Weekly Checkup

Cheaper Prices Alone May Not Lower Health Spending

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The Centers for Medicare & Medicaid Services' (CMS) actuaries recently released the 2024 National Health Expenditure (NHE), and the headline is familiar but still jarring: U.S. health spending grew 7.2 percent in 2024 to $5.3 trillion ($15,474 per person), rising to 18.0 percent of gross domestic product. In other words, health care spending continued to outpace the economy.

The initial lesson most policymakers take from this is simple: Health care is too expensive, so prices must come down to reduce overall spending. Often, the proffered solution is government-enforced price caps which – while potentially limiting the amount consumers pay – don't actually address the cost of producing or administering the unit of health care being tracked.

This is where the Jevons paradox becomes a useful frame. In the 19th century, economist William Stanley Jevons observed that improving the efficiency of coal use did not reduce total coal consumption; it increased it, because lower effective costs expanded use. The takeaway is straightforward: **When something becomes cheaper or easier to produce per unit, total consumption can rise – sometimes enough to overwhelm the per-unit savings.**

Let's apply this to health care. Health care has its own "efficiency" story. Instead of coal, the inputs include time, administrative burden, travel, scheduling delays, clinical workflow, treatments, and the cognitive cost of navigating a fragmented system. When those frictions fall, more people can complete more episodes of care, clinicians can deliver more services per day, and payers get billed for more (and often more complex) utilization.

CMS's 2024 NHE reads like a Jevons case study. The actuaries emphasize that recent spending growth was "primarily fueled by non-price factors," including higher demand and

shifts in the mix of goods and services. Private health insurance enrollment increased to 214.3 million, Affordable Care Act Marketplace enrollment rose to 21.1 million, and total private health insurance spending grew 8.8 percent to $1.6 trillion. Medicare spending grew 7.8 percent to $1.1 trillion, Medicaid spending grew 6.6 percent to $932 billion, and Americans' out-of-pocket spending grew 5.9 percent to $557 billion.

High insurance coverage does not necessarily equate to high-quality, high-value care, but it increases the probability that people will seek care and follow through on care plans, particularly when access is simplified. For example, CMS points to a rebound in the "use and intensity of services" and notes hospital prices rose 3.4 percent – the fastest since 2007 – reminding us that prices still matter, but they are not the whole story.

The central mistake is to treat aggregate spending as a standalone scorecard. As suggested by the Jevons paradox, when the effective cost of using something falls – whether that cost is time, hassle, uncertainty, or money – people and systems tend to do more of it. The result is that higher (or faster-growing) spending can be attributed to two very different realities: (1) a system that is becoming wasteful, or (2) a system that is removing barriers and meeting previously unmet need. Totals alone cannot distinguish between them.

That is why the most important questions are compositional rather than headline: What is the marginal care we are buying as access becomes more efficient and readily available? Are we converting new capacity into earlier diagnosis, better adherence, and fewer catastrophic episodes later – or into more low-yield visits, broader screening with weak predictive value, and snowballing overutilization? Are new tools shifting the mix of spending toward cheaper sites of care and more standardized workflows, or toward more complex intensity per episode because we can now identify and treat more conditions?

Innovations that make health care easier – automation, AI-enabled workflow, virtual-first access, at-home diagnostics, more effective therapies – do not have a single, predictable fiscal signature. They can reduce the cost of an encounter while increasing the number of encounters; they can lower the cost of acute episodes while increasing the treated prevalence of chronic disease; they can shift spending out of hospitals while increasing total utilization in outpatient settings. The Jevons lens therefore suggests that we should consider potential outcomes more broadly and carefully before simply reacting with austerity measures. **When efficiency improves, you should expect utilization to respond, and you should read the spending numbers as a map of shifting demand – not as a simple verdict on whether the system is "working."**

The NHE 2024 release is a reminder that the U.S. health care system is

exceptionally good at turning access, coverage, and innovation into utilization. In this context, the Jevons paradox is less of a paradox; it's no surprise that if we make care easier, Americans will use more of it. Without that context, "health spending is up" can be either a sign of growing inefficiency or a sign that the system is finally delivering care people could not (or would not) access before.