

The Thomas Willis Lambeth Lecture

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*Health Care Reform:  
Will We Ever  
Get It Right?*

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I am honored to have been asked to replace the late Elinor Ostrom, who had agreed to give this lecture before her death in June of this year. Elinor was an original thinker – a constructive maverick who made important contributions to economics from outside the mainstream of the discipline. She was a prolific researcher, who inspired a generation of development economists around the world. She focused on how real people in many parts of the developing world set up their own rules for sustainable management of the common resources on which their lives depend. Many of us were delighted when her contributions were recognized with a Nobel Prize in Economics.

In our different ways, Elinor Ostrom and I have both worked at the intersection of economics and political science. She was a professor of Political Economy and I now teach in a public policy school, not an economics department. That reflects my belief, which Elinor shared, that the world’s economic future depends not just on understanding how economic systems work (or should work), but importantly on understanding how people think about their economic situation and that of others and how they act, separately and in groups, to improve their lives. It is in that spirit that I want to talk with you about where we stand on reforming health care in the United States.

I entitled this lecture “Health Care Reform: When will we get it right?” and I want to give you two answers, which depend on how you interpret the question. First, if you mean, “When will we create a complete system of health care that

does everything we want?” the answer is clearly, “Never!” Health care is a big part of the economy (18 percent of the United States’ GDP). It is a highly dynamic sector experiencing rapid technological and organizational change which shows no sign of slowing down. It is not the same system it was a decade ago, much less a century ago. Medical interventions are much more effective than they used to be, and millions of people who would be dead or disabled if they were forced to rely only on the care available a few decades ago are now living productive lives. As this dynamism continues it will require constant reevaluation of the way care is delivered and paid for. There will always be pressure to do more for patients, so we will have to determine how much is enough or we will end up producing nothing but health care. Moreover, people have deep emotions about policies affecting their health, especially about the prospect of losing access to care when they need it most. As a consequence, how we manage and pay for health care will be a constant focus of policy making for the foreseeable future. Those members of this audience who are planning careers in health care delivery or health administration or health policy are unlikely to be out of a job – ever!

We won’t discover the perfect health care system. However, we have a shot at reaching a broad consensus on the main features of a pretty satisfactory system and then continuing to adjust it around the edges – constantly trying to make it more effective, fairer, and less costly to the combination of public and private entities that are paying the bills.

My second answer may surprise you. Despite the strident rhetoric of the election campaign, I believe that Americans are now reasonably close to consensus on such a system – one that will deliver effective care to almost everyone most of the time at sustainable cost. That sounds pretty optimistic – especially if you have been listening to the strident accusations of political candidates – but I submit that we currently have widespread agreement on keeping the basic structure of our health services delivery system and trying hard to improve it, as well as pretty strong agreement on what needs to be done to make it better. Differences

in approach exist, but are being hugely exaggerated by electoral rhetoric. What is lacking is a political atmosphere of constructive bipartisan dialogue and compromise that will assure that the necessary policy decisions actually get made.

The high decibel exaggeration and antagonism in the political campaign makes it nearly impossible to believe that we have a national consensus on anything, much less a sensitive issue such as health care. The two parties profess to believe that there is a wide gulf between their views of the role that government should play in society generally and in health care particularly. The shorthand is that Democrats believe in collective responsibility and government action, while Republicans believe in individual responsibility and private action; that Democrats believe in enhancing regulation and Republicans in freer markets. The parties claim they are presenting two distinct visions of the future of America – and of American health care. They say that voters have a clear choice between these visions. But in fact candidates' actual proposals are usually described in vague terms, because they know that if they win they will have to compromise. The differences between the two parties are only concrete when each is describing the terrible consequences of the things the other party would allegedly do if elected.

If the parties really had such clear differences in basic philosophy, a presidential election would be an ideal time for a great national debate about health care policy. Candidates with different political philosophies could explain their concepts of what the government should do or not do with respect to the health care system. They could describe what they think the health care system should look like in five or ten or twenty years, why they think that, and how they propose to help us get there. Such a debate – reasoned, civil, well-informed – would be a great blessing and much-needed evidence that our democracy is working.

But we aren't having a national debate on health care – or anything else. Instead, we are having an ugly shouting match in which each side is trying to scare the voting public by depicting the other as advocates of drastic change that will wreck the American health system, alter the relationship between doctor and

patient, and threaten all the aspects of our health care system that people value most. There is a simple reason why each side tries to scare voters by exaggerating the terrible consequences of electing the other. If they did not – if they talked honestly about policies they actually favor – they would find that the differences between them narrowed quickly and a compromise could be achieved.

In the scare style of campaign rhetoric, Republicans describe President Obama’s legislative achievement, the Affordable Care Act (ACA), as “socialism” and a huge federal power grab. They speak of “death panels” and substituting bureaucrats’ for doctors’ judgment. They claim that the ACA will raise health care costs for everyone, and will throw small businesses into bankruptcy. They make fun of the length and complexity of the legislation itself. They vow to repeal it immediately if they win the election.

A visiting foreigner listening to Republican speeches might well assume that President Obama’s health care law was radical and transformational. She might guess that the legislation set up a national health service in which physicians and other care providers worked for the government. Or perhaps that the president had established a national health insurance program with universal coverage in which all health payments came from Washington. Or at the very least she would surmise that he had taken away state flexibility and centralized health decision-making in Washington. Actually, none of these things is true. The right adjectives for the Affordable Care Act are not radical or transformational. They are moderate and incremental.

The Affordable Care Act, like the Massachusetts plan brokered by Governor Romney which served as its model, was a compromise between liberals and conservatives – otherwise it could not have been enacted. It was designed to expand health insurance coverage and constrain future costs *without* fundamentally altering the structure of American health care payments and delivery. It mandates that everyone have health insurance or face a penalty (which the Supreme Court points out is a tax well within the Congress’ power to impose). It forbids insurance

companies from denying coverage on the basis of pre-existing conditions or terminating coverage when a person gets sick. It sets up on-line markets, called exchanges, where individuals and small businesses can purchase insurance that meets a standard, and it establishes income-related subsidies to help people afford the coverage.

One of the criticisms of the ACA is absolutely true: it is a complicated law, not easily explained in sound bites. Its effectiveness will depend heavily on how well it is implemented by numerous players, especially the states. But the complexity is not attributable to its radical nature. On the contrary, the ACA is complex because its authors aspired to tweak our complicated, fragmented system of delivering and paying for health care without changing the system in any drastic way. It takes a lot of words to write that tweaking into legislation.

But the Republicans aren't the only party resorting to exaggeration and scare tactics in this election. Democrats claim Republicans propose "ending Medicare as we know it," turning it into a stingy voucher system that will force seniors to pay thousands of dollars more for their health care. "Ending Medicare as we know it" – whatever it may mean – sounds terrifying to anyone over 65, since seniors depend so heavily on Medicare to finance their health care.

This claim is based on Congressman Paul Ryan's original proposal to convert Medicare to a defined contribution plan in which seniors could choose among private plans and the growth of the government contribution would be capped. Even Ryan's original plan applied only to new beneficiaries starting in ten years: it would not have affected current beneficiaries in any way. Nevertheless, it would gradually have phased out traditional Medicare and required seniors to choose a private health plan. It also would have capped the rate of growth of the government contribution to Medicare at an unreasonably slow rate and would likely have shifted substantially more costs to seniors. It was fair to say that Ryan's original Medicare reform proposal would eventually "end Medicare as we know it."

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Since his original proposal, however, Congressman Ryan has moved to the middle and joined with Democratic Senator Ron Wyden of Oregon to craft a more moderate reform that preserves traditional Medicare. The Ryan-Wyden White Paper (*Guaranteed Choices to Strengthen Medicare and Health Security for All*) is in fact close to the proposal former Republican Senator Pete Domenici and I made in the context of our bipartisan budget proposal (*Restoring America's Future*). Democratic candidates, however, have continued to attack Ryan's original proposal because that version can be made to sound so scary. They continue to show the video made about the original proposal showing a lanky Ryan-like figure pushing sweet-faced Granny in her wheel chair off the cliff.

Not to be outdone in the Medicare battle, the Republicans accuse President Obama of cutting Medicare by \$716 billion over ten years to fund that infamous socialist project they call ObamaCare. They count reductions in the subsidy for private plans under Medicare Advantage and efficiencies resulting from changing incentives to Medicare providers as Medicare cuts and say they will repeal them. So we now have the spectacle of each party appealing for the votes of seniors by claiming that the other side, if elected will slash Medicare. What does that tell you? It tells me that Medicare is an enormously popular program, not only with seniors but also with their middle-aged children who don't want to be stuck with those bills. Given that the population of seniors is growing rapidly and that they vote, there is absolutely no chance that elected politicians are going to slash Medicare. But they will take advantage of any opportunity to claim the other guy will do so.

These exaggerations and misrepresentations of both parties leave the public frightened, confused, and believing that some drastic change in their health care is impending. These scare tactics may be effective vote getters, but they are irresponsible. Not only do they create unfounded fears; they make it far more difficult for the politicians to come together after the election and work out the compromises that will improve the system. We are not hearing the responsible

debate we should be hearing. It is not likely that huge changes in the structure of our health system will occur after the election. No matter the outcome, we are likely to see only gradual changes. What we ought to be talking about is how to ensure the incremental changes that will move the system in the direction of improved service, broader coverage, and slower growth of costs.

But why make only incremental changes? Isn't our system so messed up that we should blow it up and start over? I don't think so, although it certainly has its downsides. To begin with the negatives, the American health care system is incredibly expensive. We are currently devoting about 18 percent of total spending (GDP) to health care and that proportion is projected to keep rising to 20 percent by the end of the decade and more in the future. This rising health spending puts pressure on all budgets – federal, state, local, business, family – and tends to drive out spending for other worthy purposes.

Despite these huge health expenditures, we don't stack up well against other advanced countries on the usual measures of a healthy population, such as longevity and infant mortality. Much of our poor record is attributable to life style – poor nutrition, inadequate exercise, and substance abuse – not inadequate health care. Nevertheless, it is discouraging to realize that we spend much more on health care than countries that are healthier than we are.

Part of the high cost is attributable to waste, duplication, inefficiency, even fraud. Too much underutilized high-cost equipment results in efforts to use the equipment more than necessary because it is there and it cost a lot. Providers perform too many tests, in part because of failures of care coordination across specialties. There is plenty of evidence from careful studies that medical practice varies enormously. Some providers, especially integrated health systems, deliver much better outcomes at lower cost than others. But the careful studies just confirm what most patients know – everyone has her own anecdote about waste and duplication.

Moreover, despite its high cost, the system leaves millions without insurance

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coverage and consequently without adequate care. The uninsured do receive treatment eventually, if they get sick enough, but emergency rooms are costly settings not organized for prevention or coordinated care.

All these allegations are true: our health system is expensive, wasteful, uneven in quality, and leaves a lot of people out. But it also has many positive attributes. We have extraordinary academic health centers on the frontiers of science and patient care. There are great examples right here in the Research Triangle. Moreover, most of the Americans who have health insurance are pretty satisfied with it and know how to deal with it. That's why the first rule of anyone trying to improve health insurance coverage is: reassure people who are satisfied with their health coverage that they aren't going to lose it and they will not be forced to leave the provider they trust. Indeed, most people have remarkable confidence in health providers: they trust doctors and hospitals. There isn't a lot of trust in institutions or professions around these days, so the fact that most people trust their health care providers is a big plus. The fact that most people are pretty satisfied with what they have explains why the ACA had to involve incremental change to pass. It also explains why convincing voters that the other candidate threatens their current coverage is such an effective campaign tactic.

The Clinton Administration learned the hard way about people's attachment to their health insurance. They painstakingly crafted a proposal for expanding coverage which went down in flames. Part of the reason was a clever series of ads – financed by the health insurance industry – featuring a fictional couple named Harry and Louise worrying that the Clinton plan would take away their health insurance. The ads had no factual basis, but they scared people. This time around the Obama Administration convinced the insurers that broader coverage meant more customers for them. Harry and Louise did not make a comeback.

Since quite a few other countries have healthier populations, but less costly health care delivery systems than we do, it is tempting to ask, why can't we be like them? The basic answer is: we are not them, and we have to start from where

we are. Our history might have been different. If the framers of Social Security had convinced President Roosevelt to include health care in the new system, we might have a national single payer system now. If the wage and price controllers in World War II had decided to control total compensation rather than wages, we might not have had big industrial companies offering health care insurance rather than higher wages to attract scarce workers. If early income tax regulations had applied the tax to compensation rather than wages, we might have less generous health insurance – and maybe less over-treatment and over-spending. Instead, we got an employer-based health insurance system that was most satisfactory for big company employees and higher wage workers. But the employer-based system left huge gaps that had to be filled by enacting Medicare and Medicaid. The ACA is an attempt to fill the remaining gaps in health coverage, and starts serious efforts to improve quality and mitigate cost growth in care delivery.

After the campaign dust settles we have the opportunity to end the scare tactics and get to work improving the health care structure that we have created and that most people fear could be undermined by radical change. Progress will take both parties subscribing to incremental change in the existing system in order to move toward both broader coverage of public and private insurance and a slower rate of growth of health spending. It will take scrapping a few impractical myths that have impeded solutions.

The left will have to give up the myth that a single payer system would solve all our problems. Countries with single payer systems face all the same challenges that we do, including rising demand for services from an aging population, increasingly costly medical technology, and pressure for higher provider incomes. Indeed, Medicare is a single payer system in which the federal payer, often because of political pressure, has not proved effective in improving efficiency of delivery and reducing cost growth. It is not obvious that we could make a universal single payer system work well in our huge, diverse country, with its traditional suspicion of central authority and powerful interest group politics. In any case,

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the chances are small that the public would back a proposal requiring them to give up the familiar employer-sponsored and other health insurance that most people have now and shift to an unfamiliar new single-payer system. Both the Clinton and Obama Administrations concluded that a better strategy was to improve the complex system we have now.

At the same time the right will have to give up the myth that markets can solve all our problems. There is a role for more consumer choice and market incentives in the health care system, but health care cannot be treated as just another market in which informed consumers shop for the health care that they need, when they need it – just as they shop for cars or refrigerators. Higher co-pays and paying routine health care out of health savings accounts may make some care-seekers avoid unnecessary treatment. But others and especially those with low incomes may fail to seek care when they really need it. In any case, a high fraction of health spending is accounted for by a relatively small number of seriously ill people, who are not in a position to evaluate alternative treatments or act as informed shoppers. Advocates of market solutions would be best advised to abandon heavy reliance on consumer choice and work to introduce more effective incentives into the existing system.

I believe we already have a solid basis for effective compromises. Progress at this point will require Republicans to accept the ACA as a plausible framework for expanding coverage to the uninsured and work to reduce cost growth, while Democrats admit that Medicare can be improved by having traditional fee-for-service Medicare compete with comprehensive private plans on well-regulated exchanges.

Medicare is a hugely successful program that has extended and improved the lives of millions of seniors. Its popularity with seniors and their families makes it politically difficult to change, so it is tempting to leave it alone. We cannot afford to do so, however, for at least three reasons. First, Medicare is the principal driver of future federal spending growth. We cannot stabilize the federal debt as long

as Medicare spending is growing substantially faster than the economy. Second, Medicare is largely based on a fee-for-service model that encourages volume of services rather than quality and effectiveness of care. The fee-for-service model discourages coordination of care across specialties – a particular disadvantage for older people, who tend to suffer from multiple chronic conditions. Hence, there is substantial potential for slowing the growth of Medicare by moving to alternative reimbursement models. Third, Medicare is big enough to lead the whole health system towards a greater emphasis on quality and outcomes, rather than quantity of services. The best hope for slowing the growth of health spending nationally is for Medicare to lead the way.

Although the presidential election has made Medicare reform into a partisan issue, it is encouraging to note that a bipartisan consensus exists on some important points. Both Republican and Democratic plans have the same spending goals – that Medicare spending should not grow much faster than the economy – and both plans specify GDP growth plus half a percent. Both parties want to move away from fee-for-service and toward paying for bundles of service or episodes of care or paying integrated health plans to care for a beneficiary for a period of time (capitation). All reform proposals emphasize rewarding outcomes, improving price and cost transparency, and information sharing. Everyone favors innovation and learning from experimentation with alternative treatments and incentive structures.

The main difference is that Democrats want to rely on the new institutions created by the ACA to reduce the growth of Medicare spending. They would have the Independent Payments Advisory Board sift through the results of innovations, experiments, and demonstrations, and introduce the most promising ones into traditional Medicare by changing the regulations (subject to overrule by Congress). Republicans want to rely more on competition among private health plans that would have incentives to compete for Medicare beneficiaries' business on the basis of cost and quality.

When Senator Pete Domenici and I put together our debt reduction proposal

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we asked, “Why not try both?” We advocated preserving and strengthening traditional Medicare in the manner contemplated by the ACA. But we would also offer seniors a choice on a well-regulated exchange between traditional fee-for-service (FFS) Medicare and several comprehensive private plans offering actuarially equivalent benefits. The government contribution would be determined by the second-lowest bid on a regional exchange that included FFS Medicare. The cumulative increase of the government contribution would be capped at not much more than the rate of growth of GDP. If costs rose faster than that, which we do not expect, they would trigger an additional income-related premium. Our plan is close to the proposal by Ryan and Wyden. Some version of this hybrid proposal could be the basis for a bipartisan compromise. It could be presented as a reform of Medicare Advantage, which already offers seniors a choice of private plans, but was not structured well to induce competition and lead to cost effectiveness.

In sum, I believe we are close to a workable bipartisan solution to the health care dilemma that could move toward universal coverage, preserve Medicare for future seniors, and reduce the growth of health spending to sustainable rates. The elements of such a compromise involve retaining and improving the ACA and crafting a bipartisan compromise on Medicare that involves both regulatory and competitive elements. These reforms will not give us a perfect health care system – just one that we can keep tinkering with and improving on in order to ensure that the system offers good quality care to almost everyone at sustainable costs.

## *Biography*



Alice Rivlin is a leading expert on U.S. national health policy, as well as on fiscal, monetary and social policy. She has served as Assistant Secretary for Health, Education and Welfare; founding director of the Congressional Budget Office; director of the White House Office of Management and Budget; and vice chair of the Federal Reserve Board. In 2010 President Obama appointed her to the National Commission on Fiscal Responsibility and Reform (the Simpson-Bowles Commission),

and she also co-chaired (with former Senator Pete Domenici) the Bipartisan Policy Center's Debt Reduction Task Force. A leading scholar as well as policymaker, Dr. Rivlin is the author of *Systematic Thinking for Social Action* and *Restoring the American Dream*. In 2008, she received the inaugural Daniel Patrick Moynihan Prize from the American Academy of Political and Social Science, and she also has received a MacArthur Award. She is currently a senior fellow at the Brookings Institution.

## *Thomas Willis Lambeth*



The Lambeth Lecture honors Thomas Willis Lambeth, who led the Z. Smith Reynolds Foundation as its executive director for more than two decades until his retirement in 2000. Born in Clayton, North Carolina, Lambeth graduated from the University of North Carolina in 1957 with a bachelor's degree in history, and served as Administrative Assistant to Governor Terry Sanford and to U.S. Representative Richardson Preyer before being named to lead the Foundation in 1978. Described by one journalist as “the state’s do-gooder-in-chief,” Lambeth throughout

his career has exemplified the qualities of personal integrity, a passionate devotion to education, democracy, and civic engagement, and wholehearted pursuit of the ideals of the public good and of progressive and innovative ways of achieving it.

During his tenure, the Reynolds Foundation awarded grants totaling more than \$260 million to address many of North Carolina’s most pressing public policy issues, particularly social justice and equity, governance and civic engagement, community-building and economic development, education, and protection of the state’s natural environment. Tom Lambeth also has made a strong personal impact on many key public policy issues in North Carolina and nationally, including leadership of the Public School Forum of North Carolina, Leadership North Carolina, the North Carolina Rural Center, and a task force of the national Institute of Medicine on the problems of people who lack medical insurance. He also has been a national leader in improving the management and effectiveness of family philanthropic foundations themselves.

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The Lambeth Lecture was established in 2006 at the University of North Carolina at Chapel Hill by the generous gift of an anonymous donor. Presented annually, its purpose is to bring to the UNC campus distinguished speakers who are practitioners or scholars of public policy, particularly those whose work touches on the fields of education, ethics, democratic institutions, and civic engagement. The lecture is administered by the Lambeth Lectureship Committee composed of faculty members, students, and distinguished individuals engaged in public policy, in collaboration with the Department of Public Policy.



*The Thomas Willis  
Lambeth Distinguished  
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