

Health Financing: Challenges and Opportunities, Coverage and Cost

James J. Mongan, M.D.

Over the past four decades, two issues have driven the health care financing debate: costs and coverage. If you dug a little deeper, I think you would find that the real driver of the debate has been the cost issue rather than the coverage issue, and discussion of the cost issue has focused more often than not on the federal budgetary impact. It has not been an abstract debate about 13 percent of GDP versus 15 percent of GDP. Rather, it has been about the impact of health care spending on the federal budget, and the consequence of that focus has been a skewing of attention towards Medicare, with Medicaid getting beat up the most, and a kind of tip-toeing around the private sector.

Coverage, which I certainly find to be the more morally compelling issue, has been debated broadly and unsuccessfully about once each decade—in 1974, 1980, and 1994—and I will come back to that in concluding, after saying a bit about costs.

You have been hearing about costs all morning. It is my belief also that costs will go up, that the increasing costs of all the blessings of modern medicine—drugs, technologies, devices, pharmaceuticals—will quite likely more than offset any of the vaunted potential savings from administration, information technology, and evidence-based medicine. So, I think we are going to face continued increases in costs.

This puts more pressure on all of us in this sector to implement everything that might impact costs, because the pressure for us to demonstrate value is going to increase exponentially as costs climb beyond 15 percent of GDP. I do not necessarily take this as a message that says we should quit. Rather, I take this as a message that says we are going to have to do

everything we can and then some. Let me start by talking about what we can do, and then I will move to the “then some.”

There are real steps that we can take to limit cost increases and enhance value. I will set out three of them here. The first relates to some significant commentary that you have just heard about electronic medical records. I have become a believer that this is real. Many people think this is only about cutting down paperwork in medicine. It is about far more than cutting down paperwork, however. It is really about being able to drive medicine towards evidence-based practice through the use of various prompts, rules, algorithms, and things of that sort. So, there is tremendous potential here.

It is going to be a huge undertaking. The Bush administration budget request was for \$100 million, whereas in one large system in one city alone, we are spending \$50 million on this issue. Sizing the Bush budget request against what we are spending may not be a fair shot, because it has been made clear by the administration—at least as I understand it—that at present they do not view it as their role to be the primary financier of all this. However, if they are not the financier, then either private payers or the hospitals are going to have to pay, and the medical providers are going to have to wring the rest out of what they do. Somebody is going to have to pay this bill. It is a significant bill, as the spending contrast mentioned above shows. So, it is very significant, although I think that moving to electronic medical records has huge potential for savings.

Pay for performance verges on being a cliché, so I have to be very careful in this area. But it has the potential to cut a middle path between fee-for-service, which arguably emphasizes that there is overprovision of services, and capitation, which arguably emphasizes that there is a potential underdelivery of services. Having said that I recognize that pay for performance can be a cliché, I believe it is a reality in Boston. Our contracts with all three of the major payers—Blue Cross, Harvard Pilgrim, and Tufts—are based on pay-for-performance standards in terms of days of hospitalization, drug trend, and radiology trend. So, I believe that it can be made real.

Finally, another issue that can be an old chestnut is disease management and end-of-life care. Disease management earned a bad name over

the past decade by really meaning not paying bills, particularly in the mental health area. That is not what I mean by disease management. I am driven more by the statistics that many of you have heard: 10 percent of people account for 70 percent of costs, and 1 percent account for 30 percent of costs. It just seems to be tautological that you should be able to gain in both quality and efficiency by putting more emphasis and focus on the management of the care of these very, very sick patients.

Again, we have examples in Boston of real progress with several congestive heart failure disease management programs that have cut down on hospital readmissions. We are working with the state on seeing whether we can put in place some special support services for our 1,000 most expensive Medicaid patients. So, I think there is great promise here. These are among the things that we can, should, and must do as we go forward into the next decade.

However, even having done all that, I think that costs are going to remain a problem, and that there are two ultimate public policy issues for the out years. Frankly, if you are a senator or a congressman, I think that maybe you can dodge this bullet for another five or 10 years. I do not think that you can dodge it for 15 or 20, however. The first question is: Is 15 percent of GDP too much to spend for health care? Certainly, the common wisdom has been that the easy answer is “yes,” with facile comparisons to other international systems and commonly held assumptions on waste and abuse.

More recently, there are some developing arguments that it is not necessarily too much, that higher health expenditures yield value compared with the other things we are buying in GDP, and that obviously we have this ever-aging population and the march of biomedical science. So, in fact, if the public as consumers want to consume more than 15 percent of GDP in the form of improved health, we may not have the easy answer we thought we had to this question. However, if health care spending goes up, there are clear tax consequences, as was explained earlier by Henry Aaron and other speakers.

The second and the more pressing public policy question in this out-year period is: If health care spending as a percent of GDP is too high, what can we do about it? And here, so far as I know after 35 years in this business, there simply are no easy answers. The default answer is to let

health care spending rise with GDP. My guess is that we will continue on the path of the default answer because the other answer is so problematic that people are not going to want to embrace it quickly. The other answer, so far as I know, is rationing. (I have not heard the word explicitly used this morning, but we might as well bring it out of the closet.) And, so far as I know—the economists in the audience know more about this than I do—there are two ways to ration. One is by what I call “real market forces,” and I do not think we are talking about \$20 co-payments here. We are talking about real market pain, which will lead to great disparities between the care of the rich and the care received by the middle class and the poor. Even though this sounds like the politically easy answer, as it plays out it may not appear nearly so politically easy. We are much more ready to accept a society that allows some people to have the resources to stay in a Four Seasons hotel while others stay in a Sheraton, and still others stay in a Motel 6 or no hotel at all, than to accept similar disparities in health care. We have tough free-market rhetoric, but when the consequences are shown on TV, even the most rock-ribbed conservative politician tries to get a liver for Baby Jessica or famously tries to keep Terry Schiavo alive on a feeding tube. So, I think this is going to be a lot tougher than people realize.

Of course, the other path to rationing is the approach taken by almost the entire rest of the world, and that path is rationing by government and private payer limits. But, again, people are grownups and know that that is not an easy answer, and is an approach that often leads to arbitrary consequences—queuing and other things that we have all seen in the much-heralded bashing of the English and Canadian systems.

So, I find no easy answers here in the out years. I think this means that we have to keep doing everything we can do. The default answer will be that costs will grow, but at some point the tax consequences will be so severe that people will start edging up to one or the other version of the alternative or some combination.

At this point, I want to move towards some comments on the coverage issue—the obviously linked, twin issue. I will make three assertions here and then make a few comments about each.

The first assertion is that health insurance coverage is not only about money. It is really about health. Second—and Judy Feder made exactly the same comment—I would say that my reaction after four years of

watching this is that expansion of coverage should not wait until we solve all of these other cost issues. We are holding the uninsured hostage to our inability as a society to deal with these issues. We ought to put everybody on a level playing field and then deal with the cost issues. Also, over four decades, health care issues have always been trumped by the politics and economics of the issues. Specifically, the anti-tax movement, which I believe has been the strongest political force of the past 30 years, has trumped the issue of providing broader health coverage.

I said this is about health, not just dollars. I served on the National Academies' Institute of Medicine (IOM) Commission in 2003, which looked at this. That committee's report on the uninsured found that, compared with the insured, the uninsured were less likely to have seen a physician in past years, more likely to go without care, less likely to receive preventive care, and twice as likely to be hospitalized for avoidable complications of diabetes or high blood pressure. The IOM report led up to the finding that there were about 18,000 premature deaths a year among people under 65 years of age as a result of being uninsured. That finding leads me to the conclusion that everyone who is interested in the "culture of life" should be fighting for, rather than opposing, universal coverage. We need a switch in the political framing.

However, the coverage debate is also about dollars, and, again, this same IOM Commission looked carefully at this issue. I will specifically cite just a few things. The estimated cost of services needed but not received by the uninsured is \$35 billion to \$70 billion. This amounts to 3 to 5 percent of health spending, or about half of each year's annual increase. The estimated cost of legislation would be a bit higher—\$70 billion to \$100 billion annually—because such legislation usually has additional aims, like subsidizing employers or giving states fiscal relief.

The estimated return to society from improved health would be somewhere in the range of \$65 billion to \$130 billion. At this point, you may be asking: If we could do this for the price of one year's increase and if the cost would be offset by the savings, why don't we do it? Well, we don't do it first and predominantly because—as was mentioned this morning—the returns don't go to those who pay. Health care financing involves a huge income transfer from healthy people to sick people, from wealthy people to poor people, and from young people to old people.

We are also blocked because we hope that coverage expansion will be paid for by efficiency savings, but, as I indicated, I do not think that they are likely to occur—at least not in sufficient magnitude. And if they do, they are not likely to be captured for coverage expansion. Nobody is going to give those dollars to me to use for universal coverage. They are going to go back into people's pockets, and people are not clamoring to pay for the health care of others, as was noted this morning.

In the end, it does all come down to taxes. I think the triumphant conservative political movement of the past 30 years has had one major value to which they have stuck tenaciously, and that is an ever-lower level of taxation. We have seen some success in that on their part. Federal taxes in the 1990s, one of the most productive economic eras we have ever seen, averaged 18.5 percent of GDP. They are 16.3 percent of GDP now. That difference amounts to \$200 billion. That is twice the amount of money that would be needed to cover the uninsured. There is a fundamental political choice in front of us: Do we want a society that can boast of and have the consequences of the lowest taxes in 40 years, or do we want to see expanded health insurance coverage, which supports people's health, social justice, and the culture of life that we hear so much about?