimates adjust for age, education, gender, and race.

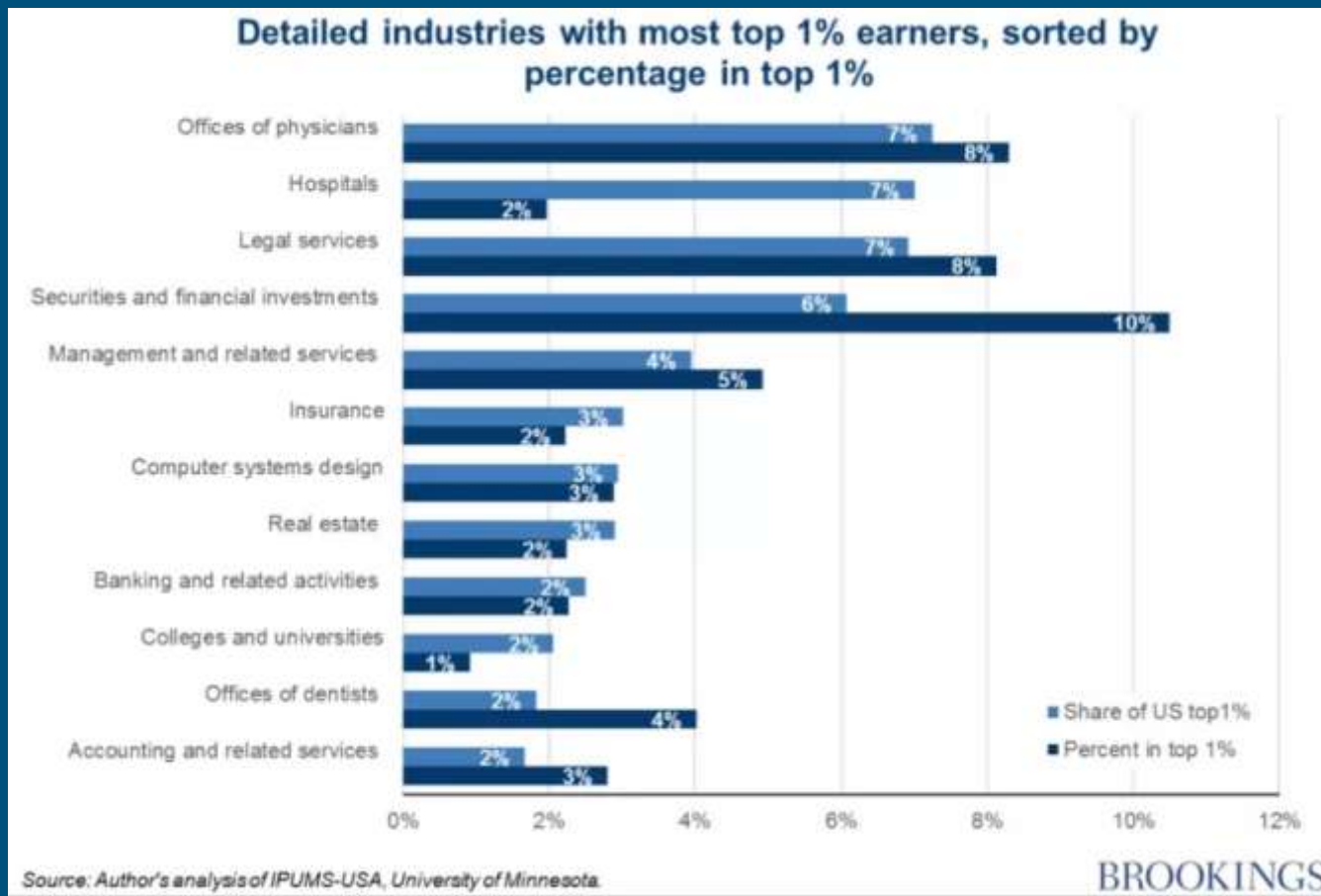
## Mean excess pay by industry, 1950-2013



Source: Author's analysis of IPUMS-USA, University of Minnesota.

BROOKINGS

# Top 1% by Occupation



# Rise of Healthcare Class, Inequality and Policy

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- What can be done?
  - Address licensure
    - Reciprocal state agreements
    - Expanded scope of practice
    - More use of certification
    - Federal engagement with states
  - Address educational bottlenecks
  - Consumer-driven health care with price transparency
  - Ease corporate practice of medicine control
  - More constrained insurance demand