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## **Opportunities for Savings: Entitlements, Defense, and Non-Defense Discretionary Spending - Opening Remarks**

Thanks. I will follow Peter and talk from up here initially (at the podium). With all the curve bending I do these days I feel like I should be taking more yoga classes, actually. So I will try to give you a few contortions about yoga.

I want to start off with a tale of two charts. So the first chart is, I think, CBO's favorite chart, at least if you judge by the number of times that CBO directors have shown the chart within say, the past 24 hours. So you can see that federal spending under the alternative scenario is the one that they think is more realistic, where basically the vast bulk of the growth of federal spending is associated with Medicare and Medicaid, at least for the next several decades. The red line is superimposed by me, which is the share of GDP that is accounted for currently by tax revenues. So this just shows you the situation that you find yourself in if you keep tax revenue constant and you have increases in federal spending, particularly on health care programs. Peter, I may make a little bit of an allowance for you for social security, but I suppose you're supposed to feel inferior as a result of this chart. And there's Doug Elmendorf smiling at his chart.

In fact, this is my favorite chart, which is federal health spending with and without modernizing the health care system. So you can see without reform the increase in federal spending as a share of GDP. And then I've shown you what I believe can be accomplished by modernizing healthcare. And I suppose you have two choices: you can either think I look better than Mr. Elmendorf or you can think my chart looks better than Mr. Elmendorf's. Either one would be okay for these purposes.

But I want to talk to you a bit about what that would mean. There's no path to budget balance that doesn't go through health care, and I believe that we can do a good deal to promote that. What I'd like to talk about is the difference between those two lines, which is what does modernizing the healthcare system involve. So the proposition that I want to put forward is that we can make healthcare be a normal industry—and John Podesta stressed this morning—a normal industry in terms of the amount of productivity growth. That is, prices should not rise but actually fall with progress over time and they should fall at roughly the rate of the average industry. And I don't want to talk about the most productive industries, I want to talk about the average industry.

First I want to say, what are the hallmarks of industries that are more productive relative to industries that are less productive. That is, what characterizes a normal industry in comparison to healthcare. And there are really, I think, three attributes of a good well-functioning industry. One is that it uses information technology a lot, so it knows what it's doing, who's doing it, why it's doing it, how much it's spending doing it. This is what the best firms do. The firms that are not very good don't do it very well. And of course in healthcare the most noticeable thing is that there's very little knowledge about what we're doing, or why we're doing it, or how well we're doing for it, and so we wind up

doing a lot of things that we shouldn't do. That's the first component, is the right information base.

The second component is to have compensation arrangements that are in line with what you want to do. And people have stressed this again this morning—the idea that people get rewarded for producing value. And by that I don't mean short-term AIG-type value, but I mean the longer term version of value which is providing the service that people want and doing so effectively, so the compensation arrangements support that.

And then the third is that once you have the information and once you have the appropriate compensation, you have people be empowered to make those changes. That is, workers, front-line workers, can do that, backed up by management, by CEOs who are saying this is really the goal of the organization.

If you characterize all of the successful firms, well they all do things differently. They all have these characteristics. They all are information-based, they all have compensation systems that work and they all have workers who are doing things right. In the famous example of Toyota, any worker can stop the production line. Why? Because they know what they're doing, they have the right information and they have the right incentives to do so.

Just to show you how out of place healthcare is, this chart shows you productivity growth by industry over the past decade or so. You'll understand in a minute why I chose the past decade or so. And you can see the most productive industries in the economy are things like information-technology—that is the production of software. Healthcare is way over on the right, the red one that is about four from the right. Productivity in healthcare is currently mis-measured, it's probably a bit higher than that, but nobody thinks that healthcare is a productive industry.

Actually you're tempted to think of the most productive industries as manufacturing industries, with very straight-forward production processes and so on. That is actually not correct. Many of the most productive industries, many of the industries which have become most productive over time are things that have all the hallmarks of healthcare, in terms of service-oriented and individual processing and so on. Look at retail trade, which is up there, and think about what has happened with the rise of Walmart and other kinds of technological changes in retail trade that have completely bypassed healthcare and you can understand the difference between them.

So how would you move health care to the left in this chart? That is, how would you make healthcare more like an average industry? I've shown you the average that I was talking about. Well, it would involve doing the kinds of things I was just talking about: information, compensation and empowerment. Let me just give you a few examples. I won't go through all the examples.

One is information. We took an enormous step along these lines in the spring with the passage of the American Recovery and Reinvestment Act. There was 30 billion dollars

gross, 19 billion dollars net, invested in healthcare IT. That will both provide the right information at the individual level, that is when you go to see your doctor, but also the right information at the system level, that is do we really know what works and what doesn't work.

Just an example along those lines. The way that we learned that Vioxx was killing people—you remember Vioxx, the painkiller that was killing people—the way we learned that Vioxx was killing people was because Kaiser did a study of their data and found that people were dying more after taking Vioxx. It was a wonderful public policy, great spirited thing of Kaiser to do. It would be nice if we had some other ways of learning that beyond having Kaiser do that kind of study for us.

So that's the first part, is taking advantage of what we will have put in place already. We need to follow that up with changes in compensation arrangements, paying for value instead of paying for volume. It's got to start with Medicare. Medicare is the 800 pound gorilla here. About 40 percent of hospital payments come from Medicare, about 20 to 30 percent of doctor payments. If you combine Medicare with Medicaid and the DOD and the VA, that's about half of medical care. We have examples of this, in various guises, the VA is a very good example of an organization that has a lot of information and has very good compensation arrangements. It's what you call—what is it, those things, a public-payer, public option, kind of thing—I can't remember exactly what it's called. But we have examples of those both in the public sector and in the private sector where you get the information and the compensation arrangements right. If you look at all the top performers they all have this property that the President and others emphasize. And so that's going to be the second pillar of it, is starting with Medicare.

Third is insurance reform. Insurance has a part to play here, too, which is to focus on value and not on, in this case not volume, but discouraging sick people from being enrolled. That's a part of many of the reforms and is something that will go a long way towards getting the incentives in the insurance industry right.

And then last would be things about worker empowerment. It is the case actually that front-line workers in healthcare do an enormous amount but within constraints. So for example, we waste an enormous amount of primary care time by having doctors do things that nurse practitioners can do, or physicians' assistants, or other folks can do. We do have a primary care crisis, and at the same time the typical doctor will report that they spend 40 percent of their time filling out non-essential forms. So we're wasting 40 percent of primary care. And by the way if you follow nurses around a hospital with a stop watch, the single thing most common thing that a nurse does far and away more than time than any other thing, is documenting things. Typically, taking readouts from computers in the patient's room, bringing them over to a desk, and entering them into a computer. [long pause] And that's about 35 percent of her time. And you ask, where does all your money going, to administrate big expenses? But that much said, there's more clerical workers in healthcare than there are nurses.

So worker empowerment, in the right sort of ways, what can we expect? Well let me tell you a little about productivity growth. It was very high in the US in the post-war period until the early 1970s. It then decline to about 1 to 1.5 percent from the 1970s to the mid-1990s, and then it sprouted up. Part of this sprouting up was the impact of information technology advances, particularly the internet and what came along with it, following up on the personal computer. Part of it was changes in the nature of firms, going from big, hierarchical organizations to flatter, decentralized organizations. And part of it was compensation arrangements that went along with that. And so productivity growth rose by 1 to about 1.5 percent in the typical business. And that's really what we're talking about trying to reach in health care.

There's no technological reason why it can't be reached. Health care is more complicated than most industries, all of which suggest that information and incentives can go further in healthcare, not that they can go less far. So I am actually quite optimistic about what one can do in terms of increasing productivity. Again not by making health care be a standout but just by making it a normal industry.

What could you do with that? Well the first ten years what I would like to do is use the money to cover people, and then after that I would like to use the money to contribute to deficit reduction. This chart shows you how you can match up over time spending on covering people with reducing health care spending, both through the methods I was telling you about as well through reducing just very obvious examples of overpayments. For example, we pay managed-care private plans that serve Medicare beneficiaries 10 to 15 percent more than it costs to serve those folks. There's no reason why in this era or any era why we should be overpaying.

So a combination of getting rid of overpayment and doing what we know we need to do could actually have a fundamental impact on the deficit, reducing the deficit by 2 to 3 percent within a few decades. The big question is how well do the bills—what's on the table—actually stack up? And I think the answer is pretty well, actually, given all the bad press that they've been getting. There's a commitment to payment change with flexibility in various bills. I think they're actually fairly good on the payment change. Everyone has their own list of gripes, and I've got a few of them. I'm not going to highlight them because the overall message I want to give you is that actually a lot of them are on the right track, and that they can really get us to the point where we can do this. As Peter said, its not that we can write down now exactly now how we are going to do it, but that we have a number of very promising ideas. And that's really where I'd like to leave things, with a few points at the end.

One is to reinforce that this is not a leap, it is a path. Covering people is a leap. Either you put the money forward or you don't put the money forward. If you put the money forward, you can cover people. If you don't put the money forward, you can't cover people. Don't pretend you're doing it if you're not doing it. Do it or don't do it and just be done with it. This is going to be a path, that is you have to get the system to work right. You have to iterate as you go along. And It's going to require 10 to 15 years, not that there won't be any savings before that but that that's the timeframe over which we're

going to have to be dealing with this. And along the way, the provider support is going to be essential. We can spend the next decade fighting over doing things, in which case it's going to be a completely unproductive decade and we will be back in a decade from now having a very similar conversation, or we can try and work on this together. In fact, most of the providers as well as most of the insurers know what has to be done.

That's why there is so much more support for reform this time around than there was 16 years ago. We have a very good sense, the question is can we lead people along the right path. I'm fairly optimistic, but then again I'm in the wrong line of business if you're not optimistic. But I think there's a lot of good stuff we can do.