

Health Care System Crisis: Growing Challenges Point to Need for Fundamental Reform



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HEALTH CARE SYSTEM CRISIS:

Significant Challenges Point to Need for Fundamental Reform

- **Federal Fiscal Challenges**
 - **Health Care System Challenges**
 - **Obstacles to Meeting Challenges**
 - **Framework for Evaluating System Reforms**
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Federal Fiscal Challenges: Changing Composition of the Federal Budget

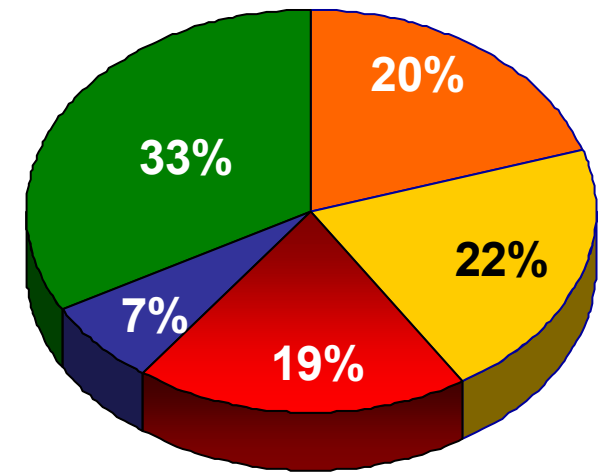
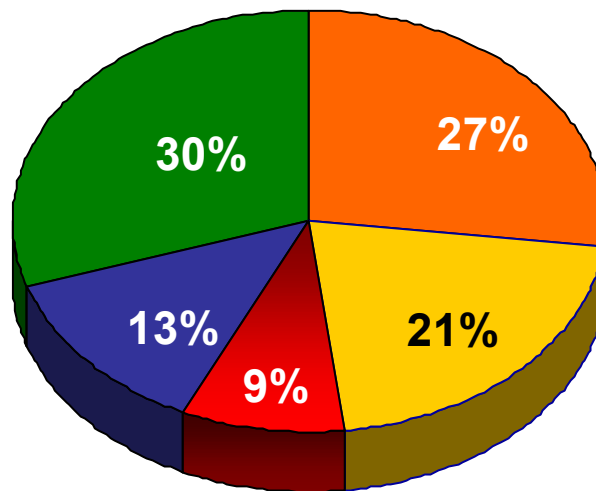
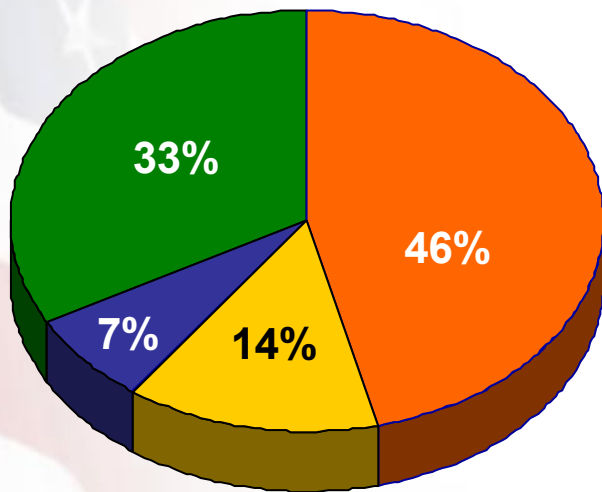
In preparing for our fiscal future, policymakers will want to consider the dramatic change in composition of spending that has occurred over the last several decades and the expected challenges shown in GAO's budget simulations.

Composition of federal spending by budget function.

1964

1984

2004 est.



Source: *Budget of the United States Government, FY 2005*, Office of Management and Budget.

Selected Fiscal Exposures: Sources and Examples (End of 2003)^a

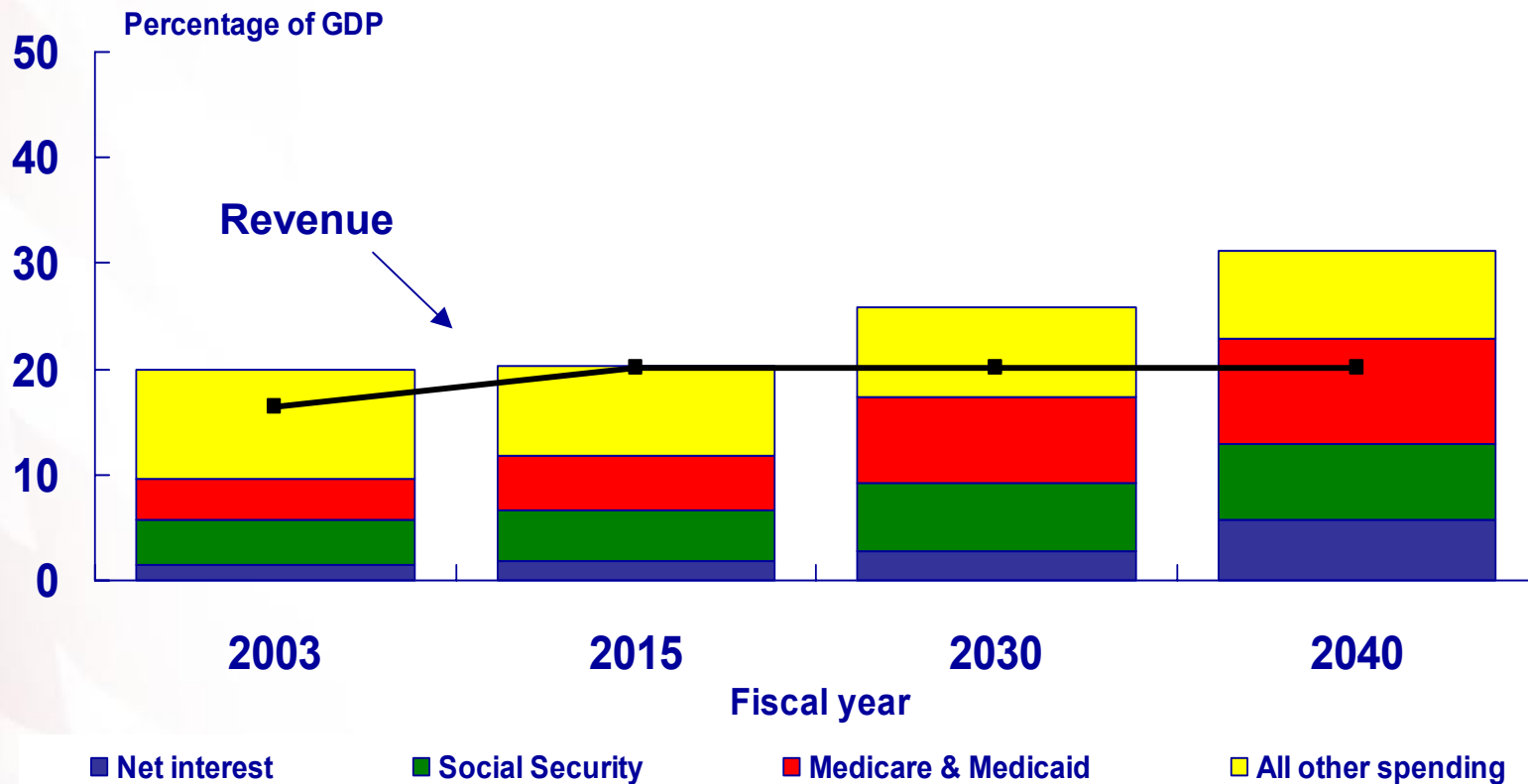
Type	Example (dollars in billions)
Explicit liabilities	Publicly held debt (\$3,913) Military and civilian pension and post-retirement health (\$2,857) Veterans benefits payable (\$955) Environmental and disposal liabilities (\$250) Loan guarantees (\$35)
Explicit financial commitments	Undelivered orders (\$596) Long-term leases (\$47)
Explicit financial contingencies	Unadjudicated claims (\$9) Pension Benefit Guaranty Corporation (\$86) Other national insurance programs (\$7) Government corporations e.g., Ginnie Mae
Implicit exposures implied by current policies or the public's expectations about the role of government	Debt held by government accounts (\$2,859) ^b Future Social Security benefit payments (\$3,699) ^c Future Medicare Part A benefit payments (\$8,236) ^c Future Medicare Part B benefit payments (\$11,416) ^c Future Medicare Part D benefit payments (\$8,119) ^c Life cycle cost including deferred and future maintenance and operating costs (amount unknown) Government Sponsored Enterprises e.g., Fannie Mae and Freddie Mac

^a All figures are for end of fiscal year 2003, except Social Security and Medicare estimates, which are end of calendar year 2003.

^b This amount includes \$774 billion held by military and civilian pension funds that would offset the explicit liabilities reported by those funds.

^c Figures for Social Security and Medicare are net of debt held by the trust funds (\$1,531 billion for Social Security, \$256 billion for Medicare Part A, and \$24 billion for Medicare Part B) and represent net present value estimates over a 75-year period. Over an infinite horizon, the estimate for Social Security would be \$10.4 trillion, \$21.8 trillion for Medicare Part A, \$23.2 trillion for Medicare Part B, and \$16.5 trillion for Medicare Part D.

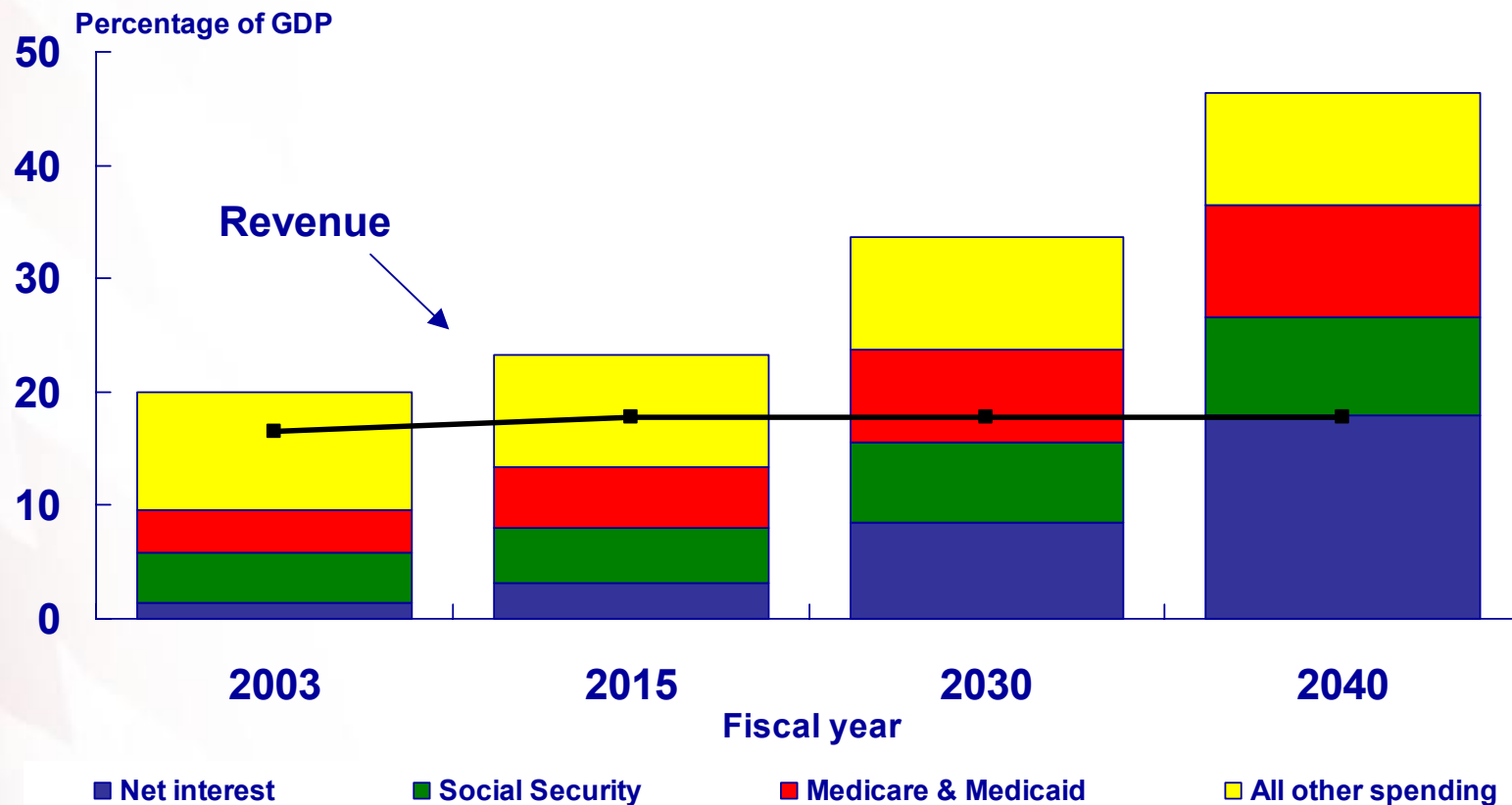
Composition of federal spending as a share of GDP under baseline extended, assuming all tax cut provisions expire.



Source: GAO's March 2004 analysis.

Notes: In addition to the expiration of tax cuts, revenue as a share of GDP increases through 2014 due to (1) real bracket creep, (2) more taxpayers becoming subject to the AMT, and (3) increased revenue from tax-deferred retirement accounts. After 2014, revenue as a share of GDP is held constant.

Composition of federal spending as a share of GDP, assuming discretionary spending grows with GDP after 2004 and all expiring tax provisions are extended.



Source: GAO's March 2004 analysis.

Notes: Although expiring tax provisions are extended, revenue as a share of GDP increases through 2014 due to (1) real bracket creep, (2) more taxpayers becoming subject to the AMT, and (3) increased revenue from tax-deferred retirement accounts. After 2014, revenue as a share of GDP is held constant.

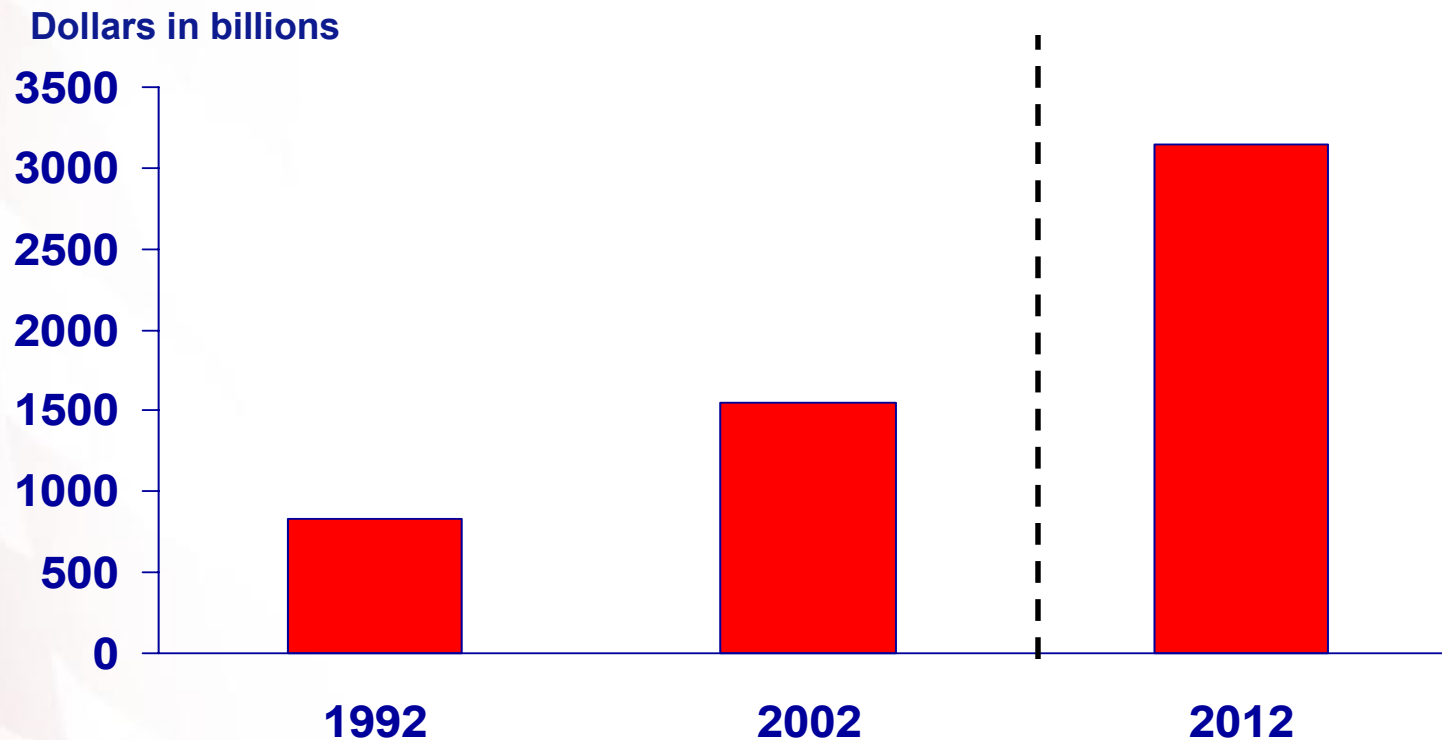
Health Care System Challenges

With respect to health care, both the private and public sectors are losing ground in their efforts to balance competing goals of sustainable cost, broad access, and good quality.

Health Care System Challenges: Costs

- **Despite containment efforts, health care spending continues to escalate:**
 - National health expenditures (in nominal dollars) nearly doubled from 1992-2002.
 - Health expenditures continue to absorb a growing share of the national economy.
 - Public obligations threaten future federal and state budgets as well as the long-term health of the economy.

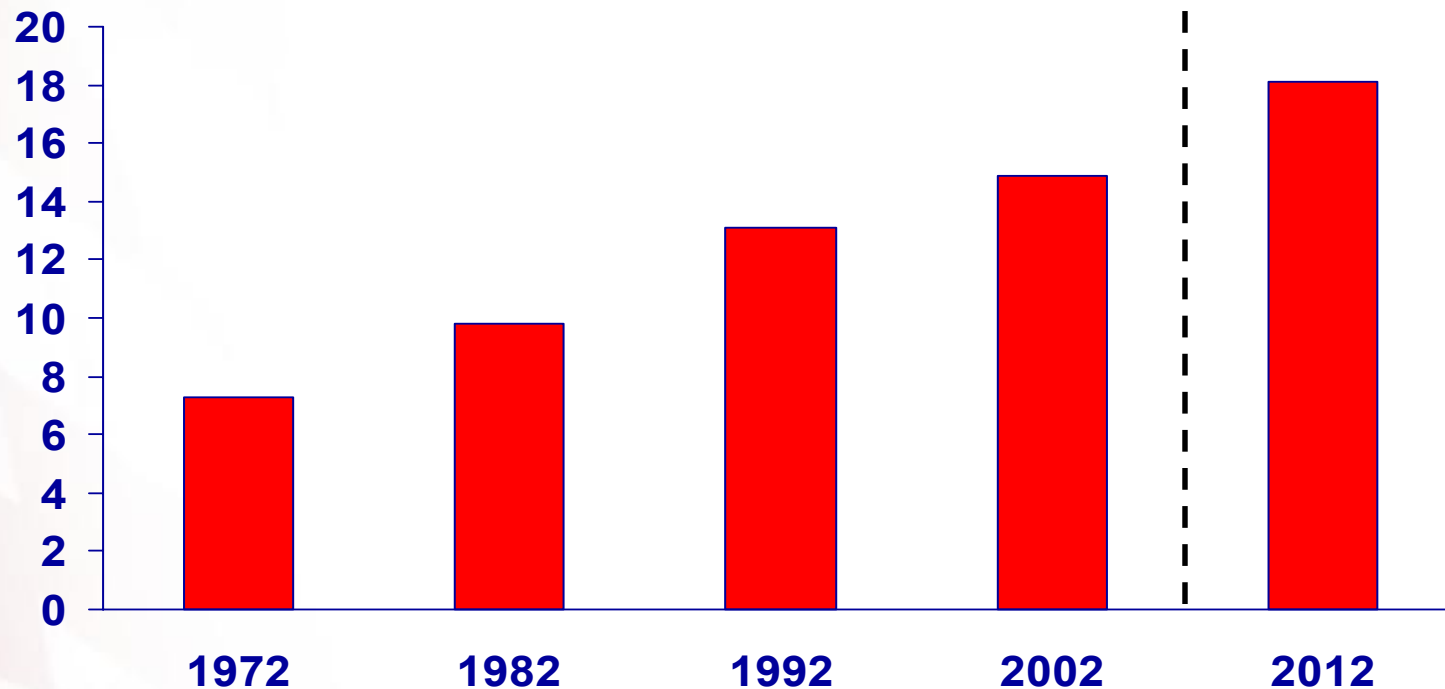
National health expenditures nearly doubled from 1992-2002.



Source: Centers for Medicare & Medicaid Services (CMS), Office of the Actuary (OACT), National Health Statistics Group.
Note: All dollars are nominal. The figure for 2012 is projected. These projections do not include the impacts of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

Health expenditures will continue to absorb an increasing share of GDP.

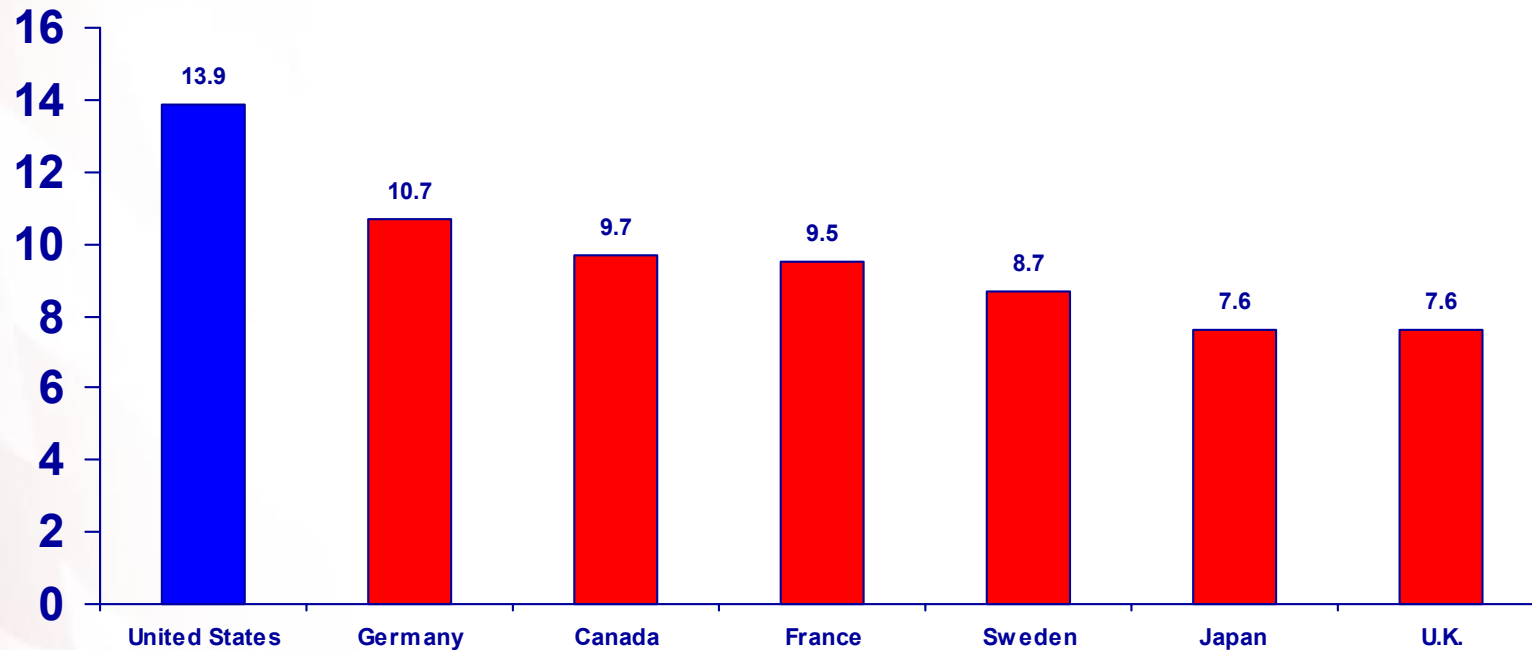
National health expenditures as a percentage of GDP



Source: CMS, OACT, National Health Statistics Group and U.S. Department of Commerce, Bureau of Economic Analysis.
Note: The figure for 2012 is projected. These projections do not include the impacts of the MMA.

The United States exceeds other industrialized nations in total health spending as a percentage of GDP.

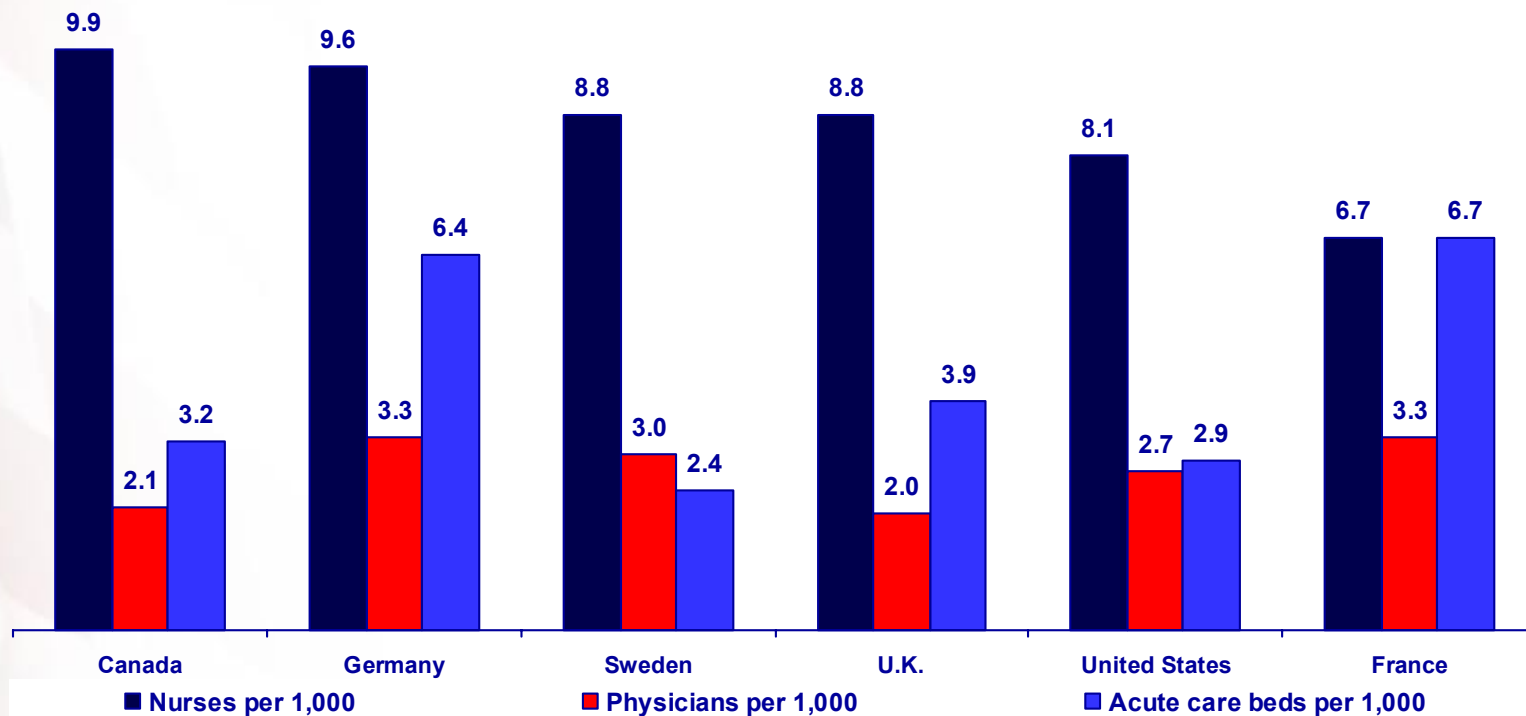
Percentage of GDP, 2001



Source: Organization for Economic Cooperation and Development (OECD) Health Data 2003.
Note: Data for Japan are from 2000.

Despite higher spending in the United States, resources devoted to health care are not always higher than in other countries.

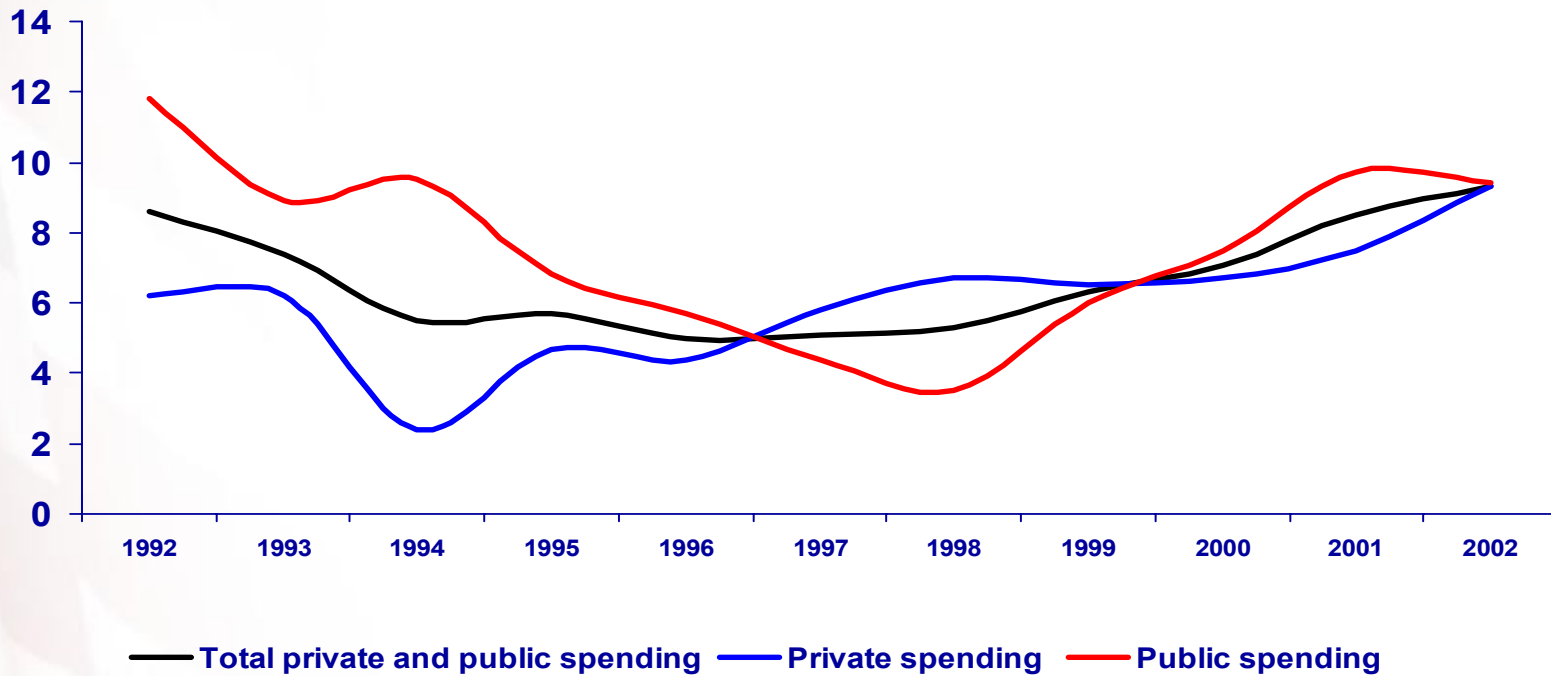
Number in 2000



Source: OECD Health Data 2003.
 Note: Data on the number of nurses and physicians for the U.S. are from 1999.

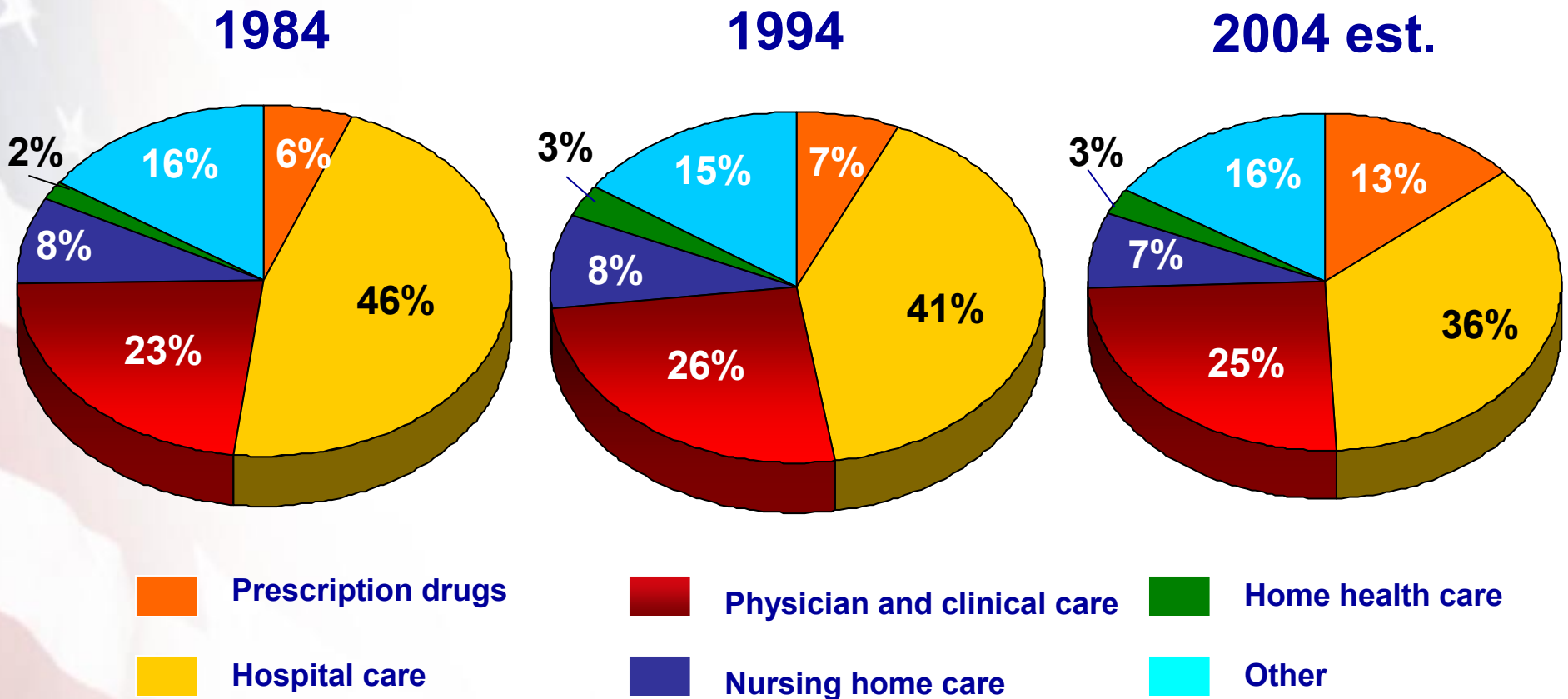
Growth in health care spending, 1992-2002.

Annual percentage growth rate



Source: CMS, OACT, National Health Statistics Group.

Composition of spending on personal health care services, selected years.

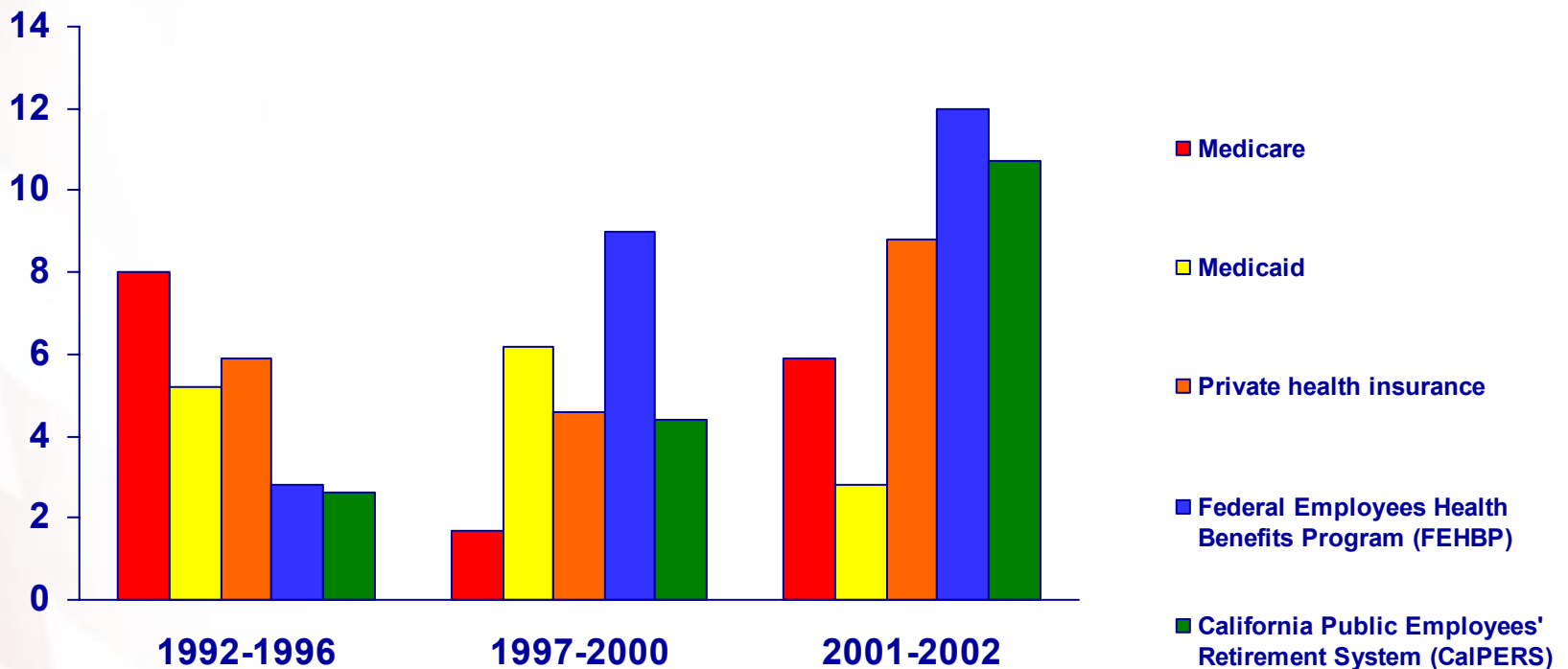


Source: CMS, OACT, National Health Statistics Group.

Note: The figure for 2004 is estimated. Other includes spending on dental services, durable medical equipment, non-durable medical products, personal health care, and other professional services. Percentages may not add to 100 due to rounding.

Change in spending per enrollee, selected public and private purchasers, 1992-2002.

Average annual percentage change

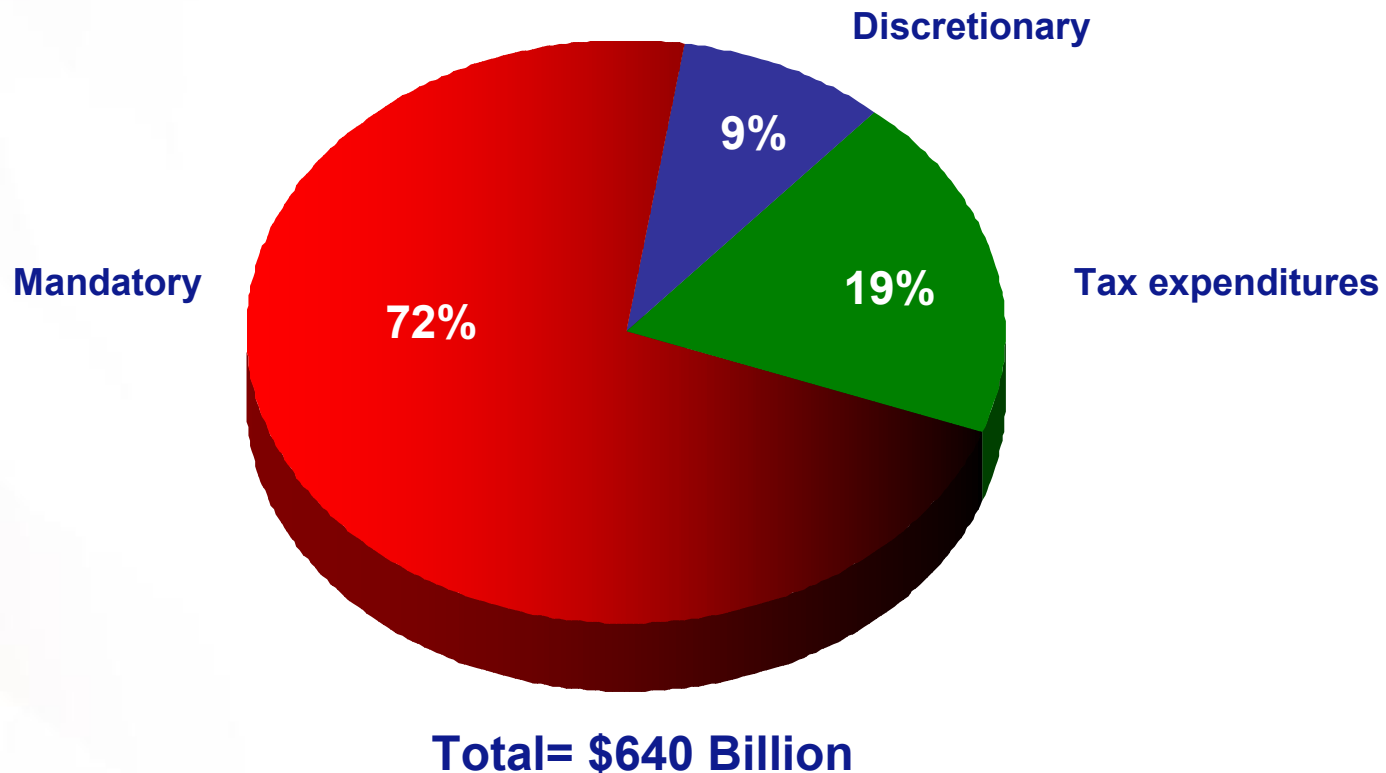


Source: Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, March 2003.
 Note: Changes in spending are in nominal dollars. Private health insurance excludes profits and spending on administration.
 FEHBP and CalPERS data represent premium increases.

The federal government acts through different tools.

- **Policy tools with respect to health care:**
 - **mandatory spending (e.g. Medicare, Medicaid, VA benefits)**
 - **discretionary spending (e.g. Indian health, public health preparedness, disease control)**
 - **foregone revenue resulting from tax provisions**
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Estimated federal resources for health care by policy tool, fiscal year 2004.

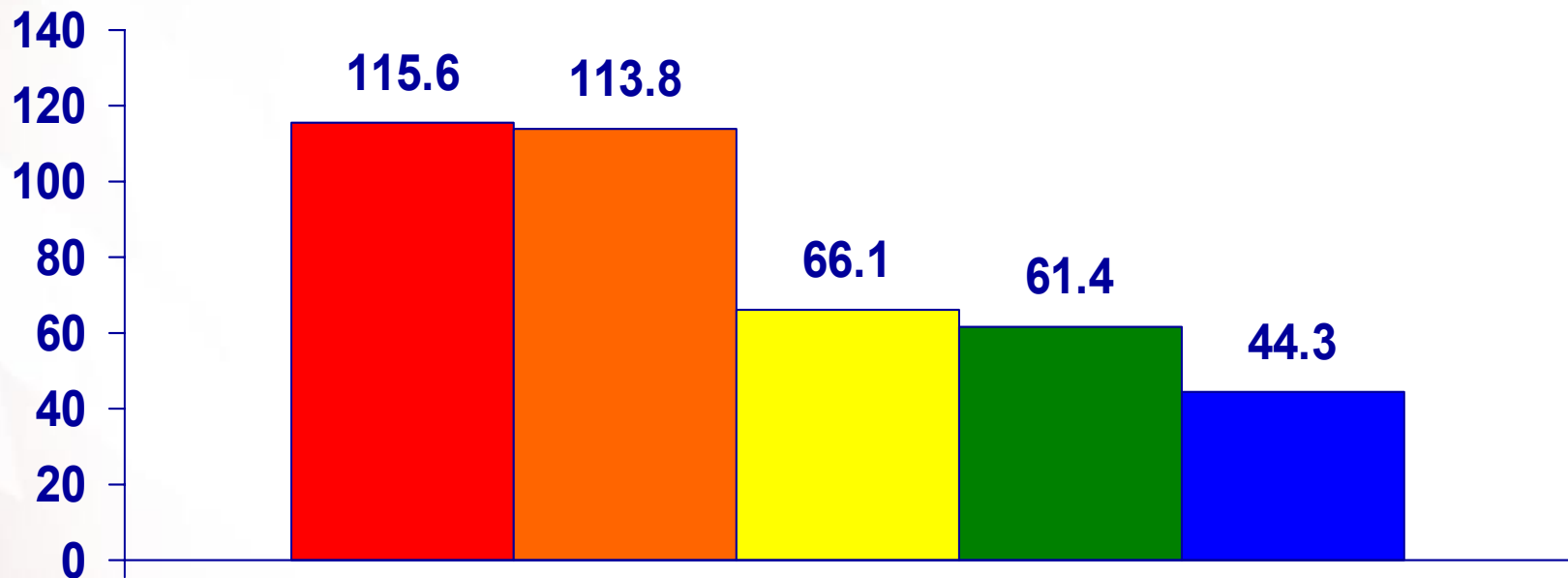


Source: Office of Management and Budget (OMB), *Budget of the United States Government, FY 2005*.

Note: Loan guarantees account for about \$167 million or about .03 percent of the approximately \$640 billion in total federal health care resources.

Health care is the nation's top tax expenditure in fiscal year 2004 (estimated).

Dollars in billions

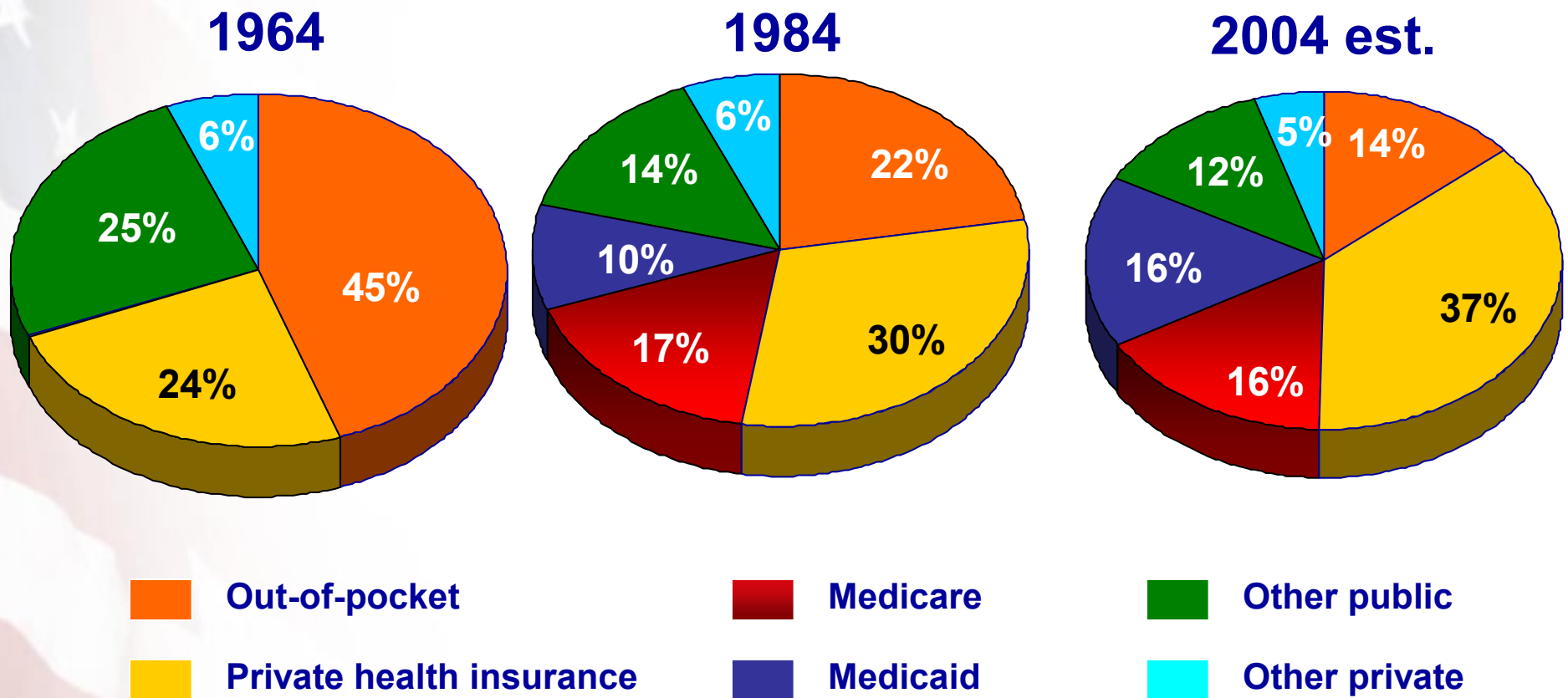


■ Health ■ Pensions ■ Long term capital gains ■ Mortgage interest ■ State and local tax deductions

Source: Joint Committee on Taxation (JCT), *Estimates of Federal Tax Expenditures for Fiscal Years 2004-2008*, December 2003.

Note: "Tax expenditures" refers to the special tax provisions that are contained in the federal income taxes on individuals and corporations. The JCT does not include forgone revenue from other federal taxes such as Social Security and Medicare payroll taxes.

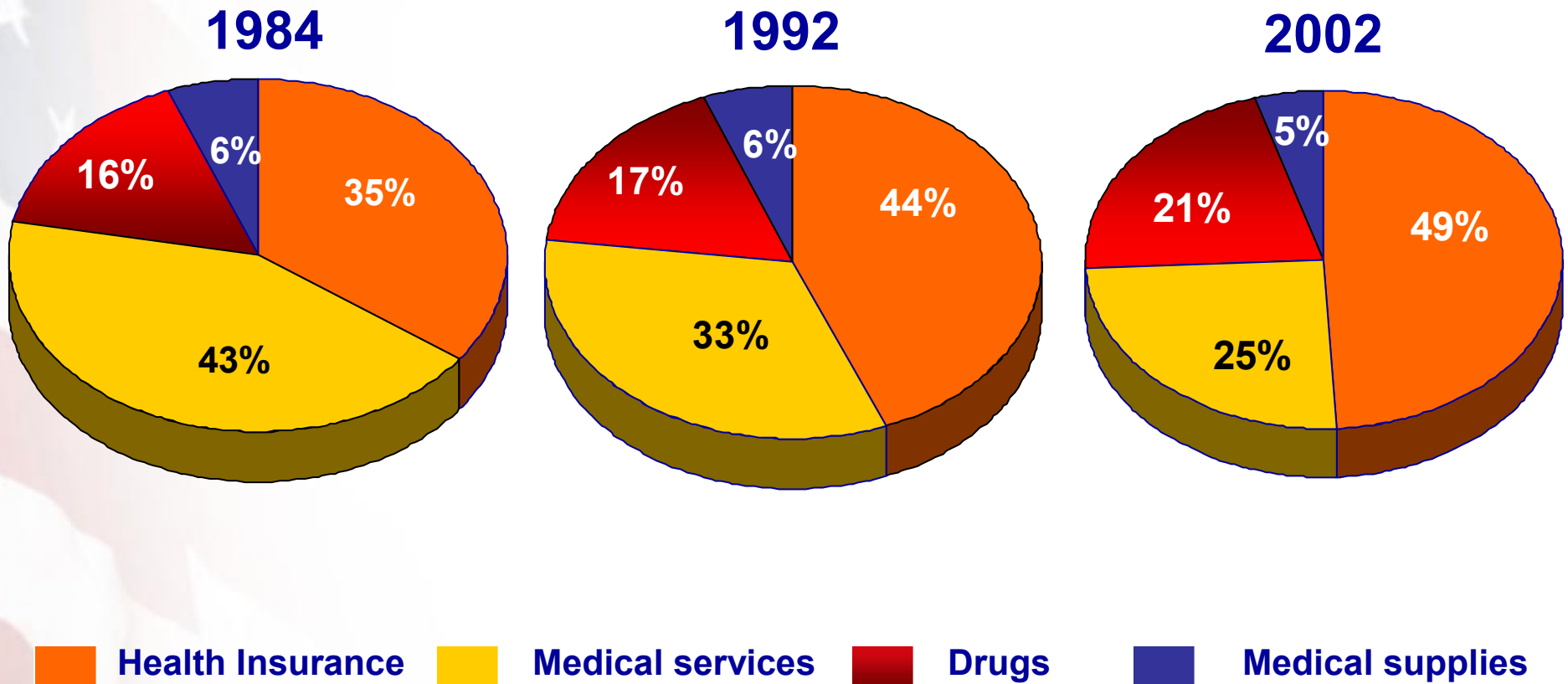
Out-of-pocket spending has declined as a share of total health care spending.



Source: CMS, OACT, National Health Statistics Group.

Note: The figure for 2004 is estimated. Out-of-pocket spending includes direct spending by consumers on coinsurance, deductibles, and any amounts not covered by insurance. Out-of-pocket premiums paid by individuals are not counted here but are counted as part of Private Health Insurance. Percentages may not add to 100 due to rounding.

Spending on health insurance, as a share of average annual household spending on health care, has grown in the 1984-2002 period.



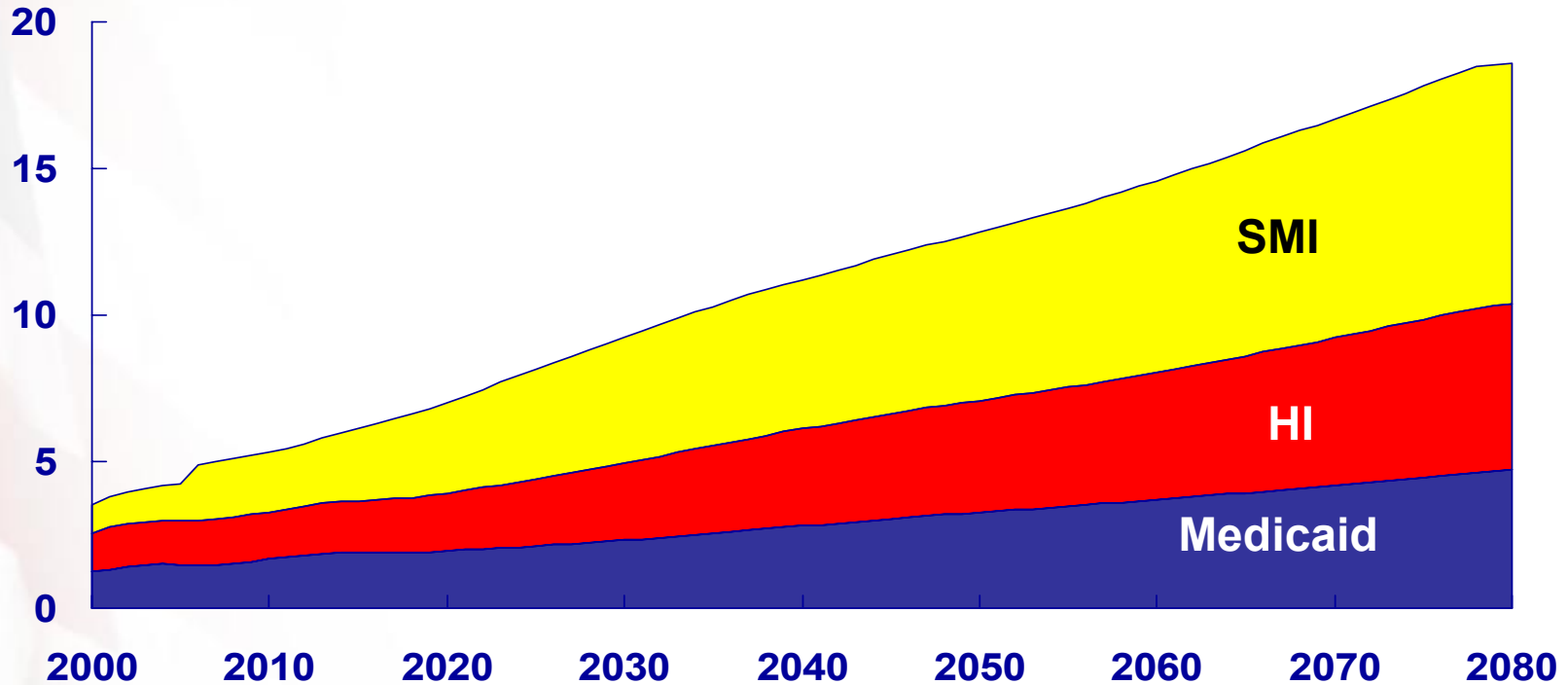
Source: United States Department of Labor, Bureau of Labor Statistics, Consumer Expenditure Survey 1984, 1992, 2002.

Public program obligations, already burdensome, will be unsustainable for future generations of Americans.

- By 2013, Medicare expenditures alone are projected to grow by about 99 percent in real dollars.
- By 2051, when this year's high school seniors turn 65,
 - the ratio of workers to pay for each Medicare beneficiary will have dropped from about 4-1 to just about 2-1.
 - Medicare and Medicaid will have more than doubled their share of the national economy.
- Medicare and Medicaid are on GAO's 2003 high-risk list of programs substantially vulnerable to waste, fraud, abuse, and mismanagement.

Medicare and Medicaid are projected to grow dramatically as a share of GDP.

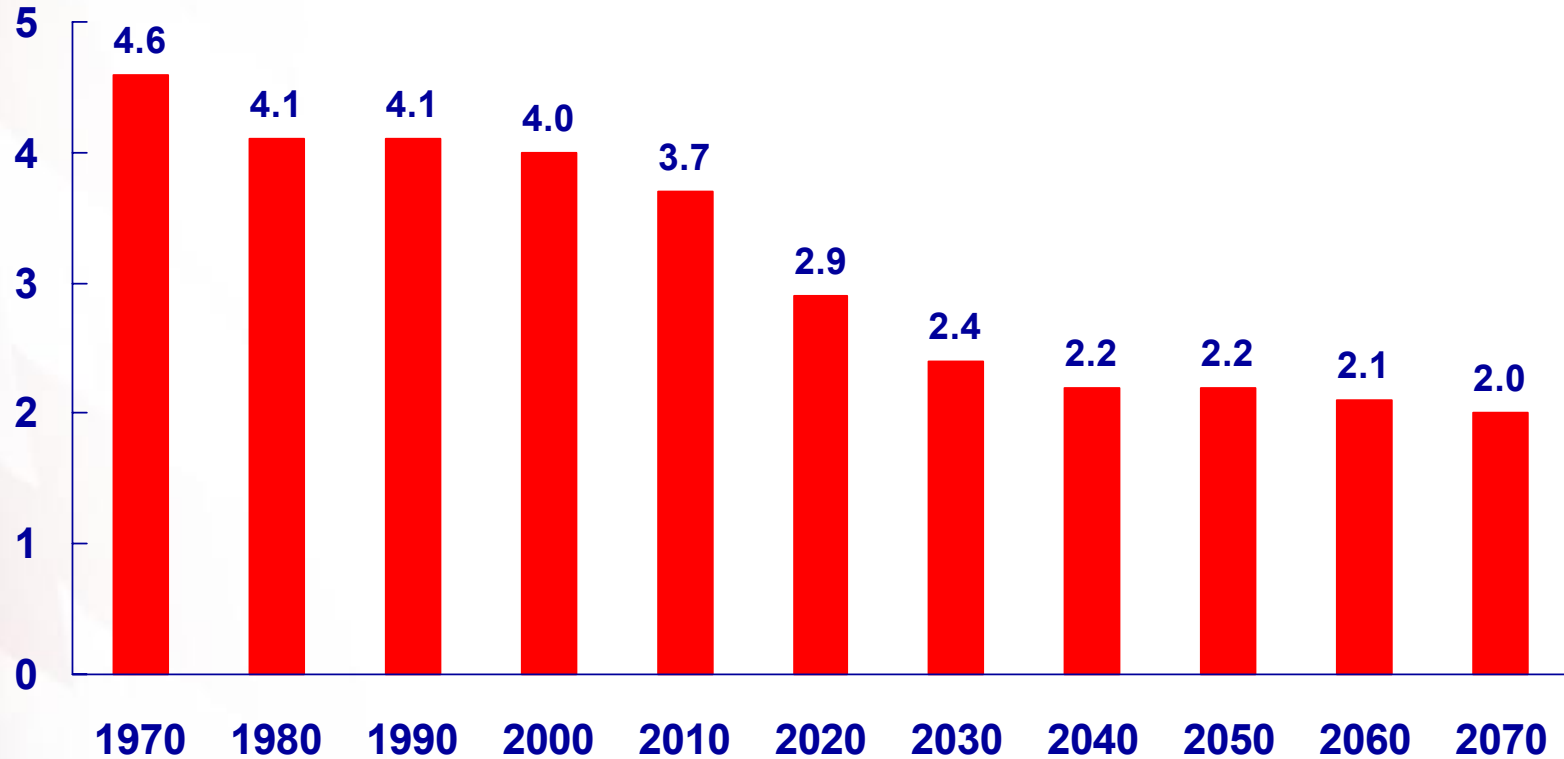
Percentage of GDP



Source: GAO analysis based on data from the Office of the Actuary, Centers for Medicare and Medicaid Services, and the Congressional Budget Office.
 Note: Medicare projections based on the intermediate assumptions of the 2004 Trustees' Reports. Medicaid projections based on CBO's January 2004 short-term Medicaid estimates and CBO's December 2003 long-term Medicaid projections under mid-range assumptions. SMI consists of Part B and, beginning in 2004, Part D.

Workers per HI beneficiary are expected to decline.

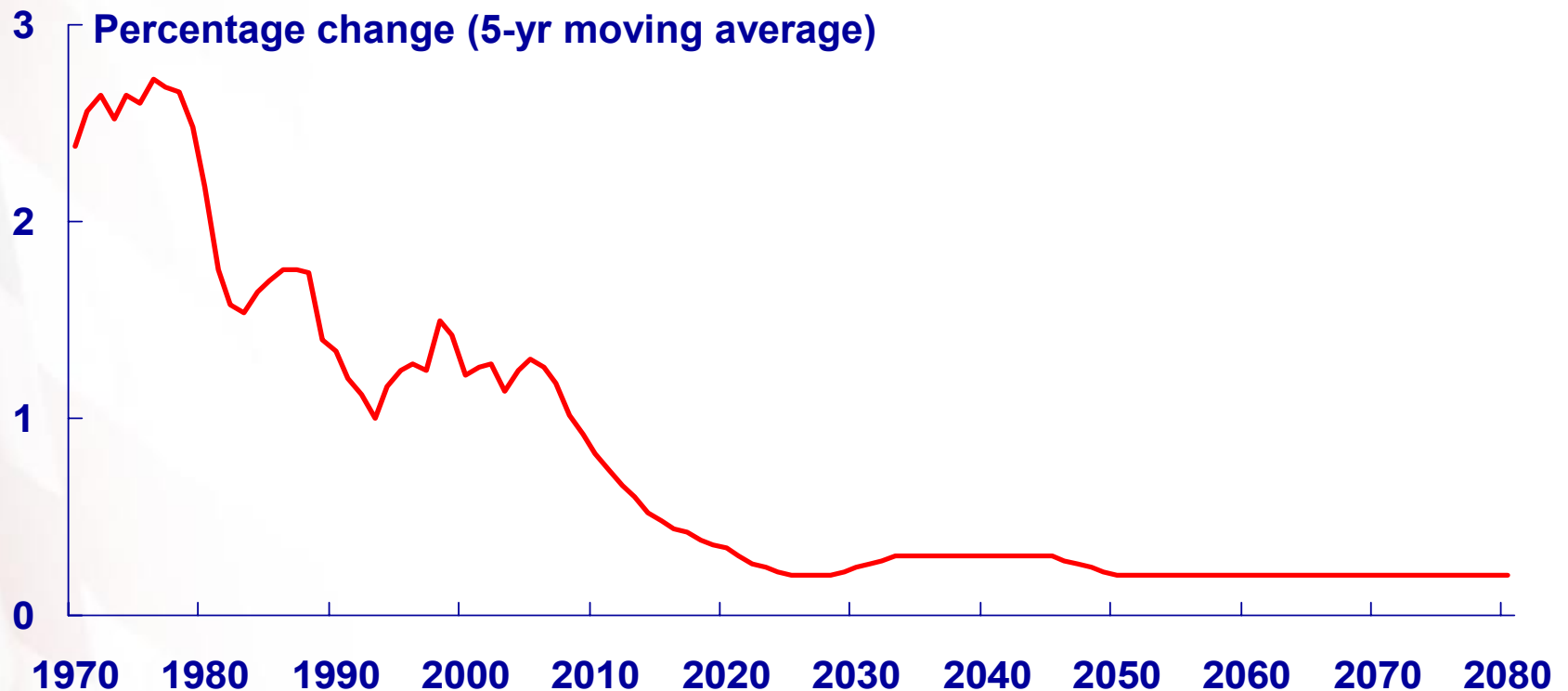
Workers per HI beneficiary



Source: CMS, OACT.

Note: Projections based on the intermediate assumptions of *The 2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

U.S. labor force growth will continue to decline.

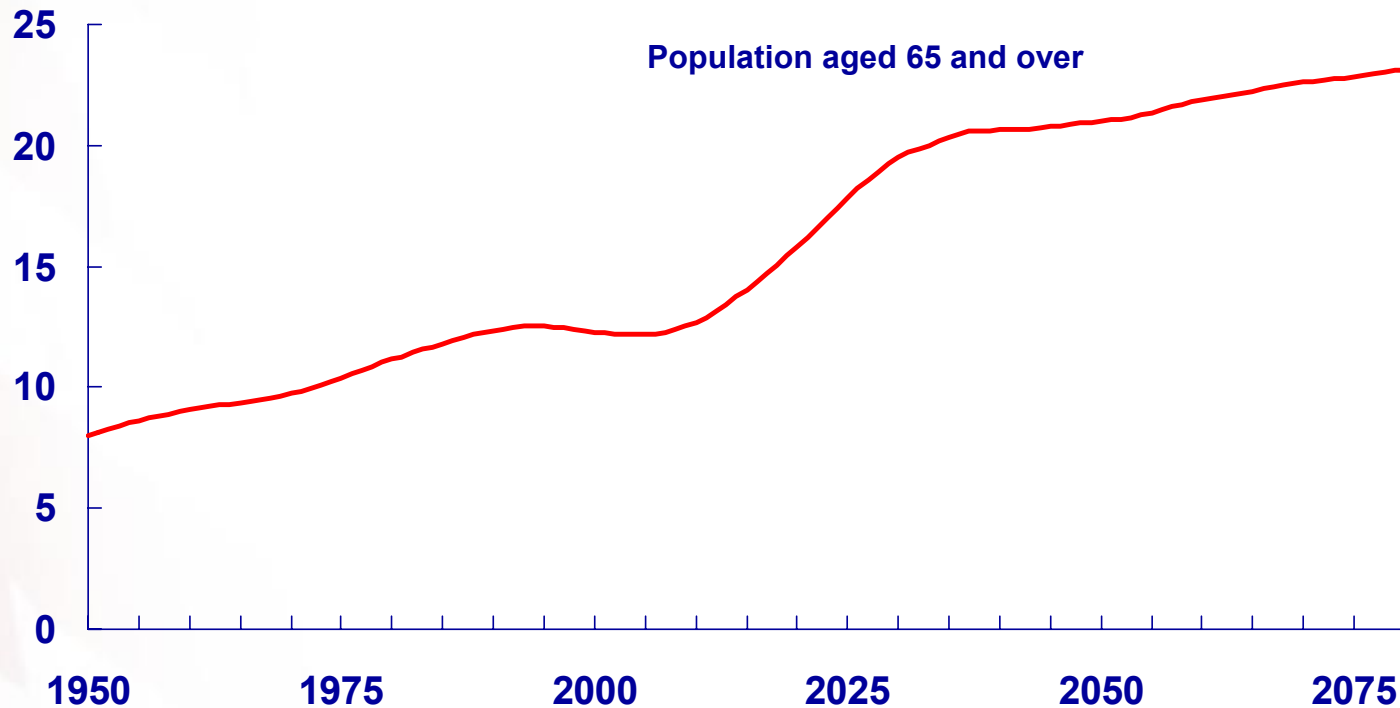


Source: GAO analysis of data from the Office of the Chief Actuary, Social Security Administration.

Note: Percentage change is calculated as a centered 5-yr moving average of projections based on the intermediate assumptions of the 2004 Trustees Reports.

Growth in elderly population will strain Medicare and Medicaid in coming decades.

Percent of total population



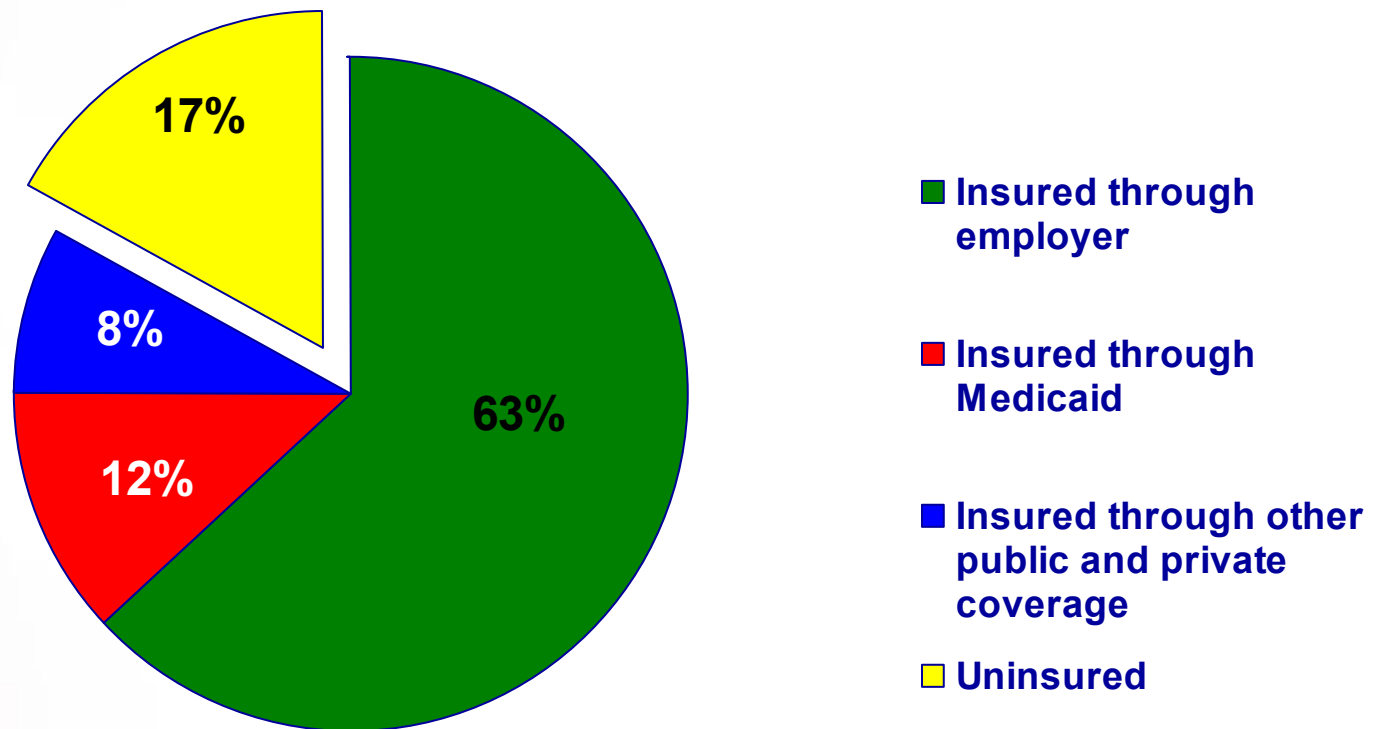
Source: Office of the Chief Actuary, Social Security Administration.

Note: Projections based on the intermediate assumptions of the 2004 Trustees' Reports.

Health Care System Challenges: Access

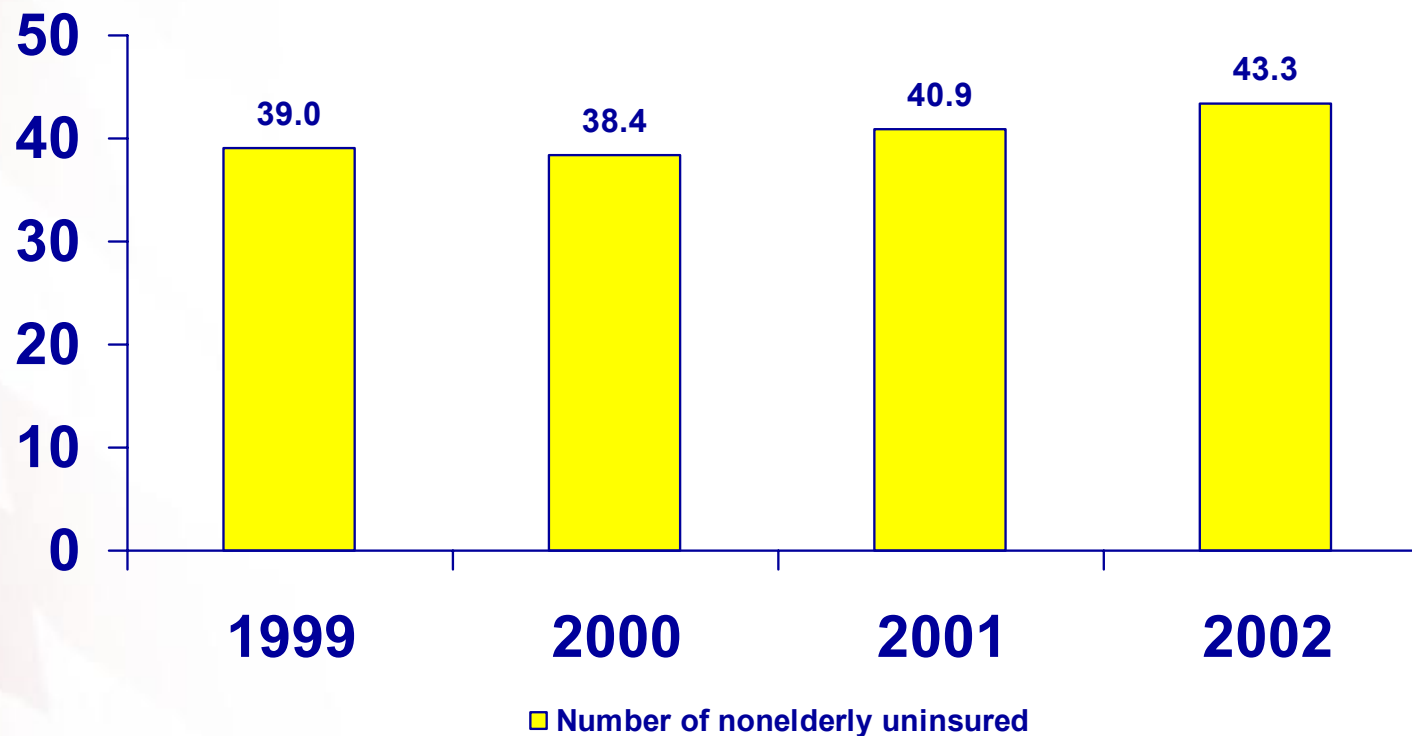
- **Despite higher health care spending, the U.S. has not achieved broad access to care:**
 - Tens of millions of Americans remain uninsured or underinsured.
 - Additional individuals are losing Medicaid coverage during period of economic downturn.
 - Health insurance may be out of reach for many individuals in poor health.
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In 2002, 17 percent of the nonelderly population was uninsured.



In recent years, roughly 40 million Americans have been uninsured.

Population in millions



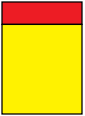



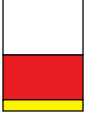




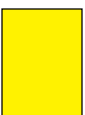
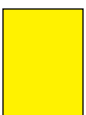

Source: GAO, Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analyses of the Bureau of the Labor Statistics and the Bureau of the Census Current Population Survey, Annual Demographic Supplements and Annual Social and Economic Supplement.

Note: Figures for 1999-2000 are from Urban Institute and Kaiser Commission on Medicaid and the Uninsured. The figures for 2001-2002 are from GAO analyses of the Current Population Survey.

Significant gaps exist in health care access and coverage.

- Coverage gaps in today's health care system exist because (1) many individuals either cannot afford insurance or do not opt to purchase it and (2) levels of coverage vary.
 - Most Americans without health insurance are lower-income working age adults.
 - Even for those with health insurance, not all important services are covered.

Simplified view of access to and gaps in health care coverage.

	Poor ^a	Near Poor ^b	Non-Poor ^c
Children ^d			
Adults (18-54)	 e	 e	
Adults (55-64)	 f	 f	 g
Elderly ^h	 i	 i	 i



Source: GAO analysis based on March 2003 Current Population Survey.

Chart notes

^aPoor is defined as below 100 percent of the federal poverty level (FPL); e.g. in 2002, families of three with income of \$14,870 or below were classified as poor.

^bNear poor is defined as 100 percent to 299 percent of FPL.

^cNon-poor is defined as 300 percent or more of FPL.

^dChildren are individuals age 0-17.

^eCertain individuals in this group are eligible for Medicaid or SCHIP coverage if they are expectant mothers, disabled, or adults in families with dependent children.













^fCertain individuals in this group are eligible for Medicaid or Medicare coverage if they are disabled, adults in families with dependent children, or kidney disease patients.




^gCertain individuals in this group are eligible for Medicare or other public coverage if they are disabled, kidney disease patients, military retirees, or veterans.

^hElderly are individuals age 65 and older.

ⁱSome individuals in this group also have access to supplemental private insurance.

Simplified view of coverage gaps by payer and benefit type.

	Acute care services	Long-term care services	Prescription drug coverage ^a	Catastrophic coverage
Medicare				
Medicaid^b				
Private insurance				

-  Covered by payer
-  Not covered by payer
-  Coverage may be substantially limited

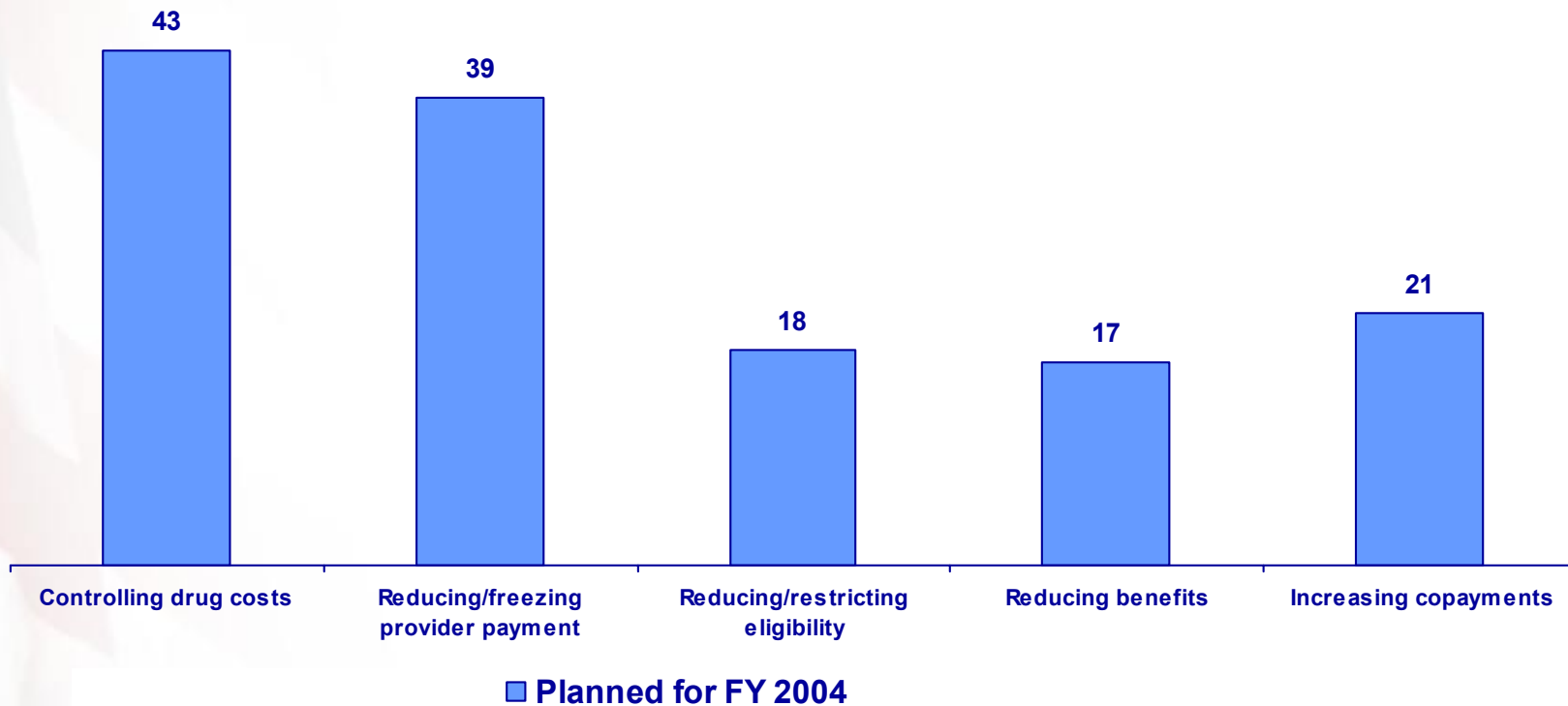
^a Medicare will introduce a voluntary prescription drug benefit in 2006.

^b While Medicaid coverage includes a broad range of services, access to these services may be limited.

For example, some providers may be unwilling to accept Medicaid's fees, which are generally lower than those of other payers.

Many states are planning to undertake Medicaid cost containment strategies in fiscal year 2004.

Number of states



Source: Kaiser Commission on Medicaid and the Uninsured survey of Medicaid officials in 50 states and the District of Columbia conducted by Health Management Associates, September and December 2003.

Health insurance may be out of reach for many individuals in poor health.

Findings from several GAO studies:

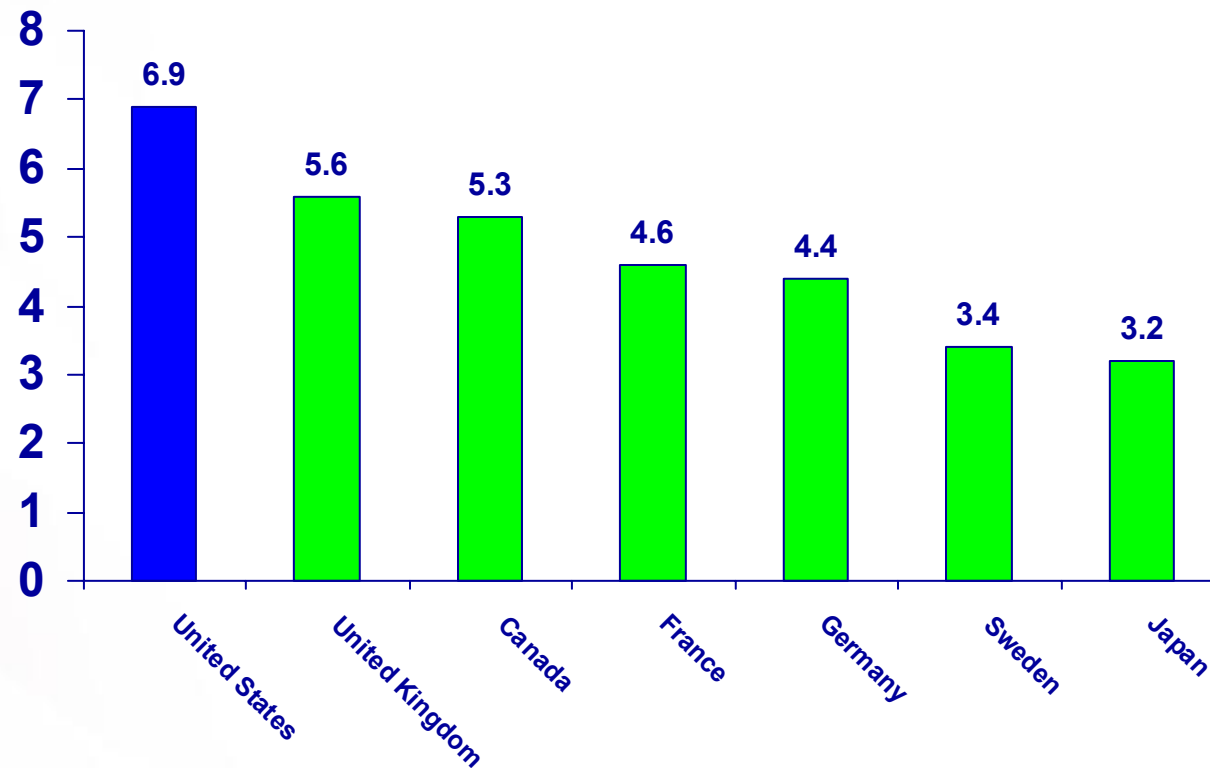
- People in poor health: in several states, premiums for individuals with juvenile diabetes were as high as 300 percent or more of standard rates for healthy individuals.
- Near-elderly people: in many states, carriers may charge premiums for a healthy 60-year-old male that are close to 4 times the premium for a healthy 30-year-old male.
- Small employers with older, sicker workers: in Texas, premiums for a small employer with older workers—some in poor health—were 2-1/2 times to nearly 4 times higher than for an employer of the same size and location with younger, healthier employees.

Health Care System Challenges: Quality

- **Despite higher health care spending, gains in health status and quality are uneven:**
 - Substantial health improvements have been made in life expectancy and mortality rates in the last several decades, but U.S. continues to lag other nations in these areas.
 - U.S. performs well in producing advances in medical science and technology, but medical errors have continued to occur with unacceptable frequency.
 - For many treatments, experts have developed consensus on recommended use, but overuse and underuse occur nationwide.

The U.S. continues to lag other industrialized nations in reducing infant mortality rates.

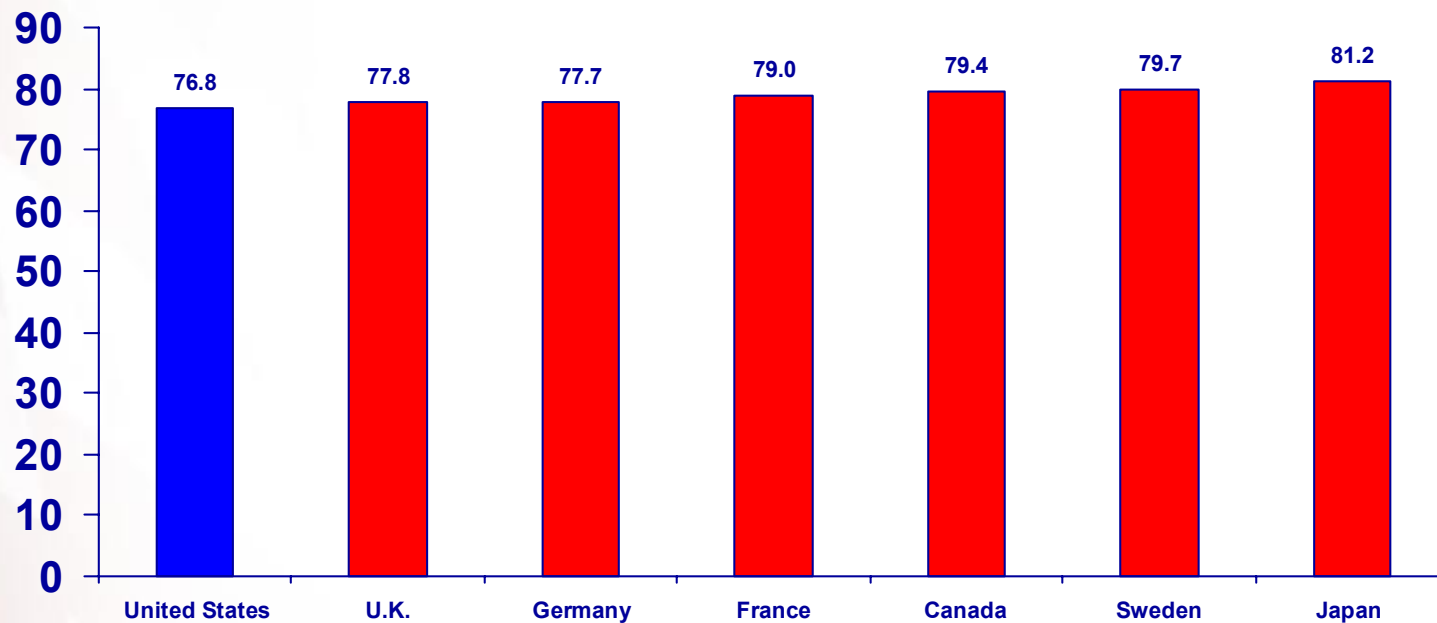
Deaths per 1,000 live births in 2000



Source: OECD Health Data 2003.

The United States lags other industrialized nations in life expectancy at birth.

Life expectancy at birth in 2000

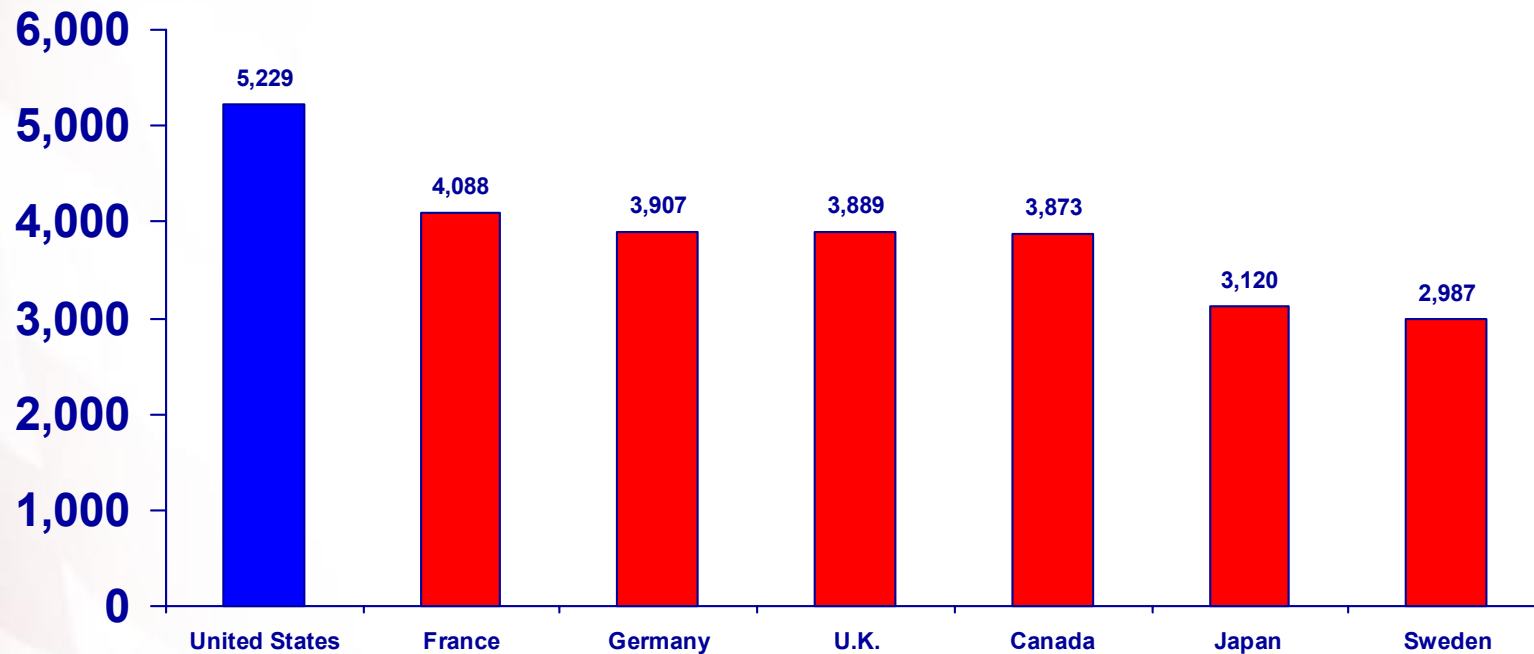


Source: OECD Health Data 2003.

Note: Life expectancy at birth for the total population is estimated by the OECD Secretariat for all countries, as the unweighted average of the life expectancy of men and women. Data for Germany are from 1999.

The United States exceeds other industrialized nations in potential years of life lost.

Potential years of life lost, per 100,000 resident population, 1999



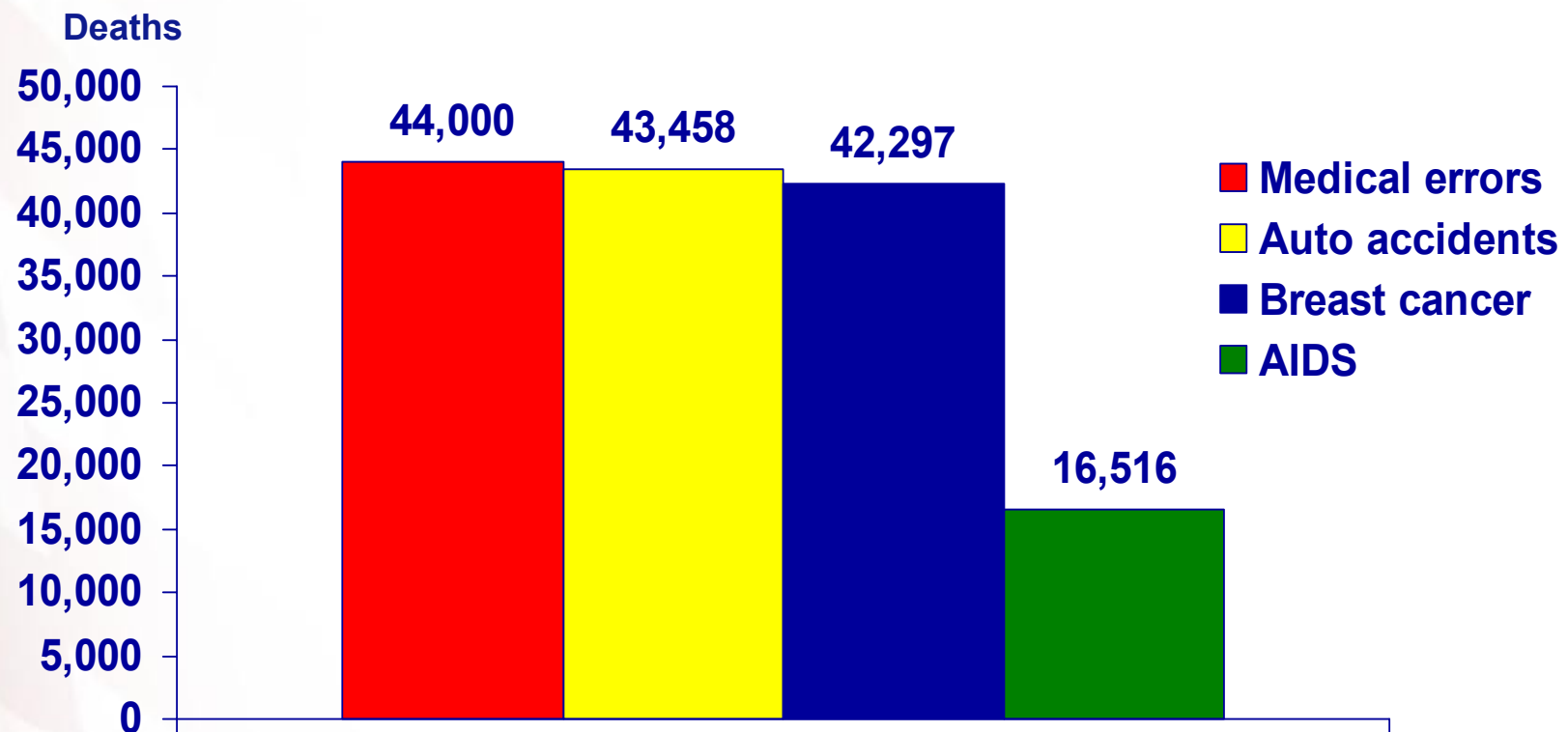
Source: OECD Health Data 2003.

Note: Data for Canada are from 1997. Potential years of life lost (PYLL) is the sum of the years of life lost prior to age 70, given current age-specific death rates (e.g., a death at 5 years of age is counted as 65 years of PYLL).

U.S. has fostered quality of care through investment and achievements in medical science.

- In less than a decade, the U.S. more than doubled NIH's budget in nominal dollars—from about \$11 billion in 1994 to over \$23 billion in 2002.
- The bulk of privately funded pharmaceutical research—over \$25 billion—was conducted in the U.S.
- Recent U.S. medical advances include mapping the human genome, treating the AIDS virus, and researching the use of vaccines for certain types of cancer.

Deaths due to medical errors in hospitals are higher than certain other causes of death in the U.S.



Source: The Institute of Medicine (IOM), *To Err is Human: Building a Safer Health System*. (Washington, D.C.:National Academy Press, 2000.)
 Note: Rates of death for cause other than medical error are from the CDC, National Center for Health Statistics, Births and Deaths: Preliminary Data for 1998, *National Vital Statistics Reports*. 47(25):6, 1999, as cited in *To Err is Human*.

Patients often do not receive recommended treatments and procedures.

- Multispecialty expert physician study: During a 3-year period, Medicare beneficiaries received certain recommended services less than two-thirds of the time. Services were for such conditions as heart disease, diabetes, breast cancer, and stroke, among others.
- Despite the proven life-saving efficacy of beta blockers for most heart attack patients, researchers estimate that at least half of these patients do not receive this therapy.

Patients often receive unnecessary treatments.

In the last two decades, studies have found that

- many of the hysterectomies performed were not needed.
- antibiotics were overprescribed for adults and children.
- many of the ear tube and pacemaker insertions, carotid artery surgeries, coronary diagnostic imaging, and endoscopies were performed for clearly inappropriate indications.

Obstacles to Meeting Health Care System Challenges

Several obstacles—health insurance issues, information gaps, and market imperfections—block the path to efficient health care delivery.

Obstacles to meeting challenges: health insurance issues

- **Insurance-related issues:**
 - The presence of insurance blunts sensitivity to the price of services and results in the tendency to overconsume.
 - Adequate protection against catastrophic loss is not universally available.
 - Access to insurance that adequately pools risks is not universally available.
 - Many health care providers face rising medical malpractice insurance premiums.

Obstacles to meeting challenges: information gaps

- **Information-related issues:**
 - Lack of information on the value and efficacy of medical services hinders providers' and consumers' decisions about appropriate use.
 - Insufficient comparative information inhibits consumer choice and hampers effective competition.
 - Because of serious lag times in the availability of cost and utilization data, policymakers lack prompt and reliable information on which to base payment reform decisions.
-

Obstacles to meeting challenges: market imperfections

- **Market-related issues:**
 - The monopoly power of providers or health plans strongly influences prices in individual markets.
 - The pricing of services in public programs can inflate or otherwise distort market prices.
 - Tax incentives can serve to mask the cost of health care and impair achievement of desired cost-containment outcomes.
 - Administrative burdens reduce market efficiency and value to consumers.

Evaluating Health Care System Reforms

- Cost, access, and quality challenges—together with obstacles to achieving efficiency—argue for fundamental system reform.
- A comprehensive review and reassessment of the overall health care system raises the following questions:
 - **What** are societal needs versus individual wants in our health care system?
 - **Who**—among individuals, employers, and governments—should be responsible for paying for health care?
 - **Where** can we find our most acute access, cost, and quality challenges? (e.g., What regions show patterns of underuse or overuse of medical services?)
 - **How** much of health care costs can government, employers, and individuals afford and sustain over time?
 - **When** are we going to get started, as the challenge gets bigger everyday and any delay compounds the problems?

Evaluating Health Care System Reforms

- Reforms, although comprehensive, may need to be incremental in order to minimize disruptions and facilitate political consensus.
- A framework can guide an orderly process for setting common goals and assessing proposed reforms.

Framework for Evaluating Health Care System Reforms: **Cost**

Does the proposal help to ensure:

- sustainable growth in public and private sector health care expenditures? e.g.,
 - are Medicare and Medicaid reform efforts aligned with the nation's long-term fiscal outlook?
 - are health care financing policies compatible with the efforts of U.S. companies to compete in global markets?
- efficient production and consumption of health care resources, including
 - economical pricing of services?
 - incentives for providers to make prudent medical decisions based on benefit and cost?
 - consumer sensitivity to the benefits and costs of health care services?
- that government tax incentives do not have unintended consequences?
- that government financing meets the nation's most critical health care needs?

Framework for Evaluating Health Care System Reforms: **Access**

Does the proposal help to ensure:

- guaranteed access to essential health care coverage, including
 - catastrophic loss protection?
 - children's preventive health care services?
- an insurance market that adequately pools risk and offers alternative levels of coverage?

Framework for Evaluating Health Care System Reforms: **Quality**

Does the proposal help to ensure:

- care that meets acceptable standards, including
 - lowering the occurrence of medical errors?
 - medical practices based on scientific evidence?
 - limiting disparities in treatment for all patients?

Framework for Evaluating Health Care System Reforms: **Implementation**

Does the proposal help to ensure:

- the development of an information infrastructure that provides prompt and reliable data to monitor cost, quality, and system integrity?
- transition to a new structure that effectively mitigates potential disruptions and any new demands on resources and affected individuals?
- oversight and enforcement mechanisms for effective accountability?
- reforms that consumers can easily adapt to and understand?

Health care system ideals: incentives, transparency, and accountability

- Ideally, proposals will include health care system reforms that
 - align incentives for providers and consumers to make prudent decisions about the use of medical services,
 - foster transparency with respect to the value and costs of care, and
 - ensure accountability from health plans and providers to meet standards for appropriate use and quality.

Conclusion:

Our challenge is huge and growing bigger each year. The time to act is now. There are no easy answers and tough choices will be required. When undertaking reform, the Congress should consider taking its own Hippocratic oath to “do no harm.” Specifically, do not make the long-range financing imbalance worse.
