



HEALTH CARE 2009

Universal Health Insurance Coverage or Economic Relief — A False Choice

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These are exciting times for advocates of universal health care coverage, with sizable Democratic majorities in both houses of Congress and a Democratic president who made universal coverage

a central pledge of his campaign. Indeed, Senators Max Baucus (D-MT) and Edward Kennedy (D-MA) are hard at work on universal-coverage legislation, and Senators Ron Wyden (D-OR) and Robert Bennett (R-UT) have already submitted a bipartisan bill that would accomplish that goal. But despite this enthusiasm, many observers are skeptical that the United States can foot the bill for universal coverage in such economically trying times. Universal coverage, their argument runs, is a luxury that we must do without in order to make way for other programs that will stimulate the economy.

This argument presents a false choice. Indeed, I would counter that now is exactly the right time for universal coverage, because it can play such an important role in growing our economy, while also enabling us to shift the focus of health policy discussions to approaches for addressing our largest long-term fiscal challenge: escalating health care costs.

The first step toward universal coverage would be to send resources to the states for maintaining and expanding their public insurance programs. For example, the recent legislation reauthorizing the State Children's Health Insurance

Program (SCHIP), which was vetoed by President George W. Bush, included large incentive payments to states for enrolling children who were already eligible for, but were not yet enrolled in, state public insurance programs. These bonus payments would have offset much of the cost that states would have incurred for the newly insured children, providing a major source of federal funds to cash-strapped states.

More generally, broad subsidies that make affordable health insurance available to lower-income families would improve not only the health of these families but also the health of our economy, by freeing up funds that the families could spend on other consumer goods. Indeed, this dynamic is exactly what we saw when Medicaid was expanded to cover additional low-income children

and pregnant women in the late 1980s and early 1990s. My colleague Aaron Yelowitz and I found that the families that gained insurance coverage through these expansions substantially increased their spending on other consumer goods¹ — by an average of about \$800 per year in today's dollars. This sizable effect could go a long way toward offsetting the decline in consumer spending that is marring the current economic landscape.

Another major benefit of universal coverage would accrue to the labor market. A fundamental problem with our employment-based health insurance system is that Americans are afraid to leave jobs that come with health insurance for those that do not. Colleagues and I have documented the empirical importance of such "job lock," estimating that this fear reduces job-to-job mobility among the employer-insured by as much as 25%.² If workers are afraid to leave their jobs, they will not move to the most productive positions, and economic growth will suffer. Universal coverage that moves beyond the restrictions of the employer-sponsored system would end job lock and increase the productivity of our labor force.

If it were part of a comprehensive reform package, universal health insurance coverage could also be a source of growth for high-quality jobs. A key aspect of most reform plans is major new investments in information technology that is necessary to bring our health care system into the 21st century. For example, during his campaign, President Barack Obama called for investing \$10 billion per year over 5 years to move the country toward the use of elec-

tronic health records. Such investments are central to the delivery of coordinated care that can improve the quality of health care and reveal opportunities for systemwide savings. But the economy would benefit as well, since this plan would require the creation and implementation of a vast new computer infrastructure for collecting and sharing medical information — which would, in turn, mean filling a large number of well-paid high-technology positions.

Moreover, making coverage universal will necessitate expanding the medical sector to meet the needs of a larger population. If this expansion were done right, it could be a huge jobs program. For example, the white paper issued by Senator Baucus in November focuses on the need for dramatic investment in the delivery of primary and preventive care.³ His plan calls for improved payments to primary care providers and community health centers, for instance, and increased reliance on "patient-centered medical homes." Such an approach would shift the focus of the health care system from specialists to preventive care practitioners with much lower barriers to entry, such as those for nurse practitioners and registered nurses. Such rewarding, high-paying jobs could provide a landing spot for workers displaced from other sectors of our economy.

Finally, providing universal coverage represents an important prerequisite to addressing the most important fiscal issue facing the U.S. government: the enormous future promises made through our public insurance programs, Medicare and Medicaid. Recent esti-

mates suggest that the future obligations of the U.S. government for the Medicare program alone, minus any Medicare payroll taxes collected, will be more than \$70 trillion — an amount that is seven times that of our national debt. Closing this gap, along with the \$15 trillion gap in the Social Security program, would require roughly a tripling of the existing payroll tax on firms and workers⁴ — clearly an unsustainable fiscal burden for the country and its taxpayers.

The primary driver of this burden is not the aging of our society or the specifics of eligibility for these entitlements, but rather the uncontained underlying growth in health care costs. These costs have more than tripled as a share of our economy since 1950, and their escalation shows no signs of abating. The Congressional Budget Office recently projected that the share of the economy devoted to health care will double by 2050.⁵ Thus, the sustainability of our public insurance programs depends on reining in health care costs.

Designing, passing, and implementing policies that will bring health care costs under control, however, will require herculean efforts on the part of U.S. policymakers. Universal health insurance coverage is, in a sense, central to these efforts, because squaring away a baseline level of coverage will allow policymakers to focus their energies on cost control. The health policy community has long been fighting a two-front war, and the goals of universal coverage and cost control can sometimes conflict. Having everyone pulling in the same direction — with the recognition that cer-

tain financial limits will be required to ensure ongoing health care for all — is key to developing the consensus necessary for cost control. I have witnessed this effect firsthand in Massachusetts, where for years our advocacy community focused exclusively on expanding coverage for medical expenditures and therefore opposed most initiatives that might have put that goal at risk, even those that might have meant controlling costs. Since Massachusetts passed its universal-coverage plan, this powerful advocacy community has shifted its attention to controlling costs as a means of preserving the program's affordability to the state. The result was the passage last year of an opening salvo in the cost-control wars

here in Massachusetts — Senate bill 2526, An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care. Other countries, such as the Netherlands and Switzerland, have demonstrated that it is possible to have both universal coverage (even coverage provided through private insurance companies) and much lower health care spending.

Thus, the choice between fixing our health insurance system and fixing our economy is a false one. A smart health care reform bill, which has at its center universal health insurance coverage for our citizens, can improve both individual health and the economy's health, both today and in the long run.

No potential conflict of interest relevant to this article was reported.

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Antibiotic-Resistant Bugs in the 21st Century — A Clinical Super-Challenge

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In March 1942, a 33-year-old woman lay dying of streptococcal sepsis in a New Haven, Connecticut, hospital, and despite the best efforts of contemporary medical science, her doctors could not eradicate her bloodstream infection. Then they managed to obtain a small amount of a newly discovered substance called penicillin, which they cautiously injected into her. After repeated doses, her bloodstream was cleared of streptococci, she made a full recovery, and she went on to live to the age of 90.¹ Sixty-six years after her startling recovery, a report² described a 70-year-old man in San Francisco with endocardi-

tis caused by vancomycin-resistant *Enterococcus faecium* (VRE). Despite the administration, for many days, of the best antibiotics available for combating VRE, physicians were unable to sterilize the patient's blood, and he died still bacteremic. We have come almost full circle and arrived at a point as frightening as the preantibiotic era: for patients infected with multidrug-resistant bacteria, there is no magic bullet.

It is difficult to imagine undertaking today's surgical procedures, transplantations, cancer chemotherapy, or care of the critically ill or HIV-infected without effective antimicrobial agents. Bacte-

ria are champions of evolution, and a few microbes have adapted to a point where they pose serious clinical challenges for humans. Among the gram-positive organisms, methicillin-resistant *Staphylococcus aureus* (MRSA) and *E. faecium* represent the biggest therapeutic hurdles (see table). The evolution of MRSA exemplifies the genetic adaptation of an organism into a first-class multidrug-resistant pathogen. After the introduction of penicillin and, later, methicillin, *S. aureus* quickly developed resistance to these β -lactam compounds, and by 2003, more than 50% of *S. aureus* isolates recovered in U.S. hospitals were MRSA.