Financing Health Care in the United States and Abroad:
Current Challenges and Opportunities Ahead

Christina Paxson
President
Brown University

An Interview with Michael Hoffman and Lorenzo Moretti
Providence, RI, 20 March 2013

Christina Paxson is the nineteenth president of Brown University. Prior to her appointment in 2012, she was dean of the Woodrow Wilson School of International and Public Affairs and the Hughes Rogers Professor of Economics and Public Affairs at Princeton University. Paxson also served as associate chair (2005–2008) and chair (2008–2009) of Princeton University's Department of Economics and was the founding director of the National Institute on Aging Center for the Economics and Demography of Aging. In 2000, she founded and directed the Center for Health and Wellbeing, an interdisciplinary research center in the Woodrow Wilson School, until 2009. Paxson has been the principal investigator on a number of research projects supported by the National Institutes of Health, the most recent of which is a study of adversity and resilience after Hurricane Katrina. She was elected vice president of the American Economic Association in 2012 and is a member of the Council on Foreign Relations.

Brown Journal of World Affairs: In the past, you have said that you have thought of economics as having a social purpose and that its main goal should be to improve human welfare. As such, how do you believe economics can help solve the challenges of financing health care?

Christina Paxson: Economics is about the allocation of scarce resources. That's a formal definition. Health care is probably one of the best examples of why we worry about the allocation of resources across people. We're facing two big

dilemmas right now in the United States. One is how much of our overall budget we should allocate to health care as opposed to other goods and services. The other is, even within a health care budget, how do we ensure that that money is used as efficiently as possible, and how do we allocate it across the age spectrum. Financing health care encounters all these allocation problems. I think what makes health care so interesting is that, unlike many goods and services, health care markets tend to not work well on their own. They are not efficient markets. Therefore, there is much more scope and need for public policy to make a big difference. This is one of the most interesting and fundamental problems that an economist could think of dealing with.

I think what makes health care so interesting is that, unlike many goods and services, health care markets tend to not work well on their own.

Journal: Do you think that, in the United States, the health care issue is more of an economic problem, a political problem, or an ethical problem?

Paxson: It's really all three, but I think that the politics prevents us from thinking carefully through both the economic issues and also the ethical issues. If I were right now to identify the biggest road blocks, I would say they're political. Health care gets tied up into all of these other issues that cross a partisan divide on the role of government and the size of government. At the same time, there are also ethical issues about end-of-life care, which are incredibly important for the whole debate. So all three are important, but right now, it seems politics trumps everything.

Journal: Your research has focused on inequalities and development. How does a health care system influence the level of inequality in a country? Through what channels does this happen, and can health care provide potential solutions to inequality?

Paxson: That's a really interesting and a very big question. I am interested in health inequality and health disparities, and a lot of my work has been in the United States, but much of it has also been in Britain, where there is universal health care. When we think about inequality in health care, we have to think very carefully about what health insurance can do and what health insurance can't do, and sometimes people mix those two things up. There's pretty good evidence that increased access to health insurance would reduce some health

disparities but not produce huge reductions. When you go to a country like Britain, which has equal access to health care or universal insurance, you see almost exactly the same disparities in health across people with high and low incomes as you see in the United States in terms of health outcomes. So the idea that universal health insurance will eliminate health disparities is, unfortunately, just wrong. Then you think, what else is health insurance there for? Health insurance protects families and individuals from the adverse financial consequences of having health problems. When you look at the factors that drive working families into bankruptcy, a very high fraction really stem from uninsured medical cost. Because we have disparities in health insurance across wealthier and poorer families, poorer families will bear the financial burden of poorer health in a much greater way than wealthier families. Despite its limitations, I believe that universal health insurance is also an ethical issue. My own personal belief is that everybody should have health insurance. We should have a society that makes sure that that is true, but we also need to understand that, while this is going to help people on financial grounds, it is not going to be the issue that ends health disparities.

Journal: In your research, you have shown that part of the intergenerational transmission of socioeconomic status may work through the impact of parents' long-run average income on children's health. In other words, an individual's potential to be wealthy in the future depends on how healthy they were when they were children. On the other hand, inequalities in health care in old age are greater because inequalities in income also tend to increase with age. How do these two parts fit into the picture, and how can health care systems prevent disparities in early life and later on?

Paxson: I think this is interesting because there is some evidence that says access to health insurance does affect health. It's not going to eliminate health disparities, but there are some periods when it's important. I think one of the times when health insurance is very important is the prenatal period and the period of delivery of children. My hope is that as women have better access to health care, even before they get pregnant, they will have healthier babies. We do know that if babies are born healthier, with a high birth weight or normal birth weight, then they are more likely to do well in school and get good jobs. These things sort of cascade, and that's the point at which the Affordable Care Act might work. It's interesting because right now most low-income children have health insurance. They have it through Medicaid or through the Children's

Health Insurance Program (CHIP) and the Affordable Care Act. The primary impact will be on adults between the ages of 18 and 65. So the potential for improving the health of young women might be one of the most important outcomes in terms of reducing inequalities over a lifetime. It's young adults really who will benefit, and who are already benefiting the most, from expanded health insurance.

Journal: Due to some demographic changes in the United States and other developed countries, health care costs are rising. Baby boomers get older, for example, and rising costs for the elderly only continue to grow. Are there any potential solutions that should be considered in order to face rising systemic expenses?

Paxson: When you actually look at many of the projected increases in health care costs in the United States—and they're pretty remarkable—they're not that heavily driven by demographic change. A lot of people assume that they are, but the truth is, even demographic change is not pronounced enough to give us such a big explosion in health care costs. That's really being driven by an increasing intensity in medical care and prices for what's being delivered. Aging is in there, but it's not the lion share of it, and that's important to note.

I do think, however, that population aging will focus attention on the issues of end-of-life care and the questions surrounding institutionalization—where people live when they're older. Can they live in their homes? Do they get moved into nursing homes? When does that happen? When we look at the cost of Medicaid for example, a lot of its expenses are for Medicare-eligible individuals who also have limited income and resources, which entitle them to Medicaid under the state plan. Medicaid is picking up nursing home care, and with more and more people in that category, we're really going to need to think about how we deal with those issues, and it is why we've been worried about end-of-life care for a long time.

Journal: You mentioned previously that you think the Affordable Care Act will have a significant impact on people ages 18 to 65. When do you think we'll start to see the effects of its implementation? Are there any other specific health outcomes that you predict will occur in the United States as a result of the Affordable Care Act?

Paxson: We already are seeing the effects of the Affordable Care Act. The part

that went into effect right away was that young adults could stay on their parents' health insurance up until the age of 26. We've already seen big increases in insurance rates among members of the group ages 18 to 26. That's a group that tends not to be particularly unhealthy; in fact, it's probably the lowest-cost group of people to insure, which is why it was pretty easy to do this. I do think if the care being provided to the people between the ages of 18 and 26 is appropriate—meaning it's focused on prevention and reducing obesity, smoking, and the kinds of behavior that lead to chronic disease later in life—then that has the potential to have a big impact on health over the life course. One of my main concerns is whether the quality of care or the type of care people are receiving is focused enough on prevention to achieve the greatest impact possible from that coverage.

A primary care focus and a focus on having a team that's really dedicated to individuals—these are good developments.

Journal: Do you see solutions outside of the Affordable Care Act that might require further policy changes?

Paxson: A couple of things. First, to the extent that health care systems realize that money will be very tight, they're looking very closely at models for alternative care. One model is to focus much more on primary care, on prevention, and on public health interventions. That's something I'm really excited about and something that Brown University is doing. We're developing a bigger track in primary care for exactly that reason. A primary care focus and a focus on having a team that's really dedicated to individuals—as opposed to fee-for-service, which treats problems as they come up—these are good developments. Will we need more policy change? Yes, because I don't think the Affordable Care Act has enough in it to push us away from fee-for-service models. The Accountable Care Organization (ACO)—where groups of health care providers come together to provide coordinated care for Medicare patients—is part of it, but no one really knows yet how that's going to work. It's cumbersome and difficult. We'll see where that goes. Some states will be innovators and will push into that area on their own.

Second, one of the aspects that I think will be interesting in the coming decade is the amount of action at the state level. We'll see a lot of experimentation and a lot of states doing different things. I think it's going to be an exciting period, and we'll learn a lot. There may be states that introduce changes that other states can then look at and realize are effective—which means getting bet-

ter health and at a lower price—and they'll start adopting the same policies too. That's the optimistic view. States can circumvent some of the thorny political issues that appear at the federal level, and that's where the states could do things that the federal government can't do.

Journal: The United States still has the best medical research in the world. At the same time, the United States also has some of the worst statistics among developed countries for health care outcomes while spending the most money. These statistics tend to have an impact on economic development and on economic growth. How do you think this will affect the United States in the future, especially compared to other developed countries?

Paxson: The United States has been the biggest innovator in health care technology ever, I would say. Some of that, you could argue, has not been that socially valuable—for example, developing a very expensive drug that does not do that much more than the drug that has been used for the previous thirty years. But we have really been a leading health care nation. And I think there's concern that inefficiency—the extra cost of delivering health care—has actually been supporting a research enterprise that has benefited the entire world, and it really has. If you look at declines in infant mortality, they started in the United States. There were some developments in Intensive Care Units (ICUs) and synthetics that helped very premature infants breathe. Then those methods spread to other countries, and this spillover helped the decline of infant mortalities overseas. That's a great thing. So there is fear that if we cut back on how much we spend on health care but don't also continue to support medical research at the same time, this will have a negative impact not only on the United States but also on the rest of the world. I think it's important to rein in health care costs, but I also think it's important to support health care research. It's critical to keep that health care edge, and this is true for our economy too.

The United States has been the biggest innovator in health care technology ever, I would say.

In terms of the Affordable Care Act and policy changes put in place afterward, they do rein in health care costs while maintaining the quality. They are going to have a huge impact on employers in the United States. Right now, we've seen very little wage growth among low-income workers. However, if you look at wage levels, including what employers are providing for health care, there's been wage growth—workers just have not seen it. It's all going to health care. I think we can do that and improve competitiveness and workers' living

standards. There are big advantages to getting this right, including bringing health care costs down while maintaining quality. It's interesting to see more and more companies taking an interest in the health of their workers because they realize that if they have healthy workers, they will have less absenteeism and lower insurance costs. It's interesting to see how far that spreads. One of the problems is that American workers change jobs often enough that it is not really in the interest of many companies to invest in their workers' long-term health.

Journal: Do you think continued innovations and elaborate technologies will continue to increase the demand for expensive health care both here in the United States as well as abroad or in low- and middle-income countries?

Paxson: Technological change in theory can increase costs or reduce costs, but it depends on what kind of technological change it is. I think one of the problems that we face is that companies developing technologies and new jobs do not face the incentive to produce things that actually reduce costs. Companies want to develop the next medication that is going to be very expensive and have the most people in the world taking it. The idea that you are going to get a big internal benefit is in part the calculation. Britain has dealt with this by building cost-effectiveness into the health care system—the idea that a medical procedure, device, or drug will be approved for use only if it really creates a significant health outcome relative to the cost. The United States has not done that. In fact, the rules for Medicare say that they cannot do that; it is not allowed to take into account cost when it is deciding which procedures to do. I think that's a huge problem. If I had one policy change I would go after, I would suggest going after cost-effectiveness. We can do it through Medicare. Medicare's the leader; that's where most of the health care costs are. A lot of the pricing policies set by Medicare filter out into the rest of the system. If Medicare is rewarding things that actually improve health without much addition to cost, that is going to change the incentive for the innovators. They are not going to invent things that Medicare is not going to improve. I see that as a really important direction for the United States. Whether we will get there, it is hard to say.

Journal: What do you think is the role of NGO-sponsored care as well as the private sector in improving public health outcomes for the underprivileged as well as in enhancing general quality of care?

Paxson: On the local, grassroots level, community clinics are more interested

in innovation, in getting things right. They have to meet their payroll and make their rent, so they do have to worry about finances, but they are very different from the large hospital systems, which are often not-for-profit. I think that what is hard for them is making sure that the rules around the Affordable Care Act give them a place at the table. Can they be integrated into an ACO? It's interesting to the extent that Medicaid patients fund these clinics, and the idea of a Medicaid-focused ACO is kind of different. It is not really what people thought of when they thought of Accountable Care Organizations. I'm looking to see how the ACOs develop, whether they are able to really bring those people in. I think they will have a lot to draw from in an integrated-care system, especially since they have a lot to offer in a system that is more family based or primary care based. Yet, they do not have the same political clout or administrative expertise.

Journal: The U.S. savings rate is known to be very low. Do you think rising costs of health care will push Americans to save more than they are saving right now and change the savings–consumption dynamics in the United States? Or, on the other hand, could extending health care coverage further reduce the savings rate?

Paxson: Let me think through that. What do people save for? They save for retirement and for the costs they are going to have to bear when they stop working. They save to buffer themselves from unexpected events as insurance. To the extent that you have more insurance, you actually reduce some of the incentive for saving. Right now, people worry a lot about saving for retirement because they are worried about unanticipated medical costs that will not be covered by Medicare or they are worried about retirement homes. This gets back to the real fundamental issue that we started with: allocation of resources. On the right, it is claimed that people need to take personal responsibility. If you give them insurance, then you are discouraging saving, discouraging good behaviors, and discouraging people from looking carefully at the costs of the medical care they are getting. In truth, there is some validity to those arguments. On the other side, if you threw everybody out on their own and expected them to finance all of their health care out of health care savings accounts and individual savings accounts, and if you really dismantle the public insurance system, then you would have huge inequities. That I see really as the tradeoff.

Moreover, I do not think moving toward better insurance and lower-cost health care would necessarily increase savings rates. In fact, it might actually reduce them because people are not as concerned about them. If we were to bring the cost of health care down, it might actually discourage saving. I think

it's true that now people are saving due to concerns about health care. It may be that people are delaying retirement for the same reason. I do not know how big that effect is, and the fact is so many Americans already save so little—especially people on the lower end of the income distribution, who are not saving much at all. So whatever they are saving is not going to change much. People on the upper end of the income distribution are so well buffered that it does not really matter. On the margin, there may be some effect but it will not be huge.

Journal: Regarding your role right now at Brown University, what do you think is the role of academia in addressing challenges to health care? Should medical schools and universities start to focus more on public health rather than medical research?

Paxson: You are throwing the biggest softball for me here. We just started a school of public health. Brown is also starting an expanded track in primary care in its medical school. Both of those things are in part motivated by the idea that we are moving into a new world in health and health care that has to be more focused on prevention and on primary care. I think we really want to be part of the innovation around policies and practices that will result in higher-quality and lower-cost health care. I think our school of public health together with our medical school and some of the social scientists that are up on College Hill can take part in that research. So that's exciting for me. It's one of the things that really drew me to Brown. At the same time, we are also doing basic scientific research as well as applied translational research in medicine. You talk about innovations that can make a difference in people's lives—they are fundamental. We need to keep pushing forward with that too. There's a wide range of research at Brown, but a lot of it is focused on how to develop better, lower-cost, more effective methods of improving people's health or their ability to enjoy life given health limitations. That's a really good focus. We can contribute in both ways: in medical education and research, both medical research and policy or practice-based research through public health.

Journal: What does a new doctor need to know today to succeed in this changing system?

Paxson: It would be irresponsible of me to claim that I know what a doctor would need to know when he or she finishes medical school. I would hope that in addition to the standard medical training that makes a doctor a very good

physician in the medical sense, they would also come away with some knowledge about the social determinants of health and health disparities. I would hope that they would come away with some familiarity with health economics and the financial structure of the system they are about to enter.

Journal: What does a potential patient need to know in order to navigate the health care system?

Paxson: That's a huge question. My own experience is that most patients need advocates who are family members and can help negotiate it with them. People who are very sick are not well equipped to navigate what currently is a fragmented, difficult, confusing, and not very patient-friendly system. What a patient needs to know is that if they have a very serious medical problem, they need to get other people involved.

Right now, so much of the health care debate is driven by ideology and not by real facts.

Journal: And what does an American citizen need to know about this complex system?

Paxson: I think it's good for American citizens to try to learn a little bit more about the facts of the health care problems we face—the economic problems as well as the medical and ethical issues. Right now, so much of the debate is driven by ideology and not by real facts. When you talk to people and start to actually talk about budgetary issues, their eyes glaze over. But these are important issues; they will have huge impacts on the taxes we pay in the future and the quality of our lives. So people should go on the Office of Management and Budget (OMB) website and actually read what the Affordable Care Act is going to do. They should look at what some of the health care projection costs really are. That would be a good thing.