The Economist

## Economic growth

# The health paradox

**America's rampant health spending threatens its economic future. It also supports tens of millions of jobs**

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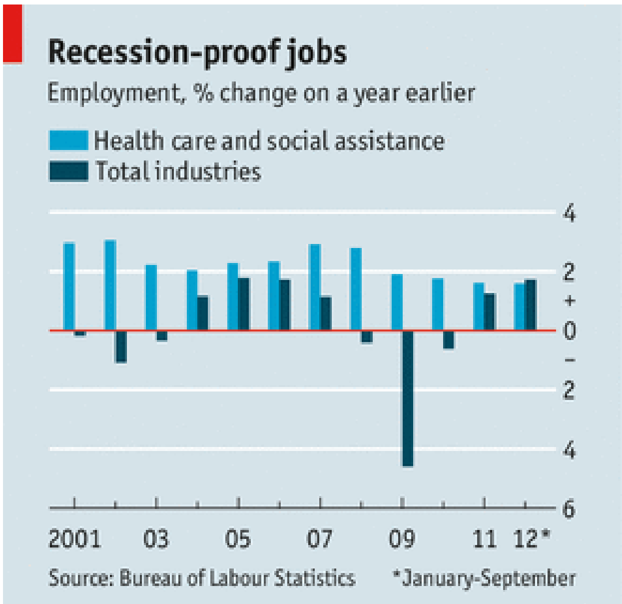
LOUISVILLE, Kentucky is known for bourbon and horse races. Its economy increasingly relies on a less glamorous industry: "lifelong wellness and ageing care", the term used by local business leaders, or what everyone else calls health care for old people. Health care now accounts for 12 of greater Louisville's 25 largest employers, including Humana, a huge health insurer, and Kindred Healthcare, which owns nursing homes and other health facilities. More than 18,000 people in greater Louisville work for health companies. That number is likely to grow.

These are cheerful figures. Unfortunately, they are made possible by gloomier ones. In 2011 America spent $2.7 trillion on health, equal to 17.9% of GDP. The government paid for nearly half of this. As public health spending continues to grow, it threatens to widen America's deficit and eclipse other public programmes, such as infrastructure and education. Nearly every politician, regardless of party, agrees that this is dangerous.

On the local level, however, the mood is rather different. The trillions spent on health care do not disappear into the ether, but support hospitals, drug companies, insurers, nursing homes, information-technology firms and the millions of people they employ. Health spending may be disastrous for America's economic future; for many local economies, it is a boon.

Each month's national employment report is slightly different, but one factor has remained constant: the number of health-service jobs, such as doctors, nurses and medical assistants, keeps growing (see chart). The trend was impervious to the recession. In September there were 18.7m such jobs, up 28% since 2001.

The growth is likely to continue, according to Georgetown University's Centre on Education and the Workforce. Demand for health services will rise as Obamacare expands insurance and Americans grow older, fatter and sicker. Health care is the rare industry that has seen labour productivity decline. Georgetown predicts that jobs in hospitals, clinics, nursing homes and health companies, such as medical-device-makers, will grow by 26% between 2010 and 2020, compared with a 17% national average. By 2020 such jobs will account for a staggering one in seven American workers—and that does not include auxiliary firms, such as health-information-technology companies or health consultancies.




Given these predictions, two phenomena naturally follow. First, unions have set their sights on health care. National unionisation rates have dropped by 20% over the past decade. Unionisation of health workers has jumped by the same margin. On May 2nd the Service Employees International Union (SEIU) was declared the winner in a fight with a rival union to represent health workers at Kaiser Permanente in California. The election was the biggest private-sector union vote in over 70 years.

Second, cities and states are eager to cash in. Some places are already centres for the health industry. Boston and Houston are America's leading medical cities, according to Scot Latimer of Jones Lang LaSalle, a property firm. Boston, for example, ranks first in the company's list of life-science hubs and is home to some of America's best academic hospitals. Other cities are hubs for other subsectors. Minneapolis has a cluster of medical-device firms. Nashville is home to big hospital and health-service companies. Most of the main drugmakers have offices in New York City or neighbouring New Jersey. California is a hub for biotechnology.

Louisville is one of many cities trying to follow suit. Two years ago the Health Enterprise Network, a consortium of local health firms, created a family tree to display the sector's breadth. The trunk comprised three local giants: Humana, Kindred Healthcare and the University of Louisville, which owns a big hospital and has a sprawling health-research campus downtown. But hundreds of health companies filled out the tree's branches. Louisville's leaders are keen to attract even more. For example, the International Centre for Long-Term Care Innovation helps to incubate firms that offer products and services for the old. Paul Kusserow at Humana praises Louisville's growing collection of venture-capital firms devoted to health start-ups.

Cleveland, a city long eager to reinvent itself, may succeed at last with health care. It is home to good hospitals, including the famous Cleveland Clinic. Local groups such as BioEnterprise are trying to foster a new generation of health entrepreneurs, with some success. Last year 43 biomedical start-ups attracted $227m in venture-capital funding. A community college is retraining car- and steelworkers for jobs with drug and device manufacturers. In a riskier move, Cleveland's surrounding county has spent about $465m on a new convention centre and a "Global Centre for Health Innovation", an exhibition building for medical companies. Local leaders hope that these will attract conferences.

But health spending will hardly be a panacea for every region hungry for jobs. Georgetown's researchers expect health employment to grow relatively slowly in the north-east. By contrast Utah, Georgia and Texas will see growth of more than 35% from 2010 to 2020. Mr Latimer estimates that hospitals will need to add 221,000 beds by 2030, but more than 80% of these will be in just six states in the sunbelt. In New York, Pennsylvania and the Great Plains some hospitals will probably have to close.

Moreover, the long-term impact of Obamacare is unknown. The law's expansion of insurance will bring more demand for care. But Obamacare also includes cuts in the rates paid to hospitals by Medicare, the health programme for the old, and incentives for doctors to provide good care while keeping costs down. Given that labour accounts for more than half of hospital costs, hospitals will probably try to squeeze more from their workers. Already services are moving from hospitals to clinics and from clinics to homes; jobs at clinics pay less than similar jobs at hospitals, explains Anthony Carnevale of Georgetown. Wages for home health assistants are abysmally low, at about $22,000 a year.

The biggest mystery is when—if ever—the federal government will do more to lower health spending. The fact that local economies depend on health care makes the task trickier. Democratic senators from Massachusetts and Minnesota, usually happy to tax businesses, recently voted to scrap Obamacare's levy on medical devices. Both states have medical-technology firms. The health industry is among the five most generous sources for campaign donations to John Boehner, Mitch McConnell, Nancy Pelosi and Harry Reid, the Republican and Democratic leaders of Congress. (For example, Kindred Healthcare and Humana are the biggest and third-biggest donors to Senator McConnell, who comes from Kentucky.)

These forces make cutting health costs politically difficult. Nevertheless, there are signs that spending, though continuing to rise, is growing more slowly. In February the Congressional Budget Office lowered its projections for health spending. Some of the slowdown is due to the recession. But more lasting forces are at work, too, including a shift in the way care is delivered. If any of these reforms slows health-care growth by improving efficiency, says Katherine Baicker of Harvard University, that may well mean fewer people employed. This may be bad news for some cities in the immediate future. In the long term, though, money saved on health could be invested in education or could allow non-health firms to hire more workers; and that would be a relief.

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