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>>Health Care

How Can We Reduce Costs and Still Get the Care We Need?

About This Issue Guide

Americans worry about the high cost of health care. Personally, many of us fear that we are one medical catastrophe from bankruptcy. On a national level, spending on health care exceeds spending for defense and threatens our country's solvency. Deliberative forums on this difficult subject will challenge participants to carefully weigh the trade-offs involved in achieving those things they most care about: good health, ability to pay their bills, personal freedom, and a nation that can meet its citizens' needs.

In productive deliberation, people examine the advantages and disadvantages of different options for addressing a difficult public problem, weighing these against the things they hold deeply valuable.

The framework in this issue guide encompasses several options and provides an alternative means for moving forward in order to avoid polarizing rhetoric. Each option is rooted in a shared concern, proposes a distinct strategy for addressing the problem, and includes roles for citizens to play. Equally important, each option presents the drawbacks inherent in each action. Recognizing these drawbacks allows people to see the trade-offs that they must consider in pursuing any action. It is these drawbacks, in large part, that make coming to shared judgment so difficult—but ultimately, so productive.

One effective way to hold deliberative forums on this issue:

- Ask people to describe how health-care costs have affected them, their families, or friends. Many are likely to mention the concerns identified in the framework.
- Consider each option one at a time, using the actions and drawbacks as examples to illustrate what each option entails.
- Review the conversation as a group, identifying any areas of common ground as well as issues that still must be worked through.

The goal of this issue guide is to assist people in moving from initial reactions to more reflective judgment. That requires serious deliberation, or weighing options for action against the things people hold valuable.

The National Issues Forums Institute
This issue guide was prepared for the National Issues Forums Institute in collaboration with the Kettering Foundation. Issue guides in this series are used by civic and educational organizations interested in addressing public issues. These organizations use the books in locally initiated forums convened each year in hundreds of communities. For a description of the National Issues Forums, log on to the website: **www.nifi.org**.

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Founded in 1927, the Kettering Foundation of Dayton, Ohio (with offices in Washington, DC, and New York City), is a nonprofit, nonpartisan research institute that studies the public's role in democracy. It provides issue guides and other research for the National Issues Forums. For information about the Kettering Foundation, please visit **www.kettering.org** or contact the foundation at 200 Commons Road, Dayton, Ohio 45459.

>>Health Care

How Can We Reduce Costs and Still Get the Care We Need?

AMERICANS WORRY ABOUT the high costs of health care, and for good reason. Medical bills are the leading cause of personal bankruptcies. Insurance premiums and copays squeeze family budgets. Insured or not, many of us fear we are one medical catastrophe away from financial ruin.

But there is a public dimension to these costs as well. Nationally, our collective spending on health care threatens this country's long-term solvency and with it the ability to pay for other national priorities. The federal government is mandated to spend 22 percent of its budget on health care. Many of us may be surprised to learn that this is more than it spends on defense—and does not even include the more than $50 billion dollars spent annually on medical care for its military forces and for veterans.

One-third of the national health-care budget goes to Medicaid and the Children's Health Insurance Program, which provide health care or long-term care to low-income elderly and disabled people, parents, and children. Two-thirds goes to Medicare, which pays most health-care costs for Americans over age 65, regardless of income.

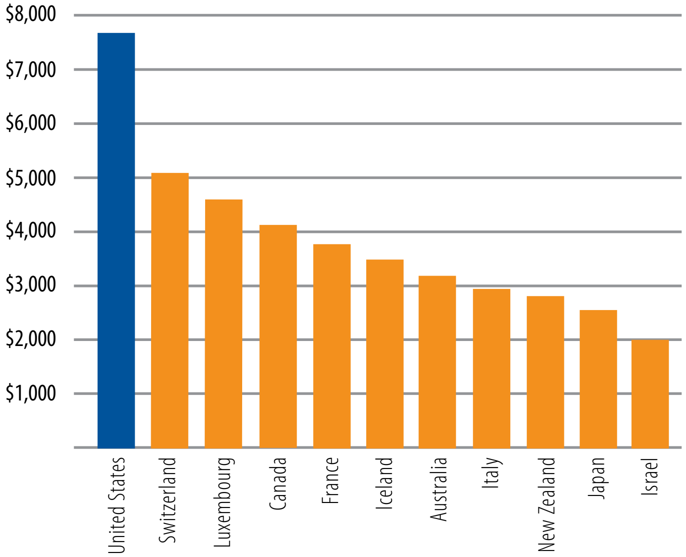
Government spending on health care is projected to rise in the years to come as Baby Boomers—the huge generation born between 1946 and 1964—turn 65, putting Medicare's viability at risk and squeezing funding for basic scientific research, education, and national security. As

Harvard economist and health policy specialist David Cutler told National Public Radio, "The US does not have a deficit problem, it has a health-care problem."

We may disagree on *how* to do it, but most of us agree that we—as individuals and as a nation—need to do *something* or face tough choices between paying for our nation's health care and paying for everything else.

There is a glimmer of good news. Since 2009, the growth of US health-care spending has slowed to less than 4 percent a year. Spending grew by an average of more than 7 percent a year between 2000 and 2008 and by double-digit percentages in earlier decades. There is considerable debate over the reasons for the slowdown, but no one really has any definitive answers to the question of why the growth of health-care spending has slowed or whether that trend will continue.

Health Expenditures Per Capita: A Global Comparison, 2009



Source: Center for Medicare and Medicaid Services

Higher Spending, Poorer Health

But even with the recent slowdown, overall US health-care spending, private and public combined, was $2.8 trillion in 2012, accounting for 17.2 percent of our gross domestic product. By comparison, other technologically advanced countries spent one-third to two-thirds less per person and 12 percent or less of their economies on health care.

It would be one thing if all our spending bought us better health. While the United States led in spending, we ranked last among 16 other high-income democracies in infant mortality and life expectancy, according to a 2013 report commissioned by the National Institutes of Health. We also have higher rates of obesity, diabetes, heart disease, chronic lung disease, and general disability.

"Our sense is that Americans don't really know about this," Dr. Steven Woolf, a family physician from Virginia who chaired the panel that wrote the report, told *USA Today*. "I don't think people realize that their children are likely to live shorter lives than children in other countries."

Governments in other countries play stronger roles through national health-care systems or regulations and negotiations—options many Americans, distrustful of government intervention, tend to reject. Unlike other developed countries, the United States has a large uninsured population, about 41 million in early 2014. There are big differences when it comes to how healthy people are between rich and poor, black and white, and educated and uneducated Americans. But even wealthy, white Americans are on average less healthy than their counterparts in other countries, the report found.

There is no easy explanation for the differences in spending and health outcomes. What's clear is that our nation would be better off if Americans were healthier and our health resources were used more efficiently.

What Can Be Done?

The Affordable Care Act, signed into law in 2010, went into effect in January 2014. It will take time to see how its reforms play out. In the meantime, we need to move beyond arguments over implementation to talk about what extra steps we might take to make our health-care system financially sustainable.

This issue framework is not about health-care reform in general but more narrowly focused on the high costs of delivering care. It suggests three possible options for deliberation, along with the trade-offs each might involve.

One option says that reining in spending is a matter of making tough choices and living within our means. A second option says that spending will be reduced automatically if we create incentives or regulations, or both, to increase transparency, efficiency, and accountability. A third option says that the best way to lower health-care spending is to change unhealthy behaviors, such as eating junk food and not exercising.

OPTION ONE

The problem is, we simply spend too much. Reining in spending is a matter of tightening our belts and sticking to a budget even if it means sacrifice.

>>As a Nation and as Individuals, We Need to Live within Our Means

SARA MONOPOLI WAS IN HER 30s and about to give birth to her first child when she was found to have incurable cancer. Neither she nor her family could accept her heartbreaking prognosis, and her doctors couldn't bring themselves to force a frank discussion.

After giving birth, Sara endured multiple rounds of chemotherapy, exhaustive radiation, and numerous hospitalizations, but the cancer continued to spread. The aggressive treatment continued for another three months until she died, not at home but after being rushed to the emergency room one last time.

"Our medical system is excellent at trying to stave off death with $8,000-a-month chemotherapy, $3,000-a-day intensive care, $5,000-an-hour surgery," wrote Boston surgeon and author Dr. Atul Gawande in an account of the case in the *New Yorker* magazine. "But, ultimately, death comes, and no one is good at knowing when to stop."

This option argues that we need to learn when to stop, and not just when it comes to futile—and expensive—care in the last few months of life. We spend more on health care than any other developed country spends yet seldom ask if *more* is always *better*. We need to ask more questions and simply spend less.

Reining in spending is a matter of tightening our belts, sticking to a budget, and making tough choices between paying for health care and paying for everything else.

Competing Values

It can be difficult, even offensive, to discuss cost when it comes to caring for the sick, especially for the dying and the elderly. Caring for the vulnerable, as Gandhi said, is the true measure of any society.

Take Medicare, the government health insurance program for Americans aged 65 and over. Before Congress

©Science Photo Library/Getty Images

Twenty-five percent of all Medicare spending goes to the five percent of beneficiaries in their final year of life, most of it in the last few months.

enacted Medicare in 1965, half the country's seniors lacked health insurance. Today, virtually all of them are covered. Most people agree that's a good thing.

The question is, what are the trade-offs of continuing to offer Medicare the way we do now—to every retirement-age American, regardless of need—given the strains caused by retiring Baby Boomers, longer lifespans, and ever-rising medical costs? Unless we can find a way to spend less on Medicare today, says this option, it may not be there for future generations.

"If we cannot get health-care spending under control, there's no hope for the federal budget," said William Gale, a senior fellow at the nonprofit Brookings Institution, at a 2014 conference on the future of health-care spending. "The main hope is . . . global warming gets us all before health-care spending gets us all."

Making Medicare Last

Studies show that most people see Medicare as a program paid by their taxes, which is one of the reasons they tell reform-minded politicians: "Hands off!" US employers and employees now pay a combined total of 2.9 percent of wages to help fund Medicare. In reality, this doesn't come close to paying for its benefits. Oklahoma Senator Tom Coburn, a doctor, says that the average American couple contributes about $110,000 to Medicare over their working careers yet receives more than $330,000 in benefits.

Because proposals to make changes in Medicare benefits are likely to draw considerable fire, it will take encouragement from the public to give political leaders room to act. Rather than telling our government representatives to keep their hands off Medicare, citizens could insist on reforms to ensure that Medicare will last. One way to make sure it is there for the future would be to convert Medicare into a "means-tested program"—that is, require seniors who are well off to pay substantially higher premiums. The Affordable Care Act includes such a provision but it will affect only about 5 percent of beneficiaries.

Another way to bring down Medicare costs and ensure that a core piece of our social safety net survives for future generations is to raise the age of eligibility from 65 to 67. This option holds that means-testing and raising the age of eligibility will help save Medicare for everyone.

The Conversation

Few of us want to acknowledge it, yet death awaits us all. And at that time, we often make valiant efforts to avoid it. Twenty-five percent of all Medicare spending goes to the five percent of beneficiaries in their final year of life, most of it in the last few months. It is not clear that this spending produces much benefit at that late stage. This option says that this is something we must look at. Doctors, patients, and family members ought to have honest conversations about how to care for the dying.

Most health insurance plans, whether public like Medicare or private, pay doctors to give chemotherapy and perform surgery—but not to talk with patients about whether such procedures are wise. This option says that Medicare and private insurance companies should not only reimburse physicians for such conversations but should go a step further and refuse to pay for invasive and expensive treatments that extend life by only weeks or months.

When asked, most people say they want to die peacefully at home, not while undergoing aggressive treatment in an intensive care unit. Encouraging patients of any age with no hope of recovery to choose hospice care is not just cost-effective, it's humane.

The end of life is not the only time that providers and patients should have a conversation about appropriate care. An astonishing 30 percent of all tests and procedures doctors order are unnecessary, researchers say. The problem is seen by health professionals as so serious that, in 2012, more than 20 professional medical societies joined forces to launch a

"Choosing Wisely" campaign, which lists tests and treatments, such as antibiotics for most sinus infections, that they believe are routinely overprescribed. But in a recent survey of physicians by the American Board of Internal Medicine Foundation, three out of four respondents said that the average doctor still continues to order unnecessary services at least once a week, usually because patients ask for them.

More at Stake

Most people in the United States are covered by employer-issued insurance. These plans, especially those with low copays and no deductibles, shield citizens from the actual costs of health care and from thinking twice about whether a test or prescription is cost-effective. This option suggests that if more people were required to shoulder more of the costs through higher insurance deductibles and copays they would be more likely to question the need for tests and procedures—to ask if more really is better. They would be more willing to take the trouble to "choose wisely" if they had more at stake.

According to this option, higher copays and deductibles would also encourage citizens to seek care from lower cost practitioners rather than from specialists. Doctors' fees account for about 20 percent of US health-care spending, second only to hospital fees. Specialists earn $400,000 and up, compared to primary care doctors who earn on average $175,000. Nurse practitioners and physician assistants are paid about half that amount, yet can do about 80 percent of what doctors can do.

To encourage more doctors to become primary care physicians rather than high-charging specialists, the government could forgive medical school loans or offer other incentives. It could also remove barriers to the kind of care that nurse practitioners and physician assistants can offer.

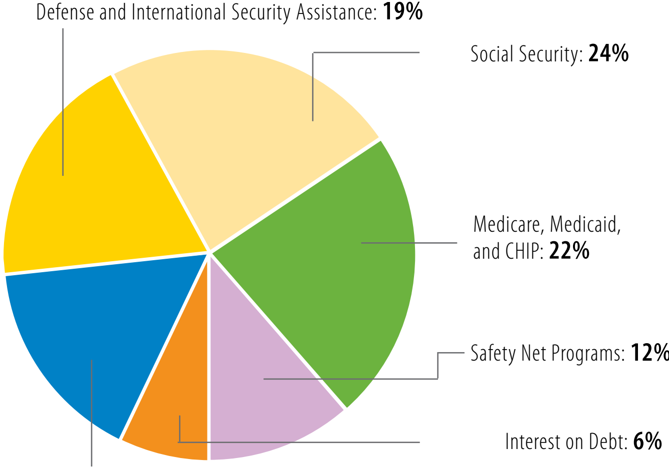
Having more at stake also means buying insurance coverage. The uninsured often end up in emergency rooms, which are legally required to treat people in need regardless of their ability to pay. Such care isn't really free, we pay for it collectively. It's passed on to the rest of us through higher insurance premiums. The Affordable Care Act requires that people get health-care coverage. Congress should give this mandate teeth by significantly increasing the penalties for those who ignore the law.

What We Could Do

This option says that the problem is we simply spend too much. We need to live within our means and make hard choices between paying for health care and paying for other things that we hold valuable.

Here are some things that this option suggests we could do, individually and collectively, along with some of the drawbacks:

Most of the Federal Budget Goes Toward Defense, Social Security, and Major Health Programs



Source: 2013 Figures from Office of Management and Budget

- Rather than telling our government representatives to keep their hands off Medicare, citizens could insist on reforms, such as turning Medicare into a "means-tested" program and raising the age of eligibility to 67.

  But . . . *providing Medicare benefits only to those in financial need could diminish Medicare's almost universal public approval. Delaying the age for eligibility could drain the savings of middle-income seniors and leave more vulnerable seniors without care.*

- Doctors could have honest conversations about the high costs of end-of-life care and encourage patients with no hope of recovery to use hospice care. Insurance companies and Medicare could refuse to pay for invasive and expensive treatments that extend life for only weeks or months.

  But . . . *patients may see such conversations as coercive, making them feel as though they are a burden to their families or society. Life-and-death decisions should be made by the patient and family, not by the government or insurance companies.*

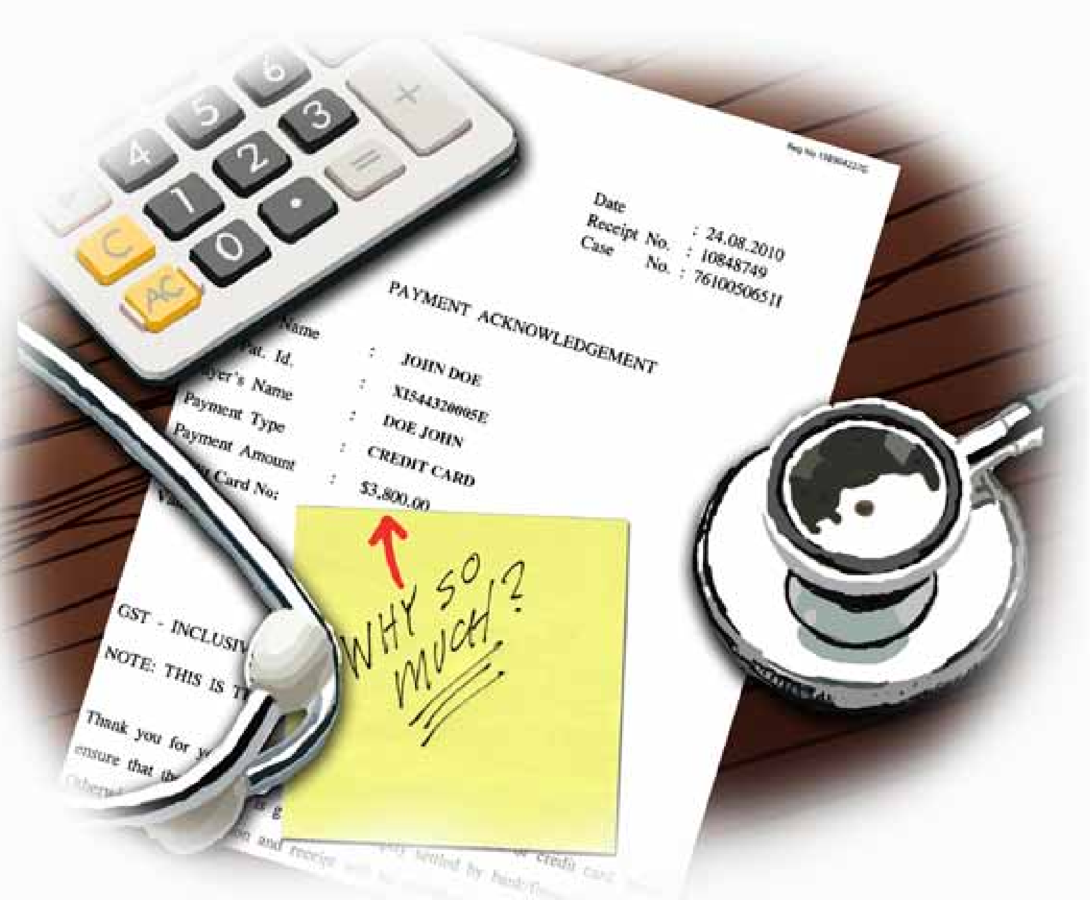
- Employers could stop offering so-called "Cadillac" insurance plans with few or no deductibles and copays because they encourage irresponsible spending. Requiring employees to shoulder a greater portion of health-care costs gives them more at stake and acts as an incentive to discuss with their doctors whether medical tests and procedures are truly necessary and cost-effective.

  But . . . *higher copays and deductibles could cause people to delay or neglect care, which could lead to more serious—and costlier—complications.*

For a summary of the possible actions and drawbacks that this option suggests, see the table on Page 12.

OPTION TWO

The biggest driver of health-care spending is the disorganized state of the health-care system. It needs regulation or incentives, or both, to instill financial discipline and end greed and abuse.



>>Make Health Care More Transparent, Accountable, and Efficient

IT'S EASY TO FIND OUT what it will cost to park your car in a hospital parking lot. But if you want to find out the price of a medical procedure, good luck.

In a study published in a leading medical journal, researchers in Philadelphia called 20 local hospitals to ask what they charged for an electrocardiogram—a basic test that measures heart rate. The researchers said they were uninsured and intended to pay for the test themselves. Just three hospitals divulged the price. But 19 of the 20 provided information on parking fees.

Many citizens say they would make more cost-effective decisions about medical care—if they only knew where to start. But prices are seldom available even when requested. Bills are not explained or broken down. And what hospitals charge often bears no relation to what insurance companies or people actually end up paying.

This option says that the biggest driver of health-care spending is the US health-care system itself—or rather, the lack of a system. Secretive pricing is just one of the problems. Perverse incentives reward hospitals for ordering more, costlier, and often unneeded tests and treatments. Doctors don't talk to each other and patient records aren't easily shared among treating physicians. US hospitals, insurance companies, and pharmaceutical companies negotiate prices that are not only much higher than what is charged in other countries, but vary from region to region and even within the same hospital.

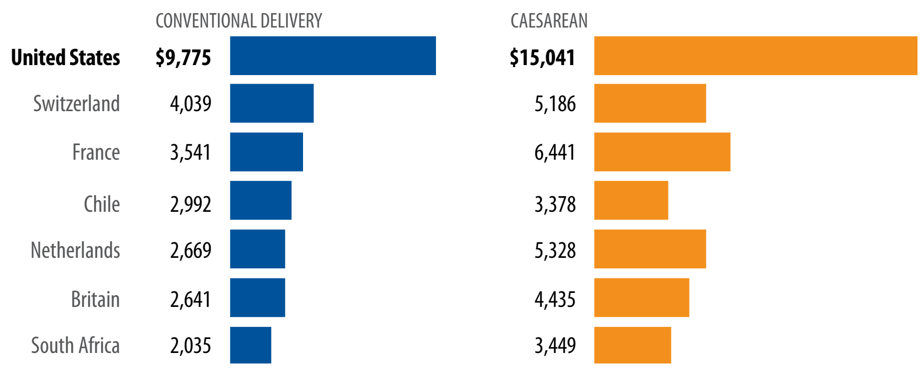
This second option calls for using incentives or regulations, or both, to fix the system by increasing transparency, efficiency, and accountability, which will bring down individual and government spending.

Follow the Money

"When we debate health-care policy," wrote reporter Steve Brill in a 2013 *Time* magazine investigation into health-care costs, "we seem to jump right to the issue of who should pay the bills, blowing past what should be the first question: Why exactly are the bills so high?"

So *Time* followed the money—and found that hospitals maintain something called a chargemaster: an internal, secret list of prices for thousands of medical procedures. The prices listed are neither consistent among hospitals nor tied to actual costs. One hospital's chargemaster rate for a box of gauze pads, for example, was $77, more than 10 times the bulk rate online.

Average 2012 Amounts Paid for Childbirth



Note: Amounts paid are the actual payments agreed to by insurance companies or other payers for services and are lower than billed charges. Amounts shown include routine prenatal, delivery, and postpartum obstetric care. Some care provided by practitioners other than the obstetrician—like ultrasounds performed by a radiologist or blood testing by a lab—are not included in this tally.

Source: International Federation of Health Plans

Veiled pricing and indecipherable bills compound the stress of dealing with serious illnesses. People without insurance—those least able to pay—are often billed the full chargemaster fee. Medicare and insurance companies negotiate huge discounts off the list prices, but those with insurance are still affected because the chargemaster sets the opening bid for negotiations.

This option argues that requiring hospitals and insurance companies to make their private fee negotiations public could help bring down costs in two ways: by allowing patients to compare prices and make cost-effective choices, and by encouraging competition among providers. It might even shame hospitals into setting prices rationally.

But secretiveness is not the only reason health-care prices are so high. The health-care system has a payment system that encourages overspending literally from birth to death. It's called "fee for service."

The American Way of Birth

As just one example, take childbirth. Giving birth in the United States costs more than it does in any other country in the world. US insurance companies pay an average of $9,775 for conventional delivery and $15,041 for a C-section, according to an analysis by the International Federation of Health Plans. This compares to $3,541 for a conventional delivery and $6,441 for a C-section in France, or $2,641 and $4,435 in Great Britain.

Although other developed countries spend far less on childbirth, studies show that they provide the same access to care, including high-tech care. Furthermore, our extra spending does not buy healthier mothers and babies. The United States has the highest infant mortality rate of any high-income country and ranks poorly on premature births and the proportion of children who live to age 5, according to a study by the Institute of Medicine.

What makes childbirth cost so much more here? Fee for service. "It's not primarily that we get a different bundle of services when we have a baby," Gerard Anderson, an economist at the Johns Hopkins School of Public Health told the *New York Times*. "It's that we pay individually for each service and pay more for the services we receive."

Only in the United States is childbirth billed item by item, the *Times* reported, with separate charges for the delivery room, a semi-private hospital room, even removing the placenta. This payment structure—fee for service—gives providers a financial incentive to perform as many "services" as possible.

In most other developed countries, hospitals and doctors are paid a flat fee for childbirth. This option calls for doing the same here, and not just for childbirth. Hip replacements, coronary bypass, broken bones, and more are all candidates for such an approach. Besides removing financial incentives to keep adding services, such a payment system would increase transparency by allowing people to know the costs upfront, and spur collaboration among doctors, hospitals, test administrators, and other providers.

Increasing Coordination, Shutting Out Big Pharma

Lack of collaboration, according to this option, is another driver of too-high health-care costs. Providers practice in silos and too often fail to coordinate patient care, leading to duplicate tests and even dangerous complications when one doctor doesn't know what another has prescribed. Compatible

electronic medical records systems that communicate with each other and coordinate patient care across providers would help cut down on duplicated services.

If there's one group that manages to penetrate silos all too well, it's the pharmaceutical industry. It spent $2.7 billion over the past decade on direct-to-consumer drug ads. That's not counting the dinners and giveaways the industry gives doctors to persuade them to prescribe the newest—and most expensive—drug rather than a generic version that works just as well.

Government should make laws that ban pharmaceutical companies from advertising directly to consumers and from giving doctors money for speaker and conference fees. Such practices encourage patients to ask for drugs they don't really need and doctors to prescribe more expensive brands.

End the Seller's Market

Americans pay extraordinary prices not just for childbirth and end-of-life care but also for ordinary, everyday care. An eye-opening series of stories in the *New York Times* compared prices in the United States to those in other developed countries. A hip replacement costs, on average, four times more in the United States than it does in Switzerland or France. Nasonex, a common nasal spray for allergies, costs $108 in the United States compared to $21 in Spain.

The difference? All other developed countries intervene to set or negotiate lower priced medical treatment for their citizens. The United States relies on market competition to hold down costs. But it's clearly a seller's market, with medical lobbyists spending half a billion dollars a year to protect the seller's prerogative to set any prices they want.

"Manufacturers will tell you it's R&D and liability that makes [hip] implants so expensive," Dr. Rory Wright, an orthopedist at the Orthopedic Hospital of Wisconsin told the *Times*. "[But] they price this way because they can."

Perhaps the most efficient way to rein in costs, according to this option, would be to toss out our old system and replace it with a national system that sets or negotiates prices for hospitals, doctors, and drugs, which would eliminate huge variations in costs. It could be modeled on the care the United States already provides its veterans through government-run Veterans Administration medical centers. Or it could be a public-private system like Medicare, which uses taxes to pay for care, but still allows citizens to choose private doctors and hospitals.

" Take one of these as often as you can afford to. "

©Roy Delgado/Image sourced from CartoonStock.com

What We Could Do

This option holds that the way to bring down spending is to fix the health-care system, so it is more transparent, efficient, and accountable. To accomplish this will require incentives, regulations, or both.

Here are some things that this option suggests we could do, individually and collectively, along with some of the drawbacks:

- Doctors and hospitals could post prices so that patients could make cost-effective decisions. Posting prices would also bring down costs by encouraging competition.

  But . . . *most people don't have the time or inclination to comparison shop, especially when they're sick and vulnerable. They also may not know enough about medical procedures to make the best decisions. Transparency could backfire if patients assume that high prices mean high quality.*

- Insurance companies and Medicare could change the way they pay providers from fee-for-service to a flat fee. Paying for each individual service rewards volume rather than quality or efficiency of care, and creates financial incentives to do more than needed.

  But . . . *a flat fee could discourage doctors from taking on challenging cases. Bundled payments could also complicate efforts to design software for electronic records and add to administrative costs.*

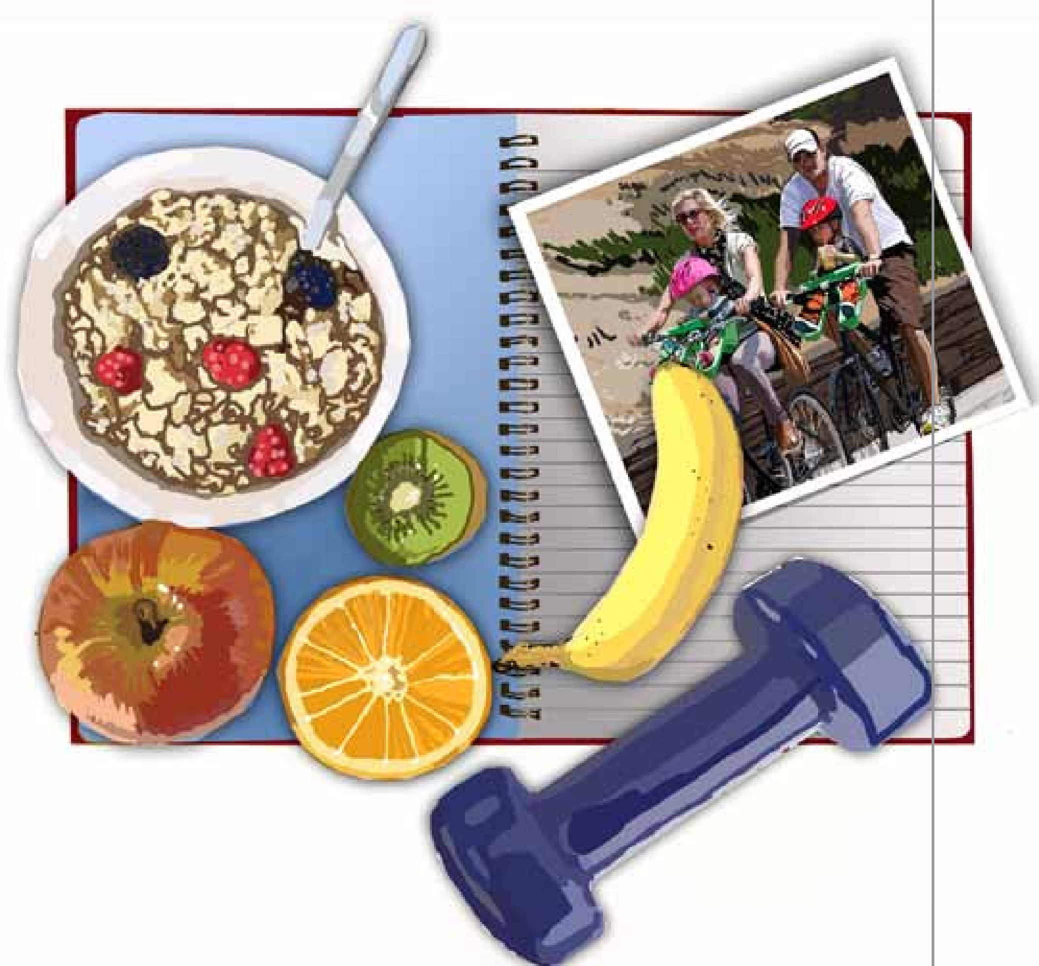
- The government should establish a national health-care system that would allow it to set or negotiate lower prices while expanding care to all citizens.

  But . . . *a national system could limit our choice of providers and services and lead to rationing in tough economic times. Lower pay and reduced profits could dissuade would-be doctors from entering the profession and discourage innovation by drug companies.*

For a summary of the possible actions and drawbacks that this option suggests, see the table on Page 13.

OPTION THREE

The high medical bills Americans complain about are often the result of their own unhealthy behaviors. Individual and collective efforts to promote healthier lifestyles are the most effective way to lower health-care costs.



>>Take Responsibility for Lowering Health-Care Costs by Focusing on Wellness

THE AMERICAN MEDICAL ASSOCIATION estimates that at least 25 cents of every health-care dollar is spent on the treatment of conditions largely brought on by our own behaviors.

Too many of us eat junk food, sit in front of the TV all evening, and mean to stop smoking, but don't. We all know that these and other unhealthy habits contribute to this nation's epidemic of obesity, diabetes, heart disease, and other preventable—and expensive—diseases.

And we know that timely preventive care, such as childhood immunizations, vaccinations against flu and pneumonia, and screening for hypertension and for colorectal and breast cancers, keep small problems from becoming large ones.

Bringing down health-care costs should begin with us, according to this option.

Making healthier choices does not sound like the kind of thing that would really make a dent. But it adds up to a lot more than people might imagine. This option argues that collective and individual efforts to improve healthy behaviors have more potential to lower health-care costs than any efforts at health-care reform.

One example: several years ago, the YMCA launched a diabetes prevention program that aimed at helping adults with pre-diabetes adopt healthier eating and exercise habits, lose 7 percent of their body weight, and head off the onset of this debilitating disease. "The results are staggering," Matt Longjohn, YMCA senior director of chronic disease prevention told *USA Today*. "We're preventing new cases of diabetes at a rate 58 percent higher than doing nothing for those with pre-diabetes." The yearlong demonstration project is projected to save tens of millions of dollars in future medical bills.

By taking—and encouraging—responsibility for our own wellness, we as individuals and as a nation would not only spend less on health care but we would be healthier as well.

The New Tobacco

"For the United States, the epidemic of smoking-caused disease in the 20th century ranks among the greatest public health catastrophes of the century," begins a 2014 report marking the 50th anniversary of the Surgeon General's groundbreaking warning on cigarettes. During those 50 years, smoking—and exposure to secondhand smoke—led to almost 21 million premature deaths from cancer, heart disease, premature births, and other smoking-related diseases.

But there was good news in the report as well. In 1965, almost 43 percent of American adults smoked. Today, 18 percent do. Behavioral change *is* possible, but warnings alone are not enough. Efforts to bring down smoking have included: taxes to drive up the cost of cigarettes; tax-funded anti-smoking campaigns; an advertising ban; a ban on sales to minors and on easily accessed vending machines; and government- and employer-mandated smoking bans.

Numerous studies document the cost savings. In California, for example, a drop in both smoking rates and the number of packs each remaining smoker consumes reduced health-care costs by $134 billion over 20 years, according to University of California, San Francisco researchers.

Today, many say obesity is the new tobacco. More than one-third, or 78.6 million, US adults are obese, according to the Centers for Disease Control and Prevention (CDC). Among children aged 2 to 19, it's 17 percent, or 12.5 million, a figure that has tripled since 1980. Obesity has been linked to higher rates of heart disease, stroke, type 2 diabetes, arthritis, and certain types of cancer. The estimated annual medical cost of obesity is $147 billion per year, the CDC reports.

The rise in obesity mirrors changes in our nation's built and social environments. Forty years ago, more Americans walked places. Today, sprawling cities with too few bike lanes and unsafe streets make it difficult to walk or bike anywhere. Many schools have cut physical education and even recess; the ones that still offer P.E. have watered-down programs that don't even require a change of clothes, much less a shower afterward. At home, we skip family meals and grab fast food. Portion sizes have grown.

This option says that, in essence, we've engineered the obesity problem, but that means we can un-engineer it with a full-bore campaign similar to that against tobacco.

Sticks and Carrots

One way to shore up healthy behaviors would be to make it easier for citizens to make healthy choices. Employers who offer wellness programs that include cooking classes and discounts on gym memberships make it easier for workers to eat well and exercise. A recent study of 56 workplace health programs conducted by the Centers for Disease Control and Prevention showed that such programs can cut health-care costs by 25 percent among other benefits.

The Institute of Medicine Offers Five Community Actions to Promote Healthy Eating Habits

Extracted from the Institute of Medicine (IOM) infographic "Obesity: Complex But Conquerable." To view the full infographic, please visit www.iom.edu/apop. Reprinted with permission from the IOM.

Another approach is to use "sticks" to discourage unhealthy behavior. Insurance companies could charge higher premiums to people who are overweight, smoke, or abuse alcohol and drugs. Governments could impose "sin taxes" on super-sized sodas to drive up prices and reduce consumption, much like high taxes on cigarettes have contributed to a dramatic decline in smoking.

Rising consumption of sugary drinks is considered a major contributor to the obesity epidemic. On any given day, half the people in the United States consume such drinks in sizes that have grown from 12-ounce cans in the 1960s to 20-ounce bottles and larger. Many sugar-sweetened beverages contain more sugar per bottle than the American Heart Association's and Department of Agriculture's guidelines for sugar consumption for a full day. Discouraging consumption would be a step toward reducing soaring obesity and diabetes rates.

Alternately, rather than adding a stick, the government could remove a "carrot." Federal support for agriculture, begun during the Great Depression, subsidizes growers of so-called "commodity crops," such as corn, driving down prices on foods prepared with corn products. Corn-fed cows keep fast-food hamburger prices low. The high-fructose corn syrup used to sweeten many beverages is so cheap that soda prices keep dropping even as medical costs for diabetes and obesity soar.

In the meantime, farmers with healthy crops, such as fresh fruits and vegetables, do not get paid extra for growing them, so they cost more in the market and families on a budget often can't afford them.

The most recent farm bill passed in February 2014 took small steps toward decreasing subsidies for commodity crops like corn and subsidizing fresh, healthy foods instead. But this option holds that it isn't enough. Commodities still get $23 billion in subsidies compared to just $3 billion for fruits, vegetables, and organic programs.

Wellness Pays

Some health economists argue that, although adopting healthier habits can extend lives and improve quality of life, it doesn't necessarily save money in the long-term. After all, people who lower their risk of a heart attack at age 50 may go on to develop cancer or dementia at 75, which would be even more costly to treat. But this option rejects that reasoning. In the first place, by that logic, the nation would be better off if we all died at birth.

But more to the point, the numbers clearly show that a healthier population reduces health-care costs even though everyone eventually dies. An analysis by the Robert Wood Johnson Foundation found that slowing the growth of preventable chronic diseases, such as diabetes and high blood pressure, by even 5 percent would save Medicare and Medicaid $5.5 billion a year, and cutting the rate of growth by 50 percent would save almost $49 billion a year. And the annual $147 billion price tag on obesity-related health-care expenses doesn't even take into account the indirect costs, such as days missed from work and lost productivity.

If businesses don't address obesity and other problems, Edwin Foulke, the former head of the Occupational Safety and Health Administration, told National Public Radio, "the cost is going to be so great it's going to affect the viability of the [companies]."

One important determinant of someone's health is how active they are. Too many people are sedentary, walking and moving very little. Many are worried that physical activity is encouraged less and less, especially among young people. This option suggests that schools bring back vigorous physical education programs in order to establish active habits—that will save on health-care costs in the long run.

What We Could Do

This option says that our top priority must be to encourage healthful behaviors and preventive care. Collective and individual efforts to improve healthy behaviors are the most effective ways to lower health-care costs.

Here are some things that this option suggests we could do, individually and collectively, along with some of the drawbacks:

- Employers could offer wellness programs that encourage workers to control their weight, blood pressure, and other risk factors and reward employees who take part.

  But . . . *health is a sensitive and personal issue, and wellness programs raise privacy concerns. In addition, autonomy—including the freedom not to participate —is an important value, especially for freedom-loving Americans.*

- Government could eliminate farm subsidies for crops like corn because it keeps prices artificially low and promotes consumption of inexpensive fast-food hamburgers and high-calorie sodas sweetened with high-fructose corn syrup.

  But . . . *removing subsidies would hurt farmers, forcing them to switch to other crops or driving them out of business. Not all farms are suitable for growing fruit or organic vegetables.*

- Schools should reinstate physical education classes and make them vigorous enough that students have to change clothes and shower afterwards.

  But . . . *this would take time away from other responsibilities and could interfere with the ability of schools to prepare students for all the testing now required of them.*

For a summary of the possible actions and drawbacks that this option suggests, see the table on Page 13.

SUMMARY

>>Health Care

How Can We Reduce Costs and Still Get the Care We Need?

MANY AMERICANS WORRY about the high costs of health care. Medical bills are the leading cause of personal bankruptcies. Insurance premiums and copays squeeze family budgets. Insured or not, many of us fear we are one medical catastrophe away from financial ruin.

But there is a public dimension to these costs as well. The federal government spends 22 percent of its budget on health care—more than it spends on defense. Most of it goes for Medicare and Medicaid programs for elderly and low-income Americans. Not included in these funds are more than $50 billion a year spent on medical care for active military personnel and veterans.

As waves of Baby Boomers turn 65, government spending on health care is projected to rise for years to come, putting Medicare's viability at risk and squeezing funding for basic scientific research, national security, and other priorities.

Including both private and public dollars, overall US health-care spending was $2.8 trillion in 2012 and accounted for 17.2 percent of the national economy. Other wealthy countries spent less per person and just 12 percent or less of their economy on health care. Despite spending far more, we trail other countries in life expectancy and have higher rates of obesity, diabetes, heart disease, and other ailments.

This issue guide is not about health-care reform in general; it is more narrowly focused on what additional steps we might take to make our health-care system financially sustainable. This issue framework suggests three possible options for deliberation, along with the trade-offs each might involve.

OPTION ONE

As a Nation and as Individuals, We Need to Live within Our Means

The problem is we spend more than any other developed country on health care without questioning whether *more* is always *better*. We need to live within our means and make hard choices between paying for health care and paying for other things that we hold valuable. Reining in spending is a matter of tightening our belts and sticking to a budget, even if it means sacrifices.

But, the most vulnerable may be forced to delay or go without care.

EXAMPLES OF WHAT MIGHT BE DONE	SOME CONSEQUENCES AND TRADE-OFFS TO CONSIDER
Citizens should urge Congress to raise the age of eligibility for Medicare to 67 and convert it to a "means-tested" program that pays benefits according to financial need.	Raising the age for eligibility could leave vulnerable seniors without care. Means-testing could undermine near universal support for the program.
Doctors could encourage patients who have no hope of recovery to use hospice care.	Patients may see such conversations as coercive, making them feel as though they are a burden to their families or society.
Employers could require employees to shoulder a greater portion of health-care costs through higher deductibles and copays.	Higher copays and deductibles could cause people to delay or neglect care, which could lead to more serious—and costlier—complications.
Government could offer incentives to encourage more doctors to go into primary care.	An emphasis on primary care could limit people's choices about the kind of doctor they believe is best for them.
Government could charge higher penalties for people who don't have health insurance.	Some people make too much to qualify for aid yet too little to afford insurance premiums. Fear of penalties could keep them from seeking care.

OPTION TWO

Make the Health-Care System More Transparent, Efficient, and Accountable

The biggest driver of health-care spending is the design of the US health-care system—or rather, its lack of design. Secretive pricing and indecipherable bills make it impossible for citizens to make good decisions. Perverse incentives reward hospitals for ordering more, costlier, and often unneeded tests and treatments. The health-care system needs regulations or incentives, or both, to instill financial discipline and end greed and abuse.

But, changing the system could put too much responsibility on patients to make difficult medical decisions.

EXAMPLES OF WHAT MIGHT BE DONE	SOME CONSEQUENCES AND TRADE-OFFS TO CONSIDER
Doctors and hospitals could post prices so that patients could make cost-effective decisions.	Most people don't have the time or inclination to comparison shop, especially when they're sick and vulnerable.
Insurance companies could change how they pay doctors and hospitals from fee-for-service to a flat fee.	Doctors might skimp on what they do, especially for difficult cases, if they're not being paid adequately.
Doctors and hospitals could fully adopt electronic patient records and increase care coordination.	Electronic records raise privacy concerns. Coordinated care could add one more layer of bureaucracy.
Government could forbid drug companies from advertising directly to consumers and giving doctors free perks.	Ads help patients learn about new drugs. And doctors would no longer have free samples to pass on to patients.
The government could cut spending the way other countries do by establishing a national health-care system.	This could limit our choice of providers and services and lead to rationing in tough economic times.

OPTION THREE

Take Responsibility for Lowering Health-Care Costs by Focusing on Wellness

Our own unhealthy behaviors are driving up health-care costs. Obesity is associated with type 2 diabetes, arthritis, heart disease, stroke, and certain types of cancer and increases medical spending by an estimated $147 billion a year. Other behaviors that contribute to poorer health—and higher costs—include smoking, excessive drinking, drug abuse, and lack of exercise. Many health-care experts say that collective and individual efforts to improve healthy behaviors are the key to lowering health-care costs.

But, this interferes with people's freedom of choice. And it's not fair to hold individuals responsible for their genetics, lack of resources, or bad luck.

EXAMPLES OF WHAT MIGHT BE DONE	SOME CONSEQUENCES AND TRADE-OFFS TO CONSIDER
Government could tax sodas and increase cigarette and other "sin taxes" to make it costlier for people to lead unhealthy lifestyles.	This creates a "nanny state" and reduces our choices.
Businesses could institute wellness programs and reward workers who participate.	Wellness programs raise privacy issues and could leave some workers feeling unfairly targeted.
Insurance companies could charge higher premiums for people who are overweight, smoke, abuse alcohol or drugs, or use too many medical services.	Circumstances outside of people's control can make exercising or eating well all but impossible.
Government could eliminate subsidies for crops like corn because of their uses in inexpensive and unhealthy fast foods.	Removing subsidies would hurt farmers. Not all farms are suitable for growing fruit or organic vegetables.
Schools should restore physical education classes.	This would take time away from many other educational responsibilities, such as preparing students for all the testing now required of them.

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