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Health Care Reform and Economic Growth: A Critique of the CEA Report

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On June 2, President Obama's Council of Economic Advisers (CEA) released a report entitled, "The Economic Case for Health Care Reform," discussing how health care reform might strengthen the economy in the long run.[1]

CEA's report offers much useful and insightful analysis of problems in the health care sector, but in the end draws a rosy conclusion based on the stated assumption that health care reform will necessarily produce a best-case scenario. The report assumes, without any justification given, that health care reform would result in the same level of health outcomes while "slowing the annual growth rate of health care costs by 1.5 percentage points," which in turn "would increase real gross domestic product (GDP), relative to the no-reform baseline, by over 2 percent in 2020 and nearly 8 percent in 2030."

No Real Solutions. The scenario of "slowing the annual growth rate of health care costs" will not be achieved by any of the current reform proposals from the Administration and congressional Democrats. None of these proposals even addresses, let alone solves, the most serious problems that CEA identifies in the current health care system. All will either increase health care spending or decrease it by limiting patients' access to necessary care.

Indeed, the CEA report conspicuously omits any discussion of specific reform proposals, either those currently before Congress or in the public eye, or any others that CEA might believe would achieve its best-case scenario.

Why Health Care Reform Might—or Might Not—Lead to Higher Economic Growth. If Americans could attain the current level of health for a lower total cost, the resources saved could be used for some other beneficial purpose, and U.S. economic well-being would undoubtedly improve. This is the basic claim of the CEA report, and it is uncontroversial—even tautological. But would health care reform lead to this idealized outcome?

The CEA claims—based on regional differences in Medicare spending[2] or the results of the RAND Health Insurance Experiment[3]—that "it should be possible to cut total health expenditures by about 30 percent without worsening outcomes."[4]

There are also many specific reasons to believe that America's health care system is inefficient, many of which are detailed in the CEA report. It is indisputable that the system is far from optimal and that reform, if done properly, would be of great benefit.

The problem is that none of the reform proposals put forward by either the Administration or congressional Democrats would accomplish this goal. These reform proposals come in basically two categories:

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1. Those that will necessarily increase health care spending (with or without improving care), and
2. Those that will restrict access to care and very likely produce adverse health outcomes.

Sadly, with the wrong reform it is quite possible to do both.

Congressional Proposals. Proposals centered around expanding coverage to the uninsured and/or mandating increased coverage for those currently uninsured (such as the draft Kennedy–Dodd bill) will necessarily increase health care spending. The problem those proposals seek to solve is that the uninsured do not spend enough on health care. Covering the uninsured will improve their access to health care by enabling them to spend more. If the goal is to improve economic growth by reducing spending on health care, these proposals will not accomplish that objective.

Proposals centered on "cost containment" (by which most people really mean expenditure containment) work by limiting patients' access to health care. If the goal is to decrease spending without regard to patients' well-being, cost containment is actually very easy—just make higher spending illegal.

This is the approach taken by the "American Health Security Act" (S. 703) introduced by Sen. Bernie Sanders (I–VT) and Rep. Jim McDermott (D–WA), and the "U.S. National Health Care Act" (H.R. 676) introduced by Rep. John Conyers (D–MI). They would establish a Canadian-style system with a "global budget" and outlaw private health care spending.

S. 703 explicitly limits total national health care spending to the 2008 level plus the GDP growth rate. It prevents health spending from *ever* increasing as a share of GDP (except in years of recession, since it keeps the health budget fixed when GDP falls). H.R. 676 calls for Congress to establish the national spending limit annually.

These proposals would limit health care spending but do nothing to assure that health care outcomes would remain the same. On the contrary, with each state (and even each hospital) assigned a specific annual budget, patients would have to be turned away when the money ran out. Everybody would be "covered," but everybody would be denied health care once the spending limits were reached. Nothing in this approach would make health care more efficient or make sure it would be no less effective than it is now. Spending would be reduced, but patients would suffer.

Unrealistic Assumptions. Health care markets clearly have substantial inefficiencies, which means that in theory the same level of health care could be delivered at a lower cost. The CEA's key assumption is that not only is this possible in theory, but reform will necessarily make it happen—and furthermore, that the savings will be directly reflected in increased GDP (which they propose to measure in a new, different, and inconsistent way).

The CEA simply guesses that reform would reduce the growth rate of health expenditures (which except in one instance they erroneously call "costs") by 1.5 percentage points. They assume—and deserve rare credit for stating so explicitly—that reform would mean the same health outcomes using fewer resources and that the savings would be spent producing other useful output. They then use convenient fractions to "calculate" estimates that are "more conservative."

Their lack of conservatism lies not in the numbers they choose but in the assumption that health care reform will necessarily achieve the same level of health at a lower total cost. Their estimates are "best case" scenarios not numerically (in the sense that some smaller saving would be more realistic) but in the sense that whatever reform is implemented achieves cost savings without degrading health care quality or health outcomes.

1. The White House, Council of Economic Advisers, "The Economic Case for Health Care Reform," June 2009, at *http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf* (June 23, 2009).
2. John Wennberg, E. Fisher, and J. Skinner, "Geography and the Debate over Medicare Reform," *Health Affairs* Web Exclusive (2002), W96-W113.
3. Willard G. Manning *et al.,* "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review*, Vol. 77, No. 3 (1987), pp. 251–77.
4. Council of Economic Advisers, "The Economic Case for Health Care Reform," p. 18.

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Useful, but Incomplete. The CEA report offers much useful and insightful analysis of problems in the health care system and offers an enticing picture of the widespread economic benefits that might accompany solutions to these problems. However, the report fails to draw a link between any particular health care reforms and the economic benefits that might theoretically be achieved.

Furthermore, the conditions required to achieve those enticing economic benefits are conspicuously absent from current health care reform proposals. In fact, most proposals from congressional Democrats explicitly contain features that will preclude those widespread economic benefits by mandating either lower levels of health care services, higher levels of involuntary spending, or both.

Health care reform is important to America's health and the health of the nation's economy. But that reform must be based on sound analysis rather than rosy assumptions. Otherwise, the U.S. will not achieve the desired results of better health levels at lower costs for more people and greater control over health care decisions by those they affect most: patients.

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