



OccasionalPaper 92

## American Health Care Policy Issues

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# American Health Care Policy Issues

by Arnold Kling

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## Introduction

On February 25, 2010, President Obama met with Congressional leaders for several hours in an attempt to iron out differences and move forward on health care reform. Although this "health care summit" failed to produce a legislative agreement, there was a consensus on several matters. Democrats and Republicans both expressed the view that America has "the greatest health care system in the world." Both sides agreed that gaps in health insurance coverage affect many Americans. Both sides cited research suggesting that roughly one-third of spending on health care in the United States goes for medical procedures that are ineffective. Both sides pointed out that standard projections show that health spending in the major government-funded health programs – Medicaid for the poor and Medicare for the elderly – are on an unsustainable path.

This paper will be organized around these areas of agreement. The commonly-held views are likely to shape the direction of health care reform in this country, not only in 2010 but over the next decade. The belief that America has the world's greatest health care system implies limits on how much reform the public is willing to accept. Gaps in health insurance coverage are a source of frustration and an impetus for changes in government policy. The belief that Americans waste resources on health care raises the issue of who should be empowered to make different choices. The unsustainable projected fiscal path suggests that politically unpopular reforms are on the horizon.

## The World's Greatest Health Care System?

The World Health Organization's *World Health Report 2000* ranked the American health care system as the 37<sup>th</sup> best in the world<sup>1</sup>. Implicitly, this rather mediocre ranking was rejected by the participants in President Obama's summit, who instead affirmed that United States has the best health care system in the world.

The contrast between the view of America's leaders and that of the World Health Organization shows that not everyone shares the same values or the

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1 World Health Organization, *The World Health Report 2000: Health Systems: Improving Performance* (Geneva: WHO, 2000), <http://www.who.int/whr/2000/en/index.html>

same perspective when it comes to health policy. Glen Whitman, an American economist, subjected the WHO rankings to a critical analysis.<sup>2</sup> He points out that three of the five main factors, accounting for 5/8 of the weight in WHO's ranking system, are distributional in character. For such measures, a country in which every citizen receives equally bad health care paid for with tax dollars would be scored better than a country where more costs are borne privately or where some citizens receive excellent care and others receive only good care.

To an American, the WHO ranking system comes across as excessively focused on distributional issues. Americans prefer to look at what we call "the bottom line:" What is the quality of care that individuals receive? Our system ensures that poor people have access to care, through the Medicaid program and through subsidies to hospitals so that they will treat people who lack health insurance. Beyond that, however, WHO's focus on equality would strike many Americans as a strange fetish.

The point here is not to argue that American priorities are correct and that WHO's rankings are mistaken. Instead, I am suggesting that the American health care system probably reflects American values fairly well. If our system seems undesirable to people from other countries, that may in large part reflect cultural differences that focus on different values.

American culture tends to include a strong faith in progress. We believe that medical research and innovation have improved the quality of life, and we expect this to continue in the future. Americans expect our scientists to one day find cures for cancer, Parkinson's Disease, Alzheimer's Disease – indeed for every major ailment, and for many lesser ones as well. Nobel Laureate Gary Becker has commented that perhaps this faith in progress explains why so many young Americans are obese.

Is it irrational to gain weight? Not necessarily. If I were a teenager now, I might well decide that the consequences won't be so bad. We already have drugs to mitigate high blood pressure and high cholesterol, and we'll probably see similar progress with diabetes, the disease most closely associated with obesity.<sup>3</sup>

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2 Glen Whitman, *WHO's Fooling Who? The World Health Organization's Problematic Ranking of Health Care Systems*. Cato Institute Briefing Papers No. 101, February 28, 2008. <http://www.cato.org/pubs/bp/bp101.pdf>

3 "The Nobel Roundtable: Arrow, Becker, Milken and Scholes tell it all to you," Milken Institute Review, July 2007, p. 89-90. [http://www.milkeninstitute.org/publications/review/2007\\_7/84-93MR35.pdf](http://www.milkeninstitute.org/publications/review/2007_7/84-93MR35.pdf)



Economists Kevin Murphy and Robert Topel estimated that the value of gains in health and longevity that accrued between 1970 and 2000, if included in the national income accounts, would have increased annual GDP by 50 percent over the conventional measure.<sup>4</sup> William Nordhaus has drawn similar conclusions.<sup>5</sup> Using a variety of methods, various authors have attributed very large benefits to medical research.<sup>6</sup>

Daniel Callahan, a medical ethicist who is highly critical of America's health care system, recognizes the ways in which it reflects our values. In his book *Taming the Beloved Beast*, Callahan attacks

the super-elevated stature given to steady medical progress and technological innovation in American culture, medicine, and industry. Progress and innovation seem self-evidently valuable, not to be questioned. The frightening thought that the innovation that has saved so many lives and reduced so much suffering could itself be playing a leading role in our health care discomfort is hard to accept, difficult to talk about openly, and politically controversial<sup>7</sup>.

He continues,

I do not believe that we can effectively cope with the practical managerial, organizational, and policy issues without attempting to change many underlying cultural, social, and ethical premises. We have a culture addicted to the idea of unlimited progress [...]. American health care is radically American: individualistic, scientifically ambitious, market intoxicated, suspicious of government, and profit-driven. I put changing those values within health care in the class of a cultural revolution dedicated to finding and implementing a new set of foundational values<sup>8</sup>.

I do not share Callahan's antipathy toward American cultural attitudes. However, I do agree that those attitudes help explain some of the differences between health care in the United States and health care in other countries.

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4 Kevin M. Murphy and Robert H. Topel, "The Value of Health and Longevity," *Journal of Political Economy*, 2006, vol. 114, no. 5.

5 William D. Nordhaus, "The Health of Nations: The Contribution of Improved Health to Living Standards," NBER Working Paper No. 8818, February 2002.

6 Kevin M. Murphy and Robert H. Topel, *Measuring the Gains from Medical Research: An Economic Approach*, University of Chicago Press, 2003.

7 Callahan, Daniel, *Taming the Beloved Beast: How Medical Technology Costs are Destroying our Health Care System*. Princeton University Press, 2009, p. 2.

8 *ibid*, p. 7.

Canada's single-payer health care system is frequently cited as a good example by Americans who would like to see a similar system here. However, Americans often encounter anecdotal evidence that when Canadians want state-of-the-art medical care they come south. Indeed, at President Obama's health care summit, one of the participants mentioned the story of Newfoundland Premier Danny Williams, who, when queried about his decision to come to the U.S. for heart surgery, replied, "But this is my heart. It's my health and it's my choice."<sup>9</sup>

Americans place a high value on medical procedures that offer hope, even when the chances of success are not very high. I saw this with my own father, who at age 88 and with terminal cancer of the esophagus, suffered a broken hip. He received hip surgery, and attempts were made to give him rehabilitation. He was given treatment in eight different medical units in two weeks. While the intentions of the health care providers were heroic, their efforts did not save his life or spare him a painful final month. He died three months later, without ever leaving the hospital or walking again.

Overall, over one-fourth of Medicare spending (or about 10 percent of all U.S. health care spending) goes for patients in the last year of life. Studies suggest that we could greatly reduce the number of procedures performed on terminally-ill patients without adversely affecting outcomes. However, this would require significant changes in cultural norms. In the United States, it is simply considered wrong to allow someone to die when there is the means to prolong life. It is considered wrong to deny someone a procedure that might cure his or her ailment, even if the cost is high and the chance of success is remote.

Again, Daniel Callahan is a critic, as he describes

one of the endemic problems of end-of-life care, that of embracing hope and unlikely treatments and of refusing to grant the obvious fact that the patient is dying. Do not give up: provide one more round of chemotherapy<sup>10</sup>.

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9 „Newfoundland Premier Danny Williams defends U.S. treatment," National Post, February 22, 2010. <http://www.nationalpost.com/story.html?id=2599186>

10 Callahan, *Taming the Beloved Beast*, p. 15.

Later, he writes,

There is a need for a public and professional recognition of the finiteness of life and resources. That would mean a different set of underlying values about health, aging, and death – a truce with them in place of the present and increasingly expensive war against them<sup>11</sup>.

It is not just terminally ill patients who absorb disproportionate medical resources. Americans are willing to see hundreds of thousands of dollars spent on a single at-risk infant or an individual with a complex chronic illness.

In summary, American culture places a high value on medical progress. We view our doctors as engaged in a heroic struggle against death, even when people are very old and very sick. We believe that treatment is justified even if it offers only slight hope for relief. Some of the peculiarities of our health care system reflect these preferences. Relative to our values, we probably do have the best health care system in the world.

Nonetheless, the consensus at the President's health care summit was that America's health care system has serious problems. In the following section, I turn to these issues.

## **Haphazard Insurance**

How can the world's richest nation have roughly fifteen percent of its population carrying no health insurance whatsoever? In other respects, our system is not so different. We are not the only country where health insurance is not uniform – in Switzerland insurance varies by canton and in Canada the health system varies by province. We are not unique in the share of health care spending paid for by consumers – in fact, the share of personal health care spending paid for out of pocket in the United States is only 12 percent, a bit below average among OECD countries.

What is unique about our health insurance system is that it has no central design. Other countries' central governments designed their health care systems, mostly in the decades following the second World War. Instead, our health care

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11 Callahan, *Taming the Beloved Beast*, p. 217.

system inherited some of its key institutions from before and during the war, and it has evolved in a haphazard fashion since. Even recent reform proposals are heavily conditioned by previous reform efforts, so that they would not fully close gaps in insurance coverage or create a system that flows from a single consistent design.

Modern American health insurance began in the 1930's with Blue Cross and Blue Shield, which are still major insurance providers today. These were an intermediary between doctors and groups of patients, with the groups typically consisting of workers in the same occupational trade or from the same employer. The Blues offered assurance to consumers that the cost of treatment would be covered, and they offered assurance to doctors and hospitals that they would be paid. The health care providers were more interested in obtaining reimbursement for services than in providing individuals with something that an economist would consider to be insurance.

Insurance, such as fire insurance, covers catastrophic events. Consumers rarely make claims, but when they do make claims the amounts can be large. The premiums are relatively low.

In contrast, health insurance in the American tradition of the Blues works more like a prepaid health plan. Consumers file claims whenever they obtain medical care, even for small dollar amounts. Premiums have to be high enough to cover all of the health expenditures of an average consumer. As medical technology has advanced, average health expenditures have soared, and premiums have risen accordingly.

The Blues offered no mechanism for fixing the health care budget. They did not challenge the doctors on their medical decisions or prices charged. In short, they did everything to encourage the use of medical procedures and nothing to restrict the incomes of health care providers. Given that they were created by doctors and hospitals, this is not surprising<sup>12</sup>.

The next step in the evolution of U.S. health insurance was the second World War, during which wage controls were imposed in order to hold down inflation. To compete for scarce labor, some firms began offering health coverage as a benefit to workers. The Roosevelt Administration was not unhappy to see this development, and so this health coverage was allowed as a means of eva-

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12 See John Goodman, "Health Insurance," *The Concise Encyclopedia of Economics*, <http://www.econlib.org/library/Enc/HealthInsurance.html>

ding wage controls. Given that the purpose of health coverage was to provide compensation, once again the impetus was toward comprehensive coverage of all medical services, rather than a true insurance model. Many firms in fact adopted Blue Cross and Blue Shield as their insurance provider.

Today, large multi-state employers are required to provide health coverage to employees. In fact, this coverage tends to be generous, with relatively low deductibles and co-payments, at least until recently.

The precedent of treating health coverage as something other than compensation was carried over into the tax code. Employer-provided health coverage is exempt from income taxes and payroll taxes. This health care tax exemption has become the largest distortion in the U.S. tax code. If the exemption were ended, taxes would rise by over \$400 billion a year.

The tax exemption represents yet another incentive for firms to offer more than mere insurance against catastrophic medical expenses. By offering coverage for even small medical expenses, firms can attract employees with compensation that is exempt from tax.

For firms with employees located in more than one of the American states, American law provides another benefit – the ability to offer the same policy in more than one state. If an individual purchases health insurance for his or her family, that insurance policy must comply with the regulation of his or her state. With fifty different state regulators, insurance companies face high overhead costs of compliance in what amounts to a relatively small market – the market for covering individuals who are covered neither by government programs nor by their employers. As a result, there tend to be relatively few companies offering health insurance in each state. Moreover, in some states, the regulations themselves impose requirements that significantly drive up the cost of health insurance. Large employers that provide health insurance are effectively exempt from this Balkanized regulation scheme. Instead, they must comply only with one set of national regulations.

In 1965, the United States enacted universal health coverage, but only for the poor and the elderly. Medicaid, which is administered and partially funded by the states, covers people with low incomes. Medicare, which is a national program, covers people aged 65 and older.

In summary, the U.S. health care system evolved with no central planning. A large class of citizens receives health coverage that is heavily subsidized by their

employers. Another large class of citizens over age 65 receives coverage that is heavily subsidized by the national government. Still another class of citizens, with low incomes, is eligible for Medicaid, administered at the state level.

What remains are people who do not fall in any of those three classes, generally workers who are self-employed or who work for small businesses. They confront a health insurance market that is fragmented by state regulation and in which they enjoy little or no government subsidy for purchasing health insurance. They confront directly the cost of health coverage, which, given the high utilization rates in this country, can amount to \$15,000 a year or more for a family of four. Faced with these costs, most of the people who fall outside the three classes choose to remain uninsured. In addition, many people who are eligible for Medicaid do not enroll, at least until they require ongoing treatment. As a result, they are counted as uninsured, even though they fit under Medicaid.

Overall, about fifteen percent of the U.S. population does not have health insurance. Thus, we have the dichotomy in which most people have comprehensive health coverage that pays too much of their medical expenses, while a large minority has no health insurance coverage at all. The net result is that in the United States as a whole, about 88 percent of personal health care expenditures are paid for by third parties – government and private health insurance, and 12 percent are paid for out-of-pocket, meaning by the consumers themselves. The share paid for out-of-pocket is actually lower than that found in many countries that have universal coverage, including Canada<sup>13</sup>.

In summary, the American health care system emerged haphazardly, rather than by design. As a result, people who are eligible for government programs or who work for large employers receive generous health coverage. Those who do not fall into those classes often elect no coverage at all.

The lack of design also means that there is no mechanism in our system for controlling costs or ensuring rational use of medical procedures. This is discussed in the next section.

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13 See Michael F. Cannon and Michael D. Tanner, *Healthy Competition: What's Holding Back Health Care and How to Free it*, Cato (2005).

## High Costs, Low Benefits

In November of 2009, the United States Preventive Services Task Force released recommendations to reduce screening on breast cancer. In particular, the task force recommended against routine mammograms for women under 50 and it recommended against teaching women to do breast self-exams. The recommendations created a political firestorm, because many women in fact are diagnosed with breast cancer under the age of 50 and/or on the basis of self-examinations. (Note that the task force did not recommend against breast self-examinations, only against programs to teach such self-examinations.)

Mammograms for women under the age of 50 are an example of what I call the gray area in medicine. Gray area medicine means procedures that are not absolutely necessary to save lives or relieve suffering, but which have the potential to offer benefit in some cases. Often, screening protocols and precautionary tests, such as those that use expensive magnetic resonance imaging (MRI), fall in the gray area.

Many discussions of health care policy ignore the gray area. For example, during the health policy summit, members of both parties cited the hypothesis that one-third of America's health care spending goes for unnecessary procedures. That makes it sound as if health care is a black-and-white issue, meaning that there are only procedures that are absolutely necessary or procedures that are absolutely unnecessary. What I call the gray area consists of procedures that are neither absolutely necessary nor absolutely unnecessary.

Another example of gray area medicine is routine colonoscopy screening for colon cancer for people over age 50. Such a protocol is not absolutely necessary. Canada does not have the trained personnel or equipment to provide routine colonoscopies for people over 50, and this may be a rational allocation of resources. The cost per life saved of using the colonoscopy screening protocol may well be over a million dollars. Yet it would be difficult to argue that this protocol is absolutely unnecessary. The colonoscopy procedure has been proven effective at preventing the development of colon cancer.

The colonoscopy protocol and other gray area medical procedures are not without benefit. However, the benefits come at high cost. As a result, many studies

show that variations in medical spending across different regions of the United States are not associated with differences in health outcomes.<sup>14</sup>

Many economists support doing more research into the costs and benefits of various medical protocols. However, as the controversy over the breast cancer screening recommendations shows, Americans tend to view health care as a personal, emotional matter, and they are not necessarily ready to embrace allowing national standards to override the judgment of individual doctors.

## Sustainability

For several decades, health care spending in the United States has grown faster than GDP. As a result, the share of health care in GDP has more than doubled over the past thirty years. Other countries also have experienced rising health care spending, but starting from a lower base. Health care now accounts for more than 16 percent of GDP in the U.S., but only about 10 percent of GDP in other major industrialized nations.

In the United States, the trend of rising health care spending as a share of GDP is known as "excess cost growth." Extrapolating this trend for 75 years, agencies such as the Congressional Budget Office have calculated that by about 2080 spending on Medicare and Medicaid will absorb 100 percent of the budget of the national government.

Of course, long before 2080 the United States government will be unable to meet its obligations if present trends continue. By 2030, the population of people over the age of 65 will have nearly doubled from what it is today. That in turn implies that spending on Medicare and Medicaid will rise from 3.9 percent of GDP in 2005 to 8.7 percent of GDP in 2030, according to standard baseline

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14 The most prominent studies come from the Dartmouth Atlas project (<http://www.dartmouthatlas.org/>). They are featured in Shannon Brownlee, *Overtreated: Why Too Much Medicine is Making us Sicker and Poorer*, Bloomsbury, 2007. Robin Hanson, in "Showing that you care: the evolution of health altruism," *Medical Hypotheses*, Vol. 70, No. 4 (2008), p. 724-742, finds that in fact many studies fail to show a relationship between the extent of medical treatment and overall health outcomes. He suggests in a related essay, "Cut Medicine in Half" (<http://www.cato-unbound.org/2007/09/10/robin-hanson/cut-medicine-in-half/>), that the United States could improve the quality of life, including health, by spending much less on medicine.



assumptions<sup>15</sup>. Along with increased spending on Social Security and higher interest on the national debt, this suggests that the United States simply cannot continue without making fundamental changes to taxes, spending, or both.

Broadly speaking, there are three ways that policy makers can reduce the growth of health care spending in order to achieve a more sustainable budget. Each approach is fraught with problems.

One approach is to try to deliver the same medical procedures at lower cost, by improving efficiency and lower payments to health care providers. However, this approach relies on cost-reductions that are unproven (such as the savings that might be achieved through use of electronic medical records) or which require cutbacks in payments to physicians and others that would be politically difficult and might have adverse consequences for the supply of medical services.

Another approach is for government to ration care, by being more selective in the way that it compensates health care providers. Today, doctors are reimbursed for services that they provide. Government could narrow the scope of procedures for which it will provide reimbursement. Another approach that has been discussed is "payment for quality," meaning that physicians would receive bonuses for following recommended guidelines and perhaps face penalties for failure to follow such guidelines.

The final approach for limiting growth in health spending would be to give consumers more responsibility for their health care spending. For example, instead of reimbursing health care providers, the government could provide its beneficiaries with vouchers. Consumers would use these vouchers to pay for services. Because they would own the vouchers, consumers would exercise discretion in selecting procedures and also take into account price differences among providers.

The voucher approach has a number of potential pitfalls. People on low incomes might find the vouchers inadequate. People with expensive medical conditions also might not be able to afford necessary treatment. Perhaps these problems could be alleviated by using a means-tested voucher system and adding a layer of catastrophic health insurance.

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15 See Committee on the Fiscal Future of the United States, *Choosing the Nation's Fiscal Future*. The National Academies Press, 2010. [http://www.nap.edu/catalog.php?record\\_id=12808](http://www.nap.edu/catalog.php?record_id=12808) Some material, including the baseline assumptions, is available only at the web site and not in the printed report.

There are also psychological costs of using a voucher approach. Throughout the industrialized world, countries have evolved systems that insulate individuals from having to pay for their own health care. Presumably, this is because consumers and doctors feel very uncomfortable about regarding medical care as a business transaction. Perhaps this is because it involves the body. Perhaps it is because people who need medical care are suffering, and it is awkward to demand payment from people who are suffering. Perhaps it is because so many medical procedures are in the gray area, and people do not want the anxiety that is associated with confronting this ambiguity and making choices. Under the present system, people can simply get the treatments that the doctor orders, which perhaps reduces their anxiety.

In spite of these psychological considerations, the United States might eventually adopt a system that is based largely on vouchers. The alternative of a centralized rationing system would probably be highly inefficient, because it would ignore individual circumstances and preferences. It also would be inconsistent with traditional American values of individual choice and limited government.

## Conclusion

Relative to American values, the United States health care system works well. However, everyone is keenly aware of its failings. A large share of the population is not insured. Americans make extravagant use of medical procedures with high costs and low benefits. The fiscal outlook for Medicare and Medicaid shows that they are not sustainable.

The health care reforms that were debated in 2009 and 2010 did not address the fundamental choices that America must eventually face. As heated as the debate became, the proposed changes were only superficial. Down the road, the choices will be more difficult. At some point, we either have to impose stronger rationing of care by the government or we have to force individuals to confront more of the cost of their own care, perhaps using a voucher system to fund health spending.

Redesigning America's health care system is extremely difficult, in part because our system was not designed in the first place. It evolved haphazardly, and several of the components that are most entrenched and popular, such as employer-provided health insurance and Medicare, are poorly structured from

the standpoint of trying to expand coverage and contain costs. The need for fundamental reform is great, but the political obstacles seem even greater.









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