Many states have already passed trigger laws that would automatically implement complete bans on abortion if *Roe* is overturned. In others, policymakers have passed legislation with the goal of evading judicial review, such as Texas Senate Bill (S.B.) 8, which recently went into effect. This bill not only bans abortion after detection of fetal cardiac activity, with no exceptions for cases of rape or incest, but also provides a $10,000 reward to private citizens who report anyone who knowingly aids or abets in the performance of a prohibited abortion. The lack of a rapid response by the Supreme Court to S.B. 8 may be an indicator of what's to come in *Dobbs*.

Our top priority, as students and future residents, is receiving the education we need to provide exceptional care to our patients. We, along with most of our peers, strive to be educated at institutions that provide thorough training, including in dilation and evacuation, medical abortion, and medical management of miscarriage. Constantly changing state regulations — many of which could become more restrictive, depending on the Supreme Court's decision in *Dobbs* — severely limit the number of institutions where we and other future Ob/Gyns will be able to acquire this training.

We are at a pivotal moment in our country's history when it comes to reproductive health. As medical students, we should advocate for the inclusion of comprehensive training in reproductive health care in our medical education. Teaching these critical skills to future generations of clinicians will help ensure that such care remains safe and accessible for all patients.

Disclosure forms provided by the authors are available at NEJM.org.

From the Pennsylvania State College of Medicine, Hershey (M.E.G., Y.P.D.); the University of Queensland Ochsner Clinical School, New Orleans (G.R.M.); and the University of Texas Medical Branch, Galveston (S.B.).

This article was published on January 12, 2022, at NEJM.org.

1. Steinauer JE, Turk JK, Pomerantz T, Simonson K, Learman LA, Landy U. Abortion training in US obstetrics and gynecology residency programs. Am J Obstet Gynecol 2018;219(1):86.e1-86.e6.
2. Jones RK, Jerman J. Population group abortion rates and lifetime incidence of abortion: United States, 2008–2014. Am J Public Health 2017;107:1904-9.
3. Schreiber CA, Creinin MD, Atrio J, Sonalkar S, Ratcliffe SJ, Barnhart KT. Mifepristone pretreatment for the medical management of early pregnancy loss. N Engl J Med 2018;378:2161-70.
4. Landy U, Turk JK, Simonson K, Koenemann K, Steinauer J. Twenty years of the Ryan Residency Training Program in Abortion and Family Planning. Contraception 2021;103:305-9.
5. Zeldovich VB, Rocca CH, Langton C, Landy U, Ly ES, Freedman LR. Abortion policies in U.S. teaching hospitals: formal and informal parameters beyond the law. Obstet Gynecol 2020;135:1296-305.

DOI: 10.1056/NEJMp2117368

Stabilizing Health Care's Share of the GDP

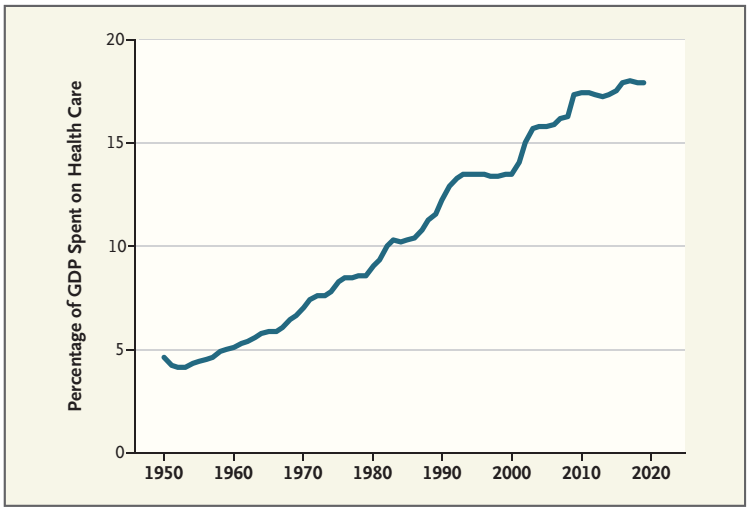
Jonathan Skinner, Ph.D., Eli Cahan, M.S., and Victor R. Fuchs, Ph.D.

The increase in U.S. national health care expenditures from 4% of the gross domestic product (GDP) in 1950 to nearly 18% of the GDP in 2019 is one of the most important economic changes that occurred in the United States during this period. Since the 1980s, policymakers and private health insurers have implemented interventions aimed at bending the cost curve, including diagnosis-related group–based payments to hospitals, managed care, deductibles and copayments, and bundled-payment programs.

But the long-term growth of health care expenditures as a share of the GDP has continued (see graph). Since 1960, health care's share of the GDP has risen by an average of 2.2 percentage points per decade, as compared with an average increase of 1.1 percentage points per decade in 15 other high-income countries since the early 1970s (when the Organization for Economic Cooperation and Development [OECD] began tracking these data; see the Supplementary Appendix, available at NEJM.org).

Increases in health care's share of the GDP in the United States haven't been uniform in the short term. In some years, increases have been higher than average (such as during the creation of Medicare and Medicaid in the 1960s), whereas in other years, they have been lower than average (such as during managed-care expansion in the 1990s and in the 2010s). The longer-term trend has been remarkably (and statistically) stable, however: the per-decade growth in health care's share of the GDP was 1.8 percentage points between 1960 and 1979, then 2.3 percentage points between 1980 and 1999, as well as 2.3 percentage points between 2000 and 2019.

Why should this rapid and



Ratio of National Health Expenditures to GDP, 1950 to 2019.

Data are from the U.S. Social Security Administration 1976 Compendium of National Health Expenditures Data and the Federal Reserve Economic Data database at the Federal Reserve Bank of St. Louis. GDP denotes gross domestic product.

persistent growth be concerning? Research has demonstrated that nearly all wage and salary increases between 1999 and 2009 for the median-income American worker were absorbed by increases in health care premiums, out-of-pocket expenses, and taxes to fund Medicare and Medicaid, which has resulted in little left over for discretionary purchases or savings.[1] There is also no evidence that life expectancy has improved more rapidly among Americans than among people in comparable countries, despite higher health care expenditures in the United States.

We believe that a sustainable long-term economic strategy should involve stabilizing the ratio of national health care expenditures to GDP. This goal could be achieved by focusing on the gap between the rate of growth of health care expenditures and the rate of GDP growth. When the gap between these growth rates is greater than zero, health care s share of the GDP rises over time; to stabilize the ratio of health care expenditures to GDP, expenditure growth must be equal to (or less than) GDP growth, which has averaged 3.0% per year since 1960 after adjustment for inflation. Focusing on this gap as a target for health policy provides a transparent goal, with results that can be easily measured and monitored. Moreover, if the goal isn t met, it s readily apparent how much change is required to meet it.

The potential savings associated with stabilizing the growth of health care expenditures are considerable. If health care s share of the GDP were to be stabilized at 18% beginning in 2022, total health care expenditures (in 2021 dollars) between 2022 and 2031 would be $52 trillion, according to Congressional Budget Office projections. In contrast, if health care s share of the GDP continued to grow at the same rate as it has since 1980 (2.3 percentage points per decade), total expenditures would be higher by approximately $3 trillion money that could instead be spent on addressing social determinants of health by means of investments in education, social services, and improved living standards.

How should the United States approach the goal of restraining the growth of health care expenditures? Various strategies have been proposed for cutting spending, such as limiting out-of-network or surprise billing, restricting the delivery of fraudulent postacute care, and expanding preferred pharmacy networks.[2] Although reducing wasteful spending is an important goal, targeting the gap in growth rates requires strategies that can slow the rate of growth of health care expenditures more generally.

A key reason for high rates of growth in this sector is the lack of institutional budgets to constrain spending. Medicare is an entitlement program without legislative limits on expenditures; hospitals respond to rising costs by increasing commercial prices, and increases are passed on to consumers in the form of higher insurance premiums. Medicaid, which is subject to state-level budget constraints, is an exception; perhaps as a consequence, Medicaid has had stable per-enrollee inflation-adjusted spending during the past several decades.[3]

In contrast, many OECD countries have fixed budgets for health care organizations that are implicitly tied to tax revenue and general economic growth. Similar approaches could be adopted in the United States. Governments and private insurers, for example, could provide capitated payments to hospitals and physician practices to help them pay their fixed costs of operation,

with annual increases tethered to GDP growth. These subsidies would create an environment under which per-service prices could be reduced (by means of either competition or regulation), thereby reducing incentives for overuse. Subsidies would also promote financial solvency when visits and admissions fall, as they did during the early stages of the Covid-19 pandemic. Such methods have already demonstrated promise: a global budget has been the hallmark of Maryland s approach to controlling hospital costs.[4] Greater reliance on capitated spending also ensures that providers have incentives to allocate scarce health care resources more effectively. When health care budgets are tied to general economic growth, the result is a stable ratio of health care expenditures to GDP.

Slowing the growth of health care expenditures doesn t need to mean restricting research and development. Most biomedical research and development in the United States focuses on product improvement, with little attention paid to cost reduction; the Food and Drug Administration is forbidden by law from considering cost when evaluating new medical technologies.[5] Other U.S. industries and health care systems in other countries have a more balanced approach, which includes standardized and rigorous use of cost-effectiveness analyses. For example, in England, the National Institute for Health and Care Excellence is required to consider cost in its evaluation of new medical technologies.

The stabilization goal we propose has several caveats. First, health care probably doesn t need to consume as much as 18% of the GDP; other high-income countries have effective health care systems that are popular across the political spectrum and consume 12% of their GDPs or less. Scaling back health care s share of the GDP would face extraordinary political obstacles, however. Second, year-to-year fluctuations in the GDP s rate of change are greater than would be desirable for health care. One solution would be to link target health care expenditures to average GDP growth over the previous 3 to 5 years. Third, new and expensive innovations may strain health care budgets, but reallocation of health care dollars from less effective to more effective products and services is an essential feature of any sustainable health care system. Fourth, balancing budgets doesn t ensure high-quality health care; further efforts would be necessary to improve clinical quality. Finally, slowing the rate of growth of health care expenditures is likely to remain politically unpopular so long as voters don t connect reduced growth with more reasonable medical bills and insurance premiums.

One might view the Covid-19 pandemic as a challenge to our proposed limits on health care spending; the ratio of health care expenditures to GDP rose to 18.2% in 2020, even after subtracting federal Covid-19 supplemental funding. We acknowledge such challenges, associated with temporary increases in health care spending (or with temporary declines in the GDP), but failing to stabilize the long-term ratio of health care expenditures to GDP could result in stagnant wages for most American workers; an increase in bankruptcies among patients, with associated unpaid physician and hospital bills; and budget crises for the federal government and state governments. We believe that stabilizing health care s share of the GDP using transparent, effective, and practical measures should be a national priority.

Disclosure forms provided by the authors are available at NEJM.org.

From the Department of Economics, Dartmouth College, Hanover, NH (J.S.); the National Bureau of Economic Research, Cambridge, MA (J.S.); New York University, New York (E.C.); and Stanford University (E.C.) and the Stanford Institute for Economic Policy Research (V.R.F.), Stanford, and the Schaeffer Center for Health Policy and Economics, University of Southern California, Los Angeles (V.R.F.) all in California.

This article was published on February 19, 2022, at NEJM.org.

1. Auerbach DI, Kellermann AL. A decade of health care cost growth has wiped out real income gains for an average US family. Health Aff (Millwood) 2011;30:1630-6.
2. Cooper Z, Scott Morton F. 1% steps for health care reform: implications for health care policy and for researchers. Health Serv Res 2021;56:346-9.
3. Colla C, Skinner J. Has the Affordable Care Act made health care more affordable? In: Emanuel E, Gluck A, eds. The trillion dollar revolution: how the Affordable Care Act transformed politics, law, and health care in America. New York: PublicAffairs, 2020:250-63.
4. Aliu O, Lee AWP, Efron JE, Higgins RSD, Butler CE, Offodile AC II Assessment of costs and care quality associated with major surgical procedures after implementation of Maryland s capitated budget model. JAMA Netw Open 2021;4(9):e2126619.
5. Cahan EM, Kocher B, Bohn R. Why isn t innovation helping reduce health care costs? Health Affairs Blog. June 4, 2020 (https://www.healthaffairs.org/do/10.1377/hblog20200602.168241/full/).

DOI: 10.1056/NEJMp2114227