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Challenges for Health-Care Reform

Remarks by

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Improving the performance of our health-care system is without a doubt one of the most important challenges that our nation faces. In recent decades, improvements in medical knowledge and standards of care have allowed people to live healthier, longer, and more productive lives. New medical technologies and treatments promise more and better to come. From a social point of view, we hope as many people as possible benefit from these advances. But health care is not only a scientific and social issue; it is an economic issue as well. The decisions we make about health-care reform will affect many aspects of our economy, including the pace of economic growth, wages and living standards, and government budgets, to name a few.

By any measure, the health-care sector represents a major segment of our economy. Spending on health-care services currently exceeds 15 percent of the gross domestic product (GDP). Indeed, health-care spending is the single largest component of personal consumption--larger than spending on either housing or food. Importantly, health care also has long been, and continues to be, one of the fastest-growing sectors in the economy: Over the past four decades, this sector has grown, on average, at a rate of about 2-1/2 percentage points faster than the GDP. Should this rate of growth continue, health spending would exceed 22 percent of GDP by 2020 and reach almost 30 percent of GDP by 2030.[1]

Health-related spending is also a large and growing share of government budgets. Last year, health care accounted for about one-quarter of total federal spending. The Congressional Budget Office (CBO) projects that, under current policies, health spending will account for almost one-half of all federal non-interest outlays by 2050.[2]

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[1] Congressional Budget Office (2007).
[2] Ibid.

As the public interest in these issues testifies, the stakes associated with health-care reform, both economic and social, are very high. But we must keep in mind that, for all its problems, the U.S. health-care system also has many strengths. We must take care that we do not lose what is good about our system as we try to address the significant concerns that certainly exist.

In the remainder of my remarks, I will discuss three key challenges for health-care reform. These challenges are, in short, the issues of access, quality, and cost.

Challenges for Health-Care Reform

Access

Access to health care is the first major challenge that health-care reform must address. In 2006, a total of 47 million Americans, or almost 16 percent of the population, lacked health insurance. Although the federal and state governments spent more than $35 billion to finance uncompensated care in 2004, the evidence nonetheless indicates that uninsured persons receive less health care than those who are insured and that their health suffers as a consequence. Per capita expenditures on health care for uninsured individuals are, on average, roughly half those for fully insured individuals.[3] People who are uninsured are less likely to receive preventive and screening services, less likely to receive appropriate care to manage chronic illnesses, and more likely to die prematurely from cancer--largely because they tend to be diagnosed when the disease is more advanced.[4] One recent study found that uninsured victims of automobile accidents

[3] Hadley and Holohan (2004).
[4] Institute of Medicine (2002).

receive 20 percent less treatment in hospitals and are 37 percent more likely to die of their injuries than those who are insured.[5]

Quality

The second key challenge is improving the quality of health care. The quality of medical research, training, and technology in the United States is generally very high. However, the quality of health care is determined not only by, say, technological advances in preventing and treating disease but also by our ability to deliver the benefits of those advances to patients. For maximum impact, advances in medical knowledge must be widely disseminated and consistently and efficiently implemented. But evidence suggests a disturbing gap between the quality of health services that can be provided in principle and the quality of health services that actually are provided in practice. For example, in 2000, the Institute of Medicine issued a landmark report that concluded that up to 98,000 Americans died each year in hospitals as a result of medical errors.[6] Many of the errors identified by the report--for example, errors caused by adverse drug events, improper transfusions, wrong-site surgery, and mistaken patient identity--could have been prevented if hospitals had adopted appropriate safety systems. Although hospitals have implemented a number of new safety practices since the time of that report, the scope for improving patient safety remains large.[7]

Inconsistent use of best practices by doctors and hospitals is also surprisingly widespread. For example, numerous studies have pointed to the lack of adherence to evidence-based guidelines for the treatment of heart attacks. In particular, it has long been well established that restoring blood flow to the heart and using aspirin, beta

[5] Doyle (2005).
[6] Institute of Medicine (2000).
[7] Leape and Berwick (2005).

blockers, and ACE inhibitors at the appropriate times significantly reduce deaths resulting from heart attacks.[8] Yet studies show that the dissemination of these treatments occurred only slowly.[9] More widespread application of evidence-based medicine could help health-care workers make better use of the medical knowledge they already have to improve patients' outcomes.

Although some patients do not receive the care they need, others receive more (and more expensive) care than necessary. Research on geographic variation in health-care practices and costs confirms this point. For example, Medicare expenditures per eligible recipient vary widely across regions, yet areas with the highest expenditures do not appear to have better health outcomes than those with the lowest expenditures; indeed, the reverse seems to be true.[10]

Cost

This observation brings me to a third important challenge for health-care reform: controlling costs. The problem here is not only the current level of health-care spending (U.S. spending exceeds that of most other industrial countries) but, to an even greater degree, the continued rapid growth of that spending. Per capita health-care spending in the United States has increased at a faster rate than per capita income for a number of decades. Should that trend continue, as many economists predict it will, the share of income devoted to paying for health care will rise relentlessly. A piece of wisdom attributed to the economist Herbert Stein holds that if something cannot go on forever, it will stop. At some point, health-care spending as a share of GDP will stop rising, but it is difficult to guess when that will be, and there is little sign of it yet.

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[8] Beta blockers and ACE inhibitors are drugs that relieve stress on the heart.
[9] Joint Commission (2007).
[10] Skinner, Staiger, and Fischer (2006).

Although the high cost of health care is a frequently heard complaint, it is important to note that a substantial portion of the cost increases that we have seen in recent decades reflects improvements in both the quality and quantity of care delivered rather than higher costs of delivering a given level of care. Notably, new technologies, despite greatly adding to cost in many cases, have also yielded significant benefits in the form of better health. People put great value on their health, and it is not surprising that, as our society becomes wealthier, we would choose to spend more on health-care services. Indeed, although quantifying the economic value of improved health and greater expected longevity is difficult, most researchers who have undertaken an exercise of this type find that, on average, the health benefits of new technologies and other advances have significantly exceed the economic costs.[11]

That said, the evidence also suggests that the cost of health care in the United States is greater than necessary to allow us to achieve the levels of health and longevity we now enjoy. I have already mentioned research that finds large regional differences in the cost of treating a given condition, with high-cost areas showing no better results. The slow diffusion of the use of aspirin and beta blockers for treating heart-attack patients shows that cheap, effective treatments are not always used, potentially leading to higher costs and worse outcomes. Moreover, because insurance companies and the government play such prominent roles in financing health care, patients and doctors have far less incentive to consider the extra costs of optional tests or treatments. But, as we all know, although testing and treatment decisions may be undertaken on the presumption that "someone else will pay," the public eventually pays for all these costs, either through higher insurance premiums or higher taxes.

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[11] Cutler and McClellan (2001).

The effects of high health-care costs on government budgets deserve special note. In the United States, a large and growing portion of both federal and state expenditures is for subsidized health insurance. In 1975, federal spending on Medicare and Medicaid was about 6 percent of total non-interest federal spending. Today, that share is about 23 percent. Because of rising costs of health care and the aging of the population, the CBO projects that, without reform, Medicare and Medicaid will be about 35 percent of non-interest federal spending in 2025.[12] This trend implies increasingly difficult tradeoffs for legislators and taxpayers, as higher government spending on health-care spending will, of necessity, require reductions in other government programs, higher taxes, or larger budget deficits.

Rapid increases in health spending also portend increasingly difficult access to health services for people with lower incomes.[13] As health spending continues to outpace income, health insurance and out-of-pocket payments will become increasingly unaffordable.[14] One way that society has addressed this problem in the past has been to expand government subsidies for health spending. The Medicare Part D program, which assists seniors with the costs of prescription drugs, is an example. However, to continue limiting the effects of rising medical costs on household budgets, the government may have to absorb an increasing proportion of the nation's total bill for health care, putting even greater pressure on government budgets than official projections suggest.

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[12] CBO (2007).

[13] For the purposes of this speech, "low income" means those in the bottom 20th percentile of the income distribution.

[14] For example, a recent study estimated that, without increases in the share of health spending that is publicly financed, the budget share of health spending for low-income elderly households would increase from about 25 percent of their income today to about 35 percent by 2040 (Follette and Sheiner, 2007).

Taking on these challenges will be daunting. Because our health-care system is so complex, the challenges so diverse, and our knowledge so incomplete, we should not expect a single set of reforms to address all concerns. Rather, an eclectic approach will probably be needed. In particular, we may need to first address the problems that seem more easily managed rather than waiting for a solution that will address all problems at once.

Thinking About Solutions

In health-care reform, it is certainly easier to pose questions than to provide answers. Moreover, even putting aside the scope and technical complexities of the problems we face, the types of reforms we choose will depend importantly on value judgments and the tradeoffs made among social objectives. Such choices are appropriately left to the public and their elected representatives. Consequently, I will have little to say here regarding specific proposals. However, I will suggest a few questions and considerations that those seeking reform might wish to keep in mind.

Regarding access, one important consideration is that people who are uninsured are not all alike. They include people who have low incomes, people who may not be poor but have costly pre-existing health conditions, those whose employers do not offer group health insurance and who cannot afford to buy insurance in the more-expensive nongroup market, and people who are eligible for Medicaid or other programs but for some reason have not enrolled. Some people who can afford health insurance do not purchase it, presumably because they do not anticipate having significant medical expenses. Broadening access to health care may thus require us to consider a mix of policies. The following are some of the questions with which we will have to wrestle.

First, should enrollment in a health insurance program be mandated, or at least strongly encouraged, for example, through tax incentives? Supporters argue that mandates lead to better risk pooling and prevent those who could afford insurance but choose not to buy it from "free-riding" on the public safety net. Opponents argue that mandates infringe on what should be an individual choice and may require a substantial government budgetary commitment to help those who cannot afford insurance on their own to meet the mandate.

Second, should we continue to rely on employer-provided health insurance as the key element of our system? The employees of large companies in particular typically constitute a good risk-sharing pool, allowing insurance to be provided at a lower overall cost. But the dominance of the insurance market by employer-provided plans means that the market for individual and small-group policies is underdeveloped and that the cost of such coverage is very high. Employer-based systems also reduce the portability of health insurance between jobs, which reduces labor mobility and the efficiency of the labor market as well as creating a burden for those changing jobs.

Third, to help people with costly pre-existing conditions, should we impose requirements on insurance companies to accept all applicants and mandate the conditions that must be covered? Doing so would help some people obtain coverage, but the resulting increases in insurance premiums might exclude others. An alternative approach would be to promote bare-bones, high-deductible policies that are affordable and attractive to healthy people while offering government help to those who need coverage for costly conditions.

Finally, to what extent are we willing to use public funds to reduce the number of those who are uninsured, for example, by providing subsidies to low-income people not covered by Medicaid or to people, such as the self-employed, who find it difficult to obtain affordable coverage in the non-group market? How would we finance additional spending? For instance, would we consider limiting the employers' tax exemption for the cost of employee health insurance?

The issue of access to health care, though difficult politically, is in some sense the technically least complex of the three challenges I have identified; it is mostly about financing, and possibly regulation, rather than about medicine. Of course, access to health care is closely entwined with the other issues, notably the issue of cost. In particular, restraining the growth of health-care costs would increase the number of people who can afford insurance coverage.

On the second challenge, improving the quality of health care, a number of private and public initiatives have been undertaken in recent years. These include programs to monitor hospitals' performance in ensuring patient safety and adherence to best practices; greater efforts to identify and disseminate best practices, as determined from clinical trials; and public and private initiatives to increase the use of information technology in health care. Researchers are also examining how the structure of health-care delivery systems affects the quality of care. For example, some evidence suggests that vertically integrated systems like that of the Veterans Administration are quicker to adopt health information technology and have been more successful in applying it. Some instances of initiatives that aim to encourage quality through financial incentives or disincentives--so-called pay-for-performance--have begun to emerge. Examples include

accreditation practices that require hospitals to comply with established standards and best practices, and the recent decision that Medicare will not cover costs caused by certain medical errors.

Efforts to improve the quality of health care are a vital component of comprehensive reform and are likely to yield high social returns. Additional research and experimentation can help us address difficult questions such as how best to measure quality and cost-effectiveness in health-care delivery and how to give doctors and hospitals incentives to adopt best practices and improved information technologies.

The solutions we choose for access and quality will interact in important ways with the third critical issue--the issue of cost. Greater access to health care will improve health outcomes, but it almost certainly will raise financial costs. Increasing the quality of health care, although highly desirable, could also result in higher total health-care spending. For example, increased patient screening may avoid more serious problems and thus be cost-saving, but it could also identify problems that might otherwise have gone untreated--a good outcome, certainly, but one that increases overall spending. These are certainly not arguments against increasing access or improving quality. My point is only that improving access and quality may increase rather than reduce total costs.

From the economist's perspective, the question of whether we are spending too much on health care cannot ultimately be answered by looking at total expenditures relative to GDP or the federal budget. Rather, the question, whatever we spend, is whether we are getting our money's worth. In general, good information and appropriate incentives are necessary to allocate resources efficiently. In health care, the necessary

information should include not only the clinical effectiveness of certain tests or courses of treatment but also their cost-effectiveness. As the regional comparison of health-care costs illustrates, cost-effective approaches may be at least as useful as more costly approaches in delivering good health outcomes.

Knowledge of the costs of alternative approaches is likely to be insufficient by itself. Patients, doctors, and hospitals must also be given incentives for choosing cost-effective approaches. However, the questions of how to structure incentives and monitor performance are hotly debated. For example, advocates of "consumer-driven" health care argue that, given appropriate information and incentives, patients--or in some cases, private insurers acting on their behalf--can effectively impose at least some degree of market discipline on health-care providers. Others see an inevitable role for government in setting standards of care and in measuring performance. Professional associations, hospitals, medical researchers, and other stakeholders may also have a role to play. At the heart of the debate are the fundamental social questions of how we determine when various medical services are worth their cost and how we measure and reward good performance by providers.

Rising health spending increases stress on both private and public budgets, and thus stakeholders in both spheres are aiming to reduce costs. Cost-saving reforms in the private sector will inevitably reverberate in the public sector and vice versa. For example, the shift toward managed care in the private sector also resulted in more managed care in the public sector. Similarly, innovations in public insurance programs, such as the introduction of reimbursement by diagnosis-related groups in Medicare,

changed the way private insurance payments were structured.[15] Our health-care system is, de facto, a private-public partnership; as a result, governments should not view health-care costs narrowly as a budgetary issue. Rather, they should consider how the totality of government intervention in the health-care market--including tax policies, insurance regulation, and the structure of Medicare and Medicaid--affect the sector as a whole. The best way to reduce the fiscal burdens of health care is to deliver cost-effective health care throughout the entire system.

Conclusion

Let me conclude by restating a point I made at the beginning: As we focus on the problems of our health system, it is easy to forget that much is good about it. Our health system has produced innovations in basic science, in the understanding and diagnosing of disease, and in pharmacology and medical technology. These advances have resulted in more-effective treatments and significant reductions in mortality across a wide spectrum of diseases. In devising policies to reform our health-care system, we must take care to maintain the vitality and spirit of innovation that has been its hallmark.

[15] Diagnosis-related groups are a system for classifying cases into disease-related groups that are likely to require the same hospital resources, on average. In the early 1980s, Medicare began reimbursing hospitals a fixed amount per admission based on the diagnosis-related group rather than reimbursing them for the actual costs incurred for each patient.

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