



ELECTION 2008

Three “Inconvenient Truths” about Health Care

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A strong case for comprehensive reform of the U.S. health care system has been made many times. The high cost of care, the large number of uninsured people, and the rapid increase in expen-

ditures year after year have convinced many that our system is a mess. The obstacles to reform, however, are numerous and complex and have thus far proved insurmountable. The present impasse must give way to recognition that major change will not be an option much longer: it will be a necessity. Divergent interests and values must find some common ground, and all sides must acknowledge that the status quo is no longer sustainable, given three “inconvenient truths” about health care.

1. Over the past 30 years, U.S. health care expenditures have grown

2.8% per annum faster, on average, than the rest of the economy. If this differential continues for another 30 years, health care expenditures will absorb 30% of the gross domestic product¹ — a proportion that exceeds that of current government spending for all purposes combined.

The negative implications of such increases for the support of education, infrastructure, national security, capital investment, and ordinary consumption would be huge. Alice Rivlin, who served as director of the Congressional Budget Office, director of the President’s Office of Management and Budget, and vice-chair of the

Federal Reserve Board, has written, “The principal challenge to achieving a sustainable long-run fiscal policy turns out to be reducing the rate of growth of health spending — all health spending, not just the federal or the federal/state portion.”²

Much discussion of reform concentrates on covering the uninsured. This is a worthy goal, but without sustained attention to the cost of care, gains in coverage will not be sustainable. At present, the United States spends about twice as much per person on health care as the average high-income country. An absolute reduction in that level of spending would be desirable but is not likely. The most tempting targets — “waste,” “fraud,” and “abuse” — have proven remarkably resistant to attack.

A major reason why it is so

difficult to reduce costs is that every dollar of health care spending is a dollar of income to someone involved in providing health insurance or health care. Administrative costs are undoubtedly too high, and insurance companies taking excess profits and executives with high salaries are frequently blamed. But they are only a small part of the story. The biggest part consists of payments to tens of thousands of telephone and computer operators, claim payers, insurance salespersons, actuaries, benefit managers, consultants, and other low- and middle-income workers. Overutilization of care is another problem that is not easily solved, partly because unnecessary or marginally useful tests, prescriptions, operations, and visits generate income for providers.

More regulation won't do much to reduce administrative costs or overutilization. On the contrary, in most industries, regulation has usually raised costs. The only way for the country to restrain costs without hurting quality is to make major changes in the way health insurance is financed and the way health care is organized and delivered. A realistic — and over the long run the most important — goal for health care reform is not to reduce costs but to slow their rate of growth.

2. Advances in medicine are the main reason why health care spending has grown 2.8% per annum faster than the rest of the economy.³

But advances in diagnostic and therapeutic interventions have

been largely responsible for increases in the length and quality of life. How can we retain most of the health benefits of future medical advances while slowing the rate of growth of health care expenditures?

Part of the answer lies in the creation of a large, semi-independent organization — something like Britain's National Institute for Health and Clinical Excellence — to evaluate the benefits and costs of new medical interventions. Such an organization must have a substantial budget, because new interventions flood the market every year and new applications of older technologies add to this problem. It is not feasible for individual physicians or even large groups of physicians to carry out the necessary analyses, especially when estimates of costs and benefits are indispensable. Furthermore, the funding for such an organization must be relatively steady over time; funding based on the vagaries of annual Congressional appropriations have doomed previous governmental initiatives for technology assessment.

The other part of the answer is for health care organizations to be willing and able to incorporate the assessments into their daily practice. They must have the information, infrastructure, and incentives to deliver high-quality, cost-effective care. This does not mean that they must be fully integrated group practices. It does mean that they must create mechanisms, relationships, and processes to achieve the coordination of care that today's patients and today's health care technologies require.

3. Universal coverage requires subsidies for the poor and those too sick to afford insurance at an actuarially appropriate premium; it also requires compulsion for those who don't want to help pay for the subsidies or who want a "free ride," expecting that they will get care if they need it.

No country achieves universal coverage without subsidization and compulsion, but U.S. politicians tie themselves and the health care system in knots by proposing reforms designed to conceal these realities. Politically, the most appealing plans are those that mislead people into thinking that someone else is paying for their insurance. Currently more than half of insured Americans obtain their coverage through employment, and workers have been led to believe that their employer bears most of the cost of their care — a belief that labor-market experts have concluded is invalid.⁴ When a firm pays \$3,000 to \$7,000 per worker per year for health care, it can get that money in only three ways: reducing potential wage increases, increasing prices for what the firm sells (which means lower real wages for workers everywhere), or lowering profits.

During the past three decades, health insurance premiums have increased about 300% (after adjustment for general inflation). Where did the money come from for higher premiums? Out of wage increases that would normally accompany growth in productivity. During these three decades, the average worker has not received any increase in inflation-adjusted wages. Corporate profits, by contrast, have in-

creased by 232% before taxes (284% after taxes), adjusted for inflation.⁵ The belief that employer contributions to health insurance come out of corporate profits rather than workers' real wages reflects the triumph of hope over experience — and represents a tremendous obstacle to gaining public support for a more efficient, more equitable way to pay for health insurance.

The confusion about employers' role is paralleled by confusion about government's role. Politicians often claim that the government is "giving" people health insurance. In fact, every dollar the government spends on health insurance must come out of the public's pocket. If the government is acting responsibly, the money will come in the form of taxes. If irresponsibly, it will be borrowed, creating debts for which

future generations will have to tax themselves in order to pay interest and principal.

The most efficient, equitable way to achieve universal coverage is to make basic health insurance available to everyone regardless of income, employment status, family circumstances, or other characteristics and to pay for it with a tax roughly proportional to income or consumption. In such a system, the wealthy and the healthy would subsidize insurance for the poor and the sick. Persons of average income and average health would pay enough to cover the cost of their own insurance.

The long-running debate about health insurance and health care that is continuing this fall will be more constructive, and possibly more fruitful, if all the participants would take these "incon-

venient truths" as a starting point.

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ELECTION 2008

Slowing the Growth of Health Care Costs — Learning from International Experience

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High health care expenditures and the growing number of people without health insurance set the United States apart from all other industrialized countries. The United States spends twice per capita what other major industrialized countries spend on health care^{1,2} but is the only one that fails to provide near-universal health insurance coverage. We also fail to achieve health outcomes as good, or value for

health spending as high, as what is achieved in other countries (see graphs).

The United States has been slow to learn from countries that have systematically adopted policies that curtail spending and enhance value. Chief among these are mechanisms for assessing the comparative cost-effectiveness of drugs, devices, diagnostic tests, and treatment procedures; implementation of information tech-

nology, including electronic repositories of patient medical information, across sites of care; easy access to primary care, including organized systems of off-hours care; a strong role for government in negotiating payment for care; and payment systems that reward preventive care, management of chronic conditions, care coordination, and health outcomes rather than volume of services.