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Statement of

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Chairman

Board of Governors of the Federal Reserve System

before the

National Bipartisan Commission
on the Future of Medicare

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Messrs Chairmen and members of the Commission, I am pleased to be here today and encouraged that the President and the Congress are undertaking a fundamental reassessment of the Medicare program. Since Medicare was established more than thirty years ago, it has provided the elderly with access to medical care. But the growth of Medicare outlays has continued to outstrip the growth of the rest of the federal budget, and we've been able to avert a full-blown financing crisis only through a series of marginal adjustments to the program. As you well know, the pressures will become increasingly intense as the baby boomers start to retire around the end of the next decade.

The challenge of adapting Medicare to meet our long-run needs is formidable and will require difficult choices. Delay could be costly. Action now would give all parties greater opportunity to adjust to a revamped program and would limit the severity of the possible dislocations that could result.

You will be hearing from health experts who will offer detailed information on Medicare options. You will also be considering how the burden of financing the elderly's medical care should be split between the government--and thus funded by taxpayers--and the elderly themselves. But, at a more fundamental level, you must address the basic question of how much our nation is willing to expend for the ever-increasing capabilities of medicine and, in the process, how we allocate the economy's scarce resources between Medicare and our many other competing needs. These latter issues will be the subject of my remarks today.

In some ways, health care is like any other good or service, and, in the absence of regulation, the share of consumer income going to medical care would reflect the trade-off of choices against other consumer desires. That share will vary from individual to individual depending on their incomes and their need for medical care. There is no predetermined share of income that should, in any abstract sense, be devoted to health care--either for an individual or for an economy as a whole--and an increasing share, or for that matter, a decreasing share, in itself, need not indicate a problem.

For most goods or services, prices reflect both the cost of the resources used to produce that good or service and the value of that good or service to consumers. Thus, prices are vital in the allocation of resources to their highest value uses. That is the process that maximizes standards of living. Households purchase most products directly from their income and assets. But some outlays, such as those to repair or replace a home damaged by fire, are potentially too large and uncertain to easily budget. Under such circumstances, individuals can gain from pooling their risks through private insurance.

Medical care has increasingly fallen into that category as costs have swelled. Clearly, individuals benefit from having insurance because it relieves them of concern about the possibility of devastating medical expenses. But, as is its purpose, insurance reduces individuals' sensitivity to the total underlying economic cost of care. Because individuals do not pay

the full incremental cost of services covered by insurance, they have less incentive to restrain the use of medical care and the adoption of technologies that divert resources from other highly valued nonmedical goods and services. Indeed, there is a tendency for the insured to seek any medical service expected to offer at least some benefit, regardless of its cost in real resources. It also is probable that this system supports the development of more new technology and greater diffusion of existing technology than would be the case were all medical care purchased directly from family resources. Such behavior is a manifestation of so-called "moral hazard," which is a characteristic of virtually all insurance markets. Of course, the private insurance system, reflecting the supply and demand for medical services, will adjust prices, that is premiums, to cover costs.

But, as medical costs have risen, they have exerted pressure on profit margins of businesses and indirectly on real wages of workers. Presumably in response, we have witnessed considerable innovation in recent years in private markets for medical insurance in an endeavor to contain inefficiencies and excess costs. The rapid expansion of managed care, in its many forms, is the clearest evidence of these efforts.

In the public sector, Medicare was initially designed to supply the elderly with insurance coverage similar in structure and scope to that enjoyed by the non-elderly population. Clearly, it remains an exceptionally popular program, but it has

not kept pace with changes in the private health care system. Unlike the market-driven private insurance system, cost pressures in Medicare are reflected mainly in the federal budget. There are no automatic signals such as those that balance supply and demand for medical care in the private sector. Hence, in managing Medicare, we must be particularly sensitive to the fact that, like any product, medical care is produced ultimately by the work of individuals, and the more human effort that is expended to provide medical care, the less effort that is available for making other highly valued products.

Thus, a key question confronting this Commission is whether the current stance of public policy, lacking a market test, is altering medical demand in a way that distorts economic choices and lowers overall productivity and standards of living. If Medicare is to be sustained as a viable program, it is important that this question ultimately be answered in the negative.

If the answer is ambiguous, or in the affirmative, the Commission may wish to recommend that the Medicare program be reshaped in a way that would encourage beneficiaries and medical providers to make more cost-effective decisions than many do now. If successful, this approach would reduce the resources used per unit of health care produced, presumably lower overall health care expenditure growth from an unsustainable trajectory, and help ensure continued access to affordable care for Medicare beneficiaries.

As I noted, the private medical marketplace has been moving

rapidly in this direction in recent years. The adjustments have not always gone smoothly, but institutions, acting on behalf of individuals, are increasingly confronting the trade-offs between the consumption of health care and the consumption of other goods and services. That process may have received a push in 1989 when the Financial Accounting Standards Board circulated a draft rule to require companies to record future contingent medical costs for retirees on their balance sheets and make appropriate charges against current income. That rule was subsequently adopted and, perhaps by happenstance, roughly coincided with the onset of a major effort by American businesses to contain medical costs for all workers.

In any event, much of the working-age population now belongs to health plans that actively manage care in order to hold down costs. In part, this is accomplished by offering incentives to providers to practice cost-effective medicine. For example, we are seeing a closer scrutinizing of services delivered by highly paid medical specialists, some of whom have experienced a decline in compensation in recent years.

It is regrettable, but probably inevitable, that moving from an unconstrained fee-for-service system to a more cost-effective one is perceived by some patients as a major reduction in the quality of care. While the extent is arguable, any shift away from nearly unlimited use of even only marginally beneficial procedures will be seen as a reduction in quality, irrespective of the size of the savings of real resources devoted to that

marginal increment of care. There is always one more test that will reduce the risk, however infinitesimal, of a misdiagnosis.

Businesses' efforts to rein in payments for health insurance are also forcing employees to think more about the trade-offs between additional company-financed medical insurance and higher wages.

These developments have helped stem the uptrend in the share of GDP going to health care, which caused so much concern just a few years ago. Nonetheless, Americans still devote a far higher share of GDP to medical care than does any other major industrial country. In the past few years, medical costs have amounted to about 13-1/2 percent of our GDP, compared, for example, with about 10 percent for Germany and France and about 7 percent for Japan, Sweden, and the United Kingdom.

From an accounting perspective, the difference between the percentage of GDP that we devote to health care and the percentage in Germany or France appears to reflect mainly our higher pay for doctors and other medical practitioners relative to the average wage in the economy and our measured higher administrative costs. It is difficult to obtain comparable net administrative cost estimates because our system includes a closer monitoring of costs by private insurers, which presumably reduces other costs. Among the industrial countries that devote the lower shares of GDP to health spending, the health share in the U K, for example, is further depressed relative to ours by fewer doctors per capita and less high-tech equipment. Almost

certainly, our system produces the most sophisticated, and perhaps the highest quality, medical care in the world. But we have little evidence that, as a result, our population is any healthier, on average, than those populations that devote fewer resources to health care, recognizing, of course, that health outcomes depend on a host of other influences in addition to the level of medical expenditures.

Whether the share of our GDP going to medical care will remain flat over the next few years--or whether it will start rising again--is uncertain. But it almost surely will increase as the baby boomers move into the age brackets in which medical costs tend to accelerate. Indeed, on average, medical outlays for persons aged 65 and over are nearly four times the size of those for persons aged 19 to 64 and roughly seven times those for persons under age 19. Currently, 12-1/2 percent of the U.S. population is age 65 or older. This share is not much greater than it was twenty years ago, indicating that aging alone has played a relatively minor role in explaining the growth in aggregate health spending over the past two decades. But, by 2030, shortly after the last of the baby boomers has turned 65, the elderly are expected to account for about a fifth of the population. A simple calculation suggests that, all else being equal, the projected change in the age distribution of the population over the next thirty years will add nearly 20 percent to the level of health care spending.

Demographics aside, the trajectory of health spending in

coming years will depend importantly on the course of technology, which has been a key driver of per-person health costs. To be sure, technological innovation improves the quality of medical care, but its effects on overall costs are not always clear-cut. Technological innovation can decrease the cost of a given course of treatment and thus has the potential to reduce overall costs. But it also can expand the range of treatment options, with the potential of adding to overall costs. Advances in arthroscopic surgery, for example, have greatly reduced the cost and difficulty of repairing many kinds of knee damage, but the new techniques doubtless have contributed to the enormous increase in the number of knee surgeries that are performed each year.

The future path of medical, indeed all, technology is exceptionally difficult to forecast. Many effective new technologies result from synergies of two or more previously developed technologies. Remarkably, when the laser was invented about forty years ago, lawyers at Bell Labs reportedly did not rush to seek patents because they thought it had little bearing on Bell System interests. In fact, its full potential could not be realized until the development of fiber optics, and the synergy of the two is one of the most powerful and versatile advances in telecommunications technology in the twentieth century. Examples in medicine abound as well. For instance, organ transplantation was a huge technological advance whose effectiveness was greatly enhanced by improvements in immunosuppressant drugs.

Despite the consensus among economists that technology is a driving force behind rising medical costs, the empirical evidence in this area has been limited. Fortunately, that situation is beginning to change. Some recent studies that focus on specific medical conditions provide useful insights into both the cost-decreasing and cost-increasing aspects of technology. For example, analysts have documented a sizable saving in the cost of treating cataracts, which thirty years ago required a long operation and extended hospital stay but is now routinely done on an outpatient basis.¹ In contrast, a separate study exhibited the potential for technology to raise costs.² This study examined the appreciable increase in Medicare outlays to treat heart attacks between 1984 and 1991, which the authors attributed entirely to the dramatic expansion of intensive cardiac surgeries.

The new technologies also carried other significant benefits, contributing both to enormous improvements in the post-operative vision of cataract patients and to longer life expectancies and higher quality of life among heart attack survivors. Parenthetically, this is the same measurement issue that chronically bedevils economists who try to allocate changes

¹Matthew D. Shapiro and David W. Wilcox, "Mismeasurement in the Consumer Price Index: An Evaluation," Macroeconomics Annual (National Bureau of Economic Research, 1996)

²David M. Cutler and Mark McClellan, "The Determinants of Technological Change in Heart Attack Treatment," Working Paper 5751 (National Bureau of Economic Research, September 1996)

in dollar outlays on medical procedures between changes in price and changes in real output. The problem arises for any good or service for which changing technology is greatly affecting the characteristics and quality of the output.

Measurement issues aside, the fundamental point here is that a structure that provides appropriate incentives for the development and application of technology is key to a well-functioning health care system. In this case, an appropriate incentive is one that encourages technologies whose benefits are at least equal to their economic costs, while discouraging those that do not meet that standard. It is still too soon to know how the evolving incentive structure in private insurance markets will affect the pace of medical technology. However, a recent analysis provides some preliminary evidence that managed care may be fostering a more efficient use of technology.³ If the results continue to be borne out in the marketplace, we may be seeing the beginning of a significant restraining effect on the growth of health costs over the long run.

Clearly, the jury is still out on many of the changes in private health insurance markets, and some may turn out to be unsuitable for Medicare. But some of these ideas, especially those that improve efficiency or foster greater cost-consciousness among users and providers of health care, are worthy of study. In that regard, some Medicare beneficiaries,

³David M. Cutler and Louise Sheiner, "Managed Care and the Growth of Medical Expenditures," Working Paper 6140 (National Bureau of Economic Research, August 1997)

attracted by the rich benefits packages offered by some HMOs and frustrated by high Medigap premiums, have enrolled in these plans, and the Balanced Budget Act of 1997 expanded the range of options available to participants. Nonetheless, Medicare remains largely a fee-for-service program. Unless its disparities with the private sector are addressed, political support for Medicare may well begin to wane, especially if escalating Medicare costs force tax increases or reductions in other government programs that serve important functions.

Regardless of what changes are eventually put into place, the nation should be prepared to revisit the issue of Medicare reform--perhaps many times--as unanticipated technological changes alter medical practice and private insurance markets evolve. Other broad economic and social trends--for example, unforeseen changes in labor market activity among the elderly--may also make adjustments in the structure of Medicare desirable.

Perhaps the hardest issue with which you will have to grapple is the very real possibility that the projected demands by Medicare recipients exceed a realistic estimate of our budgetary capabilities. Medical rationing is anathema to the American psyche, though it often appears in subtle forms. We know, for example, that we can never offer all new technologies or medical procedures immediately to all patients who would benefit. In practice, new technologies are allocated by physicians who use their own criteria to choose the recipients. In this case, the system likely works largely because an

innovation that was not previously available does not seem to be missed except by the most knowledgeable. That might not be perceived as fair, but the thought of our political system attempting to improve the process gives me great concern.

Medical decisions have always raised difficult ethical considerations. We expend vast resources to prolong life a few weeks or a few months whereas some other democracies rely more on hospice care and restrict the use of scarce equipment, especially among older persons. We practice super high-tech medicine although, as I suggested earlier, it is not clear how much it raises average life expectancy or reduces morbidity.

It is difficult to discern a consistent American standard in these matters. When it comes to medical care, we seem to hold life as an unequivocal value with pressures to fend off death by any means, regardless of the costs in real resources. Yet we tolerate more than 40,000 motor-vehicle-related fatalities a year when modest restrictions on car use could lower the casualty rate. The value of travel freedom and convenience clearly outweighs life as an inviolate value. People demonstrate through their behavior a willingness to risk life for other values. Indeed, risk is inherent in life and can be contained, but never eliminated. Given the disparity between the way we deal with risks in health and the way we deal with risks in other aspects of our lives, one might expect a more calibrated real cost-benefit analysis to emerge eventually as health care policy matures.

Before concluding, I'd like to offer a few points about the experience of the Social Security Commission of 1982 that may be relevant to your deliberations. First, I believe that the Commission, which I chaired, succeeded, if that is the word, because, from the start, it was integrated with the political system. I kept President Reagan's chief of staff James Baker informed of our deliberations on an ongoing basis. Robert Ball, the former Social Security Commissioner and social insurance professional, kept the Speaker informed. Many members of the Congress also were members of the Commission. Senators Dole, Heinz, and Moynihan and Congressmen Archer, Conable, and Pepper. The interplay between the deliberations of the Commission and parallel policy discussions in the White House and the Congress was continuous, ensuring political support for the final product. Had we not done that, the report would have ended up on the dust-filled shelves along with the many fruitless Commission reports of the past.

In the end, the large majority of the Commissioners, the President, and much of the Congressional leadership signed onto the principal recommendations in the Commission's final report. Tactically, we chose to do something unusual to help ensure that our recommendations would be implemented. As with all tightly crafted compromises, pulling one provision might have caused the whole structure to unravel. Therefore, Robert Ball and I, the designated presenters of the Commission's findings to the Congress, agreed to defend the report in total. The internal

debates within the Commission were behind us, and we exhibited a unified front to the Congress. In the end, the legislation that passed differed little from the Commission's recommendations.

In conclusion, programs to support a rapidly expanding aged population threaten budget balance in the early decades of the next century. Preemptive action could avoid wrenching disruptions to our federal medical programs and our economy. The longer we wait, the more difficult the adjustments. Moreover, I have no doubt that the budget discipline of recent years has been instrumental in lowering long-term interest rates--a key factor in our current economic vitality. Unless this discipline can be sustained, our overall economic performance will be seriously jeopardized. If this Commission can assist in expediting the seemingly necessary adjustments to Medicare, the nation will owe you an enormous debt of gratitude.