Comments for

CONFERENCE ON HEALTH CARE CHALLENGES FACING THE NATION
WASHINGTON UNIVERSITY IN ST. LOUIS
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by
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Thank you for inviting me to be part of this event inaugurating the new Center on Health Policy. We at the Brookings Institution wish this fledgling Center a future worthy of this distinguished university and of one of the finest medical schools in the nation. We also hope to be able to work closely with you on topics of shared interest.

Your timing in establishing this institution is splendid. So is your selection of topics for this event. Health care resembles an already over-sized teenager who keeps popping the financial seams on his clothing, is already the largest kid in the class, and gives every sign of continuing to grow until there isn't any space left in the room for anyone else. A conference that focuses on health care financing is a splendid way to begin.

The presidential candidates clearly agree. Once they heard about this event, it seems that they decided to run on your coat-tails and scheduled their second presidential debate here. Cynics may think that Missouri's eleven electoral votes and pivotal position in the middle of the nation were what attracted them to this event. We know better.

So, I shall organize my comments around both the theme of this conference and that other event that will take place tomorrow evening. First, I cannot forbear saying a few words about the candidates positions on health care finance. Then, I'll turn to the longer term issue that the candidates have taken great care *not* to address—the relentless cost increases that threaten to force the United States to ration health care even for the well insured.

I.

The campaign has so far been dominated by issues of personality and character, by the management or mismanagement of the Iraq war, and by whether the war in Iraq is part of, or a distraction from, the larger effort to combat terrorism. But at some point public attention should turn to domestic issues—possibly as early as tomorrow night. When it does, the electorate will find that no issue better distinguishes the candidates priorities and political philosophies than does their positions on health care. The programs of Senator Kerry and President Bush differ in size, philosophy, and effect.

The U.S. health care system—*melange* might be a better word than *system*—consists of two large chunks. The larger is employment-based coverage. It serves most of the employed and their families. Almost as large is government financed coverage for the elderly and long-term disabled and many of the poor through Medicare, Medicaid, and the State Child Health Insurance Program. Some people buy health insurance on their own, but not many. And with good reason. Premiums are very high because of administrative overhead and the knowledge of insurance companies that sick people are more likely than are healthy people to buy insurance.

Against that background, Senator Kerry proposes to spend a lot of money—nearly $700 billion over ten years—to shore up that system and fill in some of the gaps. He would pay for that program by rolling back tax cuts enacted in 2001 for the wealthiest 2 percent of filers, those with annual incomes exceeding $200,000 annually. His program would encourage more employers to sponsor insurance. It would offer incentives to employers who now sponsor insurance to make sure all employees are covered, and it would reduce the cost to employers of this coverage. It would also extend eligibility for Medicaid and the State Child Health Insurance Program. And it would extend health insurance coverage to an estimated 25 million of the currently uninsured.

President Bush's program calls for tax deductions to encourage people to shift to so-called high-deductible health insurance and tax credits to help lower-income individuals and families buy individual health insurance. He would encourage small employers to band together in so-called association health plans. The net cost of the Bush program is estimated at approximately $90 billion over ten years. It is relatively inexpensive because the tax credits he proposes cover only a minor fraction of the premiums for standard health insurance coverage. Estimates of how many of the currently uninsured would be newly covered vary widely. I believe the most careful work, by MIT economist Jon Gruber, indicates that the Bush program would extend health insurance coverage to a net of about 2 million people. The number is small because some of the uninsured are estimated to buy coverage because of the credits, but

some are assumed to lose coverage when employers drop plans they now offer. The net gain in coverage is therefore small.

So, what we have here are two programs. One is large, one small. One paid for by rolling back tax cuts on the wealthy, one affirms those tax cuts. One builds on the current system of work-based coverage and current public programs, one begins a shift to individually purchased health insurance. My purpose here is not to argue the virtues of big versus small, employment-sponsored versus individually-purchased health insurance, or the wisdom or folly of tax cuts—although that *is* a subject to which I shall return. My intent is to draw attention to an issue that distinguishes the positions of the two major candidates more clearly than any other. If voters are looking for an issue on which to base their preferences, they need look no further than their positions on health care.

II

Beyond the time horizon of the issues being discussed in this campaign lie fiscal challenges so large that I believe they will threaten the stability of American democracy. The source of that fiscal challenge is the cost of health care. The nation will have to choose among dramatically higher taxes, shredding the social safety net, and across-the-board rationing. Rising health care costs will also begin to crowd out our capacity to enjoy additional consumption of other kinds.

Well, you may now be thinking," Where did THAT come from?" We were sailing along thinking about the current political campaign and this Brookings guy suddenly comes on like Jeremiah. My reason for doing so is that I believe that our elected

officials—of both parties—are failing the nation by not explaining the very serious fiscal problems that the nation will confront and the need to start addressing them now.

We have heard a lot about the deficit (slide 1). It is a bit more than 4 percent of gross domestic product. If that were all there were to it, then there would be little cause for concern. An economy growing as fast as the U.S. economy does can handle deficits of that size for a long time.

But that is not all there is to it. A graduate school roommate of mine once quipped that there are three laws of life, but that he knew only two. The first law is: life is a catastrophe. The second is: all people are jerks. Then, one day, he said he had found the third law: things get worse.

Well, from a fiscal standpoint, things get worse. For what follows, I am going to leave out all of the detail of what the federal government spends other than Social Security, Medicare and Medicaid.

We have all heard about the looming Social Security deficit and the rising costs of Medicare and Medicaid. Let's start with Social Security (2040: 6.5). The baby-boomers are retiring and pension costs will rise. Some say that Social Security is a crisis. Well, by 2040, all the baby-boomers will have retired. The costs of Social Security will have risen, but only by a bit over 2 percent of gross domestic product. Hardly a crisis. An increase in federal spending of 2 percent of GDP spread over forty years would be barely noticeable.

But the costs of Medicare and Medicaid are projected to rise far more. How much more depends on a crucial trend. For the past half century, per capita health care

costs have risen faster than per capita income. The differential has averaged 2.5 percentage points a year. Why? Because biological, physical, and medical research have generated an ever growing menu of beneficial diagnostic and therapeutic interventions. The good news—and the bad—is that recent advances in basic science portend no slowdown in these cost-increasing forces any time soon. Furthermore, our health care system assures that essentially all beneficial care will be financed for those who are well insured. Physicians and insured patients know that some third party will pay most of the cost of whatever care they decide on—all, when patients reach the stop-loss range of their insurance. Patients have every incentive to ask for and physicians to provide all care that produces any benefit, no matter how small, at whatever cost, no matter how large. We have a name for care that costs more than it is worth—waste—and our finance system pays for it.

So, let's take a look at the implications of continued rapid growth of per capita health costs (2040; M&M#). Let's assume that health care spending between now and 2040 grows 2 percentage points a year faster than income—a bit, but not much, slower than it has over the past half century. Were that to happen, Medicare and Medicaid alone would become nearly as large as all of the federal government is today. Doubling federal taxes from the current share would not come close to eliminating the resulting deficit.

Well, you may say, that can't happen. Nothing can indefinitely grow materially faster than something of which it is a part, so something is likely to give. True enough. So, let's assume Medicare and Medicaid benefits are significantly cut. Maybe we narrow

the menu of covered services. Maybe we shift costs to the elderly and disabled. However we do it, let's assume that per capita Medicare and Medicaid costs grow only 1 percentage point a year faster than per capita income (2040b). Even then, we would need to nearly double taxes to balance the federal budget.

So far, I have said nothing about what would be happening to private health care spending—and I'm not going to say much. But the same forces will be acting on privately financed health care that are projected to push up per capita costs of Medicare and Medicaid. Growth of private health care spending, in turn, would mean that an ever larger share of the annual increases in worker compensation would go to pay for health care.

We might, of course, simply pay the bills. But the bills will be fearsomely large, so large that I believe we are likely to think about ways to limit care to those services that produce significant benefits—benefits that are as large as total cost. That has an innocent sound. But it is, in fact, health care rationing, a term that has been anathema in this country until now.

Two decades ago, William B. Schwartz and I wrote a book exploring the kinds of choices that health care rationing raises. We did so by comparing British use of a number of relatively new medical technologies in Britain with that in the United States. Our strategy was to try to understand how a health care system with values not radically different from our own responds to severe budget limits. Was everything rationed equally? If not, what considerations dictated what services were particularly

constrained? How did physicians and patients respond? What lessons could we learn from Britain experience?

The facts were striking. And the anecdotal reports were compelling. The book sold well—about 25,000 copies—and garnered a lot of attention. But it is out of date. So, over the past two years, I have been trying to write a new version of that study. I have done so for two reasons.

First, the issue of health care rationing has come back to life. It went dormant during the 1990s because growth of health care spending slowed. Like Floridians in the eye of Jeanne, some people thought that the storm of health care inflation has passed. Well, high winds have resumed. Rapid spending growth has now resumed and few expect it to slow any time soon. Second, a lot has happened in medicine over the past two decades. In particular, we ignored drugs. They cannot be ignored now. drugs which claimed an ever-smaller share of the health care dollar from 1960 through 1982 have been claiming an ever-increasing share ever since. Other important facts have changed.

I am going to begin with some quantitative information about the availability of several medical services in the two countries. Then I am going to present some inferences about what lies behind these quantitative comparisons. I want to acknowledge–no, I want to emphasize—that none of these inferences is solidly backed by quantitative analysis. The number of technologies that I am going to refer too is too small to test any hypothesis rigorously. You will have to judge whether they make sense

to you. To nudge you along, I shall report what British physicians said two decades ago and what they say today.

The overarching fact is that British spend less than half as much per capita on health care as we do. So, the British have to buy less of something. But they do not buy proportionately less of everything. (Slide 2) Two decades ago, the British rationed treatment for renal failure stringently. People over the age of 55 had little chance of being dialyzed or receiving a kidney transplant. The U.S. dialysis rate was three times higher than the British rate. The head of the renal registry told us that doctors had to make up reasons why such rationing was medically justified "in order to live with themselves." Another British physician demonstrated this allegation by explaining that, yes, it was legitimate to deny dialysis to the people over the age of fifty because everyone who had completed five decades was "a bit crumbly." That view has now changed. British nephrologists now claim that no one is turned away exclusively on the basis of age. Overall, the British are now treating at twice the U.S. rate of 1980. And the median patient's age is now well over age 50. Rather strikingly, however, the overall relative gap in treatment rates has widened slightly. Nephrologists complain that resources remain limited and that keeping up is a struggle, but claim that the principal reason for the remaining gap is that we over treat. Many U.S. physicians might agree.

In other cases the British treat as intensively as we do. (Slide 3) Hemophiliacs are all treated and receive dosages similar to those recommended for U.S. patients. Queues for hip replacement were once the "poster-child" for critics of the British system. Those queues have now largely vanished. Surgery rates seem to be similar, although the

data are imperfect and hard to compare. Two decades ago, British hospitals had few intensive care beds—about 1 percent in one of London's most distinguished teaching hospitals. That proportion has doubled, but remains a small fraction of that of U.S. hospitals. The reason, we were told by a dedicated ICU physician back then was that large numbers of beds would be out of proportion to the rest of the system. Several physicians recently reported to us that such remains the case. They also noted that a scarcity of ICU beds limits capacity to perform certain kinds of surgery.

The continuing gap in frequency of coronary revascularization remains striking. The British now perform angioplasties and by-pass grafts half again as often as the United States did in the early 1980s. But U.S. rates have exploded, and the absolute gap has widened. What explains the gap. Part of the reason is that screening examinations for coronary disease are less common than in the United States. As one cardiologist recently told me:

> "By and large, people in this country would not, if they were perfectly fit and well, go and have things like their cholesterol done...We don't have annual physicals in this country, or biennially or however frequently its done...You go to the doctor when you're ill...

Part of the reason is a lack of resources to perform these procedures, part a difference in medical philosophy, and part a difference in patient attitudes. The following two comments illustrate the subtle interplay among these three factors. A British physician reported:

> "Over here, simply because of the logistics and limited resources, many times the patient will be watched. If the pain doesn't persist and there doesn't seem to be any urgency one will discharge the patient, do an exercise test, make sure that there are ECG [electrocardiogram] changes when the heart is stressed and bring the patient back later. And so, one is doing less of that procedure than one would be doing almost automatically in the USA."

And an American, with experience in the United Kingdom told me:

> "My impression is that in general in the United Kingdom, there are much more rigid criteria to institute life-saving procedures....I saw it over and over. Where certain procedures would just not be offered because it was not felt appropriate because these people were elderly. And they were going to die anyway. I don't think it is a capacity issue. I think it is a philosophical issue. I think philosophically they're much more willing to accept death in the elderly without major intervention, more so than in the United States."

I am at the beginning of my work comparing use of drugs in the United States and Great Britain. I am going to focus on three classes of drugs: drugs used in treating schizophrenia, anxiety, and depression; those used in treating diabetes, and those used to lower cholesterol.

The case of statins will be of particular interest. Coronary mortality in the United Kingdom is somewhat higher than in the United States. Screening for high cholesterol

is less reportedly less common than in the United States. And British physicians reportedly do not recommend the use of statins in cases where cholesterol is high but no disease is present unless the patient is classified as "high risk." In the United States a high risk patient is one who is considered to have a 20 percent chance of having a serious cardiac event in the next decade. The British use a 30 percent probability cut-off. Officials at a meeting to develop local prescribing guidelines for statins concluded that prescribing them for primary prevention—to forestall the development of the first signs of disease—in low-risk patients was not worth the investment. One said, "I mean these people aren't in pain. The statins won't make them feel better or anything."

I am not making this up. And I do not mean to suggest that the British are fundamentally different from us. Yes, we have different traditions and we would be starting from a very different place. But what I am illustrating are psychological mechanisms for coping with resource scarcity that would play out here as well.

Several factors seem to influence decisions in Great Britain on how to distribute limited resources. Most are obvious, but no less important for that characteristic. First, treatment of diseases of the elderly is limited more stringently than is treatment of diseases of the young. Second, visible illnesses seem to be treated more fully than are conditions with silent or concealed symptoms. Third, diseases for which potent lobbies can be formed have an advantage in a budget limited system. One nephrologist gave a large share of the credit for increased dialysis resources to the lobbying efforts of patients.

> "[I]f your patient has coronary artery disease and is thought to require an intervention [and] that intervention is unavailable..., they will not be dead three weeks on Friday....But the pressure that dialysis gives us is being able to say [that] this patient is going to die in three weeks unless we dialyze them....The great thing about renal patients is that you are a renal patient for life. [They say] "Look at me. This is my life. I've been on dialysis for ten years and I have had two transplants. So don't tell me I don't know what is going on." And they are incredibly powerful."

Fourth, technologies that can be applied fully at modest aggregate cost fare better than do ones that are very expensive. Coronary revascularization at U.S. rates or sharp increases in intensive care beds would each increase the NHS budget by 10 to 20 percent. Hemophiliacs can be treated fully at little aggregate cost. Fifth, treatments that require specific and costly equipment or specially trained personnel can be controlled more readily than can procedures that any physician can perform with readily available supplies and equipment. And last, treatments that achieve direct and obvious savings by avoiding costly alternative care can command resources better than can treatments that produce long-delayed or probabilistic savings.

When and if the United States decides that it cannot afford to provide all beneficial care for all well-insured patients, we shall have to rethink the whole concept of medical negligence. Historically the courts have almost always accepted "customary standards of medical practice" as the standard with which actual behavior is compared. This rule is coherent and enforceable provided that a health care system provides all

beneficial care. It is coherent also in a budget-limited system if some central body establishes uniform standards of treatment. It is not coherent if separate elements of the health care system are free to use limited resources differently, reflecting diverse judgments of physicians and other providers or varying community preferences.

There can be little doubt that if beneficial care is not provided because of spending limits, some patients will suffer bad outcomes that would not have occurred without those limits. Those who suffer adverse outcomes would point to standards of practice in other areas where the denied care is actually given. When physicians in state X regard common x-rays as adequate for diagnosing arthritic knees, while physicians state Y insist that an MRI is essential for sound diagnosis, there is no good basis for establishing customary standards of medical practice.

Yet, absent a degree of centralized decision making that is unthinkable in the United States, such differences in response to limited resources are inescapable. Because different hospitals and doctors would choose to limit different services, therapies unavailable in one place might be plentiful elsewhere. Pregnant women denied treatment for fetal defects, parents of children borne with irremediable defects who are denied palliative care, and anyone who suffers consequences of aging that could be slowed or arrested by medical therapy not actually on offer would look to the courts for redress. If care were available in some comparable jurisdiction, what would the courts do? Patients denied a service available at one institution would allege that arbitrary decisions had violated their right to equal protection under the law. Procedures for allocating budgets would be challenged on similar grounds.

Such litigation could threaten the sustainability of expenditure controls, unless national criteria for judging medical negligence emerged. The redefinition of negligence would be slow and contentious. Litigation over the myriad medical decisions appealable under current law could both choke the courts and paralyze medical practice.

III

I hope that I have persuaded you of two propositions. The first is that the economic costs of the quite wonderful advances that medical science seems poised to make will pose enormously difficult problems for the political system and for the private economy. These developments will force us to choose among two very difficult alternatives.

We can refuse to ration care and sustain benefit coverage of public and private insurance. That course will require unprecedented tax increases by a tax-phobic nation. It will mean that an increasing share of increases in worker compensation must be used to pay for health care.

The other course is to ration care in some explicit fashion. That means denying some beneficial care to the well-insured, a practice with which Americans have no experience.

There are no other humane alternatives. I do not know which course we will take. But I do know that as a nation we have not yet begun to think about these issues. It is important that we begin to do so.