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**Family Well-Being, Public Policy and Economic Growth:
Lessons from History and Insights for the Future**

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U.S. Health Care Challenges

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JACK EBELER: Thank you. I have a couple problems speaking here today. One is that you have an eminent economist and historian presenting a paper, and comments by political scientists, attorneys, and economists. I'm the other guy on the panel. (Laughter.)

The second is that I come with two biases. One is that Dr. Lindert's work is extraordinarily appealing to me because it points in policy directions that I am very positive about. By the same token, over many years, I have learned to be – and try to force myself to be – very skeptical of strong analytic work that supports my personal opinions because something must be wrong with it – (laughter). I worry about playing the Washington game of “I like that study, it proves my point, now move on.”

Finally, I'm here to talk about the area where our country has screwed up according to this work, which is healthcare. I'm going to cover some basics in healthcare, the messiness of the U.S. system in the analytic model that Dr. Lindert has laid out, and then propose a view of this work through the lens of what is called variations literature in healthcare, and then finally, touch on some issues for review.

The basics

The quick overview is that U.S. healthcare spending as a percentage of GDP has grown consistently for many, many decades. Those of us who derive our revenue from healthcare thank all of you for this; we appreciate the support. (Laughter.)

The U.S. spends more on healthcare than any other nation, far more than the OECD average. Our spending is not only well above the OECD median but also well above even the next highest country, Switzerland.

And as has been pointed by other speakers, we have shown that you do not have to have high social welfare spending to run large government deficits. CBO's deficit projections highlight a point that Itai made, that we have a potentially false presumption that the deficit will improve in the next couple of years under the 'current policy' baseline. But if you extend the current tax cuts and do something about the AMT, the deficit in fact gets worse. Again, this is not because we have high social spending. It is because we have not balanced our appetite for taxes with our appetite for spending, even though we have lower social welfare spending than other nations.

As is pointed out in Dr. Lindert's paper, the U.S.' higher level of health care spending is not coupled with higher health status or health outcomes, and it certainly isn't accompanied by better health coverage. The dominant source of coverage for those under age 65 is the employment-based system that, as earlier speakers noted, is in some ways an artifact of wage-price controls during WWII. That is the main source of health coverage in the country, covering more than 60 percent of the population, but it is slightly declining in recent years. Public coverage, largely the Medicaid program, has picked up some of the slack. Individual coverage has remained stable. The uninsured, those who fall in the gap between the public and private systems in our county, are a growing percentage of the population.

The US health care system

Second, let's look at the messiness of the U.S. health care system in the context of an analysis like this. It is hard to categorize the U.S. system in the clean terms of the revenue sources that Dr. Lindert talked about. Let's look at Medicare, Medicaid and private insurance.

Medicare is seen as our classic national social insurance program but it is really very diverse. We finance it, not only with payroll taxes but also with taxes on Social Security benefits for higher-income individuals. We have premiums, and we're moving to means-tested premiums, and there are subsidies for the low-income Medicare savings programs, and a much more comprehensive drug benefit with virtually no premium for the low income.

Prior panelists were talking about growth in Medicare and social welfare programs as a percentage of GDP. Medicare is the prime example of that in the U.S., consistent with what Dr. Lindert was saying. The majority of the growth in Medicare as a percentage of GDP between now and 2050 isn't because of aging; it is because healthcare costs grow faster than the rest of the economy. Aging itself only accounts for about 40 percent of the growth; the rest is due to underlying healthcare cost growth.

Medicaid, our other major public program, backstops Medicare among many other functions. It covers about a fourth of the Medicare population, and the most expensive fourth at that. It also has multiple streams of financing: federal general revenues, state general revenues,

as well as whatever creative sources of financing states have been able to come up with to finance their share of Medicaid.

Medicaid is really multiple programs. About half the beneficiaries are children, but they only account for about 20 percent of the spending. At the other end of the spectrum, about a fourth of the beneficiaries are elderly and disabled, and they account for more than two-thirds of the spending. Medicaid functions as our nation's default social insurance program for long-term care.

The private health insurance market in the country is equally diffuse. We spent about \$1.9 trillion on healthcare in 2004. I love using the word trillion in mixed company. (Laughter.) About a third of that, \$658 billion, was private health insurance premium. That share alone is about 5.6 percent of GDP, which if counted as social welfare spending would move us substantially towards Dr. Lindert's definition of a social welfare state. Employers pay about 70 percent of those premiums; employees pay about 30 percent. And while this is a private flow of money, there is about a \$106-billion tax subsidy in the form of tax expenditures, because we do not tax those employer payments as income to individuals. That is about 1 percentage point of GDP of revenue that we forgo to subsidize that private transaction. That is a subsidy that flows disproportionately to those of us who are fortunate to have good health insurance package and those of us with higher income – the higher your income, the more that subsidy is worth.

International variations, and variations within the U.S.

I want to turn now to the variations literature. There is a lot of work in the U.S. health community on variations in care and costs around the country. And I think we can look at Dr. Lindert's work, internationally, in that context. Again, he lays out the U.S. – international variations. The U.S. spends about 38 percent more on health care than the average of the next highest three countries, and about 72 percent more on healthcare than the median of OECD. This includes all healthcare spending, public and private, in these countries – so he confirms that there are enormous variations around the world.

If we look at the United States Medicare data, the Dartmouth team – this is Elliot Fisher's work – has divided Medicare up into hospital referral regions around the country. They have adjusted for all those things that one can adjust for that could be causes of underlying cost and care differences, and divide us up into spending quintiles. They find variations that are similar to the international variations. The highest quintile of regions in the United States spends on Medicare about 28-percent more than the middle-spending quintile and about 61 percent more than the lowest-spending quintile. So there are enormous differences in spending for a program where the insurance package is the same around the country.

And again, as with international variations, you ask, does that higher spending get you much? Looking at the same quintiles, we see that the quality indicators across those quintiles are at best flat and in fact trend down in the higher spending areas. So you spend 28-61-percent more in the highest spending quintile, and you don't appear to get much, if anything, for it in this analysis.

Taking it up to the state level, you see a number of states that seem to have relatively lower spending and relatively higher quality compared to states, which are spending more and getting less. Even setting aside the extremes, there is about a 30 percent spending difference among the high cost, low quality states and the low cost, high quality states. So looking at these types of variations, it may well be that the best question is not how does the U.S. get to OECD averages, but how and why do some areas and states already appear to have accomplished, within this country, levels of spending that look comparable to the levels we see in Switzerland and Germany, and with better health quality than their higher spending neighbors?

What is the cause of these U.S. variations? The key variant in this country appears to be the delivery system – the supply side. It is supply-induced demand. The high-cost, low-quality areas seem to have more hospital beds, more physicians overall, and in particular, more specialists and fewer primary-care physicians. And in a fee-for-service economic model, that yields more discretionary services in those communities, without improvements in health care quality.

Questions and issues

Lets turn now to some questions and issues that I think are interesting in Dr. Lindert's work. Is healthcare in his analysis an issue for the U.S. because it limits GDP growth, that we are simply not getting value for the dollar, or something else?

I love hearing there is no equity efficiency trade off. In this case, no is a very large number; I'm encouraged by that but it strikes me as a finding that is worth pushing at and confirming a little bit. The final question is: should we be concerned about Medicare? It does grow substantially. We spend a lot more on the elderly than on other groups in the country. David Cutler, as some of you know, just came out with a very interesting article that finds that our spending and spending growth on healthcare in the United States has in fact produced value and, he converts that into a calculation of the cost per years of life gained as a result of the extra spending.

But even in that very supportive article about higher spending in the United States, he flags some long-term issues. We're spending \$36,300 overall per year of life gained, but for those over 65, we are spending a lot more, about \$145,000. And the trend line keeps pointing up for the elderly, so it is certainly worth looking at.

Also, there are four policy issues; I'll talk about three of them. The fourth is Medicaid. But I don't hear Medicaid under attack so I don't think I need to defend it today.

What do we do about health coverage expansions? There is one potential reading of a work like Lindert's that says single payer is "the" answer. That is an awkward solution in the United States where we are more likely to answer the question with some type of revised private-plus-public combination. Can we get there? It strikes me that the interesting question posed by Lindert's work is how would we finance the combination that we choose?

Given his analysis, the value-added tax is, obviously, a very attractive option to look at. I think the difficulty in this country is that the conservatives see it as a way to replace existing taxes and have probably spent it twice that way. On the spending side of the equation, liberals see it as potential new revenue and have spent it three times in fixing Social Security, fixing Medicare, providing national health insurance. So it is difficult to see how exactly we get to a decision about the VAT.

Do we really care and should we care about international cross comparisons? The main differences between the U.S. and other countries are that we have higher unit prices and revenue within the healthcare system for what we do – doctors, hospitals, and elsewhere. How do we deal with that?

And second, we have higher administrative costs – as Dr. Lindert point out, we have multiple public and private payers, a whole structure of private health insurance. And the real challenge is that those types of payers have to more clearly demonstrate value. If all we are doing is being transactions processors, one should assume over time that we should be paid as a transaction-processing commodity as we go forward. But that is a fundamental question of demonstrating value for the administrative load, or seeing fundamental change.

Finally, we have to look at the cost-quality variation within the country and do something about the volume differences around the country. Again, this appears to be a very important delivery system/supply issue and it may be a window through which we can look at international comparisons as well. And we can say that we are different than those other countries, but look at the comparable variations within the countries. Can we norm against the more efficient areas within the United States, which have achieved, in some cases, European-level efficiencies in their healthcare system?

I want make sure we end on time, so thank you very much. I look forward to the discussion.

(Applause.)