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Thank you very much for that kind introduction. Tonight I'd like to talk about some economic issues relating to health care, and explain the Administration's policies for addressing some of our pressing health care problems.

Much of the current health care debate has been driven by two related concerns – access to health care and the costs of obtaining it. I'll discuss each of these issues in turn.

To begin, it is useful to provide some basic facts about insurance coverage in the United States. Eighty-two percent of Americans under the age of 65 have some form of health insurance. This leaves 18 percent, or about 45 million people, uninsured. The percentage of the population under age 65 without insurance has been growing over time. In 1987, it was only 13 percent**.** Much of the anxiety over the state of US health care is due to concern for the uninsured.

The uninsured are a rather diverse group. For example, 31 percent of those with incomes below the poverty level are uninsured, but so are 8.2 percent of those whose incomes exceed $75,000. With respect to employment status, about 24 percent of part-time workers are uninsured, but so are 18 percent of full-time workers. Indeed, most of the uninsured are employed or the family member of someone who is employed. The probability of having health insurance rises with the size of the firm for which one works. This is partly because the cost of

insurance depends on firm size. As the number of employees increases, the per-employee administrative costs of running an insurance plan fall. Moreover, firms with many employees spread the risk of serious health care problems over a large number of people, and hence can obtain better rates.

It is crucial to realize that the absence of health insurance and the absence of health care are not the same thing. Some people pay for their health care out-of-pocket, although on average, the uninsured pay for only 49 percent of the medical services they use. The free (to them) care is provided, primarily through hospitals. According to the American Hospital Association, in 2003, US hospitals provided almost $25 billion worth of uncompensated care, which is partly financed by increasing the bills paid by other parties. Nevertheless, people without health insurance generally consume fewer health care services than those with similar health problems who are insured. Surprisingly, it is not clear how this lack of care translates into health outcomes. As Helen Levy of the University of Michigan has observed, some studies find that extending insurance to the uninsured improves their health, but other studies do not.

Why has the proportion of people without insurance been increasing? Cost is the key factor. Rising health insurance costs have contributed to both a decline in take-up rates and firm offer rates, with falling take-up rates explaining more than half of the decline in employment-based coverage since 1987. As health insurance becomes more expensive, people have to give up more of their wages in order to receive a given set of health benefits; at some point, obtaining the insurance just isn't worth it. Indeed, only about 85 percent of workers who have access to employment-based health insurance and do not have insurance through another family member take up the option. Low-income workers are particularly likely not to take up employer-provided insurance. Their personal tax rates are low so that the benefit of excluding health

benefits from taxation is relatively small. Hence, the issue of declining health care coverage is intimately related to the problem of increasing costs, to which I now turn.

Health care expenditures in the United States have been increasing at a breathtaking rate. In 1970, health care expenditures were 7.3 percent of GDP. They are now about 15.3 percent, and according to government projections, they will be 18 percent by 2012. The United States has much higher per capita expenditures on health care than other countries. In 2001, per capita health care expenditures in the United States were $4,887, while in other developed nations, the figure is substantially smaller: $2,792 in Canada, $2,808 in Germany, $2,131 in Japan, and $1,992 in the United Kingdom. Although the United States has a higher level of expenditure than these countries, Harvard health economist Joseph Newhouse argues that, over the long-term, our rate of growth in these expenditures has not been out of line with theirs. These four countries have very different systems for financing health care than the United States has. In particular, health care coverage is not provided by employers as it is in the United States, the government plays a much larger role in setting prices, and to a greater or lesser extent, care is rationed. Thus, as we seek explanations for the growth rate of health care expenditures in the United States, we should not focus exclusively on factors that are idiosyncratic to the U.S. system. The following discussion is based on the work of Newhouse, who attempted to calculate how much each of the following factors has contributed to this growth rate.

The Graying of America. In 1980, 11.3 percent of the U.S. population was over 65; currently the figure is 12.4 percent. During the same period, the proportion of the population over 85 increased from 1.0 percent to 1.5 percent. As the population ages, one expects health care expenditures to increase as well. To what extent can this phenomenon explain the rise in health care expenditures? To obtain a rough answer to this question, Newhouse calculated how

much total spending would have changed if the per capita expenditures in each age group of the population had stayed the same over time and only the proportions of the population in each age group changed. He found that the change in age structure accounts for just a tiny fraction of the increase in expenditure. That said, the speed of the current demographic shift will accelerate in the future, so we can expect that the contribution of aging to cost growth will increase.

Income Growth. To the extent that the demand for medical care increases with income, then income growth may drive the increase in health care expenditures. On the basis of econometric analyses of medical demand, Newhouse estimated that every 10 percent increase in income leads to a 2 to 4 percent increase in the demand for health care. Multiplying this relationship by the actual percentage increase in income over time, Newhouse concluded that increases in income account for less than 10 percent of the growth in health care expenditures. Richer societies want more health care, but not enough more to explain the increase in health expenditures.

Third-Party Payments. Typically, consumers of health care do not bear the full cost of their treatment. Rather, a substantial portion of the cost is born by "third-parties" such as insurance companies or employers. In effect, this reduces the price of health care. Econometric studies show that, like any other commodity, when the price of health care goes down, more of it is consumed. In other words, third-party payments increase the consumption of health care, and likely lead to a high *level* of health care expenditures. Recall, however, that our task is to explain the continual growth in health expenditures over time. For third-party payments to be the reason for the growth in health care expenditures, it is necessary for insurance coverage to have been *growing*. The number of insured people has been increasing, but according to

Newhouse's calculations, not by enough to account for more than about one-eighth of the growth of expenditures.

Improvements in Quality. Newhouse concluded that if all the preceding factors are considered, and a few others (such as the practice of defensive medicine, administrative costs, etc.) are thrown in as well, it explains less than half of the increase in expenditures. He argued that the rest of the increase is due to technological improvements. Physician training, medical techniques, prescription drugs, and equipment have all improved over time. The last several decades have witnessed breaktaking developments in medical technology. As a result, the quality of health care has improved—diagnostic techniques, surgical procedures, and therapies for a wide range of medical problems get better all the time. Treatment of a heart attack today is simply not the same "commodity" as treatment of a heart attack in 1970. In fact, although innovations like coronary bypass surgery and cardiac catheterization have raised expenditures per heart patient, they have actually reduced the prices of obtaining various health outcomes, such as surviving hospitalization due to a heart attack.

Now, some improvements in medical technique are quite inexpensive. Prescribing aspirin for heart attack victims leads to a substantial improvement in their survival probabilities. But new medical technologies are often costly. For example, it costs about $2 million to acquire a PET (positron emission tomography) machine, which can detect changes in cells before they form a tumor large enough to be spotted by x-rays or MRI. Hence, even in the absence of the factors already noted, medical expenditures would be growing.

This technology-based theory also helps explain why countries with different health care financing and delivery systems have all experienced increases in health care expenditures. These

societies have at least one thing in common—they have all been exposed to the same expensive innovations in technology.

This technology-based explanation puts the debate over cost containment in a new light. If costs are rising mostly because of quality improvements, is it a bad thing? A key question in this context is whether people value these innovations at their incremental social cost. No one knows for sure, but Newhouse offers a provocative insight: "If many consumers felt that new technology wasn't worth the price, it seems odd that we do not observe some firms trying to enter and offer at least some aspects of 1960s medicine at 1960s prices."

Buttressing this argument is a calculation by University of Chicago economists Kevin Murphy and Howard Topel that improvements in life expectancy added about $2.8 trillion (in 1992 dollars) per year to U.S. national wealth between 1970 and 1990. Any such calculation must be regarded as just a rough approximation for several reasons. First, how does one put a dollar value on added years of life? Murphy and Topel use measures derived from statistical estimates of the increased wages that workers require in order to compensate them for taking jobs that require relatively high risks of dying on the job; this approach is controversial. Second, it is not clear that all the improvement in life expectancy was due to changes in health care. They note, though, that "about $1.5 trillion of the overall $2.8 trillion annual increase was due to the reduction in mortality from heart disease—an area in which medical advances in both prevention and acute care have been significant." Third, although increases in life expectancy are very important, advances in medical care have also improved the quality of life, and these are valuable as well. Just think of hip replacements, Viagra and arthroscopic surgery. While it is difficult or impossible to attach a dollar value to these improvements, the benefits must be

substantial. Hence, even allowing for the roughness of the Murphy-Topel calculation, its basic message that there are enormous benefits to spending on health care is compelling.

The focus of this discussion has been on whether medical expenditure is driven by technological change. An intriguing possibility, however, is that at least to some extent, causation runs in the other direction—increases in spending increase the profitability of medical innovations and therefore encourages technological change. This is a difficult proposition to test, but some evidence suggests there is something to it. Harvard's Amy Finkelstein notes that in 1993, Medicare began covering the cost of flu vaccinations for all Medicare recipients, without any copayments or deductibles. She found that after this change in policy, pharmaceutical firms invested significantly more money on research and development for new flu vaccines.

In any case, there is no reason to believe that all the growth in health care expenditures is a bad thing, or that there is some magic percentage of GDP that is the right percentage to devote to health care. Cost-containment measures that impede technological improvements may make society worse off. The trick is to implement changes in public policy that would make the health care system more cost-effective without sacrificing the incentives that are essential to continued innovation. Reforms that lead to more direct interaction between consumers and health care providers, relying less on third-party payers such as insurance companies, have the potential to increase the efficiency and therefore the cost-effectiveness of health care markets. Coupled with changes that provide consumers with more flexibility and more information, such reforms would continue to provide the market signals important for developing new and useful health care innovations.

The President has proposed several reforms that promise to move the Nation in the direction of achieving these goals. Taken together, these reforms will help preserve the innovative strengths that have proven so valuable to Americans and will improve the efficiency of the U.S. health care system. Let me summarize them briefly.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 adds a prescription drug benefit to the Medicare program. The new drug benefit will give more Medicare beneficiaries access to prescription drug coverage and will provide benefits for individuals with limited means and low incomes. A prescription drug discount card is available for beneficiaries until the full drug benefit is available nationwide.

The Act also established another key element of the President's health care agenda, Health Savings Accounts (HSAs). With an HSA, individuals and their employers may contribute pretax dollars to fund an account that can then be used to pay for medical expenses. Once established this money belongs to the individual and can accumulate over time. The account remains with the individual if he or she changes employers. With such accounts, there is an increased incentive to purchase insurance that only covers events that are truly random and large, and to pay for other expenses using an HSA. Indeed, the law requires that such accounts be coupled with a high-deductible insurance plan.

With less reliance on insurance for routine health expenses, consumers would place a greater value on information about health care prices, treatment options, and providers. More prudent use of insurance would also reduce "middle-man" costs of involving an insurance company in what could otherwise be a simple transaction between the patient and the caregiver.

Much remains to be done on the healthcare front. A number of proposals on the President's agenda for health care reform would lead to improvements in the health care market.

The Association Health Plan (AHP) proposal enables small business and other employers to come together through industry associations to purchase health insurance for employees and their families. These plans offer small businesses and self-employed individuals the potential for lower health insurance premiums resulting from decreased administrative costs and increased bargaining power with insurers and medical providers.

The President has also proposed a new tax deduction for health insurance premiums. Individuals who purchase a high-deductible insurance policy coupled with an HSA would be able to deduct the value of the insurance premium from their income taxes even if they do not itemize their deductions. This would encourage the use of high-deductible insurance by providing a tax benefit similar to that given to employer-provided insurance.

Many workers do not have the option to obtain insurance through their employment. The President has proposed a refundable health credit that could be used to purchase insurance. This credit will help expand health care access for low- and middle-income workers who do not have good employer-based coverage options. Another proposal to enhance the vitality of the individual market is to permit cross-state purchases of insurance.

Malpractice premiums are a significant cost for physicians and hospitals. The President has proposed the national adoption of standards to make the medical liability system more fair, predictable, and timely. Adoption of these proposals would lower the cost of providing health care. Similarly, fear of litigation keeps health care providers from sharing vital information on quality problems and medical errors. The President has called for legislation to allay these fears and make it possible for health professionals to share information to reduce errors and complications.

The use of information technology in health care holds the promise of reducing medical errors facilitating communication between care providers and patients, and reducing administrative costs. Computerized physician order entry, a type of technology that allows physicians to write medication orders electronically, has been shown to reduce significantly the rate of serious medication errors. Intensive care telemedicine, a type of technology that allows remote specialists to monitor patients continuously with videoconferencing and computer-based data transmission tools, has been found to decrease intensive care costs substantially in certain settings. The President is proposing to double the funding (for a total of $100 million)for the Department of Health and Human Services to increase the use of these new technologies through demonstration projects.

To conclude, the U.S. health care system has provided tremendous benefits for both American citizens and the global community. New knowledge, innovative products, and life-saving medical procedures are the results of the U.S. market for health care. The President's proposed policies will help preserve the strengths of the U.S. market and will improve the efficiency and affordability of health care.