



Can the ACA Improve Population Health?

DANA P. GOLDMAN AND DARIUS N. LAKDAWALLA

Health care reform may accomplish a number of different objectives—most notably, that of providing valuable financial protection. However, its impact on population health is likely to be quite modest.

Consider the evidence: Many of the greatest improvements in health during the last century had little to do with the healthcare system. Clean water, public sanitation, and reduced smoking all reflect public-health interventions that had dramatic benefits.

Cardiovascular disease also provides

Dana Goldman is a Professor and the Norman Topping Chair in Medicine and Public Policy at the University of Southern California. Darius Lakdawalla is the Director of Research at the Leonard Schaeffer Center for Health Policy and Economics and Associate Professor in the School of Policy, Planning, and Development at the University of Southern California.

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an example that yields significant insights. Between 1980 and 2000, the death rate for coronary heart disease was cut in half.¹ But only about half of this reduction came from better medical therapies. The rest—caused by lower blood pressure, lower cholesterol, less smoking, and other factors—came from healthier behavior and some drugs. And the treatment of heart disease is one of our greatest success stories. Our accomplishments in diabetes, cancer, and lung disease are not nearly as impressive.

Thus, good health has only been partially a story about excellent health care. And that remains true today.

PROponents of the ACA may be promising too much health improvement

One reason why health care reform proposals always seem to fail is that

proponents promise too much. Reformers declare they will improve quality, lower costs, and increase access—all at the same time. This mantra is repeated so often—on both sides of the ideological divide—that the public tends to believe that it is possible, when it really isn't.

Advocates of universal coverage often get confused on this point. They equate good health with having health insurance, and cite myriad academic studies. The problem is that these studies don't account for all the other differences between the insured and uninsured—what they eat, where they live, whether they smoke or drink, the amount of stress in their lives, and even their genetic predisposition to disease. No healthcare system is good enough to fully compensate for bad behavior and poor environmental factors.

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Perhaps the strongest and earliest such evidence came from the RAND Health Insurance Experiment (HIE), which randomly assigned families to health insurance plans of varying generosity.² One of the main findings of this experiment was that families in the least generous plan (95 percent coinsurance) spent nearly 30 percent less on medical care—with little or no difference in their health.

Numerous other studies—such as the work of the Dartmouth group on regional variation in the use of medical care—have found, similarly, that greater utilization is not associated with better health outcomes in the traditional Medicare system. Elliot Fisher and his colleagues have demonstrated that end-of-life spending by Medicare beneficiaries varies widely across regions. Enrollees in higher-spending regions receive more care, but do not appear to live longer or otherwise experience better health outcomes.

And these conclusions do not just apply to the elderly: Baicker, Buckles, and Chandra find similar results for the use of Caesarean sections across counties—areas with high use (and, presumably, high spending) perform

more C-sections on healthy mothers, and yet enjoy no beneficial effects on either maternal or neonatal mortality.

WHEN DOES INSURANCE MATTER? WHEN IT AFFECTS COMPLIANCE WITH HIGHLY EFFECTIVE THERAPY

So when does insurance matter? Many studies examine the insured and uninsured populations, and find much worse health among the uninsured. But this evidence confounds health insurance with numerous other factors—including worse health behavior, environmental risk factors, and social stressors.

The HIE examined many medical-outcome measures in various subgroups of enrollees. Although it did not find compelling evidence to show that higher cost-sharing led to worse health outcomes, low-income participants who were in poor health appeared to be more vulnerable to adverse outcomes. For example, poor people with high blood pressure had slightly higher mortality rates if they had high co-payments. In addition, the HIE found that participants in the high-co-payment group were as likely to reduce

‘appropriate’ as ‘inappropriate’ care, as defined by groups of medical experts. These findings mirror the evidence from the most careful studies in this area.³

Of course, the HIE was conducted in the 1970’s, and medicine has advanced since then. Better but more costly drugs for heart disease, cancer, mental illness, and other diseases are available, but these require patients to pay more money out-of-pocket. The result is that people do not take their medication. The impact of high prices on patient compliance is important because poor compliance can lead to worse health outcomes through uncontrolled hypertension, high cholesterol, untreated psychiatric illness, and resistant bacterial infection, to name a few of the relevant conditions. But non-compliance is particularly unfortunate: Not only can it worsen patient health, but it can also reduce productivity and significantly increase medical costs as well.⁴

With a growing elderly population—and a larger Baby Boom generation approaching retirement—the prevalence of chronic diseases will rise. If current trends continue, health-care costs will consume an ever-increasing

share of national income. The future liability of the Medicare program alone is estimated to be \$24 trillion over the next 75 years, absent any policy changes.

HOW CAN WE TRULY IMPROVE POPULATION HEALTH? INVESTMENTS IN EDUCATION AND PREVENTION

So what can we do to more significantly improve population health?

The first step is to invest—not in the healthcare system, but in education. We should take the \$120 billion it might cost for universal coverage, and use it, instead, to provide earlier education and to improve the quality of education. Better-educated people live longer, are less likely to be disabled, and engage in healthier behavior. For nearly 40 years, distinguished health economists led by Michael Grossman have observed that more-educated people have much more powerful incentives to protect their own ‘investments’ in education by practicing healthier habits and reducing their risks of death.⁵ They also are better at self-managing chronic diseases.⁶ And, unlike universal coverage, more education has other valuable benefits to a person and to society. Less crime,

less divorce, and higher earnings—can universal health insurance promise that?

The second place to invest is prevention. Primary prevention has the capacity to slow or reduce the rising prevalence of chronic disease, and simultaneously attenuate the downstream spending that is associated with it. Equally importantly, however, prevention leads to a life with less disability and more years of an active lifestyle. It simply makes a lot of sense to avoid disease in the first place, rather than try to treat it later.

THE ECONOMIC ARGUMENTS FOR A GOVERNMENT DISEASE-PREVENTION ROLE

There are also sound economic arguments for a strong government role in the prevention of disease. Because the benefits of prevention often accrue decades later—long after someone has switched employers or health plans—private plans will skimp on prevention coverage. The government needs to step in to fill this void. Medicare could save itself money, for example, by paying for anti-hypertensive medication before people turn 65.

Perhaps most strikingly, my colleagues and I estimate that if we could roll back obesity to

levels seen in the 1980’s, we could save up to hundreds of billions of dollars. We need to find a way to make this happen. One way may involve better medicine—an obesity pill would be a good start—but it may involve other methods that have little to do with health care. Maybe solutions could include an extra hour of physical education at school, or subsidized treadmills in the workplace, or even pedometers for all Americans. Clearly, there would be huge returns for society on a substantial investment in combating obesity.

WHAT THE TREATMENT OF HYPERTENSION CAN TEACH US ABOUT THE TREATMENT OF OBESITY—AND ABOUT TREATMENT GENERALLY

Too many policymakers and researchers view medical care and medical technology as the first and only line of defense against illness. In fact, medical care has always functioned as a safety net, both for the unlucky and for those without the means or the incentives to protect themselves against the risk of illness.

The treatment of hypertension provides an instructive example. In the 1960s, primary-care physicians would instruct their hypertensive

patients to manage their diet and exercise regimens to avoid worsening their disease. While this counsel is accurate, it is also difficult for many patients—particularly, the least-educated—to comply with. Thus, the era of ‘behavioral’ treatments for hypertension saw wide disparities in the health outcomes of more-educated and less-educated hypertensives. The arrival of beta-blockers in the 1970’s changed the nature of hypertension treatment. Instead of employing a vigilant and sophisticated approach to monitoring their diet and exercise, hypertensive patients could instead take an oral medication to control their disease. The result was a dramatic increase in health outcomes for the least-educated hypertensive patients, relative to their better-educated peers. Fifteen years after the arrival of beta-blockers, virtually no disparities across education remained among hypertensive patients.⁷

This is not to say, of course, that medical technology is a blanket remedy that eliminates the value of education. A host of important diseases continue to wait for a breakthrough to supplant behavioral treatment. Obesity treatment is today’s equivalent of 1960’s hypertension treatment: Few effective medical

treatments exist for the vast majority of patients suffering from obesity or being overweight. While dietary restriction and regular exercise are proven weight-loss strategies, they rarely lead to long-term solutions for the growing proportion of American adults who are obese. And, not surprisingly, the less-educated are heavier and more likely to be obese than the more-educated.⁸

Moreover, obesity is not the only disease for which complex treatment regimens are the norm. Diabetes also requires sophisticated self-monitoring and adjustment—as does HIV. As a society, we can wait for breakthroughs to simplify the treatment of these conditions for the least-educated, or we can invest in education in order to provide more Americans with the means and the incentives to control their weight or otherwise manage their own health. Prevention-investments complement this strategy by identifying opportunities to intervene with disadvantaged populations whose schooling has long ago been completed.

Hypertension is but one example of an area in which all patients can benefit from cheap and simple therapeutic options that forestall complications. The use of aspirin for

primary prevention of cardiovascular events in high-risk adults is another.⁹ Education lays the groundwork for improved health behavior by future generations; prevention can help mitigate the omissions of the past.

Now that we have covered the uninsured, it is time for us to put the priority on health, not health insurance.

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NOTES:

1. See Ford, E.S., et al., 2007.
2. See Newhouse, p. 489.
3. See Levy, H. and D.O. Meltzer, 2002.
4. See Goldman, D.P. and J.P. Smith, 2002
5. See Grossman, M., 1972.
6. See Goldman, D.P. and J.P. Smith, 2002
7. See Goldman, D.P. and D.N. Lakdawalla, 2005.
8. See Lakdawalla, D. and T. Philipson, 2009.
9. See Wolff, T., T. Miller, and S. Ko, 2009.

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