A Health Dividend for America
The Opportunity Cost of Excess Medical Expenditures

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As of 2010, health care–related expenditures in the U.S. totaled some $2.6 trillion (17.9% of the gross domestic product [GDP]). Year after year, healthcare spending rises at double the rate of overall GDP growth, and total healthcare spending growth consistently outpaces overall inflation. This exuberant growth would be welcome if health care were thriving because of its efficiency. Instead, it is among the least-efficient parts of the economy, and much of the healthcare spending does not improve health outcomes substantially.[1] Indeed, the IOM recently conservatively estimated that some $750–$765 billion spent on health care in the U.S. is in excess[a] of what should be spent to achieve the observed health outcomes.[1] Others have estimated the excess to be between $700 billion[2] to upward of $1.2 trillion.[3]

Despite spending almost 50% more per capita on health care than the Organisation for Economic Co-operation and Development (OECD) country with the next-highest expenditure and 2.5 times the average of all OECD countries,[4] U.S. outcomes are much worse than other developed countries. The U.S. ranks 26th among 34 developed countries in life expectancy, and 30th in infant mortality.[4]

Many analyses of the relatively poor health of the American population and the large disparities in health among various subgroups of the population point to two underlying determinants: social environment and physical environment. Babies born to mothers who did not graduate from high school are twice as likely to die in the first year of life as those born to mothers with 16 or more years of education.[5] Adult men with less than a high school education can expect to live 7 years less than those with 16 or more years of education; for women the difference is 5 years.[5]

Thirty-one percent of those living below the federal poverty line (FPL) are in fair or poor health compared with less than 7% of those over 400% of FPL.[5] Rates of diabetes are twice as high among those below the poverty line as those above it.[5] The physical environment, too, has profound effects on population health, through the walkability of neighborhoods, the safety of streets, the viability of infrastructure (e.g., transportation and water supply), and the abatement of environmental toxins.

Poor health outcomes matter not only for equity, but also for efficiency. Although the U.S. has slipped to fifth on the Global Competitiveness Index, it has fallen even further to 42nd on the health and primary education component, suggesting a bleak economic future if it does not change course. Because so much of U.S. health care is federally financed, a poorly performing healthcare sector contributes substantially to a federal debt that has ballooned from less than 40% of GDP in 1980 to close to 100% of GDP today.

Although economists disagree on how urgently this debt level should be addressed, all agree that, left untreated, this debt will sooner or later adversely affect employment, further erode essential infrastructure, and reduce the U.S. standard of living. States, required by law to balance their budgets, must make agonizing tradeoffs between exploding healthcare budgets and priorities such as education and infrastructure. In 2011, Medicaid alone consumed 23.6% of total state spending, an increase of 10.1% over 2010,[6] and states incur additional expenditures for current and former employee health benefits and for prison health care.

Healthcare-related spending at this level has been shown to crowd out other expenditures on social goods including primary, secondary, and higher education; economic development; and maintenance of critical infrastructure.[7] The IOM recently concluded that spending on

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[a]The IOM calculated "excess" costs in six domains: unnecessary services, services inefficiently delivered, prices that are too high, excess administrative costs, missed prevention opportunities, and medical fraud. Total excess costs were calculated through three separate methods: extrapolation from geographic variation healthcare expenditures (estimated at $750 billion); comparison of U.S. expenditures with other OECD nations' (estimated at $760 billion); and consensus estimates from IOM workshops (estimated at $765 billion).

population-based prevention efforts is unstable and insufficient, largely a result of a disproportionate attention to clinical care.[8] The report called for a transformation in the way the U.S. invests in health; the authors believe this transformation could come from reducing excess healthcare costs.

Using the IOM's estimates of excess costs and the CMS breakdown of health spending, approximately 55% ($412.5 billion using the IOM's estimate[1] or between $385[2] and $660[3] billion using the full range of estimates) of excess healthcare cost accrues to the private sector and is functionally a tax that limits the international competitiveness of the U.S. and reduces the economic welfare of the population. The current paper, however, focuses on the public sector, which pays the remaining 45% or $337 billion[1] (between $315[2] and $540[3] billion using other estimates) per annum of the excess healthcare costs and the question of what the public opportunity costs are of unnecessary healthcare spending. If it were possible to extract the amount of unnecessary and frequently unhealthful healthcare costs and services from U.S. oversized healthcare expenditures, the nation could benefit from what is referred to here as the "health dividend," a sizeable stream of resources that would come at no net cost to people's health, and that could be invested in achieving two important objectives: stabilizing the nation's fiscal health and improving well-being.

As an illustrative exercise, the authors propose allocating this windfall across several uses of fiscal stability, social investments, and infrastructural investments. Of course, a health dividend could in fact be allocated in an infinite number of ways, but providing one set of possibilities demonstrates the magnitude of the health dividend. Estimating the potential causal outcomes of these new investment allocations is a process fraught with methodologic challenges. However, given that excess healthcare expenditures necessarily provide no additional health benefit, *any* additional health benefits that accrue as a result of these programs would be greater than those currently enjoyed by the U.S. public. Instead of quibbling over the point-estimate in these cases, the authors thought it more prudent to present the less-controversial cost and "output" estimates for each investment and allow readers to gauge how instrumental that outlay would be in shaping a society that makes better use of the $337 billion in excess health spending.

Fiscal Stability

If half of the government's share of the health dividend (i.e., $168 billion per year in perpetuity) were applied just to federal debt reduction, it would amount to substantially more than the $1.5 trillion debt reduction over 10 years the U.S. Congressional Joint Select Committee on Deficit Reduction ("Supercommittee") sought—and failed—to achieve in late 2011.

Social Investments

Investments in social programs, such as Job Corps, home visitation for single pregnant teenagers and their infants, and preschool programs in low-income neighborhoods have also demonstrated good health, quality of life, and economic outcomes, such as lower teenage rates of pregnancy, drug use, and violence, as well as improved educational outcomes. Because such programs tend to be more labor-intensive than the unnecessary component of healthcare spending that they would be replacing, there also would be a net positive effect on job growth.

Approximately $104 billion per year could fund all of the educational initiatives reported below along with some of their projected health benefits (all cost estimates are in 2012 dollars). All of these proposals have substantial support in the literature, and many have been endorsed by national bodies that systematically review evidence for best practices. (Because of space limitations, references are not provided for all calculations below. Additional details are available on request from the authors.)

- All 24 million students in elementary school could have smaller class sizes (a reduction from 22–25 students to 13–17 students). Studies have shown that such a class-size reduction could lead to 70,000–140,000 additional high school graduates,[9] with each student potentially gaining as much as 1.7 additional quality-adjusted life-years,[10] to say nothing of the economic benefits. (cost: $53.3 billion annually)
- The successful anti-tobacco truth® campaign currently funded by dwindling Legacy Foundation funds could be funded at a level of $100 million annually, an amount that has been shown to prevent 300,000 students from smoking and save nearly three million life-years.[11] (cost: $100 million annually)
- All 700,000 pregnant smokers and pregnant teenagers could receive regular home visits from trained nurses, which could reduce the number of low–birth weight newborns by almost 35,000 and emergency room visits by some 435,000 during the first 2 years of life.[12] (cost: $4.2 billion annually)
- Half of all 3.9 million first-grade students, along with their parents and teachers, could participate in a social development program that decreases risky sexual behavior and drug use and improved work, social, and emotional functioning as adults.[13] (cost: $13.6 billion annually)
- Head Start could be doubled in size to include an additional 904,153 children. Head Start enrollment has