ducting research on improved detection methods are all necessary activities. Interpol, national authorities, drug companies, academic groups, the United States Pharmacopeia, and the WHO are collaborating on these actions.

The threat posed by emerging artemisinin resistance on the Cambodia–Thailand border is widely acknowledged, but an effective response requires that critical operational and basic research questions be answered quickly. Researchers, funders, and policy leaders must recognize the urgency of the problem, take action to address simultaneously several important knowledge gaps, and focus immediately on eliminating the threat of artemisinin resistance. It will be essential to coordinate research and containment efforts globally and to share data, research tools, and experiences. Important existing global forums for action include the WHO, the WorldWide Antimalarial Resistance Network, and the Malaria Research and Reference Reagent Resource Center. The artemisinins have been crucial to recent successes in reducing the malaria burden, and artemisinin-based combination therapies are essential to all plans for malaria elimination. Losing artemisinins to resistance will not only jeopardize the goal of malaria eradication, but will also result in large increases in African childhood mortality like those that occurred during the last century when chloroquine failed against newly evolved drug-resistant parasites.

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Health Care Policy in an Age of Austerity
Jonathan Oberlander, Ph.D.

The 2010 elections transformed U.S. politics. Emboldened by winning majority control of the House of Representatives and by the election of a new wave of fiscal conservatives, Republicans are resetting the national agenda. The recent agreement between congressional leaders and the Obama administration linking an increase in the government debt ceiling to significant cuts in federal spending underscores the change. The United States is entering a new age of austerity.

The rise of austerity politics has important implications for health policy. The pervasive belief in Washington that deficit reduction is an economic imperative alters normal political rules. In a crisis environment, policymakers are more likely than usual to take on powerful interest groups and contemplate controversial reforms. The cycle of crisis and reform has long played out in the Medicare arena, where warnings of impending trust-fund bankruptcy have triggered important program changes, including the adoption of the prospective payment system for hospitals in 1983. Budget politics, in fact, drove federal health policy during much of the 1980s and 1990s. Policymakers sought to reduce federal deficits by restraining Medicare payments to medical providers, an effort that culminated in the 1997 Balanced Budget Act (BBA) that aimed to cut projected Medicare spending by 9%.6

Yet the dominance of deficit concerns over health policy reced-
ed thereafter. In 1998, the federal budget reached surplus for the first time since 1969, and in 2001, the Congressional Budget Office (CBO) forecast a 10-year surplus of $5.6 trillion. That helped pave the way for a new Medicare prescription-drug benefit in 2003. By that time, the federal government was running up deficits again, but fiscal constraints were loosened: deficit reduction took a back seat as the Bush administration and Congress pursued tax cuts, increases in defense spending, and a Medicare expansion. No major reforms reducing Medicare spending were enacted between 2001 and 2009, and Congress rolled back some of the BBA’s cuts. The 2010 Affordable Care Act (ACA) did contain significant Medicare savings ($424 billion between 2010 and 2019), but they were largely dedicated to financing health care coverage for the uninsured.

Now that deficits again loom over federal health policy, with the added specter of international debt crises, policymakers are eyeing savings from federal health programs. The deal to raise the federal debt ceiling reduces discretionary spending by $917 billion; Medicare and Medicaid are exempt from those cuts. It also establishes a bipartisan congressional “super committee” to find another $1.5 trillion in deficit reductions. If Congress fails to enact such savings, that will trigger $1.2 trillion in automatic spending cuts, including a decrease of up to 2% in Medicare’s provider payments (though Medicare benefits and Medicaid would remain untouched). Congress must simultaneously find the funds to offset the cost of canceling a 29% cut in Medicare’s physician payments currently scheduled for 2012. The budget trigger could also affect the ACA by reducing the federal payments to insurers that will help defray the cost-sharing liabilities of low-income enrollees who purchase private coverage in the new insurance exchanges.

As they search for savings, deficit cutters are likely to focus on health programs, whose size makes them an inviting target. Together, Medicare and Medicaid account for 23% of all federal spending, and in Washington the long-term deficit problem is seen largely as a health care problem. In their failed negotiations to reach a “grand bargain,” House Speaker John Boehner (R-OH) and President Barack Obama discussed reducing Medicare and Medicaid outlays by $350 billion to $400 billion over the next decade. Other bipartisan groups working toward deficit reduction—such as the Senate’s “Gang of Six” and the Bowles–Simpson commission—have similarly targeted health care. The new congressional super committee may follow suit, and no program is exempt from its purview.

One option under discussion would change the formula by which Washington pays states for Medicaid, resulting in lower federal payments. Republicans also want to turn Medicaid into a block-grant program—limiting annual federal Medicaid spending to a fixed amount—but that proposal has no chance of becoming law in the short term. As for Medicare, proposals for generating budgetary savings range from increasing premiums for higher-income beneficiaries (such income-related premiums, often confusingly called “means testing,” already exist in Medicare) to raising the eligibility age and increasing cost-sharing for enrollees (for example, by prohibiting privately purchased Medigap plans from providing first-dollar coverage). Another plan—authored by Congressman Paul Ryan (R-WI)—would reform Medicare by eliminating the traditional federal insurance program and instead subsidize beneficiaries’ purchases of private health insurance. It would create a de facto program budget that would limit federal Medicare spending, though only by shifting substantial costs to beneficiaries. That plan, too, has no chance of becoming law in the short term. Finally, policymakers are discussing reducing Medicare payments for medical services.

There are also large potential savings to be had by reforming the tax exclusion for employer-paid insurance. The health insurance exclusion—the largest tax expenditure in the budget—will cost the federal government about $660 billion in forgone revenues between 2010 and 2014. The ACA limits the exclusion by taxing high-cost plans, but not until 2018. Moving up that tax’s effective date and capping at a lower level the amount entitled to the exclusion would generate more funds. Securing bipartisan agreement on any revenue increases is extraordinarily difficult in this political environment, but Republicans have previously supported limiting the exclusion.

Congress is unlikely to alter the ACA’s coverage provisions much before 2013. But the law’s new long-term care program—which deficit hawks view as a fiscal burden—could be in jeopardy. The longer-term impact of debt politics on the ACA is uncertain (though the CBO projects that it will reduce the deficit). Deficit pressures could catalyze...
efforts to strengthen the ACA's cost-containment measures or invigorate the campaign to overturn its insurance coverage expansion. Much depends on the outcome of the 2012 election.

There is broad agreement that the United States must slow rising health care costs. To the extent that deficit concerns enhance the prospects for stronger cost controls, they can be a positive force in health policy. However, the predominance of fiscal issues also distorts health policy by producing "reforms" that are exercises in cost shifting, not cost saving. For example, raising Medicare's eligibility age would actually increase total health care spending while shifting federal costs to employers, private health insurance, and seniors. Plans to cut federal Medicaid payments would compel states — which are already struggling to fund their programs — to make up the difference or restrict access to medical care for low-income enrollees. And proposals for reducing Medicare and Medicaid payments could lead some providers to try to raise rates for private payers, though the scope and magnitude of such cost shifting is often overstated.5

As health care costs rise and the population ages, spending on Medicare and Medicaid will grow substantially. The new politics of austerity mean that the health care industry and medical providers should anticipate increasingly tough efforts to restrain that growth. Yet the focus on limiting federal health care spending and generating budgetary savings ultimately distracts us from tackling the larger issue of restraining systemwide — and not just federal — health care spending. Rising spending on medical care is not simply a problem of government budgeting; it also affects private insurers, employers, workers, and their families. If we are to slow the rate of growth of health care costs and make both public and private insurance more affordable, dubious reforms like raising Medicare's eligibility age and reducing the federal share of Medicaid will not suffice. The United States needs systemwide cost control, not budget gimmicks.

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