DESPERATE MEASURES

Jan 26th 2006

The world's biggest and most expensive health-care system is beginning to fall apart. Can George Bush mend it?

GEORGE BUSH had big ideas for his second term. He promised to fix Social Security, America's public pensions system, and revamp the tax code. Despite his best efforts, Social Security reform sank last year. Rejigging the tax code has proved so politically tricky that the White House dare not push it. With almost three years to go, Mr Bush seems less a radical reformer than a struggling lame duck.

White House officials, desperate to show that the president still has a domestic agenda, have now changed the subject--to health care. The buzz in Washington, DC, is that health-care reform will loom large when Mr Bush gives his annual state-of-the-union address on January 31st. Al Hubbard, Mr Bush's top domestic policy adviser, adds that the focus will be on ideas that control costs, boost access and improve quality.

Health care? The idea seems preposterous. How can an administration that is too timid to push tax reform tackle one of the most complicated challenges facing America's economy? What's more, the timing looks terrible. Mr Bush's team is under fire for botching its biggest health-care initiative to date, the introduction of a prescription-drug benefit for elderly people covered by its Medicare programme. Thanks to bureaucratic tangles, thousands of poor old folk have been denied drugs they used to get free, and more than 20 state governments have had to step in to pay for the medicines. Republican lawmakers dread what this fiasco may cost them in November's mid-term elections.

Yet Mr Bush may be able to push more radical change in American health care than anywhere else. Both politicians and the public recognise that spiralling health-care costs are a problem--second only to the Iraq war, according to a recent WALL STREET JOURNAL/NBC poll. Those costs are a big reason for the sluggish growth in workers' wages, the widespread perception that America's middle class is being squeezed and the huge job cuts at Ford this week.

America's health system is a monster. It is by far the world's most expensive: the United States spent $1.9 trillion on health in 2004, or 16% of GDP, almost twice as much as the OECD average (see charts 1 and 2). Health care in America is not nearly as rooted in the private sector as people assume (one way or another, more than half the bill ends up being paid by the state). But it is the only rich country where a large chunk of health care is paid for by tax-subsidised employer-based insurance.

This system is a legacy of the second world war, when firms, hamstrung by wage controls, used health insurance as a way to lure in workers. It means that, according to census figures, around 174m Americans get health coverage from their own, their spouse's or their parents' employer. Another 27m buy health insurance individually, for which they do not get a tax subsidy. The government picks up the tab for 40m elderly and disabled Americans (through Medicare) and about 38m poor (through the state-federal Medicaid scheme). That leaves around 46m uninsured, though many of these, whether students or workers, go without insurance by choice. In practice, they get emergency care at hospitals, which is paid for by higher premiums for everyone else.

Set alongside other rich countries, which typically offer all their citizens free (or very cheap) health care financed through taxes, America's system has some clear strengths. Consumers get plenty of choice, and innovation is impressive. One survey of doctors published in HEALTH

AFFAIRS claimed that eight of the ten most important medical breakthroughs of the past 30 years originated in America. Equally clearly, the American system has big problems, notably inadequate coverage (no other rich country has armies of uninsured), spotty quality and high cost.

Huge discrepancies lurk within the system. John Wennberg, Jonathan Skinner and Elliot Fisher of Dartmouth College have pointed out that Medicare spends more than twice as much on people in Miami than in Minneapolis, and, if anything, results are better where spending is lower. Up to 30% of Medicare spending, they concluded, is wasted. Poor treatment is rife: a study by the Institute of Medicine has suggested that medical error is the country's eighth-largest cause of death.

For decades, American health-care spending has outstripped income growth, by an average of 2.5 percentage points a year. There have been clear cycles within this trend: for instance, herding employees into managed-care schemes, notably Health Maintenance Organisations (HMOs), which negotiated discounts with doctors and restricted the services available to patients, helped slow down health inflation in the mid-1990s. But voters loathed HMOs, there was a political backlash and in the late 1990s costs shot up again. Although the pace of medical spending has slowed slightly recently (to 7.9% in 2004), spending has risen by 40% since 2000. Typical insurance premiums have gone up by more than 60%.

THE GREAT UNRAVELLING With medical inflation far outpacing inflation in general, American firms are scaling back the health coverage they offer. The share of workers who receive health insurance from their own employer has fallen from almost 70% in the late 1970s to around 50% today. In the past five years, the proportion of firms offering medical benefits has fallen from 70% to 60%, with the steepest decline among small firms and those employing the low-skilled.

Those employers who do offer health insurance have pushed more costs on to workers by raising co-payments and deductibles (the expenses before insurance kicks in). Employer-provided health coverage for retirees, once common, has shrunk, although America's big carmakers, including Ford and General Motors, are still hobbled by having to provide it. Mr Hubbard's assessment is stark: "The private market is broken."

At the same time, the burden on government is about to soar. Add together Medicaid, Medicare and other publicly financed health care, such as that for ex-servicemen, and the public sector already pays for 45% of American health care. (The total is nearer 60% if you include the tax subsidies.) But as America's firms limit their health-care spending and, particularly, as the baby-boomers retire, that share will rise sharply. On current trends, federal spending on health will double as a share of the economy by 2020. That would mean much higher taxes, something Americans do not want to pay.

With employers limiting their exposure and government unable to fund its commitments, America's health system will unravel--perhaps not this year or next, but soon. Few health experts deny this. Nor do they disagree much on the sources of the problem. Health markets are plagued with poor information, inadequate competition and skewed incentives.

Since most bills are paid by a third party (the insurance company or the government), neither patients nor doctors face real pressure to control costs. Overall, Americans pay only $1 out of every $6 spent on their health care out of their own pockets. Doctors are generally paid for individual services and so have an incentive to perform too many procedures. The huge tax subsidies for employer-purchased health insurance encourage expensive care. Rapacious lawyers and the risk of being sued exacerbate the tendency towards unnecessary "defensive" medicine.

The first question is whether to try to make America's imperfect market work better, or to accept that markets cannot work in health care and focus more on government regulation. The second is whether to go for incremental reform or a comprehensive overhaul.

The history of American health policy is littered with failed efforts at radical change. Harry Truman wanted to create a system of national health insurance in the 1940s. When Canada introduced its government-run health system in 1971, many American politicians hoped to do the same. The biggest recent effort was Hillary Clinton's health-care plan of 1993, which mandated health-insurance coverage for all delivered through carefully regulated health alliances with price caps. All these efforts failed, thanks to the enormous power of health-care lobbies and Americans' horror at anything that smacked of "socialised medicine".

Today's debate is scarred by those failures, though some brave health experts still favour comprehensive reform. The Physicians Working Group, for instance, argues that America has to move to a single-payer system, as in Canada or Britain. Victor Fuchs and Ezekiel Emanuel, two prominent health experts, argued in the NEW ENGLAND JOURNAL OF MEDICINE last year that the current mess should be replaced with a universal system of health vouchers funded by a hypothecated VAT. In a new book from the Brookings Institution called "Can We Say No?", Henry Aaron, William Schwartz and Melissa Cox argue that America will sooner or later have to ration health care, though they are coy about exactly how.

Washington's politicians, however, have shown little appetite for radical change. Their focus is still on expanding coverage rather than controlling costs. The biggest recent policy initiative, the 2003 decision to add drug coverage to Medicare, was the biggest expansion of a government health programme since 1965.

Some states have been thinking more radically. Massachusetts, for instance, may require everyone to have minimum insurance, with the state helping poorer people with subsidies. Maryland has a new law that requires all large employers to spend at least 8% of their payroll on health care, supposedly to prevent the state's Medicaid system having to pick up the tab. Though that particular law has more to do with Wal-Mart-bashing than health care, unions are pushing for similar legislation in 30 states.

The most interesting innovations, however, have come less from think-tanks or politicians' offices than from within the health-care industry. One trend, called "Pay for Performance", is to shift doctors' and hospitals' incentives towards providing more efficient and better care, by measuring quality and adjusting payments accordingly. According to Karen Davis, president of the Commonwealth Fund, a health-care research foundation, there are now around 100 "Pay for Performance" initiatives in place. Early evidence suggests that they are having some effect.

PATIENTS AS CONSUMERS The second shift within the health-care industry has been to change patients' incentives with more cost-sharing and larger deductibles. If patients pay more of the upfront costs of their health care, the argument goes, they will become more discerning consumers. And some of the cost saved by employers can be put into special Health Savings Accounts (HSAs), which workers can tap to pay routine health costs. Once the account is empty, workers are responsible for paying for their health care until their deductible is reached. This should make them think twice before visiting a specialist when they get a sore throat.

The trend towards HSAs was given a big push by a tax change in 2003 that was part of the Medicare drug legislation. Provided that an individual buys health insurance with a high deductible (at least $2,100 for a family), he can put the equivalent amount of money into tax-free accounts, whose balances can accumulate over years.

The number of people with high-deductible plans is still relatively small: only 2.4m in early 2005, according to government figures. But health economists expect HSAs to grow rapidly, as ever more employers offer them to try to control costs. A new survey by consultants at Deloitte shows that in these kinds of plans, in 2004-05, costs rose by less than half as much as in traditional ones.

The Bush agenda picks up both these new trends. Without much fanfare, Medicare too has been introducing its own incentive schemes. Hospitals must now provide proofs of quality to qualify for some Medicare payments. Medicare is also experimenting with bonuses for hospitals and doctors that improve their quality and efficiency. Where Medicare leads, many others may follow.

The White House's main focus, however, is the private market. One goal is legal reform. Mr Bush has already pushed (unsuccessfully) for laws that cap payments for medical malpractice lawsuits. He will keep trying. His health advisers would also like to deregulate the health-insurance market, freeing it from the stifling rules, imposed at state level, that can raise the cost of an insurance plan by as much as 15%.

Chiefly, Mr Bush wants to accelerate the trend towards consumer-driven health care. One uncontroversial idea is to encourage doctors and hospitals to provide more information on the cost of treatment. The other is to cut taxes. Mr Bush's team wants to eliminate the bias in favour of employer-purchased, low-deductible health insurance in America's tax code, not by reducing the existing tax subsidies for employers, but by increasing the tax subsidies for individuals.

This philosophy is conveniently summarised in a new book, "Healthy, Wealthy and Wise", by three economists with close ties to the White House, Glenn Hubbard of Columbia University (formerly Mr Bush's top economic adviser), and John Cogan and Glenn Kessler of the Hoover Institution at Stanford. They argue that since it is politically impossible to get rid of tax subsidies for employer-based health insurance, the best way to eliminate the tax bias towards high-cost insurance is to make all health spending tax-deductible and expand HSAs. Legal, insurance and tax reform together, they argue, could reduce America's health spending by $60 billion and cut the number of uninsured by between 6m and 20m. Since overall medical spending would slow, the authors reckon their suggestions would cost a modest $9 billion a year.

To an administration that believes the answer to every problem is lower taxes, the appeal of these ideas is obvious. Many health experts, however, are deeply sceptical, both about whether the shift to higher-deductible plans will actually reduce health-care inflation and, even if it does, whether the government should encourage this trend with more tax cuts.

The logic of consumer-driven health care assumes that unnecessary doctor visits and procedures lie at the heart of America's health-care inflation. And it assumes that individual patients can become discerning consumers of health care. Both are questionable. Most American health-care spending is on people with chronic diseases, such as diabetics, whose health care costs many thousands of dollars a year, easily exceeding even high deductibles.

Instead, critics worry that greater cost-consciousness will deter people, particularly poor people, from essential preventive medical care, a trend that could even raise long-term costs. A classic study by the Rand Corporation in the 1970s showed that higher cost-sharing reduced both necessary and unnecessary medical spending in about equal proportion.

Nor is it obvious that people actually behave like discerning consumers in health care, even when they have information. Proximity of hospitals and word-of-mouth reputation often matter more to patients than published quality indicators. Sceptics of consumer-directed care like to point to Bill Clinton, who chose to have his heart surgery in a hospital that New York state rates as having merely average mortality rates for such operations.

The truth is that the shift to consumer-directed health care and greater cost-sharing involves a culture change that may take decades. It will also come at the price of greater inequality. The burden of health spending will be shifted on to those who are sick, and not just because people will pay a greater share of their health costs themselves. High-deductible insurance policies are attractive to the young and healthy. But as these workers leave traditional insurance, the risk pool

in other insurance plans will worsen and premiums will rise even faster. The real losers will be poorer workers with chronic illnesses.

American health care has already become more unequal as employers have cut back, and this will continue. The Bush team argue that "fairer" ta xtreatment will slow cost rises and enable more people to get basic insurance. The opposite is more likely. Bigger tax subsidies for health care are, if anything, likely to raise overall spending. Worse, since most tax breaks benefit richer people most, more tax incentives are likely to bring more inequality. They will also reduce tax revenue and worsen the budget mess.

Mr Bush's health-care philosophy has a certain political appeal. It suggests incremental change rather than a comprehensive solution. It reinforces existing industry trends. And it promises to be pain-free. Unfortunately, it will not work. The Bush agenda may speed the reform of American health care, but only by hastening the day the current system falls apart.

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