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Statement by

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Chairman Akaka and Distinguished Members of This Committee:

My name is Uwe E. Reinhardt. I am the James Madison Professor of Economics and Public Affairs at the Woodrow Wilson School of Public and International Affairs and the Department of Economics at Princeton University, Princeton, New Jersey. My research over the last several decades has focused primarily on health economics and policy, although I also teach or have taught at Princeton University general economics, financial accounting and financial management. In the early 1980s, I had the privilege of serving on the Special Medical Advisory Group (SMAG) of the Department of Veterans Affairs (VA)-hence my long-standing interest in the VA health system. Over the years, I have also served on several other government commissions, including for some nine years on the Physician Payment Review Commission (PPRC) which advised Congress on payments of physicians by Medicare.

I would like to thank you, Mr. Chairman, and your colleagues for inviting me to testify before this Committee on a matter I personally deem of the utmost importance to the well being of our nation's most deserving citizens: our veterans.

## I. VA HEALTH SPENDING

As is shown in Figure 1 below, in the decade from 1997 to 2007, the Department of Veterans Affairs' annual funding for medical care rose by 100%, that is, it doubled. During the same

period, the total federal outlays increased by only 74%, and gross domestic product per capita (GDP) by roughly only 69%.

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FIGURE 1 -- THE DEPARTMENT OF VETERANS AFFAIRS' FUNDING FOR MEDICAL CARE, 1996 TO 2008

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(Billions of dollars)

SOURCE: Allison Percy, "Future Medical Spending by the Department of Veterans Affairs," CBO Testimony

Before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies,

These differential growth rates naturally lead to the question whether the annual spending on health care by the Department of Veterans Affairs is "sustainable." It is a fair question calling for a thoughtful answer. That answer, however, should be developed against the broader context of health spending in the U.S., lest Congress inadvertently make the VA health system the fall guy for a much wider problem with America's health system and, in the process, impair what one distinguished member of this Committee has called "the VA's world-class health system." It is a judgment, by the way, with which the health services research community in this country and abroad wholeheartedly agrees.

This testimony is intended to provide that broader perspective. Section II presents comparisons of VA health-spending trends with overall health spending trends in the United States. It will be seen that, if anything, health spending by the VA has risen slightly less rapidly than it has in other segments of the health sector. Section III extrapolates the burden that VA health spending is likely to impose on total federal health spending and on gross domestic product (GDP) in the decades ahead, to make a judgment on whether the system is sustainable. I conclude that it is. Section IV explores the fiscal sustainability of the entire U.S. health system and Section V the potential savings in health-care spending that appear available to the United States. Curiously, the Congress has never shown any interest in harvesting these savings. Section VI offers some concluding observations, including the suggestion that, if federal budget increases must be cut, agricultural subsidies are a much more logical target for cuts than the budget of the VA.

## II. VA HEALTH SPENDING AND OVERALL HEALTH SPENDING IN THE U.S.

Figure 2 presents percentage increases in health spending over the decade 1997-2007 under (1) private insurance, (2) Medicare and (3) the VA health system, along with the increase in (4) total national health spending. The numbers at the top of the vertical bars represent total percentage increases over the period. The numbers in the middle of the bars are the equivalent annual compound growth rates.

SOURCES: Data for the VA from CBO op. cit.; data for the other segments from CMS data base

on "National health Spending 1965-2015."

#### A. VA Health Spending in Perspective

Figure 2 shows that, as far as spending growth goes, the VA health system is in good company. In fact, its spending over the past decade grew less rapidly than did spending in the rest of the U.S. health system. Although the data in Figure 2 are not adjusted for differences in case mix, benefit packages and growth in the number of insured, it is safe to say that, even after such adjustments, any particular segment embedded is bound to share in the overall cost-growth experience of the U.S. health system, which has long ranked as the most expensive health system in the world (see Figure 3 below).

In this connection, it must be kept in mind that during this period the VA had to absorb increasing numbers of young veterans who were physically and mentally traumatized by the wars in Iraq and Afghanistan. Furthermore, during the last decade the VA health system has transformed itself from a system with highly varied quality to what is now generally acknowledged to be a system with the smartest use of electronic information in U.S. health care. In a recent, rigorous exploration of the quality of U.S. health care researchers at the Rand Corporation concluded that the probability that a patient receives the recommended medical treatment is significantly higher in the VA health system than in the rest of the U.S. health system.

Cost growth in the VA system in the decades ahead may well begin to outrank that in other segments of the U.S. health system, for at least two reasons.

First, the rapid cost growth in the entire health systems has begun seriously to erode traditional, employment-based private insurance coverage, particularly among low-wage workers in smaller business firms. Veterans hitherto covered by employment-based private insurance are bound to look to the VA health system for insurance coverage of last resort. That shift will reduce spending growth under private health insurance, but increase VA spending.

Second, the wars in Iraq and Afghanistan, and possibly yet other sites abroad, will continue to confront the VA health system with new challenges. In fact, counting in the future cost of health care for veterans and of yet other deferred expenses associated with the Iraq war, Nobel Laureate economist Joseph Stiglitz and his co-author Linda Bilmes of Harvard University have estimated that the properly counted cost of that war may already have reached \$2 trillion. Although, like all estimates about future spending, these authors' estimate depends on a number of assumptions, including the duration of hostilities, it is safe to say that the properly calculated, true cost of the wars in Iraq and Afghanistan far exceed the \$500 billion or so frequently cited in the halls of Congress and the press. The VA's future budgets represent a good fraction of these larger costs.

It is appropriate to apprise U.S. taxpayers now of this debt owed their patriotic fellow citizens and of the added future tax burden it will impose on the rest of society.

#### B. Why is U.S. Health Care so Costly?

Figure 3 presents the most recent available data on national health spending per capita in the OECD nations. All dollar figures are expressed in international purchasing power parity (PPP) dollars.

It is seen that in 2004, the U.S. spent close to twice as much per capita on health care as did neighboring Canada and more than twice per capita than most other nations in the OECD. It can fairly be asked whether Americans receive commensurately higher benefits from their health system, given that the U.S. is known to rank rather low on common health-status indicators, such as longevity, infant mortality and general health status.

Switzerland, for example, spends only two-thirds as much per capita on health care as does the U.S., although the Swiss health system has more physicians, hospital beds and MRI machines per capita than does the U.S. and has a flourishing pharmaceutical industry. Swiss patients spend more days in the hospital than do American patients, have a higher number of physician visits per capita, consume more prescription drugs per capita and face no queues to health care. Switzerland does not have a significant number of uninsured citizens and has generally superior health-status indicators (such as longevity and infant mortality) than does the U.S.

What, then, can account for the higher U.S. health spending? Cross national health services research has shown that Americans pay much higher prices for particular health care goods and services than do citizens of other countries. It was first noted in a paper by Mark Pauly. Subsequent research based on OECD data has corroborated the finding.

These higher prices paid by Americans for health care are the result of two main factors.

First, U.S. GDP per capita is higher than that in most other countries. Through its effect on prices, on the technical sophistication of health care and on the degree of the luxury of health care facilities, GDP per capita is the most powerful predictor of cross national differences in health spending per capita.

Second, the demand side of U.S. health system - that is, its health insurance system -- is highly fragmented. This structure is not only very costly to administer. It also accords relatively more market power to the supply side of the health-care market than to the demand side. It allows the supply side considerable discretion in dictating to society the terms on which health care is delivered, including volume and prices.

The point here is not to criticize the current configuration of the U.S. health system. Presumably it is what the American people prefer or are willingly accept. Rather, the point here is to apprise members of this Committee (and of the Congress) that a health system configured in this way will be extraordinarily expensive and will inevitably burden the budgets of government programs intended to provide health care to citizens. The VA system can never fully escape the effects of these market forces.

The only consolation in this regard is that government budgets are not the only ones struggling under the ever increasing burden of growing health-care costs. These costs now threaten to push

some large American employers to the brink of bankruptcy, make other employers simply shift costs to their employees or drop health insurance coverage for their employees altogether, and drive many American families first into the ranks of the uninsured and perhaps increasingly into bankruptcy.

### III. THE FISCAL SUSTAINABILITY OF THE VA HEALTH SYSTEM

On his previously cited website, Senator Larry Craig, Ranking Member of this Committee, presents the following chart on the VA budget with the remark:

"All of us are committed to making life and services better for veterans, but can double-digit, annual increases in VA's budget be sustained over the long haul?"

It is a fair question deserving a thoughtful answer.

For starters, it must be noted that the figures in this graph represent the Department of Veterans Affairs' total budget, which includes many items other than outlays for health care proper. A larger portion of the budget was allocated to non-medical care, "mandatory" spending - for the most part, disability pension payments and other pension benefits. In 2007, for example, the VA's "discretionary" budget for "medical care" proper amounted to only \$31.511 billion. It was close to \$32 billion if one includes funding of the research for which the VA is so well known.

How heavy a burden is a sum of \$32 billion on the federal budget and on GDP?

In 2007, it represented only about 1.15% of that year's total federal outlays of about \$2.8 trillion. Seen in that light, the VA budget is not a large burden on the federal budget.

The VA budgets represents an even smaller burden if one relates it to this nation's ability to pay for its veterans, best measured by the nation's GDP of about \$14 trillion in 2007. VA health spending accounted for only 0.22% -- that is, about one fifth of a percentage point - of the nation's GDP.

But what about future VA spending? Are current spending trends "sustainable"?

Suppose we assumed that nominal (not inflation-adjusted) VA health spending were to grow by 7.5% per year annually (faster than the 7.2% over the last decade). Next, suppose we assume somewhat pessimistically that nominal GDP grew by only 5% per year (slower than the rate of 5.5% to 6.8% in recent years). Finally, suppose quite optimistically that Congress somehow managed to keep the growth of total federal outlays in step with GDP, that is, at 5% per year only. On this rather conservative set of assumptions, what would be the time paths of the future VA health spending as a percentage of the total federal budget and of GDP? The projection in Figure 4 sheds light on this question.

In light of these data, what, then, might be meant by "sustainability"? Clearly, the answer here is highly subjective, reflecting mainly the respondent's personal moral values. In my own view, the burden our veterans will impose on the rest of us - as a percentage of the federal budget or of our GDP - is now and will remain rather small for the foreseeable future. In my own subjective view, that burden is a small price to pay for the valuable service our soldiers, Marines and sailors render the nation, for the risk they voluntarily assume, for the anxiety they impose on their loved ones, and for the tragic personal sacrifices in life and limb that service all too frequently entails.

I would hope that all members of this Committee and, indeed, all Americans, would see it that way, too.

#### IV. IS AMERICA'S HEALTH SYSTEM SUSTAINABLE?

The previous section suggested that the sustainability of the VA health system certainly is not the major issue confronting American society in health care. Large as it is, with its budget of about \$32 billion in 2007, that system represents only about 1.4% of the currently estimated total U.S. national health spending of \$2.262 trillion. The truly important question confronting American society is whether the entire health care system is sustainable.

##### A. Total National Health Spending

During the past four decades, the growth of total real (inflation adjusted) national health spending in the United States has grown, on average, by about 4.5% per year. During the same period, real GDP per capita has grown at a long-run average annual growth rate of only 2%. From these numbers follows what one might call the "2½% Rule of U.S. health spending," meaning that, on average, the annual growth in real health spending in the U.S. has tended to outpace the annual growth in real GDP by about 2½ percentage points.

The gap of 2.5 percentage points is, of course, a long-run average. In some years - e.g., 1993-1997 the growth gap was smaller, in others - e.g., 2001-2004 it was larger. Indeed, during the period 2001 to 2004, the growth in U.S. health spending was the chief economic locomotive pulling the economy along and crating most of the new jobs. During 2001-2002 alone the growth in health spending represented over half of the entire growth in GDP that year.

How long is the growth in overall U.S. health spending sustainable? Figure 5 sheds light on that question.

The actuaries of the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (DHHS) estimate that in 2007 the U.S. health system will claim 16.2% of GDP. They estimate that by 2016 that percentage will have risen to 19.6%. In their

projections, the CMS actuaries assume a growth differential between health spending and GDP of only about 2.2%, which is a bit lower than the traditional 2.5%. Therefore, Figure 5 presents projection for two assumed growth differentials: the traditional 2.5% and only 2%, a range that brackets the CMS assumption. It is seen in Figure 5 that, at the growth-trend assumptions in the graph, five decades hence the U.S. health system will claim somewhere between 35% to 40% of GDP.

Most economists would be reluctant to offer a judgment on whether so large a claim on GDP is "sustainable" or will be "affordable" 50 years hence, because these are entirely subjective terms. Economists would ask what the health system would offer society in return for such an enormous claim on the then much larger GDP. A priori, one cannot rule out the possibility that those benefits might be so enormous - e.g., the conquest of cancer, Alzheimer's disease and similar dread diseases - that society might want to accept the bargain.

In fact, however, there is a substantial body of research suggesting that a considerable fraction of past and current U.S. health spending cannot be justified on the basis of clinical outcomes and patient satisfaction. I return to that point further on, in Section IV.

## B. Medicare

Shown below is a chart from the most recent report of the Medicare Board of Trustees.

Figure 6 - Medicare Expenditures and Non-Interest Income by Source as a Percent of GDP

SOURCE: Summary of the 2007 Annual report of the Social Security and Medicare Boards of Trustees, Chart D. <http://www.ssa.gov/OACT/TRSUM/trsummary.html>

It is seen from the chart that, currently, the Medicare program claims about 3% or so of GDP. Under Medicare's current structure, that claim is projected to triple to about 9% by 2050. The chart also shows that, under the current tax structure, the program would have a huge annual deficit. These numbers lead many commentators to argue that the Medicare program is "unsustainable" in the future. Once again, however, one needs to explore what could be meant by the word "sustainable" in this context. In that exploration, it will be helpful for starters to project real (inflation-adjusted) GDP per capita under plausible assumptions. That figure is an indication of the nation's ability to pay for the health care of its elderly population in the future.

During the period 1980 to 2006, real, inflation-adjusted GDP per capita grew from \$22,700 to \$38,400. Although there were year-to-year fluctuations in that growth, it represents a long-run average growth rate in real GDP per capita of about 2%. Suppose we assume somewhat pessimistically that the future long-run average growth in real GDP per capita will be only about 1.5% per year until 2050. Even at that assumed lower growth rate, real (inflation adjusted) GDP per capita would grow from \$38,400 in 2006 to \$75,124 by 2050. In other words, it would roughly double.

Even if 9% of the real GDP per capita of \$75,124 in 2050 were then taken away for Medicare at that time, the remaining real GDP per capita of \$68,274 would still be 83% larger than the \$37,248 of non-Medicare GDP available to Americans in 2006. To this observer, it is not clear why anyone would argue that Americans living in 2050 could not afford to take care of their elderly.

Figure 7 illustrates these numbers graphically. The solid parts of the bars represent non-Medicare real GDP per capita; the dotted parts represent Medicare spending per capita.

To be sure, as Figure 6 illustrates, the 9% that might be claimed by Medicare in 2050 could not be paid for under the current tax structure. Taxes would have to be raised to effect that transfer. Here one may note, however, that the U.S. remains, with Japan, the least taxed nation in the OECD. Although raising taxes is never much appreciated by citizens, it cannot be argued that a higher tax burden for Americans would put them quickly at a competitive disadvantage relative to other nations whose tax burden now is already significantly higher than ours.

### C. Styles of Rationing Health Care

The upshot of this discussion is that "affordability" and "sustainability" in the context of the macro-economy of the U.S. are not purely economic terms on which all sensible citizens can agree. Both terms are, in essence, value-laden political terms. "Sustainability" in the context of health care really means "political feasibility." It has to do with the question whether or not well-



to-do taxpayers are willing to pay added taxes to afford their low-income fellow citizens access to the kind of health care the well-to-do would prefer to have for themselves.

If commentators argue that current health-care programs for veterans, for the poor or for the aged are not "sustainable," they implicitly allude to the need for rationing health care to these groups. It is a topic worth discussing openly in the health policy debate. There are basically two approaches to rationing: (1) rationing by administrative mechanisms, hopefully on the basis of clinical need, and (2) rationing through market-forces through price and ability to pay. (As textbooks in economics teach their student readers, prices are the mechanism by which markets ration scarce resources among unlimited ends.) The distribution of economic privilege under these two distinct forms of rationing is, of course, quite different.

## V. IS U.S. HEALTH CARE COST-EFFECTIVE?

The preceding sections implicitly assumed that the current modus operandi of the U.S. health system will remain in place for the indefinite future, including the overuse, underuse and misuse known to characterize that system. There is no reason, however, why that modus operandi should be preserved.

Figure 8 presents data on total Medicare spending per beneficiary in 1996 in diverse market areas (counties or groups of counties) of the United States, after adjustment for inter-area differences in the age and gender composition of the elderly population, case mix and prices. In other words, the data in effect reflect different utilization patterns of health care which, in turn, reflects differences in the medical practice style preferred by physicians.

It is seen in Figure 8 that the adjusted Medicare spending per beneficiary varied by a factor of close to 3 across the United States. As a general rule of thumb, Medicare spending per beneficiary in the Sun belt states tends to exceed comparable spending in the Wheat belt states (all the way west to Oregon) by a factor of 2 or more. Research funded mainly by the Robert Wood Johnson Foundation suggests that these spending variations appear to make no discernible difference to the quality of health care processes, to medical outcomes or even to patient satisfaction.

SOURCE: John E. Wennberg et al., Dartmouth Atlas of Health Care 1999, AHA Press, 1999: Chapter 1, Table, pp. 33-40.

Furthermore, a paper published in Health Affairs in 2004 by Katherine Baicker (now on President Bush's Council of Economic Advisors) and Amithab Chandra suggests a negative correlation between spending per Medicare beneficiary and the quality of health care processes. These authors' explanation for this perplexing result is that high-spending states tend to neglect the role of primary care in favor of specialty care, which generally leads to more expensive treatment patterns but less cost-effective, timely or appropriate care. Exhibit 1 from their paper is reproduced on the next page.

More recent work by Wennberg and associates at Dartmouth University has concentrated on Medicare spending per beneficiary during the last two years and the last six months of these beneficiaries' lives. The authors find vast variations in Medicare spending per beneficiary in their last two years of life not only across the United States, but even within states. Table 1 below illustrates such data for the State of New Jersey alone. Figure 9 exhibits similar data for patients in hospital market areas within Los Angeles.

Using the U.S. average as a benchmark and setting it equal to 1, Table 1 shows that Medicare beneficiaries in their last two years of life residing in hospital market area A in New Jersey cost tax payers 3.21 times the national average for inpatient care, while in New Jersey's hospital market area J similar patients cost taxpayers only 1.11 times the national average. Although the data in Table 1 may not be fully adjusted for differences in the morbidity of patients, it is hard to believe that morbidity alone can explain this vast difference in hospital utilization. A more plausible explanation is that these differences reflect differences in the practice style preferred by physicians in the various hospital market areas - differences that may reflect either differences in professional opinion or differences in professional profit-seeking.

SOURCE: Katherine Baicker and Amitabh Chandra, Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care, Health Affairs Web Exclusive, April 7, 2004

Table 1 -- Medicare Payments for Inpatient Care During the Last Two Years of Life of Medicare Beneficiaries (Ratio of New Jersey Hospital's Data to Comparable U.S. Average, 1999-2003)

Inpatient reimbursements Hospital Days Reimbursements  
per Day CMS Technical Quality  
Score

HOSPITAL A	3.21	2.34	1.37	0.91
HOSPITAL B	2.32	1.26	1.83	0.95
HOSPITAL C	1.86	1.85	1.01	0.81
HOSPITAL D	1.83	1.83	1	0.59
HOSPITAL E	1.75	1.72	1.02	0.74
HOSPITAL F	1.58	1.86	0.85	0.83
HOSPITAL G	1.27	1.36	0.94	0.90
HOSPITAL H	1.17	1.26	0.93	0.94
HOSPITAL J	1.11	1.12	0.97	0.89

Source: Data supplied to the Commission by John H. Wennberg, M.D., Director of the Dartmouth Atlas Project, December 2006.

Wennberg and other health services researchers have for over a decade and a half apprized members of Congress and their staff to these variations in health care utilization and spending under the Medicare program. Remarkably, Congress has never shown any interest in enquiring what difference these enormous variations in health-care utilization and health spending make to the quality of care or life of patients. Alternatively put, Congress has never justified to taxpayers

why they must spend twice as much or more per Medicare beneficiary in some states than for similar beneficiaries in other states.

In fact, the total amount of funding Congress allocates to the operations research (health services research) has always been paltry - much less than ½% of total Medicare health spending. Few enterprises could function efficiently with so paltry an allocation of operations research. The neglect of operations research for health care can fairly be called penny wise and pound foolish.

The upshot of this discussion for a hearing on the VA health system is that there is much evidence of inefficiency in the U.S. health system in general and that the VA health system may not be free of sin in this regard either. In this regard, however, it is reassuring that the VA now is endowed with a world-class electronic information infrastructure (IT), and that it in recent years has been found to attain significantly higher quality standards than have been attained in the rest of the U.S. health system.

Congress should encourage the VA in its campaign to root out whatever waste remains in its system and to strive for the highest quality attainable in the care it renders. Congress can do its part by making sure the VA's health services research and IT operation, and its management in general, are adequately funded for the remaining task at hand.

## VI. CONCLUDING OBSERVATIONS

The central focus of my testimony has been the future "sustainability" of current spending trends in the VA health system. My overarching conclusion is that "sustainability" really is not the issue. Rather, it is cost-effectiveness, and in that regard the VA health system is likely to be the leader among the various segments of the U.S. health system.

It was shown above that the VA health system, large as it is, nevertheless imposes only a modest burden on the federal budget and an even more modest one on the nation's GDP. Most Americans -- and especially members of the nation's moneyed elite - view America mainly as a great source of wealth and income, rather than as something worth personal sacrifice. They rely on the few patriots and warriors among us to stand tall for this country in dangerous fields abroad. It was not always so - certainly not in WWII -- but it is so now.

Speaking now as a citizen, rather than an economist, it seems to me that the very least the rest of us who are unwilling or unable to sacrifice physically for America can do for our soldiers, Marines and sailors is to grant them an entitlement to the best health care this nation knows how to give its people. This country's highly paid corporate executives take it largely for granted that shareholders owe them fully comprehensive health care for the rest of their lives after retirement. Why ought not someone ready to die for this country be entitled to the same privilege?

To be sure, an economist always is the first to point out that resources are finite and that trade-offs must be made within our GDP and within the federal budget. If budget cuts must be made, however, targets other than the VA easily suggest themselves. Foremost among these targets, for example, would seem to be this nation's vast system of agricultural subsidies, which can range as

high as \$30 billion a year. Rare would be the economist ready to defend these subsidies, either on the ground of economic efficiency or on the basis of horizontal equity. To this economist's mind, these subsidies would be an inviting source for funding future health spending by the VA within the government's budget constraint. Yet other inviting targets come to mind.