Health Reform in America

By Uwe Reinhardt, PhD

As more and more American families find their budgets pinched by the ever-rising cost of healthcare and a growing volume of scholarly research convinces health policy experts that the quality of American health too often falls short of what it should be—given that Americans spend about twice as much per capita (in purchasing power parity dollars) on healthcare than its neighboring Canada—it is inevitable that the topic of health reform will have a prominent place in the forthcoming presidential elections.

Although the details of any such reform will be mind-numbing, its overarching goals are 2-fold: (1) enhancing the “cost-effectiveness” of American healthcare, and (2) better protection for American families against the financial burden of ill health.

Enhancing Cost-Effectiveness

Among health policy experts, the term “cost-effectiveness” means costs per unit of clinical outcome, or its inverse, outcome per dollar of cost—“bang for the buck,” in the vernacular. Clinical outcome can be variously defined here, from the very narrow “reduction in measured blood pressure” to a very broadly defined metric, such as quality-adjusted life-years, widely known by the acronym QALYs. The latter converts life-years in a specified, less-than-perfect health status into fewer life-years in perfect health, with the conversion ratio being based on the responses to surveys of citizens asked to evaluate different health outcomes.

Embedded in the overarching goal of cost-effectiveness, of course, are 2 subgoals that must be reached—(1) enhancing the quality of healthcare in the United States, and (2) controlling spending on treatments for given illnesses. Attainment of one or the other subgoals, or both, automatically will enhance the cost-effectiveness of healthcare.

It may be thought that everyone should applaud the enhancement of cost-effectiveness of American healthcare. In fact, all 3 current presidential candidates—Senators Clinton, McCain, and Obama—share pretty much the same view on the imperative of moving toward that goal. But the pursuit of that goal faces more obstacles than may be surmised, which is why its attainment has eluded policymakers for so many decades.

First, correctly viewed, there is a large and powerful constituency for inefficiency in healthcare. It is so because, in healthcare as elsewhere, one person’s cost usually is another person’s income. To the loser, “cost-effectiveness” therefore implies reducing healthcare income. Those whose income is reduced by enhanced cost-effectiveness can be counted on to throw any barrier they can think of onto the path of greater cost-effectiveness. So far, their barriers have been largely impenetrable to employers, private insurers, and government.

Second, the steps required to enhance the appropriateness and quality of healthcare and to control spending thereon are not costless. There is a wide consensus among the experts that this step requires vast upfront investments in information technology on the part of the private and public sectors. Governments in other nations—notably the United Kingdom—have stepped up to the cashier’s window to make that investment. Antigovernment ideology and tight public budgets remain major obstacles to a significant government role in constructing the required 21st-century information infrastructure for the US healthcare. The private sector has so far not seen the business case for the huge private sector outlays needed to construct a truly 21st-century health information platform, nor will it see it as long as the public and private payors remain as willing as they have always been to adequately compensate the providers of healthcare, even for low-quality, cost-ineffective healthcare.

Financing an information infrastructure aside, there is no reason to assume that the providers of healthcare—be they physicians, hospitals, or the suppliers of medical devices and pharmaceutical products—would welcome the greater transparency on their prices and the quality of their services or products that any move toward greater cost-effectiveness would entail. Both the medical-device and pharmaceutical industries, for

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example, have lobbied for years against the establishment of cost-effectiveness research institutes, such as those now operating in Europe, Canada, Australia, and in some parts of Asia. The raw competition likely to be unleashed by such transparency, and consumer awareness of the relative cost-effectiveness of alternative therapies, inevitably would put financial and professional pressure on the providers of healthcare—pressure they have so far had the luxury to elude.

Finally, the benefits that would be yielded by the large upfront investments required for more cost-effective US healthcare would not necessarily accrue to those who make that investment. Such misalignment between investment and return, too, will remain an obstacle to the attainment of this overarching goal.

Attaining Universal Coverage

If attaining the goal of cost-effectiveness is difficult, it is even more challenging to attain the second overarching goal of health reform—better protection for American families against the financial burdens triggered by ill health.

This is not so much a problem of economics but rather of social ethics, that is, the hitherto open question: To what extent should Americans in the upper third or so of the nation’s distribution of family income help subsidize the healthcare received by families in the bottom third or so of that distribution? It is a problem in the political economy of sharing. The nation has long been divided into 2 camps on that issue—those who believe that healthcare is basically a private consumer good whose financing should be the responsibility of its recipients, and that rationing healthcare by income class is alright, and those who believe that healthcare is basically a social good that should be available on roughly equal terms to all who need it and financed by all members of society on the basis of their ability to pay for healthcare, so that if rationing healthcare becomes necessary, all members of society should be exposed to it with equal risk. Unfortunately, any open debate on these delicate ethical dimensions of health reform can easily overstep the bounds of political correctness in a nation whose media (certainly the television media) convey political debates on public policy in terms of sound bites.

How much public spending would it take to protect every American family from the financial inroads of ill health? How might one go about moving toward that goal, and how would we know whether we have reached the goal?

Starting with the last question, the most practical approach to defining “universal coverage” would be to specify the percentage of household income that Americans believe individual families should be asked to devote out-of-pocket to the purchase of health insurance and healthcare. An honest public debate on the social ethics of healthcare may start at that point. Quite possibly, Americans may decide that that percentage should increase progressively with family income, although one cannot be sure of it. Currently in the United States, that percentage tends to decrease with family income, except for the very poor who are on Medicaid, who enjoy a truly comprehensive, first-dollar coverage.

It is clear that the additional federal outlays required to reach universal coverage would rise inversely with the percentage of family income Americans would be asked to pay out-of-pocket. The lower the percentage, the higher are the required federal outlays. For example, Senator Clinton has recently proposed that this percentage should be between 5% and 10%, which is why she would ask Congress for as much as $110 billion a year to subsidize lower-income families.

As to the administrative mechanism of reaching universal coverage, a myriad of alternative proposals have been developed over the past several decades, ranging all the way from a single-payer system (eg, Medicare for all) to merely plugging the gaps existing in the current health insurance system. Policy analysts differ on how best to plug such gaps, by publicly subsidizing the purchase of private health insurance or by simply expanding the existing public insurance programs—Medicare, Medicaid, and SCHIP. These differences of opinion are rarely driven by empirical research; for the most part they reflect the analyst’s personal ideology.

Health Reform in the Presidential Campaign

With this general backdrop on health reform, we can look briefly at the health reform proposals put forth by the 3 current candidates for the presidency. The major design parameters one should focus on are:

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1. What total added, annual federal budget is the candidate prepared to ask Congress to devote to the reform?
2. How would the extra spending proposed (whatever that is) be financed?
3. Is insurance coverage to be mandated on the individual, or will it remain a voluntary consumer choice?
4. Is extended coverage to be achieved by subsidizing private insurance coverage or by extending existing public programs?
5. What provisions are made to reorganize the market for health insurance purchased by individuals? Would there be new risk-pooling mechanisms for the individual insurance market? Or would premiums charged to the individual in that market continue to be based on that individual’s health status?
6. What would happen to employment-based health insurance? Would the tax preference now enjoyed by that arrangement be perpetuated? Would small employers be subsidized to provide insurance to their employees?
7. What cost-control mechanisms do the candidates propose?

On the first design parameter, the total new federal spending for health reform, Senator Clinton has suggested $110 billion in new funding in the initial year, which would, of course, have to increase year by year in step with overall increases in health spending per capita. Senator Obama estimates the cost of his health plan at between $50 billion and $65 billion in the initial year. Senator McCain has not offered a specific budget figure.

Only Senator Clinton would mandate the individual to have health insurance. She does so to prohibit adverse-risk selection (freeloading) by individuals, which occurs when insurers are required to offer anyone health insurance at “community-rated” premiums unrelated to the individual’s health status, a requirement Senator Clinton would impose on insurers. Neither Senator McCain nor Senator Obama would require individuals to be insured. Senator Obama’s opposition is based on his surmise that too many families simply could not afford the mandated insurance, a phenomenon now manifest in Massachusetts, whose then-governor Mitt Romney did impose such a mandate on state residents. Senator McCain probably opposes such a mandate on ideological grounds alone.

Finally, although Senators Clinton and Obama would use existing public programs (and new ones yet to be created) as well as private insurers to expand coverage, Senator McCain would not expand public programs and, indeed, would allow veterans to opt out of the VA system for private healthcare delivery.

Space does not permit a detailed analysis of Senators Clinton’s, McCain’s, and Obama’s health reform plans on all their design parameters. A superb side-by-side summary of these can be found at http://www.health08.org/sidebyside.cfm.

In reacting to these proposals, it must be kept in mind that they are merely that—proposals. It will be Congress who writes any specific health reform legislation, and the bureaucracy that “legislates” further, so to speak, through its detailed regulations. It is a lesson Senator Clinton certainly will not have forgotten.

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**Unmanaged Moment**

“How much medical skill are you willing to pay for?”