

Health Care Challenges for the 21st Century

Between 1992 and 2002, overall health care spending rose from \$827 billion to about \$1.6 trillion; it is projected to nearly double to \$3.1 trillion in the following decade. This price tag results, in part, from advances in expensive medical technology, including new drug therapies, and the increased use of high-cost services and procedures. Many policymakers, industry experts, and medical practitioners contend that the U.S. health care system—in both the public and private sectors—is in crisis. In the public sector, long-term simulations of the federal budget show a large and growing structural deficit resulting, in large part, from known demographic trends and rising health care costs. Since Medicare spending is driven by both these factors, its burden on the budget and the economy will balloon—tripling by 2035 and quintupling by 2075. One of the fastest-growing segments of health care in both the public and private sectors is prescription drugs. In 2004 the Medicare Trustees estimated that over a 75-year period the federal share of the new Medicare benefit would be \$8.1 trillion in current dollar terms. In the private sector, employers and other private purchasers of health care services find that the soaring cost of health insurance premiums poses a threat to their competitive position in an increasingly global market, often contributing to company decisions to outsource American jobs overseas, to hire part-time rather than full-time workers, and to minimize cash wage increases and pension costs.

Despite the significant share of the economy consumed by health care, U.S. health outcomes continue to lag behind other industrialized nations. The United States now spends over 15 percent of its gross domestic product on health care—far more than other major industrialized nations. Yet relative to these nations, the United States performs below par in such measures as rates of infant mortality, life expectancy, and premature and preventable deaths. Moreover, evidence suggests that the American people are not getting the best value for their health care dollars. Studies show that quality is uneven across the nation, with a large share of patients not receiving clinically proven, effective treatments. At the same time, access to basic health care coverage remains an elusive goal for nearly 45 million Americans without insurance, with a growing percentage of workers losing their employer-based

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coverage. Many more millions of Americans are underinsured or have lost some of the benefits their health plans previously afforded.

The following challenges and illustrative questions provide a framework for thinking about these issues in the future.

Defining differences between needs, wants, affordability, and sustainability is fundamental to rethinking the design of our current health care system. Americans with good health insurance have access to an array of advanced technology procedures at world-class health facilities, but clinical studies suggest that not all of this care is desirable or needed. Rising health costs are compelling both public and private payers to examine whether these procedures can continue to be financed without better accounting for their clinical effectiveness. Additional health care spending over time will draw resources away from other economic sectors and could have adverse economic implications for all levels of governments, individuals, and other private purchasers of health care.

► *How can we perform a systematic reexamination of our current health care system? For example, could public and private entities work jointly to establish formal reexamination processes that would (1) define and update as needed a minimum core of essential health care services, (2) ensure that all Americans have access to the defined minimum core services, (3) allocate responsibility for financing these services among such entities as government, employers, and individuals, and (4) provide the opportunity for individuals to obtain additional services at their discretion and cost?*

The impact that federal health care outlays have on the federal budget cannot be overstated. Medicare and Medicaid—entitlement programs for which federal spending is mandatory—are consuming increasing shares of the federal budget and shrinking the government’s flexibility to pay for other federal obligations, such as national and homeland security, environmental cleanup, and disaster assistance. Today, Medicare and Medicaid’s combined share of the federal budget—at 20 percent—has more than doubled in the last 2 decades. Moreover, long-term care for chronic illness will be a growing challenge as the aged population continues to grow. In addition, health care expenditures for the Departments of Defense

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(DOD) and Veterans Affairs (VA) are increasing. DOD's health care spending has gone from about \$12 billion in 1990 to about \$26 billion in 2003—in part, to meet additional demand resulting from program eligibility expansions for military retirees, reservists, and the dependents of those 2 groups and for the increased needs of active duty personnel involved in conflicts in Iraq, Bosnia, and Afghanistan. VA's expenditures have also grown—from about \$12 billion in 1990 to about \$24 billion in 2003—as an increasing number of veterans look to the VA to supply their health care needs.

▶ *How can we make our current Medicare and Medicaid programs sustainable? For example, should the eligibility requirements (e.g., age, income requirements) for these programs be modified?*

▶ *How can the federal government best leverage its purchasing power for health care products and services?*

▶ *What options are there for rethinking the federal, state, and private insurance roles in financing long-term care?*

▶ *How can the benefits, eligibility, and health delivery systems of VA and DOD be optimally structured to ensure quality and efficiency? For example, should changes in eligibility and the benefit structure of VA and the military health system be considered?*

▶ *With billions of federal dollars going to DOD and VA for health care, what options are available to reduce spending growth through increased collaboration in, and integration of, health care delivery between those two agencies?*

In the past several decades, the responsibility for financing health care has shifted away from the individual patient. In 1962, nearly half—46 percent—of health care spending was financed by individuals. The rest was financed by a combination of private health insurance and public programs. By 2002, the amount of health care spending financed by individuals' out-of-pocket spending at the point of service was estimated to have dropped to 14 percent. Tax preferences for insured individuals and their employers have also shifted some of the financial burden for private

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health care to all taxpayers. Tax policies permit the value of employees' health insurance premiums to be excluded from the calculation of their taxable earnings and exclude the value of the premium from the employers' calculation of payroll taxes for both themselves and employees. Health savings accounts and other consumer-directed plans, which shift more of health financing to the individual, also have tax preferences. These tax exclusions represent a significant source of forgone federal revenue and work at cross-purposes to the goal of moderating health care spending.

▶ *How can health care tax incentives be designed to encourage employers and employees to better control health care cost? For example, should tax preferences for health care be designed to cap the health insurance premium amount that can be excluded from an individual's taxable income?*

▶ *What reforms will encourage the private health insurance market to sufficiently pool risk and offer alternative levels of affordable coverage to ensure that all Americans have access to essential health care coverage? For example, are there alternatives to employer-based coverage through professional organizations, trade associations, or other entities?*

The variation by geographic region in Americans' use of health care services suggests, in part, quality and efficiency problems. Studies of Medicare patients in different geographic areas have found that despite receiving a greater volume of care, patients in higher use areas did not have better health outcomes or experience greater satisfaction with care than those living in lower use areas. Public and private payers are experimenting with payment reforms designed to foster the delivery of care that is clinically proven to be effective. Ideally, identifying and rewarding efficient providers and encouraging inefficient providers to emulate best practices will result in better value for the dollars spent on care. However, implementing performance-based payment reforms, among other strategies, on a systemwide basis, will depend on system components that are not currently in place nationwide—such as compatible information systems to facilitate the production and dissemination of medical outcome data, safeguards to insure the privacy of electronic medical records, improved transparency through increased measurement and reporting efforts, and

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incentives to encourage adoption of evidence-based practices. These same system components would be required to develop medical practice standards, which could serve as the underpinning for effective medical malpractice reform. Policymakers would need to consider the extent to which federal leadership could foster these system components.

- ▶ *How can technology be leveraged to reduce costs and enhance quality while protecting patient privacy?*
- ▶ *How can industry standards for acceptable care be established and payment reforms be designed to bring about reductions in unwarranted medical practice variation? For example, what can or should the federal government do to promote uniform standards of practice for selected procedures and illnesses?*
- ▶ *How can a medical information infrastructure be fostered, complete with privacy safeguards, that will help reduce the occurrence of medical errors and malpractice litigation and will furnish health outcomes data to better inform consumer choice?*
- ▶ *What reforms will help control health care costs associated with medical liability without undercutting provider accountability?*

The attacks of September 11, 2001, and subsequent anthrax incidents—as well as disease outbreaks, such as the West Nile virus and SARS—have elevated to priority status concerns about the quality and availability of the nation’s public health resources at the federal, state, and local levels. In recent years, it has been apparent that, despite improvements, the nation’s public health infrastructure remains too fragmented and uncoordinated and lacks the capacity to effectively manage a large epidemic or bioterrorist attack. Since fiscal year 2002, substantial federal funding has gone to state and local governments to improve disease surveillance systems, laboratory capacity, communication systems, and workforces. Federal funds directed at basic biomedical research to improve treatment and vaccinations for infectious diseases caused by biological agents have also been substantial. In an era of growing demand and shrinking resources, however, it may be prudent to determine how best to target the nation’s public health dollars.

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- ▶ *What are the most effective strategies for tracking emerging infectious diseases and targeting resources to prepare for treating these diseases?*
- ▶ *How can our international agreements encourage the equitable sharing of financial responsibility for developing pharmaceuticals and other medical technologies and eradicating AIDS and other worldwide disease outbreaks? For example, what can be done to facilitate more international burden-sharing for prescription drug research and development currently financed through public expenditures and higher U.S. prices?*

Global interdependence and efficient transportation systems have heightened U.S. vulnerability to a broad range of infectious diseases, such as SARS and avian influenza. Moreover, HIV/AIDS, tuberculosis, and malaria are increasingly viewed as a threat to economic growth and political stability in many nations. The number of people with HIV/AIDS will grow significantly by 2010, driven by the spread of the disease in five populous and strategically significant countries—China, India, Nigeria, Russia, and Ethiopia. To combat the spread of these diseases, the United States pursues multiple approaches, including partnerships with international organizations, such as taking the lead in support of the World Health Organization (WHO). At the same time, the United States also supports numerous bilateral programs to strengthen other countries' health care systems. The increasingly global spread of infectious diseases presents a challenge to these approaches and prompts the need to reexamine the balance between and possible integration of these approaches.

- ▶ *Should the United States reexamine its central role in supporting WHO in global efforts to control the spread of emerging diseases such as SARS and encourage other nations to provide more support to WHO with their personnel and resources? Do U.S. commitments to infectious disease interventions abroad, such as those for HIV/AIDS, need to be reexamined to better ensure human well-being, economic growth, and political stability in many nations? For example, can better coordination or integration of current multilateral and bilateral approaches to combating disease achieve greater effectiveness and efficiency?*