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Perspective

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The Health Care Jobs Fallacy

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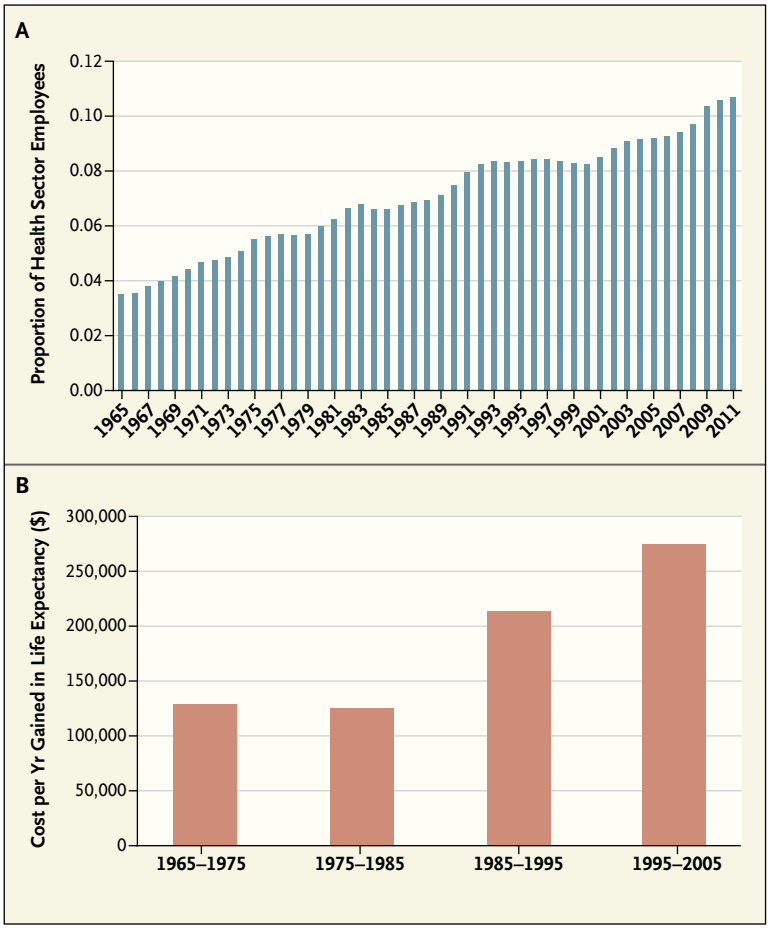
The United States is in the throes of the most serious recession in postwar history. Despite improving employment numbers, the official unemployment rate still exceeded 8% in June 2012.

Amid this malaise, the health care sector is one of the few areas of steady growth.[1] It may seem natural to think that if this sector is one of the bright spots in the economy, public policies should aim to foster continued growth in health care employment. Indeed, hospitals and other health care organizations point to the size of their payrolls as evidence that they play an important role in economic recovery, a role that must not be endangered by reforms that seek to reduce spending on health care. Politicians on both sides of the aisle are quick to emphasize the "job-creating" or "job-killing" aspects of reforms.

But this focus on health care jobs is misguided. The goal of improving health and economic well-being does not go hand in hand with rising employment in health care. It is tempting to think that rising health care employment is a boon, but if the same outcomes can be achieved with lower employment and fewer resources, that leaves extra money to devote to other important public and private priorities such as education, infrastructure, food, shelter, and retirement savings.

Consider an example involving two hospitals that serve the same number of patients: one employs 100 physicians, and the other 120 physicians. The leadership of the second hospital might claim that the additional employment is benefiting the local economy. But unless the employment of 20 extra physicians in the second hospital generates additional health improvements that are commensurate with the additional spending on physicians' salaries, the higher employment is not socially beneficial. Salaries for health care jobs are not manufactured out of thin air — they are produced by someone paying higher taxes, a patient paying more for health care, or an employee taking home lower wages because higher health insurance premiums are deducted from his or her paycheck. Additional health care jobs leave Americans with less money to devote to groceries, college tuition, and mortgage payments, and the U.S. government



Health Care Employment and Productivity.

Panel A shows the proportion of employees in the health sector relative to the total non-farming civilian workforce. Data are from the Bureau of Labor Statistics (BLS) (2012). Data for years before 1990 represent "health services employment" plus "medical services employment"; data for 1990 through 2011 (after the change in the BLS employment classification system) are for "health care employment." Panel B shows the cost per year gained in life expectancy. Data were calculated in constant 2006 dollars with the use of the gross domestic product (GDP) deflator on the basis of Garber and Skinner (1960–1970, $186,308; 1970–1980, $71,767; 1980–1990, $178,000; 1990–2000, $276,535)[2] and Cutler et al. (1985–1995, $213,012; 1995–2005, $273,642).[3] Values represent cost per year of life expectancy gained at age 45, under the assumption that 50% of the gain is attributable to health care.[4] If 75% of the gain were attributable to health care, each bar would be one third lower (and still well over $100,000 by 1985).

with less money to perform all other governmental functions — including paying teachers, scientists, and social workers. That trade-off can be justified if it goes along with improved health outcomes, but not if those jobs do not generate benefits that exceed those of alternative uses. (Of course, local politicians may still prefer the larger hospital to be in their district, as long as the people paying for it are not — but this is not a strategy that serves the greater good.) The challenge is that it's easy to count jobs but much, much harder to figure out who paid for them and whether those resources could have been put to better use.

The way we view rising employment in the health sector should therefore be governed by the health produced by those people and resources. Panel A of the figure illustrates the growing share of the workforce employed in the health care field.[1] If we were confident that resources were flowing into health care solely because they were driving innovation, raising quality, and improving health and longevity, that would indeed be cause for celebration. There is, however, mounting evidence that our health care system could deliver better care without spending more and that there are tremendous opportunities for improvements in productivity — which suggests that the increase in resources devoted to health care has not generated commensurate value.

The graph in Panel B shows that the cost per year to produce a 1-year increase in life expectancy has risen dramatically over time,[2,3] far exceeding conventional cost-effectiveness thresholds of $100,000 per life-year — findings that suggest that those resources could do more good if put to alternative uses. Although the specific numbers depend on the share of health gains attributed to health care spending itself,[4] there is ample evidence that incremental health care spending is producing, at best, small gains in health, and these high prices for small gains are seen both for interventions at the start of life and for those after age 65.[2,3] This

misallocation is driven by features of our current health care system that interfere with getting the most health for each dollar spent — such as the fee-for-service payment structure, the lack of incentives for patients to select and providers to recommend more conservative care options, and the tax preference for first-dollar employment-based health insurance.[5]

Many reforms aim to reduce these inefficiencies, thereby improving health and potentially slowing the growth of health care spending. These reforms would focus spending by public programs such as Medicare on rewarding higher-value care and reducing the incentives to provide therapies with unproven benefits. The net effect of such policies on employment in the health care sector is unclear: on the one hand, they might reduce employment by improving efficiency and allowing us to get the same health outcomes with fewer health care workers. Such policies might also lead to a change in the mix of people employed within health care — such as increased numbers of nurse practitioners or reduced numbers of administrators. On the other hand, improving the productivity of the health care sector might increase the incentives to spend more on health care, thereby increasing the share of the economy devoted to health care in the long run.

Although such efforts would improve overall health and people would be better off on average, there would be losers as well as winners. Taxpayers and workers who would take home bigger paychecks (because of lower health insurance premiums) would be better off. The people who lost those jobs would be worse off (at least in the short run), and some of them might be lower-income workers. Although we may very well want to do more for the poor, continuing to subsidize an inefficient health care system through outdated payment policies and distorted insurance markets is a singularly inefficient way to redistribute resources. A far more effective way to help low-wage workers who are displaced would be through expanding anti-poverty programs such as the Earned Income Tax Credit or other social insurance programs such as Medicaid and food assistance. Of course, such reforms must be implemented gradually to avoid harming patient care in the transition, and changes in public spending must take into account the current economic climate, but public spending produces the most stimulus when it goes to the most productive activity.

The bottom line is that employment in the health care sector should be neither a policy goal nor a metric of success. The key policy goals should be to achieve better health outcomes and increase overall economic productivity, so that we can all live healthier and wealthier lives. Our ability to ensure access to expensive but beneficial treatment is hampered whenever health care policy is evaluated on the basis of jobs. Treating the health care system like a (wildly inefficient) jobs program conflicts directly with the goal of ensuring that all Americans have access to care at an affordable price.

Employment in the health care sector should be neither a policy goal nor a metric of success. The key policy goals should be to achieve better health outcomes and increase overall economic productivity.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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