THE BROOKINGS INSTITUTION

Engelberg Center for Health Care Reform

THE ECONOMIC IMPACT OF HEALTH CARE REFORM

Washington, D.C.

Tuesday, June 2, 2009

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Presentation:

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Panel Discussion:

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P R O C E E D I N G S

MR. MCCLELLAN: Good afternoon, everyone. I'm Mark McClellan. I'm the Director of the Engelberg Center for Health Care Reform here at Brookings, and I'd like to welcome you to this very important and timely discussion on the economic impact of health care reform. This is a discussion occurring in the context of the release of a new report from the President's Council of Economic Advisers on the economic case for health care reform.

Health care reform is clearly an important health issue, an important public health issue, but this report emphasizes that it is also a first-order economic issue. Health care is such an important part of our economy and it's such an important part of our fiscal outlook. I think I've heard from both Christina Romer who will be speaking shortly, and David Cutler one of our panelists, that if you're an economist working on public policy, sooner or later you're going to become a health economist and I think this event reinforces that. I think that's true for Doug as well.

Because of the health care importance in the overall economic outlook, reform that has a positive impact on health and on slowing cost growth in economic terms, reforms that increase the efficiency of the value of health care can also have a significant impact on the economy, and vice versa, failing that or acting in a way that

compounds the inefficiencies in the cost growth in our health care system could have a significant negative impact.

We're going to talk about all this today. Here's the plan for the event. We're going to start out with some remarks from Christina Romer, the Chair of the President's Council of Economic Advisers, about that report issued today on the economic case for health care reform. Then we're going to discuss the issues that were raised in that report with David Cutler and Doug Holtz-Eakin, and we want all of you to be involved in this discussion as well.

Let me just mention a few logistical points. This event is being recorded and videotaped, so all the remarks and questions are going to be on the record. For questions later on in the session, we're going to be turning to those of you here participating today. There will be roving microphones and I would like you to raise your hand, identify yourself and go ahead and start thinking about some of the questions now. I'd like to do that too because we've got a limited amount of time today and I want to keep moving things along, so we'll be asking you keep your questions succinct so we can fit in as many as possible.

To those of you who are here from the media, we are going to have a media availability directly after this event at 1 o'clock, so in the interests of getting as broad participation as possible, I'd like you to hold your questions until then. We'll have availability right outside of this room

at 1 o'clock, and if you have any questions about that, Brynn Barnett, our communications director whose hand is up in the back, can help you out in making sure you get there.

Let's get started. I'm going to introduce all of our participants right now so that we don't have to interrupt the flow later on. We're very pleased to have with us first of all Christina Romer, the Chair of the Council of Economic Advisers, and we also have the privilege of being joined by Christina's family here today. It's nice to see all of you. Dr. Romer is the Chair of the Council of Economic Advisers. Before that she was Co-Director of the Program in Monetary Economics at the National Bureau of Economic Research and also served as Vice President of the American Economic Association. She is also a Fellow of the American Academy of Arts and Sciences. And she previously served as the Class of 1957 Garth Wilson Professor of Economics at the University of California, Berkeley, and taught economics and public affairs at Princeton University. She is very well known today for her research on the causes of and the recovery from the Great Depression and on the role of fiscal and monetary policy played in the country's economic recovery, with a lot of her recent work focusing like our discussion today on economic growth and the impact of government policies.

David Cutler is the Otto Eckstein Professor of Applied Economics at Harvard University, and he is also a Research Associate at

the National Bureau of Economic Research. He is in the Kennedy School of Government at Harvard University as well. He also recently completed a 5-year term as Associate Dean of the Faculty of Arts and Sciences for Social Sciences. In addition to that, he's got a very distinguished and highly productive career in health economics and in public economics, including some good research collaborations on medical innovation. He is also a Research Associate at the National Bureau of Economic Research, and he's previously served on the Council of Economic Advisers and the National Economic Council during the Clinton Administration and has advised a number of presidential candidates including President Obama as well.

Doug Holtz-Eakin is the President now of DHE Consulting. Previously he was the Chief Economic Adviser for Senator John McCain's 2008 presidential campaign, and before that he was the Director of the Congressional Budget Office. Dr. Holtz-Eakin has served as Chief Economist for the Council of Economic Advisers for President George W. Bush in the early part of the Bush Administration, and is a Research Associate at the National Bureau of Economic Research and was previously a Senior Staff Economist in President George H. W. Bush's Council of Economic Advisers as well. He has been a tenured faculty member at the Maxwell School of Citizen and Public Affairs at Syracuse prior to his move to CBO and his distinguished career in public economics

also included time at Princeton University and Columbia University. We've got a distinguished group of economists here with us today, and let's get right to the discussion. Christina, please come on up.

MS. ROMER: Thank you. It is wonderful to be here, and what Mark said is so absolutely true. I think of myself as a macroeconomist, an economic historian, and it is true, you only have to be in Washington a very short while to realize that there is no more important issue than health care and so that's what I'm going to be talking about this morning.

This morning the Council of Economic Advisers released a report entitled "The Economic Case for Health Care Reform." The key contribution of the report to my mind is to show that if we do research reform well, the benefits to the economy will be enormous. If we can genuinely restrain the growth rate of health care costs significantly while assuring quality, affordable health care for all Americans, living standards would rise, the budget deficit would be much smaller, unemployment could fall, and labor markets would likely function more efficiently. Because the economic benefits that we identify depend crucially not on just doing health care reform but doing it well, we hope that this report will help strengthen the resolve of policymakers to undertake the serious changes that are necessary.

The report has four key sections. The first discusses some key projections of what's likely to happen in the absence in the health care sector without successful reform; if you want, it shows the cost of doing nothing. One fact that's well known is that health care expenditures in the United States are currently about 18 percent of GDP, by far the highest of any country. These expenditures are projected to rise sharply. By 2020, our projections suggest health expenditures could be roughly one-third of total output in the U.S. economy.

For households, rising health care expenditures will likely show up in rising insurance premiums. Even if employers continue to pay the lion's share of premiums, both economic theory and empirical evidence suggest that this trend will show up in stagnating take-home wages. So this figure which is Figure 3 from our report shows our projection of total compensation, that's the top line, and compensation less insurance costs, that's the lower dashed line, both in inflation-adjusted dollars. We project that without reform, the noninsurance part of compensation will grow very slowly and likely fall eventually as premiums, that wedge between those two lines, rise sharply over time.

Rapidly rising health care costs also means that government spending on Medicare and Medicaid will rise sharply over time. Our projections suggest that these expenditures which are currently about 6 percent of GDP will rise to 15 percent of GDP by 2040. In the absence of

tremendous increases in taxes or reductions in other types of government spending, this trend implies a devastating, and, frankly, unsustainable rise in the federal budget deficit.

Another trend that's well known but too crucial to be ignored is the rise in the number of Americans without health insurance. Currently 46 million people in the United States are uninsured. In the absence of reform, this number is projected to rise to about 72 million by 2040.

The second key part of our study looks at the inefficiencies in the current system and the market failures that lead to our lack of insurance. It's important to diagnose the problem before one can sensibly discussion solutions. This part of the report also discusses the key goals that the President had laid out for reform. One is to slow the economic rate of health care costs while maintaining and chose of doctors and plans, and another is to expand health insurance coverage to all Americans. Since reform plans are very much in the process of being developed cooperatively with the Congress, we don't describe in detail the reforms that would enable us to achieve these goals, but to make the analysis credible, we give a sense of the kinds of changes that might be implemented. We also survey the evidence, must of it from international comparisons and for comparisons across different parts of the United States that there is substantial inefficiency in the current system. This is important for making the case that slowing the growth rate of costs by

improving efficiency is absolutely possible. For example, our estimates suggest that we could slow cost growth by 1.5 percentage points per year for almost a quarter of a century before we would have exhausted the existing degree of inefficiency.

However, I don't want to sugar coat the situation. Slowing cost growth by 1.5 percentage points per year may sound small, but it is likely to be very challenging. It will take an incredible degree of resolve and cooperation among policymakers, consumers and providers to bring this about, but what our study shows that it should be possible. More fundamentally, what our study shows is that the economic benefit of slowing cost growth would be enormous. This is in fact the conclusion of the third key part of our study which looks at the economic effects of successful reform.

In our study we examined the effects of cost containment and coverage expansion separately, but obviously the two are related. For example, expanding coverage is likely to make certain types of cost containment easier to achieve.

In our analysis of cost containment, we focus on slowing the growth rate of costs. This is the so-called curve bending that can last for decades. This is quite separate from actions that we might take immediately to cut the level of government medical spending such as the roughly $300 billion of Medicare spending cuts proposed in our budget.

These immediate level changes are unquestionably important for paying for the expansion of coverage in the next decade, but for thinking about the changes that will save us from the unsustainable long-run trends that I've been discussing, slowing cost growth year after year is essential, and that's what we focus on in our study.

You're also going to see that we consider various degrees of cost containment. In particular, we're going to look at the effects of slowing the annual growth rate of annual health care costs by the 1-1/2 percentage points that's really been the focal point of much of the discussion. We're also going to look at smaller levels, 1 percent or half a percent. To be conservative, we're also going to assume that it's going to take a few years before any genuine curve bending could kick in.

The fundamental thing that slowing cost growth does is to free up resources. If we restrain costs by eliminating waste and inefficiency, we can have the same real amount of health care with resources left over to produce the other things that we value; this causes our standard of living to rise.

We analyzed the effects of freeing up resources in a standard growth accounting framework. For those of you who like equations, the framework is spelled out in an appendix to the report. The President had great fun with that yesterday. I told him that there was actually a version with calculus if he wanted it.

Nothing says how we would use those freed-up resources. We may spend some of them on increasing the quantity of health care by expanding coverage. We may spend some of them on increasing the quality of health care as well. But the crucial finding of our analysis is that we can have a lot more of the things that we value as a country if we slow the growth rate of health care costs.

We then expand our framework to analyze what slowing cost growth would do for the deficit and capital formation or investment. Because the government is a major provider of health care, slowing the growth rate of health care costs would lower the government budget deficit and therefore increase public saving, and efficiency gains that raise income would lead to some additional private saving, and all of this increased saving would tend to lower interest rates and encourage investment. That extra investment tends to increase output even more.

Our estimates suggest that the combined impact of greater efficiency in health care and greater investment is very large. One way to make these effects concrete is to translate them into income for a typical family of four in constant dollars. These effects are shown in this figure, Figure 15 from our report. The bottom line shows the projected path of family income without any health care reform. The higher paths show family income under different degrees of cost containment, so the top line shows if we can manage to slow cost growth by the 1-1/2 percentage

points. What you find is if we do that, family income would be about $2,600 higher in 2020 than it otherwise would have been; by 2030 it's nearly $10,000 higher.

I also want to show you what our analysis implies about the effect of health care cost containment on the federal budget deficit. Here I need to be very clear that our estimates are not official budget projections that would be based on detailed projections of costs and revenues. They're much more a back-of-the-envelope calculation. And they do not include the costs of coverage expansion because most of those costs will be covered by the spending cuts and the revenue increases that are currently under discussion. Our numbers really focus on the effect of slowing cost growth over the long term.

What we find is that the effects on the deficit are very large. So this figure, which is Figure 14 from our report, shows the deficit reduction in key years. If we can slow cost growth by 1.5 percentage points, that's the purple columns, in 2030 the reduction in the deficit would be 3 percent of GDP. By 2040 what you see is that it would be 6 percent of GDP. These numbers illustrate the crucial truth that serious health care cost growth containment is the number one thing that we can do to ensure our long-run fiscal health. Health reform is just simply central to long-run fiscal stability.

Another possible macroeconomic effect of cost growth containment is perhaps a short-run impact on unemployment and employment. When health care costs are growing more slowly, wages can grow without firms' costs rising, so firms do not raise prices as much. This allows monetary policy to lower the unemployment rate while keeping inflation steady. Studies show that this mechanism was one source of the unusual prosperity of the 1990s. Widespread replacement of fee-for-service medicine with managed care led to a period of much lower health care cost growth which contributed to the unusually low unemployment rates in the mid- and late-1990s. Our estimates suggest that slowing cost growth by 1-1/2 percentage points per year would lower normal unemployment by around a quarter of a percentage point. This translates into an increase in employment of about 500,000 jobs. While this is surely not a permanent effect, it could last for a number of years.

The fourth and last part of the report discusses the benefits of coverage expansion. The most important of these involves the economic well being of the uninsured. We used the best estimates available to try to quantify the costs and benefits of expanding coverage to all Americans. Among the benefits that we try to put a dollar value on are the increase in life expectancy and the decreased chance of financial ruin from high medical bills. The costs to society of covering the uninsured represent a mix a public and private costs and come from existing studies,

not from any estimates or plans currently being contemplated by Congress.

Not surprisingly, we find that the benefits of coverage to the uninsured are very large, but crucially, we find that the next benefits, the benefits minus the costs, are also very large, roughly on the order of about $100 billion per year, or about two-thirds of a percent of GDP.

Another effect of expanding coverage that we consider is increased labor supply. With full health care insurance coverage, some people who would not be able to work because of disability will be able to get health care that prevents disability. They would therefore be able to stay in the labor force longer. A related effect is that some workers currently in the labor force would be more productive with better health care. How large these effects might be are hard to predict and there could be offsetting effects, for example, with a better insurance market, some workers who are working just to get health insurance might retire earlier. But we believe that the net impact on effective labor supply will be positive and will further increase GDP.

The final impact that we identify is the effect of expanding coverage on the efficiency of the labor market. Expanding coverage and eliminating restrictions on preexisting conditions could end the phenomena of job lock where worries about health insurance cause workers to stay in their jobs even when other jobs that pay more or maybe

are a better match is available. Our estimates based on a range of economic studies are that this benefit could be about two-tenths of a percent of GDP each year.

Similarly, we examined the fact that small businesses are currently disadvantaged in the labor market because employer-sponsored health care insurance is so expensive for them. Moving to an insurance system that removes this disadvantage would be beneficial to the competitiveness of the crucial small-business sector of the economy.

The bottom line of our report is that doing health care reform right is incredibly important. If we can put in place reforms that slow cost growth significantly and expand coverage, the benefit to American families, firms and the government budget would be enormous. To put it simply, good health care reform is good economic policy.

MR. MCCLELLAN: Let me just take a second to get everyone seated. While people are doing that, let me just review that what Christina was talking about is a basic economic model, I'm going to stay away from the math too, where the economic output depends on spending on capital investments and on labor and on the economy's productivity in turning capital and labor and turning its resources into more valuable outputs. So in basic economics, if you have more resources to spend on capital and labor you can get more output. Where might that come from? As she discussed, if we can identify resources that are being

wasted in health care and stop doing that, then those resources can be used productively to increase our economic well-being in increased output. Some of those resources would be saved as well leading to more capital investment too. In the model in the paper, all of the federal share of reduced spending I think goes into deficit reduction and not into new government spending, and that plus the share of private spending reduction that is saved amounts to an increase in investment.

Of course, this model works the other way too. If we take some resources that we could use in other parts of the economy and add them into health care, then if they aren't used very well or if they aren't adding to value, if they're wasted, then economic output would go down and savings would fall and so on, the reverse direction in terms of economic well-being. Or if we take out resources from health care that are actually doing good, extending lives and improving lives, then the value of our economic output could also decline. The same thing goes for a slowdown in spending growth that reflects not a reduction in waste but a reduction in valuable medical innovation; our health won't improve as much as it could.

In fact, in the report as Christina just described, there are some economic benefits of some types of spending increases. Particularly in the model, expanding coverage showed how valuable health care spending could be if it led to results like reducing uncertainty

about economic well-being, reducing uncertainty about spending, ending lock and of course improving health as well.

So a lot of the work in the health care reform effort and certainly a lot of the things that we're doing here at Brookings is about how to make health care dollars more productive, how to go about achieving this goal to get even more health benefit for what we're spending or maintaining the same level of health benefits while spending less. Some of the policies that could help do that were included in the report that Christina presented, things like measuring what we want. Historically we focused on paying for more labor, more materials, more volume and intensity. We're in a process of moving to more an outcomes focus. Then along with that, incentives and other steps that help redirect health care resources to uses where their impact on health is the greatest such as payment reforms focusing on value like accountable care and benefit reforms that enable consumers to save more money when they take steps to get the care they need at a lower cost, and reforms in health care coverage systems that provide stronger support for getting people in the coverage that have payments and benefits designed in a way that lead to greater value. But as Christina said, it's very challenging to do this and this illustrates why health care reform is so important and also why it's so important to do it right. There is definitely serious interest in doing it right. I think at that press conference this morning, Christina, where you

participated, a lot of the political leaders, Senator Baucus, Peter Orszag, and others, clearly emphasized that they mean it about taking steps to reduce costs and improve the efficiency of the health care system.

So let me ask that same question to the economists who are with us here starting with David. Can it happen? Can we do this?

MR. CUTLER: Yes, and yes.

MR. MCCLELLAN: Great. Let's hear about how.

MR. CUTLER: Let me just start off first by congratulating Christina and the staff of the CEA because this is actually an extremely well-done and very, very nice report. In between 104 footnotes and the 100-some-odd citations, it's really very impressive.

I actually just want to come back to one thing you said about universal agreement. As every academic does, I looked through the references. I tried to count up what was the ration of citations to people who I traditionally think of as left to center relative to who I traditionally I think of as right of center, and I didn't do it in any formal sense, but it struck me as roughly about equal, which is say that what the CEA has done is bring together literature from across the spectrum and say what do we know about the benefits of doing better here without regard to particular ideology or so on in really the best traditions, and I think it's fantastic.

Can it happen? Yes. How can it happen? It's going to require hard work. Let me give you an example, and I want to start off focusing on the cost saving end of this which clearly plays an enormous role here. What will it mean to bend the curve, in essence? I'm going to give you three example which will illustrate both the possibilities and why it's hard. One example which I thin we economists often understate is that successful health reform will reduce the cost of doing exactly the same things we do now. Think about your doctor's office for a moment. Your doctor's office has a person or more whose full-time job is to pull records and place them back. This is something that used to be common in every industry and is now virtually unheard of. There are some people who do that in health care than are nurses. Hospitals have more people involved in billing than they have care staff. What this means is forget about what we do, forget about what we give people, we can do exactly the same thing that we do now cheaper. If you asked any person involved in management consulting how much could you take out of the cost structure of a typical hospital and do exactly the same thing, they will tell you easily 20 or 25 percent. Hospitals are about 40 percent of medical care spending, so what they told you is they can eliminate about 8 to 10 percent of health care spending off the bat without getting into who receives what treatment for anything. It's not going to easy. It's going to involve things like IT and changes in practice design and all of that sort of

stuff, but it's possible. The same is true about physician spending. You can easily save a lot of money. That's not even in the 30 percent that Christina was talking about. That typically refers to care that people receive that they don't necessarily need to receive that's not benefiting them in any way. This has to do with how you go about providing things.

Second is prevention and preventing disease. About three-quarters of medical spending is for stuff which is preventable, and we know in many cases how to do better. Just to take an example of that, in some studies if you look at people who are given a prescription for a drug they should take for the rest of their lives, high cholesterol, high blood pressure, whatever it is, about 50 percent of the prescriptions are never filled, then about 50 percent are never refilled. It keeps going down so that about by 9 months or a year after people are given a prescription for something they take for the rest of their lives, somewhere between a quarter and a third of people are actually taking the medication.

We know how to do better. There is a very big, easy way to do better. People take their drugs more when the cost-sharing is lower. It makes you wonder why it is we charge increasingly high cost-sharing on drugs that are so obviously beneficial to people that they should be taken forever. So we clearly have to get smarter about how we design things. There are also technological ways that we can use. Prevention is also intimately tied up with getting people insurance coverage. A third of

Americans are either uninsured or into and out of insurance. There is no way to prevent disease when a third of the people including many of the most needy people are just into and out of coverage and not seeing any regular course of care. Again the savings are enormous. If you could reduce it by 10 percent as many studies say you could, that's about 8 percent of medical spending, and you haven't rationed anything to anybody. What you've done is reduce the demand for care because you're getting people to take stuff in the way that they ought to. And lots of these clinical trials show benefits that then don't carry over into common use because in the clinical trials people are monitored so carefully and we have to figure out the way around. So that's the second part.

The third part is thinking about stuff that's done that doesn't need to be done, and here is where a lot of the issue come up that Mark was alluding to about where do we give services that we don't need to. Some of those services are really just things we don't need to do. For example, we repeat imaging tests because the first one wasn't around, or we do things just because you went to a surgeon and the surgeon does something even though it's shown that the medical management is much better almost all of the time or we don't take account of patient preferences. Then some of it's in that gray area where probably it's useful for some people, probably it's not for other people, where we need more information, we need appropriate financial incentives and all of that. That

will clearly be hard to get at. I think of this as a longer-term thing, but nonetheless it's absolutely crucial. The sort of curve bending that Christina talks about, I don't think of it as one thing. I think of it as a series of things. Just like in manufacturing firms don't say how am I going to improve productivity by 2 percent a year or 2-1/2 percent a year even though they do, they always think about what thing can I do that's going to improve productivity.

If you look at what that involves, the most productive firms have three components. If you look at productive firms versus unproductive firms, productive industries versus unproductive industries, there have three components. First, the productive ones use information technology a lot. They know what they're doing, they know who's doing it, they know where it's happening and they know what it costs. In health care of course, health care is probably the most information-intensive industry in the economy and it uses information technology the least of any industry in the economy. So it's no wonder that we have no idea what we're doing. That's the first item.

The second thing about productive firms and productive industries is that they compensation systems that reward creating value, that the goal of the employees financially is aligned with the goal of the company. In health care as Mark said, you get paid for doing more and not for doing anything better. So if there's a way to save money and

improve patient care, your typical provider could go bankrupt if they tried to do it. That's the second hallmark. Again it's completely off.

The third hallmark of productive industries or productive companies is that they empower the workers to make decisions, so that in Toyota the worker on the assembly line can pull the switch and stop the line. Workers can do things to make the production smoother, and they can do that because they have the information and because they have the right incentives.

In health care there are really two kinds of workers. There are the workers who you think of, the nurses and so on who typically say, no, you can't do this because we've got a law saying you can't do this. The other component of the worker here is the patient who is an input into the production and who we have not enabled in any way. I'm always amazed how much more you can know about say buying a car than about buying a surgeon, even though the difference in mortality rates between surgeons will vary by a factor of 5 or 8 or 10 to 1 for exactly the same thing. Those three things are what we know about in other industries. If we translate them to health care, I believe they can be done and I believe they will show up in all of these ways, if not more. I think there is 30 percent or more to be saved and I think if we're really serious about it we will produce the kinds of benefits that Christina spoke about and we'll think

of this as one of the greatest things we've done for the economy in some time.

MR. MCCLELLAN: David, that's a pretty clear yes. I'm going to come back in a little bit as to how. But let me turn to Doug. David, I want to ask you where you put the members of this panel in your little classification and political leanings, but on the panel at least Doug is left of center. Right?

MR. CUTLER: Doug is to the left of me.

MR. HOLTZ-EAKIN: I'm delighted to be here and to the left of David. Thank you for the chance.

I think David has been very eloquent about the potential and the opportunity for reform, and for those you have followed health care per se for a long time, this report makes the very important observation that this is an economic growth opportunity as well and that if you are a pro-growth economist as I hope everyone is, that this is an opportunity that we do not want to squander, that we can take advantage of the one-sixth of the economy that is performing below par, remove some inefficiencies and take advantage of the freed-up resources.

I want to congratulate Christina and the CEA staff for continuing a CEA tradition which is take policy issues and analyze them through the analytic lens that the training they've acquired gives them and to deliver quantitative and important insights into these public policy

issues, and this report really stands out as one of those contributions. Given that it is so numerical in its content, I think it's important to be fair, and just let me some reasons why you might not want to take every number in this report at face value, because these are hard things to do and I think there are some places here for some slippage.

The first is the comparison to the counterfactual. This is a counterfactual that says the word trends straight off the abyss no matter what and we compare all of the things that we could potentially do to that trend. That's not likely to be the real counterfactual. Somewhere out in the future there will be a messy ad hoc reform to the health care system so that doesn't overwhelm the whole economy and the federal budget. We don't really know what that looks like, but we need to compare in order to do an apples-to-apples comparison versus that and not versus the trend line. So that probably says that we're overstating the potential gains somewhat.

The second is this report contains a very optimism view of reform. I think they're honest about that, but what could a great reform and a great government accomplish? My favorite line which I could not pass up in this report is, "In this analysis, we assume that all of the savings to the federal government take the form of deficit reduction. The assumption is a reasonable approximation," not to any Congress I've met. So you do have to think of this as the upper bound of reform that happens

essentially costlessly. We don't have to go through the cost of the management and consultants in the hospitals, we just get the freed-up resources and off we go.

The third is the issue of timing. I think there is probably a lot of unanimity across different analytic perspective, across party line, about the importance of delivery system reform, the types that David mentioned and Mark has spent so much work on. We really believe that those reforms have the potential to deliver higher-quality care and lower costs in the future? We believe it. We don't have an overwhelming amount of evidence so far. We don't know what the timing will be. So all of the sizes here and all of the projected paths are very speculative but we just don't know for sure. We got to do them because we know the system we have now is broken, but what the timing and gains will be is not really clear.

Then I guess the last thing is I think the timing does matter because part of a good reform, the kind that's potentially sketched out in this paper is one where there are delivery system reforms and they are done in tandem with coverage expansions in a way that is fiscally responsible and adds up. Getting an actual reform to line up in that way I think is an enormous political challenge and we'll see whether we can pull that off. One of the things the report does which I thought was really quite striking is it actually takes the current received wisdom around town that balancing the budget is health care reform and says no, because if you

look at the numbers in a budget outlook that the CBO priced at having deficits at 4 percent of GDP are greater out to 2019, even the best health care reform here gets you 1 percent of GDP. So we have a deficit problem that's not solved just by health care reform and it's important that the report flags that. We need to do health care reform for all these longer-run issues and for health care per se, but it's not the solution to all of our deficit problems and I think that that's another contribution that the report lacks.

I would take all the numbers with a big grain of salt, but this is an opportunity. The report identifies the potential size of that opportunity and it's one that we should not squander by doing a bad reform or by failing to reform at all.

MR. MCCLELLAN: Thanks, Doug. Christina, any comments? Are you an optimist?

MS. ROMER: There are a couple of things to say. One is I think that this is a representative of what we may be facing and maybe we do have a really good chance of getting health care reform passed because I think the degree to which we all agree that this is a major issue and that there really are billion dollar bills lying on the sidewalk, a lot of inefficiency that we could deal with.

Let me just mention a few of the things that Doug mentioned. On the idea of the counterfactual, one of the things you will notice is that

our projections of where we're going are less pessimistic than the CBO's, so we're not as much going over the abyss, so we did try to go a little bit in your direction in being a little less dire of where the world would be, and it's still awfully dire. The other thing is in thinking about very much we're not trying to be optimistic in the sense that though the number that's been out there on what we could actually accomplish, the numbers that have been talked about are slowing cost growth by 1.5 percentage points, we do actually consider suppose we only do a half a percent, suppose we only do 1 percent. One of the things that you do find is that it is very important.

The last thing that Doug mentioned went to the question of the deficit and those kinds of things, and it is so incredibly important to realize what our report is talking about is that what Peter Orszag with his gesture, the curve bending, the slowing the growth rate of cost by a significant fraction. One of the things that we have pledged and I just heard Senator Baucus make the same pledge is paying for anything that we do now with hard scorable savings or revenue increases, that the things that are in here are crucial for our long-run deficit, absolutely to do. There tend to be things that if you were back at CBO you wouldn't score because they are hard to say what's an absolute number on, but they are absolutely fundamental for going out 20 or 30 years, how do you prevent

the fiscal ruin that we are headed toward, but they are above and beyond the other things that we are committed to doing.

MR. MCCLELLAN: Christina, or actually for the whole panel, one of the reasons why there is so much agreement I think among economists that there is this potential economic benefit of health care reform is that we've had so much evidence of inefficiencies and the kinds of waste and failed prevention opportunities that Dave had mentioned. We've had so much evidence on that for so long that the evidence is actually very compelling which is good news in the sense that there's a lot to be gained but potentially concerning in the sense that this evidence has built up over a long time and we haven't seemed to be able to make too much progress on it. Let me ask why is this going to be different? There clearly is a commitment from key political leaders that they are going to do steps to improve the economic efficiency of our health care system as part of reform. This is a very ambitious goal along with expanding coverage as Doug said trying to coordinate this all together. How can we be sure we are really making progress on this and that this is actually going to be a case where hope triumphs over experience? Is it to go by CBO scored savings even though as Christina said the savings that CBO recognizes really don't have that much to do with the kinds of policies that we've been talking here? Are there some other steps? David? Doug?

MR. CUTLER: Let me start off with an analogy on that. Corporate America has been investing in computer systems in a very heavy way since the early-1980s and there was so much investment and yet you never saw any productivity improvement until the mid-1990s. In fact, it was sufficiently noticeable that Bob Solow wrote that you see the impact of computers everywhere but in the productivity data. Then more or less overnight what you saw was productivity in the typical American business go from 1 and a little percent a year to 2-1/2 percent a year, virtually overnight sustained for now close to a decade and a half. If you asked what happened, the answer is they finally put it all together. At first they didn't know how to use the computers right and so on, and then they figured it out, by the way, if we combine it with the internet and so on we can do this. They got the compensation systems right. They finally got how to run the business right. In the 1980s they thought that your headquarters had to have 2,000 employees and now people believe that 80 is too high, so they figured out how to streamline the organization. So it takes time. The hallmark of a lot of industries and a lot of change is that it's slow in coming, but when it happens it happens fast.

That's actually true about health care as well. If you think about the last big revolution, it was the managed care revolution. It took years and years. Everyone asked why don't we go into cost savings things, why don't put people into HMOs? Within a year or two everybody

was in. Then they stayed there and people hated it and hated it and hated it and everybody comes out. So, yes, it sort of takes a while. Hopefully it won't take 15 years this time because we've learned something, but to me it's not surprising that things stick around, but then at some point they reach the tipping point and when you do that then things change very rapidly.

That's why I was telling beforehand, I think there's a upper-bound case, that 1-1/2 percent a year is too low, not as a central tendency, but as to how fast it could be. And ask yourself the question if there is really 30 percent waste do you think there's absolutely no chance that you could eliminate 30 percent waste in under 20 years? If you think the answer to that is, sure, there is at least some chance it could happen in less than 20 years, then you think that what you've got is not an upper bound.

MS. ROMER: But see I'm not the true optimist here.

MR. MCCLELLAN: So we're going to see some measurable impacts soon is what I take away.

MR. CUTLER: I think it will take probably 3 to 5 years through a very concerted effort before you start to see change. Again, some of it can be on the easy stuff with IT like in the recovery bill and administrative simplification you can fire a bunch of workers. That's going to be the first thing that you can see.

MR. MCCLELLAN: Doug, what do you think? If we're not going to see impact for 3 to 5 years, is there something we ought to build into reform to make sure that we actually are getting this kind of progress or we're at least not increasing spending?

MR. HOLTZ-EAKIN: The first thing is getting reform. David mentioned one of the reasons why this is so hard is because the first thing you think of is firing workers and that gets in the way of the politics of reform pretty quickly because we have all these people's livelihoods that are going to be radically rearranged, so that's sort of point number one.

The second point which is really an informational issue is there is lots of evidence out there about the inefficiencies in the health care system, so one of the ways people do this math is they look across regions and say a 30 percent difference in spending with no difference in outcome. The analogy I have for that is coffee makers. I used to have a coffee maker where you just put a filter, you press one button and the water came down and you made coffee. I now have a coffee where I put beans in every 5 days or so, I set the time when the coffee maker is off and when I wake up I have fresh-brewed coffee freshly ground every day. The outcome is the same. It's a cup of coffee. So you could say I have a highly inefficient coffee making system now. If I look at the difference between those I'm wasting a lot of money, but the truth is I actually care enough to spend more on some things that we don't see just measuring

the cup of coffee and one of the resistances to reform is going to be embedded in this system are some things that people may be paying for that they sort of like in the way of convenience, that they like in the way of the practice of medicine that are going to be hard to root out just on the grounds of medical outcomes. So that that makes the reform harder to get because you've got to rearrange some things that are really fundamental.

For me that means that you have to have a game plan to actually get there. Reform is a process. It's not a 2009 event, and that means that when you do reforms, you cannot overreach on coverage expansions and the dragging of resources from outside the health sector into the health sector, you have to make sure that you only cover what you are genuinely getting out of additional savings, and you've got to measure them and find them first. That makes the reform much, much harder.

MR. MCCLELLAN: But that's the challenge.

MR. HOLTZ-EAKIN: That's the challenge.

MR. MCCLELLAN: As David said, it's going to take several years optimistically for savings.

MR. HOLTZ-EAKIN: I don't think you can overreach in that and that says that reform is slower than some like, but not all the uninsured are created equally. This paper doesn't go into the uninsured very much, but we've got about 11 million who are eligible for public

programs, we've got nine who are residents in the United States illegally, we've got four or five who are college students, we got about nine million or so who are making more than $75,000 a year, and then we have the rest. Do you want to treat those all equally? They have different inefficiencies. Not all of them are rationed out of health care because of adverse selection and moral hazard. You could say it's a different kind of problem. So you can go slow on coverage than everybody at once and you can set up the measurable benchmarks to get real delivery system savings. That would be a reform that would get us there over the long haul.

MS. ROMER: I wanted to say a word about firing workers, because remember what we're talking about is slowing the growth rate of health care costs. What that really means is by all of our estimates is that the health care sector is still going to be growing as a share of the economy, so the idea that we're throwing a bunch of people out of the health care sector just I think is not plausible, that really what we're talking about is shifting them around within the health care system.

MR. CUTLER: But there do seem to be some concerns about people who are working in hospitals now or people who are working in certain specialties may be needing to redirect.

MS. ROMER: Right, but then again you have to also be thinking about your freeing up resources and those don't just sit idle.

Right? That is what Doug was saying is that it would move into other industries.

MR. CUTLER: Right. I'm not disagreeing. I'm just saying that when we restructure manufacturing and got all these productivity gains we lost a whole layer of middle management. They didn't like it very much. A political obstacle is that, and when you restructure health care you'll have the same political obstacle.

MS. ROMER: I also wanted to come to your point about how will we know, because the real challenge here is going to be doing these things that we know are good that no one will be able to say, yes, that's paying for X and yet it's just a good thing to do. And I actually think it's going to be a job for the health care experts, the people who actually know what are the reforms we need to do to stand up and say these are the really good things, even if you don't see the productivity gains now, 5 or 10 years from now that's going to be crucial.

MR. MCCLELLAN: It's a good transition. Looking around the room I see a number of health care experts here as well as a number of people who are interacting a lot with the health care system. So I'm going to take a few questions. If you could raise your hand. I'm going to try to get the microphones around to you. Maybe up here in front first.

MS. DYER: Barbara Dyer from the Hitachi Foundation. I wanted to keep going on this thread of employment. There are about 6

million front-line workers in health care and these are workers who have disproportionately high amounts of time with patients and low levels of foundational skills, computational skills, literacy skills. Also within that population there are upwards of 100 percent in some parts of health care turnover rates. I don't want to overlook. It's not simply a question of building in efficiency and reducing numbers because it's on the backs of these workers that efficiency gains will either be made or broken.

How are you thinking about the reorganization of learning and organization of work? You touched on it, David, with compensation systems and so forth. But it's a really important and significant challenge that has to be taken seriously, that is, how we organize skills development, integrate them into the care team, really shift the way those workers are viewed in the system.

MR. MCCLELLAN: So big changes that need to come and delivery implications for workers. How do we facilitate that?

MR. CUTLER: Let me just pick up on this theme because it comes back a little bit to the distinction between the middle manager for whom I think as a society we'd be happy if there were fewer middle managers and the front-line production workers. I saw a study recently that did a kind of time-in-motion study of nurses in 36 medical surgical units of hospitals. The single most common thing that nurses were doing with their time, over a third of third time was documenting stuff, not dealing

with patients, not administering medication, but documenting things. You kind of say in what other industry is a third of what you do documented? If you ask a typical doctor, I haven't seen a formal study, what share of your time is spent documenting things -- they'll tell you about 40 percent of it or so.

What I think is that for a lot of the front-line workers, what we'll do is free up their time so that they can actually be say administering services to the patient, and this is the answer to the question how are we going to actually give people care if we've got a primary care crisis and so on? The only way you're doing to do that in the short run is by cutting out some of that third which is spent literally often times taking things that were digital, making it be on paper, and then reentering it digitally again, and we call that health care. For a lot of the front-line workers I think it's going to be freeing up their time so that they can actually do the things for which you need the training to do.

MR. MCCLELLAN: Doug?

MR. HOLTZ-EAKIN: Can I tag team since I'm the voice of doom on this panel? I also walked around a hospital watching one of these sort of modern bar-coded pharmaceutical systems in practice and it was mind-boggling because we had patients who had 10 pills to take three times a day and each pill was bar-coded, and so the person had to open it up, scan the bar code, document that the patient actually swallowed the

thing, document that, and by the time they were through they didn't free up any time. So this goes to David's point that you've got to get everything right. You can't just do one of these things and expect to get the gains. It's going to be very hard.

MR. MCCLELLAN: The next question back here?

MS. LERNER: My name is Michelle Lerner with LaRouche -- I just want to get your comment on a quote from an article written by Dr. Leo Alexander who was one involved in the prosecutions at Nuremberg. I want to read this because he makes a very specific point to the American health system. I'll try to keep it short.

MR. MCCLELLAN: Maybe just the bottom line.

MS. LERNER: I can read it in less than a minute. "Hospitals like to limit themselves to the care of patients who can be fully rehabilitated, and the patient whose full rehabilitation is unlikely finds himself at least in the best and most advanced centers of healing a second-class patient faced with a reluctance on the part of both the visiting and the house staff to suggest and apply therapeutic procedures that are not likely to bring about immediately striking results in terms of recovery. I wish to emphasize that this point of view did not arise primarily within the medical profession which has always been outstanding in a highly competitive economic society for giving freely and unstintingly of its time and efforts, but was imposed by the shortage of funds available both

private and public. From the attitude of easing patients with chronic diseases away from the doors of the best types of treatment facilities available to the actual dispatching of such patients to killing centers is a long but nevertheless -- "

MR. MCCLELLAN: I think I got the point of the question which is --

MS. LERNER: No, you said you'd give me a minute. You said you'd give me a minute.

MR. MCCLELLAN: Especially if we're having health care reform that focuses on getting more efficiency, isn't it going to be tougher on these patients who don't have problems that are easy to solve?

MR. CUTLER: I think this is an enormous -- because some of the most expensive patients are the patients who have multiple co-morbidities and their treatment at this point is basically an unknown in the U.S. health care system. We do not document the different attempts by multiple physicians who treat them simultaneously. We don't coordinate those multiple physicians. They operate as silos. And until we get a better information infused health care system, we will not treat them better and at lower cost.

MR. HOLTZ-EAKIN: Mark, you might answer this question by talking a little bit about the idea --

MR. MCCLELLAN: I'm the moderator.

MR. HOLTZ-EAKIN: -- patients because there's really a lot of thinking that's gone on toward how would you take a patient as a whole and get the medical system to focus on that patient in exactly the right --

MR. MCCLELLAN: It's absolutely agreed that we need to provide more support for focusing on the holistic needs of the patient and not just each particular technical issue. However, even there it is challenging to make sure that you account for the fact that some patients are just going to be harder and more challenging than others and you need to provide some support for the innate desire of health professionals to help those patients as well. That means on the one hand we've talking about going fast for all these changes, it also means some caution, and in some of the accountable care work that we've done we don't advocate moving completely away from fee-for-service payments and into pure capitated system or one with very strong economic incentives to keep costs down, that maybe something in between, something that's more incremental but real and strong progress. The last question over here.

SPEAKER: -- practicing physician. I have often wondered what you mean by prevention because the only thing that we can really prevent are illnesses that we prevent through vaccines. But when you really talk about prevention, what you mean is adequate care to maintain chronic illnesses so that they deteriorate slowly or slower, and as we become more and more successful you need more and more care.

Pneumonia for an 85-year-old patient is a train wreck because all of the organs they have are 85 years old and they don't have any reserve, and pneumonia in a 20-year-old is no problem. You treat it with antibiotics and they bounce. So as we become more successful like the Swiss have, you need more and more care. You're not preventing. You're prolonging the ultimate reality of death.

MR. MCCLELLAN: David, you talked about some of the savings from prevention. Let me come to you on this one. If you prevent some of those illnesses like heart attacks, people aren't going to live forever. They're going to go on and develop some other more chronic conditions, perhaps Alzheimer's or frailty. How does that figure into the costs?

MR. CUTLER: It does, and that's why the savings are not just immediate savings. But most of the studies that I've seen when they look at the lifetime costs show that you can save money, not in all cases but in a lot of the cases, in part because there is often a very lengthy period of very expensive care associated with say the patient with chronic disease having a very bad event and if you cut that out, yes, you still get something at the end but not enough to offset it.

But I do want to actually come back. There is more in the way of prevention and that has to do with primary prevention particularly for things like obesity and smoking cessation. I actually think that one of

the keys to health care reform will be whether we deal with those or whether they get squeezed out. I'm struck that last year the "Wall Street Journal" did a survey of the number of CEOs, I don't think it was a big random sample but they gathered 10 CEOs of companies and asked, What's on your list for health care reform? The number one item on their list was dealing with obesity, before Medicare and all that. So I think there are a lot of facets here that we'd better be prepared to address.

MR. MCCLELLAN: Doug?

MR. HOLTZ-EAKIN: I don't disagree.

MR. MCCLELLAN: I want to thank all of you for attending. There's been a lot of discussion on very important issues here, a very important aspect of health reform and the need to focus on actually making health care work better, emphasizing prevention, taking some tough steps to help achieve the kinds of numbers that Christina has talked about in the report today.

On this same topic, next week on June 9 we're going to have another event here at Brookings co-sponsored with the Hamilton Project on one of the tools that has been talked about as potentially leading to greater efficiency and that's comparative effectiveness with Peter Orszag and Senator Baucus and a number of economists participating in that as well. So this is a topic that marches onward and I want to thank all of you,

and it sounds like you're health economists now, thank you for the contribution.

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