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Cost Control and Health Care Reform: Act 1

*Commentary from the **Health Care Cost Monitor** blog, May–September 2009*



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Health Care Reform: The Beginning of the End, or the End of the Beginning?

The *Health Care Cost Monitor* came to life last May, beginning with a wise, and less than optimistic, post by Henry Aaron. American health care, he pointed out, seems designed to make cost control as difficult as possible. Nothing in the ensuing months, as congressional efforts to shape legislation have made clear, has disproved his perception. The Congressional Budget Office had, in 2008, released a comprehensive survey about many cost control possibilities, showing their potential benefits and liabilities. Many of them were strong and made economic sense. But it has so far been hard to find evidence that any of the tough proposals will get anywhere. So far, they seem to have disappeared. The politics of cost control counts for more than the economics of control.

As editors of the blog—the only blog devoted entirely to curbing health care costs—we saw as our task getting out on the table a wide range of perspectives on cost control, many of them not familiar to the media or legislators. We worked hard to recruit the best minds in the country on health care costs, gave them more than the usual blog space to develop their ideas, and sought to take on a wide range of pertinent topics. Among other topics, we posted commentaries on comparative effectiveness research, prevention, the public plan choice, competition, Medicare, regional variation, rationing, and efforts in other countries to manage costs. We hoped to help dispel some widely held beliefs—the British NICE program for medical technology assessment, for instance, cannot make the final decision on technologies not worth the money; it can only make recommendations to the National Health Service, and they are sometimes rejected.

We were pleased when someone characterized ours as an “elite blog.” We like to think that was because we did tolerate long pieces, mainly on the grounds that not just opinion but

also good analysis are important. Our posts were models, we believe, of civilized discourse. No fingers were bitten off, we are proud to say, even granting the difficulty of doing that in the blogosphere.

We have called the blog posts collected here Act 1—up to early September 2009—to signal that they were all written while the health care debate was beginning to heat up and formal bills were still in an embryonic state. Act 2, perhaps the decisive phase (though who can say?), got under way when Congress reconvened in early September. We will follow carefully the emergent legislation, focusing as we did earlier on cost control, but this time on the cost control details of the legislative proposals.

How those details are handled will be a crucial test of their seriousness. The danger in neglecting them, or treating them vaguely, may not be immediately obvious, but any legislation that, say, is light on cost control in the name of making certain that access is expanded as a first priority will have built into it the long-term likelihood of collapse in the face of cost escalation. The state of Massachusetts gambled that it would be smart to deal with access first and costs later. It is only now taking up that latter issue, and its overall fate is at stake. The outcome of that effort will be important to watch.

We expect the fall to be a fateful season for the future of American health care. We will be watching carefully.

—DANIEL CALLAHAN
editor, *Health Care Cost Monitor*

SUSAN GILBERT
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Comparative Effectiveness: One Size Doesn't Fit All

PETER UBEL, M.D.

JULY 1, 2009 > Does comparative effectiveness research force “one size fits all” decision-making? Not necessarily. With the right data, comparative effectiveness research can improve medical care by splitting patients into relevant groups, rather than lumping them all together.

No sooner had the Obama administration committed a billion dollars to comparative effectiveness research than the critics began laying out their concerns: such research is a prelude to rationing, they said; it threatens to thwart doctors' and patients' abilities to make their own decisions. It will transfer too much power to government bureaucrats and treat medical practice like a cookbook.

Now that the Institute of Medicine has issued its priorities for comparative effectiveness research (CER), I will look at a common criticism: that it acts as if medical care is a “one size fits all” enterprise, and thereby forces policy makers to make blunt decisions that will unjustifiably harm people who don't respond to medical interventions the way an “average” person would respond. This concern is legitimate, but an intelligent use of CER should allow us to avoid this fate.

If your life, like mine, has been touched by breast cancer, then you probably share my hope that researchers will find new treatments to reduce the harms of this awful illness. But if you also share my concern for the fiscal solvency of our nation, you might also be disturbed at the high price of some new cancer treatments.

Consider a drug like Avastin: a treatment that increases life expectancy of patients with some metastatic cancers by interrupting blood flow to the tumors. Avastin can cost more than \$100,000 per patient, and in some cancers leads to an increase of only two months in median survival. Two months for \$100,000—a steep price to pay.

With medical costs consuming an increasing portion of government budgets, and with U.S. businesses struggling to offer employees healthcare coverage, many experts contend that we cannot afford treatments that bring such modest benefits at such a startling price.

How might comparative effectiveness research inform such issues? CER strives to provide information to guide decision making. A comparative effectiveness study might evaluate the cost effectiveness of competing breast cancer treatments. Or it might not analyze cost at all, and focus instead on estimating the relative impact that alternative treatments have on people's quality and quantity of life.

In neither of these cases would CER, on its own, show us whether to use these treatments. Like its name suggests, CER promises to provide decision makers with information on the relative effectiveness of common medical interventions, so that government payers, insurance companies, doctors and, yes, patients can spend their health care dollars more wisely.

To understand the “one size doesn't fit all” criticism, let's suppose that a new drug increases median survival in patients with metastatic breast cancer by two months. That doesn't mean that it increases everyone's survival by two months. It might have no effect on the majority of patients, harm a small minority, and bring huge benefits to another minority.

CER, by lumping all patients into one group, would ignore these important differences. And if policymakers, unimpressed by this two-month figure, decided not to pay for this drug, some patients will lose a chance at these huge benefits.

This criticism of CER, however, overlooks more nuanced ways decision makers can potentially use CER information. With the right data, CER can improve medical decision-making by splitting patients into relevant groups, rather than lumping them into a single group.

For example, if we know in advance that patients who meet certain criteria stand to gain much more than other patients, then CER is a tool to help identify this subgroup. A treatment that costs \$600,000/life year across all patients may be much more cost effective in a specific subgroup of patients.

A treatment that brings no benefit to the majority of patients but a substantial benefit to a minority of patients could very well deserve to play an important role in the treatment of that subgroup of patients. CER can potentially identify such subgroups. Indeed, if our country starts emphasizing comparative effectiveness in making treatment coverage decisions, it will give researchers in academia and in industry an incentive to find out which patients stand to benefit the most from various healthcare interventions.

On the other hand, if we do not know in advance who will benefit from a specific treatment and who will be harmed—if we can't, for instance, figure out who will gain years rather than months of survival from the drug—then the only rational way to decide whether to use such a treatment is to assume

that each patient is roughly the same and has the same chance of benefit and harm as all other patients.

If only 5 percent of patients benefit from a certain treatment, and we don't know who those patients are upfront, then we have to assume that any given patient receiving that treatment stands a 5 percent chance of benefiting. And then we have to decide, as a society, whether that 5 percent chance of benefit is worth the costs—both medical and financial—of that treatment.

It would be unwise to use CER to lump together the unlumpable: the long-term survivors from those destined to die soon regardless of treatment. But rather than dismiss CER for treating everyone as if they are average, we should fund the kind of research that will identify who stands to benefit the most from the health care available to them.

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COMPARATIVE EFFECTIVENESS

How Comparative Effectiveness Research Can Save Money

SUSAN BARTLETT FOOTE

JULY 7, 2009 > The prospect of using comparative effectiveness information, especially in relation to costs, causes concern in the eyes of those who would lose profits. In reality however, an embrace of more research may reduce waste and unnecessary care.

Even for those of us who have studied and participated in both medical technology assessment activities and the push for evidence-based medicine for years, watching the comparative effectiveness research (CER) “debate” has taken some surprising twists and turns.

I was surprised at how easily the supporters of CER managed to persuade Congress to embrace the concept as something new and important. And I was surprised when CER emerged as one of the few “silver bullets” worthy of several billion dollars of support on the promise it would save health care dollars down the road. And, I admit to a little titillation when right-winger Senator John Kyl claimed CER was a step down the road to socialized medicine, following the Republican pollster Frank Luntz’s script. Supporting CER is a bit like being on Nixon’s enemies list.

Now, however, the interest groups, most notably pharma and device companies, joined by some medical specialty societies, are quietly working to neutralize any cost-saving or value-producing impact of CER, while superficially embracing the “concept.” This tactic follows a tried and true pattern of undercutting efforts to actually use CER or other technology assessment tools, including cost-effectiveness, to change the practice of medicine.

I’ve recounted early efforts to blunt medical technology assessment for years. In 1986 I described a variety of successful efforts by the nascent device industry to undercut a National Center for Health Care Technology in the early years of the Reagan administration. I’ve also analyzed the successful effort

of the device industry and its physician allies who used Congress to derail efforts to include cost-effectiveness in a coverage rule for Medicare. The Agency for Health Care Policy and Research (now Agency for Healthcare Research and Quality) was nearly dismantled by the spine surgeons when it issued a study on the ineffectiveness of certain spine surgeries in the 1990s.

What happened in those instances, and what is now happening in Washington, is the embrace of the concept of assessment as long as it includes only the gathering of evidence—data collection. Interested groups do try to be part of the decision-making on what interventions to study, but tactically embrace the idea of evidence as a good thing. They even will acquiesce to some analysis of the evidence, though they have rigorously opposed the use of some criteria, such as cost.

But, the axe falls and the political muscle emerges when there is any hint that the evidence might actually be USED to make decisions— which is, of course, the only value in collecting it in the first place. Already we are seeing draft language in health reform bills that will prevent Medicare from making decisions on the basis of comparative evidence studies!

We have a serious lack of good scientific evidence to support much of our medical interventions, and if there were more evidence, and if it were used by providers and payers alike, we could reduce waste and unnecessary care. No question. Adding support for more and better evidence, such as comparative effectiveness, is good.

But, its value looks like it will be undercut by the interests

responsible for health care spending. Just as it has been in the last three decades. Comparative effectiveness will not save money unless supporters of value-based care stand up and say—let’s not just gather evidence, let’s be sure we do not pay for care that is inconsistent with it. But that will put you on the enemies list!

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Comparative Effectiveness Research and the Doctor-Patient Relationship

ERIC CASSELL, M.D.

JULY 21, 2009 > A fear of comparative effectiveness research is that it might compromise the doctor-patient relationship, interfering with individualized treatment. But this research has the potential to improve that relationship as long as it leaves room for clinical judgement.

Do studies of comparative effectiveness have a negative impact on the relations between doctors and patients—do they get in the way of individualized treatment?

Put more positively, how does a physician take data from studies whose results are expressed in statistical terms for a group of patients and use it in the treatment of individual patients? Does doing so take away from consideration of the individual nature of the person who is the patient?

This is an issue that has been raised for decades—probably since the 1930s and certainly since the 1950s.

It is a little bit strange, since all of the knowledge base of medicine is general knowledge accumulated from the sum of either a doctor's individual experience or the cumulative experience of the profession. Medical science in clinical (as opposed to experimental) medicine is a way of taking that general knowledge and making it more valid—more true to the circumstances. Making it more reliable—knowledge you can count on. Making it more replicable—knowledge that will be the same even if you garner it from a different group of similar patients.

If you want to apply this knowledge, or any general knowledge, to individual patient then judgment is required. Judgment enters anytime the general is applied to the specific. Clinical medicine is a judgment profession.

It is true that we do not teach doctors how to make judgments, but it is something that they must learn because they must do it all the time. They must decide what to do for *this particular patient* based on what they know about similar patients with similar diseases.

One of the most important medical advances of the 20th century has been the quality of the evidence, the knowledge base on which medical action depends. This is largely the result of rigor in the conduct of clinical studies—of the effects of treatment, for example. The double-blind clinical trial that is now the gold standard is an example.

Good clinical research requires rigorous statistical methods. Statistics is not about *my patient*, the individual; it is about a group of similar patients. Here again, to apply clinical research about a treatment requires judgment—is my patient sufficiently similar to the patients and their difficulties in the clinical trial so that I can use the results to guide the treatment of my patient?

Over these recent decades, good doctors have learned how to make those judgments. They have been helped by work in the field of clinical epidemiology to make more precise judgments, but ultimately their judgments are about individual patients—and individuals, as we all know are *all different*.

In recent years there has been much more emphasis on “evidence based medicine.” This, despite the special name, is what we hoped doctors were doing all along—basing their decisions on the evidence.

Some have gone another step and assembled the evidence so as to make guidelines, rules for treatment of patients with this or that condition. As always however, good doctors who care about their individual patients do not apply these rules unless they are sure that the rules apply to their particular patient. It is rarely an all or none phenomenon—some part of the

guidelines apply and others may not.

Some rules are so general that they *do apply* to all patients with a particular disease. For example, it is always important to know how well patients with diabetes are controlling their blood sugar because recent evidence has made it clear that persons with diabetes whose blood sugar is well controlled do better than those with poorly controlled blood sugar. Even here, however, there are particular diabetic patients who, for one reason or another, cannot achieve good control of blood sugar. The doctors of these patients—with the help of the patients themselves—have to find an alternative solution to the problem.

The proposal for studies of comparative effectiveness have raised the fear that doctors will be forced to follow the dictates of the studies whether they apply to an individual patient or not. I don't understand those fears. The history of medicine, recent and past, is littered with treatments or diagnostic methods that seemed good at first but when studied didn't pass muster.

There was a time when, for bleeding ulcers, we pumped *ice cold* saline into the stomach. There were even machines to do this. That treatment failed a trial of comparative effectiveness—the machines were all thrown out.

Comparative effectiveness studies don't get in the way of the doctor-patient relationship; they provide a reason for *making it better*. The key to good judgment in medicine *is knowing the particular patient as an individual*. The better the doctor knows the patient, the better able the doctor is to judge how to apply the evidence that comes from the studies.

Good, solid evidence can only be a good thing, even if it makes us scratch our heads from time to time and change our judgments. Comparative effectiveness studies also emphasize a point that is sometimes forgotten: all good medicine flows through the relationship between patient and doctor. It is within that relationship—it cannot be done in abstract—that judgment about the importance of evidence to a particular patient should be made by an individual physician.

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The Fine Line Between Waste and Marginal Benefits

DANIEL CALLAHAN

AUGUST 4, 2009 > The struggle to determine how best to deal with services deemed to be marginal is perhaps the most difficult puzzle in the control of costs. Although research may find a treatment to be wasteful, a doctor or patient may think it is valuable. Policy efforts to quell the use of sound scientific research on marginal benefits threaten the classic idea of medicine as a mix of art and science.

The long-running, all-time favorite cure for our ailing health care system is to rid it of those malign twins, waste and inefficiency. No one has figured out how to do that, but it sounds so commonsensical that they retain their popularity in the face of a massive failure, well over 50 years now, to even make even a little progress against them.

At the same time, we have heard much of late about their first cousin, marginal benefits, which many see as the low-hanging fruit on the waste/inefficiency tree. By marginal is usually meant treatments, technologies, or other procedures that are either useless or of a wastefully low probability of benefit.

But it is time to recognize that perhaps the most difficult puzzle in the control of costs is to learn what to do with marginal benefits. The essence of the difficulty is that (a) a marginal benefit from a population perspective may be decisively beneficial for some (statistically unknown) individuals, and (b) that individuals (and their physicians) can have radically different notions of what counts as a benefit.

Marginal benefits, moreover, can be of at least two kinds. One of them shows up in a class of treatments that are—often for many—health enhancing (hypertension or arthritis treatments) but where other efficacious treatments are available for the same conditions. The other kind occurs when there is life or death at stake, or some highly desired improvement bearing on a patient's quality of life (some cancer treatments in the former case and some Alzheimer's treatments in the latter), and with few or no available alternatives.

These distinctions become important in determining what to do about both kinds of cases. In the instance of health-enhancing but where (perhaps somewhat less) health outcomes can be had with alternative treatments, we might readily let cost considerations enter in. A marginal benefit for one treatment may seem self-evidently worth sacrificing for an (almost) identical health outcome with another one.

The matter will most likely be otherwise with treatments that directly affect survival or make a major contribution to quality of life. A number of cancer treatments, and Aricept and similar drugs for Alzheimer's, all expensive, fall into that category. Some cancer drugs, for instance, improve overall survival for a short time only for a huge amount of money (Erbix, \$80,000 for 1.2 months additional survival time, and Avastin, \$90,816 for 1.5 additional months).

The use of the drug Aricept is a good example of an expensive treatment (over \$2,500 a year) that does not extend life expectancy but does seem to slow the progression of the disease for a short period (a few months). For a time Aricept was considered controversial, with the debate focused on whether it did in fact slow the progression. More recently, however, it has generally been accepted as a valid treatment in European countries and in the U.S. Medicare program.

A common description of its benefit is that it can have a small but statistically significant value in marginally slowing the loss of cognitive function and the rise of behavioral problems. In 2006 it was the seventh most prescribed drug in the Medicare program.

Are the cancer drugs and Aricept worth the large amounts of money spent on them? That question seems to me appropriate and necessary, but our culture and our health care system all conspire to reject it for serious consideration.

The most generic way this is done is to declare that life is priceless and even to pose such a question is immoral; and so also with the idea of rationing beneficial treatments. Considerations of cost should simply have no place in our reform calculus.

But there are more subtle ways that cost are sidelined in the reform debate. One of them is the powerful role of the pharmaceutical industry, also taken up in the New Old Age. By treating any consideration of cost as a threat to innovation, both the profit motive is protected (patents run out), and the American romance with endless medical progress is pandered to.

The drug industry spends millions of dollars lobbying Congress and marketing its products, and the latter is particularly important for drugs with marginal benefits. One interesting study found that, almost invariably, industry-sponsored research findings were rhetorically hyped far more than non-industry results, and that difference was reflected in marketing techniques, especially in the media.

To be sure, the marketing always includes the proviso that one's physician should be consulted about whether the drug is appropriate for the patient's condition. But here is where the other subtle barrier to considering the cost of marginal bene-

fits is raised. As the resistance to comparative effectiveness research has made eminently evident, industry and at least some important segments of the medical community want the doctor-patient relationship to remain free of any government interference.

The Senate Finance Committee has made clear that the research findings should not be used to establish practice guidelines or even to make treatment recommendations. In that context, there will be no grounds whatever for a physician or a patient even to resist rejecting a treatment with marginal benefits. They need only to want it. By casting the use of solid scientific evidence as optional if it comes from the government—the only institution with the resources to carry out expensive studies—the classic idea of medicine as a mix of art and science is rejected for policy purposes.

No less rejected is any feasible way to combat the waste and inefficiency brought about by treatments and technologies with marginal benefits, now turned into a private matter between doctor and patient. Almost all new technologies these days are marginal in their benefits. To deprive our society of effective means of coping with them seems to me a disastrous “reform” outcome. A potentially powerful way of controlling costs has been deliberately pushed aside.

Daniel Callahan is editor of the Health Care Cost Monitor.

Virtual Colonoscopy: A Window into the Challenges of Health Care Reform

RUTH FADEN *and* SEAN TUNIS

AUGUST 6, 2009 > Medicare's controversial decision in 2009 not to cover virtual colonoscopy underscores the tremendous challenges involved in interpreting medical research findings. Although they examined the same evidence, different review groups emphasized different risks and other scientific information. Such choices are judgments, not facts, and this is true of all such clinical policy decisions, no matter how "evidence-based."

Two recent events underscore dilemmas at the heart of the future of Medicare, and health care reform more generally. The first one was the Hospital Trust Fund's finding that Medicare will run out of money in 2017. The other was Medicare's decision not to pay for virtual colonoscopy, a noninvasive CT imaging test to screen for colon cancer.

The story behind this decision and the reaction it has provoked illustrates just how difficult it is to control health care costs.

Medicare's decision was based on a comparison of the risks and benefits of virtual colonoscopy and standard optical colonoscopy, an invasive procedure. After an exhaustive review of all published studies, and extensive consultation with experts and organizations, Medicare concluded that there was not enough evidence to determine whether virtual colonoscopy was as good as regular colonoscopy, particularly for the older patients that Medicare covers.

While some proponents argued that virtual colonoscopy would encourage more people to be screened for colorectal cancer, Medicare noted that there was no clear evidence that more screening had occurred in places where the procedure was available.

Medicare also addressed the question of whether the higher cost of virtual colonoscopy factored into its decision; it said that the costs were considered but emphasized that its decision was based on uncertainty about the clinical benefits. When Medicare first proposed to deny payment for virtual colonoscopy, prominent industry groups, professional societ-

ies, and cancer patient advocacy organizations that strongly favored reimbursement protested vigorously. Members of Congress signed letters urging Medicare to change its position. After Medicare made its decision, opponents continued to argue that the scientific evidence was good enough to conclude that virtual colonoscopy is a reasonable alternative, and that Medicare beneficiaries should be able to decide with their doctors which approach was best for them.

We agree that respect for patient choice is at the heart of the practice of medicine and should be fully reflected in public policy. But this commitment should be understood in the broader content of what also matters morally for current and future Medicare beneficiaries—preserving guaranteed access to high quality medical care.

Adding to the challenge, what is really best for patients often is not clear from the analysis of published scientific studies. The conclusion that evidence is or is not sufficient, or that a particular technology has crossed the line from "promising" to proven, is determined by groups of individuals applying personal judgments to scientific results. The evidence does not speak for itself—people speak on its behalf.

In its recent review of virtual colonoscopy, the Blue Cross Blue Shield Association commented on the inevitable impact of subjective considerations in these policy decisions: "Given that much of the evidence supporting colorectal cancer screening is indirect, it is not so surprising that consensus groups reviewing the same evidence might come to different conclusions..."

The Association pointed out that even though they examined the same evidence about virtual and standard colonoscopies, different review groups emphasized different risks, like radiation exposure during virtual colonoscopy or anesthesia reactions during standard colonoscopy. Those choices about relative weighting of scientific information were judgments, not facts, and this is true of all such clinical policy decisions, no matter how “evidence-based.”

Bottom line: Medicare’s decision about virtual colonoscopy is a window into two difficult challenges at the core of any serious attempt to preserve Medicare and secure the goal of universal access to comprehensive health care.

First, we will be faced with tough decisions about which health services to buy, based on a lot of uncertainty and differences of opinion. More research on what works best for whom in medicine is critical, but uncertainty and differences in judgment will never be completely eliminated.

Second, these decisions will require ensuring that the needs and interests of all of us are respected. In the colonoscopy case, we need a mechanism to meet the special needs of those few patients for whom regular colonoscopy is medically contraindicated.

Let’s assume that the weight of evidence over time supports the conclusion that virtual and standard colonoscopies are equally effective. If virtual colonoscopy continues to be more expensive, then the decision not to reimburse for it becomes an ethical no-brainer. But in the meantime, it appears to be anything but.

And the colonoscopy example is hardly unique. New and more expensive alternatives to existing treatments and diagnostics tests are constantly emerging. There is strong demand from patients and clinicians for proton beam therapy for prostate cancer, MRI scans for uncomplicated back and knee pain, and coronary stents for mild symptoms of heart disease. In each of these cases, there is no clear scientific evidence that the new intervention produces better health outcomes than

older ones.

How should American health care handle these difficult situations? First, we need to develop inexpensive and efficient ways to do the studies necessary to determine whether newer interventions are better.

One option would be for Medicare and private insurance companies to pay for new technologies only for those patients who agree to participate in comparative studies. The decision about unrestricted coverage for the new intervention would then be delayed until there is evidence that it produces better outcomes.

Meanwhile, we might allow patients who want new treatments or diagnostic tests to pay some or all of the extra cost or to purchase supplemental insurance to cover them.

We also need to do a better job of engaging the public and the medical community in discussion about the difference between what is newest in medicine and what is best. Considerable cost saving may be found if less expensive (often older) interventions turn out to be just as good as or better than more expensive (often newer) interventions. In the end, however, we may face much more ethically challenging choices, in which a new intervention offers a very limited additional benefit, but only at substantially higher cost.

Medicare’s virtual colonoscopy decision is but one of countless choices that will need to be made for both Medicare and health reform to survive. The key to success will be to anticipate the complexity, the necessity of trade-offs, and the fact that “evidence” does not make decisions—people do.

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Cancer and Comparative Effectiveness Research

JOHN GEYMAN, M.D.

AUGUST 25, 2009 > It is no longer unusual for chemotherapy to cost more than \$100,000 a year. Oncologists are often reluctant to be “the bad guy” by denying patients the option of a treatment. Comparative effectiveness research may help determine which treatments are truly valuable, controlling costs and improving quality.

The soaring costs of cancer care in this country give us a useful lens with which to look more closely at how high the stakes have become for health care reform. As described in my recent book, *The Cancer Generation: Baby Boomers Facing a Perfect Storm*, cancer will soon outstrip heart disease as the nation’s leading cause of death. The American Cancer Society estimates that, over their lifetimes, 45 percent of men and 38 percent of women will develop cancer.

While diagnostic methods and treatments have improved greatly in recent years, the costs of cancer care are growing faster than most other parts of our health care system. It is no longer unusual for chemotherapy to cost more than \$100,000 a year. And the costs of cancer care can be expected to rise even faster over the next few years, when nanotechnology (involving molecular-sized particles) takes methods of diagnosis and treatment to a new level.

All of this forces us to confront long-neglected questions, such as whether or not health care is a right or a privilege based on ability to pay, societal vs. individual priorities in health care, the role of government vs. the market in the delivery of care, and whether we can ever rein in the costs of health care?

An excellent recent article by two researchers at the National Cancer Institute brings urgency to these questions. Writing in the *Journal of the National Cancer Institute*, Tito Fojo and Christine Grady illustrate the cost problem by noting that cetuximab (Erbix), a treatment for patients with non-small cell lung cancer, adds just 1.2 months in survival at a cost of \$80,000.

They conclude: “We must deal with the escalating price of cancer therapy now. If we allow a survival advantage of 1.2 months to be worth \$80,000, and by extrapolation survival of one year to be valued at \$800,000, we would need \$440,000 billion annually—an amount nearly 100 times the budget of the National Cancer Institute—to extend the life of the 550,000 Americans who die of cancer annually. And no one would be cured....The current situation cannot continue.”

Fojo and Grady suggest some useful standards for comparative effectiveness research, which together could move us toward better evidence:

Comparative effectiveness studies that are powered to detect a survival advantage of two months or less should only test interventions that would be marketed at a cost of less than \$20,000 for a course of treatment. (They base that figure on the experience of other developed countries that pay less than \$129,000 a year for an extra year of life.)

Drugs found to be active in one subset of patients should be advocated, approved, and prescribed only for that subset of patients.

If a drug is approved by the Food and Drug Administration only for first-line treatment, it should not be used as a second-line treatment without supporting evidence.

Use of marginally effective treatments for advanced cancer should be discouraged; emphasis should be first on quality of life, and then on cost.

Toxic effects should be examined more rigorously for therapies of marginal benefits.

The very word “cancer” evokes anxiety and fear among so many people. Payers face a “taboo” that makes it difficult to deny payment for treatments, even when they are of limited or no benefit. Oncologists find themselves in a market-based culture where “anything at all costs” tends to prevail, and they are often reluctant to be “the bad guy” by denying patients the option of treatment when it is likely to be ineffective or even futile. In a [survey](#), four of five oncologists in Boston said they did not believe that costs should be a deciding factor in treatment decisions and that costs in the range of \$300,000 a year were acceptable.

Comparative effectiveness research is an element in the current proposals in Congress for health care reform. The House Bill (H.R.3200), for example, includes a provision to establish a new federal agency to make science-based recommendations on the comparative effectiveness of health care services. And, true to form, conservative opponents are quick to attack these proposals on the unfounded grounds of too much government control, a slippery slope to socialism, loss of choice, adverse impact on innovation, and rationing.

We know enough about the failures of comparative effectiveness research in the past to try to avoid problems in the future. When such studies find that a drug or medical device is ineffective or even harmful, manufacturers and providers fight back in an effort to retain their markets.

As one example, when the Agency for Health Care Policy and Research in the 1990s found that spinal fusion surgery had higher costs and more complications than other back operations, it recommended nonsurgical approaches to back pain. The political backlash from industry and the North American Spine Society resulted in sharp cuts in funding for the agency and removal of the word “policy” from its name—it was reconstituted as the Agency for Health Care Quality and Research.

Any new federal agency that oversees this research must be independent, science-based, adequately funded, and protected from lobbyists and political interference. But even if we are successful in establishing a new agency with the mandate

and funding to evaluate the comparative effectiveness of medical technologies, there is still a gaping gap between recommendations and effective health care policy. For example, many studies have shown that physicians often do not follow clinical practice guidelines, current reimbursement and coverage policies encourage early adoption and overutilization of new technologies of unproven benefit, our physician work force is skewed toward specialists practicing high-technology medicine of uneven value, and we have no effective methods of accountability or cost containment built into our fragmented multipayer financing system.

So just expanding comparative effectiveness research, even if it is well done this time, will fail once again to contain health care costs unless we attend to other fundamental problems of the system. We also need to eliminate the wasteful bureaucracy of the private insurance industry; establish a not-for-profit single-payer system of national health insurance (Medicare for all), coupled with the strengths of our private delivery system; revise reimbursement policies to rebuild primary care and reduce perverse incentives to over-utilization; address ethical issues in practice and research; and empower regulators to provide more effective oversight of best practices and products.

All that can be done, if we have the political will to assert the public interest over the self-interest of industry stakeholders in the medical-industrial complex. This will be an uphill battle, since our costs are their revenue and shareholder returns.

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COMPETITION

Competition and Health Care Costs

JOSEPH WHITE

MAY 29, 2009 > Advocates for competition in health care are rarely deterred by the evidence that its measures have never worked. While there should still be room for “virtuous” competition in health care reform, we must realize and accept that, at present, competition in the health care system takes largely unconstructive forms.

The political scientists Paul Sabatier and Hank Jenkins-Smith explain much policy-making as a conflict between rival advocacy coalitions, comprised of not just politicians and organized interests, but also of members of the media and academics. Within a policy community, each coalition is united by core beliefs that are extremely resistant to change. Deep core beliefs about the world support policy beliefs about particular issues.

This framework is especially relevant to proposals for controlling health care costs. Conflicting views about markets as a way of life inform alternative views about health care reform. Republicans equate competition with choice and responsibility and assume it must control costs. Liberals see market competition as rigged to favor corporate and provider interests and so as increasing costs. In the center, many analysts seek ways to make competition work without the problems perceived by liberals—but without much evidence this can be done.

For supporters of competition in principle, hardly any evidence against it will change their minds. The pro-competition advocacy coalition dominates health policy because its premises dominate American policy discourse more generally.

The fact that its measures never work, however, does occasionally allow for more regulatory initiatives. These tend to win support when budget pressures force legislatures to adopt measures that offer immediate savings, and especially if those measures can be described as in some sense competitive rather than regulatory.

Both happened, for example, with the adoption of the Prospective Payment System (PPS) for hospital services in Medicare in the early 1980s. Congress and the Reagan administration were desperate for savings, and some conservatives concluded that bundling payments by diagnosis would provide incentives for hospitals to be more efficient, and so indirectly save through competition. It worked.

Three factors currently weaken the advocates of competition. First, the need for health care savings in the short run is immense, both for businesses that are charged most of the bill for care for the working-age population and for a government facing massive deficits and possible bills for health insurance expansion. Second, the failure of market forces to control costs after the brief glimmer of hope in the mid-1990s creates some doubt about the core belief in market forces for health care. Third, the deep core belief that pursuit of profit by competing firms or individuals naturally leads to social optima is rather less credible after the financial market meltdowns.

Nevertheless, the alternative view of cost control has been advocated only quietly and indirectly. It says that health care costs are too high in the U.S. mainly because we pay too much for individual services and overhead. This argument is supported by a wide range of studies that have investigated why costs are higher here than in other countries.

Prices are so high mainly because the competing and therefore fragmented payers in the U.S. do not have the market power to negotiate or impose lower prices. In other countries, either having a single payer for most services or a way to coor-

dinate most payers (an “all-payer” system) concentrates payer market power.

Overhead costs burgeon because the competition among insurers in the U.S. generates extra expenses for marketing, profit, and underwriting. In addition, each insurer’s effort to save by *selective contracting* on different terms with providers leads to extremely complex billing arrangements.

Other countries with multiple insurers have lower direct overhead costs and their billing systems are much less complex and expensive because most or all payers follow the same terms. Even in the U.S., Medicare’s market power has for most of the past 30 years helped it restrain spending more successfully than private insurers.

Advocates for a public plan option, as originally proposed by President Obama’s campaign, hope that it would, indirectly, yield some of the benefits of a single-payer system. Ironically, even they have framed this as a matter of competition! Supporters and opponents both suspect that the public plan, with greater market power and lower administrative costs, could provide better value than the private insurers do.

Defenders of private insurance then suggest eliminating either the public plan or its bargaining power. There has been little discussion of eliminating the competition itself, by coordinating the rates paid by both the public plan and the private insurers. Stuart Altman has [testified](#) for some form of all-payer regulation to the Senate Finance Committee, and I have [written](#) two papers that have been informally circulated and posted to the Institute for America’s Future website.

Much more prominent in current debate is a set of ideas about reforming the delivery of care.

These measures presume, first, that the problem is not prices but volume. They presume, second, that the volume of services can be reduced by making care more appropriate, through some combination of information, guidelines, and management. Finally, they presume that the system can be structured to give providers incentives to compete by providing more appropriate (and, by assumption, lower volume and lower cost) care.

In short, “managed care” has been renamed, or split into a series of names. Ideas for savings include chronic care case management (which requires some sort of management organization); medical homes (cozy HMOs); research on comparative cost effectiveness (which then requires some way to manage providers to get them to follow the guidelines); and more health information technology (to do profiling or research or direct management).

There are two main problems with these ideas. First, we don’t know how to save money through any of them. Anyone who believes differently should check out the Congressional Budget Office’s December, 2008 report on [Key Issues in Ana-](#)

[lyzing Major Health Insurance Proposals](#). Second, none of them will save money unless supplemented by better control of prices.

“Medical homes,” for example, will require extra payments for services that integrate care, and as CBO has noted, those payments could exceed any savings from reduced utilization of care. Moreover, competition per se does not resolve these problems: it cannot tell providers how to reorganize to increase value, and payers at present do not know how to measure value anyway.

All-payer regulation is far more likely to gain savings. It is more promising, first, because it would be more effective on both prices and overhead costs. These are major aspects of the high costs in the U.S., and they can be more easily affected than volume of care provided.

Standard objections such as that providers will raise volume to counter price limits, or that increased costs are not due to increasing prices so that prices can’t be the real problem, at best misunderstand the evidence, as I explain in a [recent paper](#).

Even periods of better cost control within the U.S. private sector, as in the mid-1990s, came about because of better control of prices. Both competing payers and all-payer systems try to drive down prices. The difference is that competing payers have to do so by having limited networks.

The threat to exclude a hospital or physician practice is the chip that Aetna or Cigna or the Blues have to use to get better rates from them. But that means patients have to deal with network restrictions in order to get lower prices; in an all-payer system network restrictions are unnecessary, which is much easier for everybody. It also, as experience shows, is a much more reliable way of limiting prices.

Many of the proposed delivery reforms would also be encouraged by creating an all-payer rate-setting system. For example, a standard set of categories of services and payments would encourage the standard platforms needed for interoperable information systems.

There should still be room for virtuous competition in any reform. For example, truly integrated delivery systems should be able to compete with regulated fee-for-service insurance. If the restricted choice in those models is accompanied by perceived better value, they should thrive. If an insurer can sponsor chronic care case management for a given disease, and so increase the value of its product compared to other insurers, that case management should be encouraged (and protected by adequate risk adjustment).

But current competition largely takes other forms. It involves competition by insurers to avoid risks, through underwriting and proliferation of plan designs. It involves competition by insurers to restrain payment rates through selective

contracting, which doesn't restrain rates much but adds major billing costs and makes the system much more confusing for sick people. It involves competition by providers to grab enough market share to set rates when negotiating with fragmented insurers—which would not work if the payers were united in the rate negotiations. It involves providers purchasing excess equipment because rates are so high that underused equipment can still be profitable—which would not work if the payers had the power to lower excessive prices.

I'm not naïve enough to think members of the competition advocacy coalition will be convinced by any arguments I make.

But perhaps some people who are neutral will look some more at the issues, and come down in favor of more effective reform.

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COMPETITION

Competition: The Public Plan's Fatal Flaw

DANIEL CALLAHAN

JUNE 19, 2009 > The greatest flaw of the proposed public plan is its embrace of competition as the central mechanism for cost control. History suggests that competition as a whole is an ineffective way to run a health care system. Real reform lies in price controls and other regulatory strategies.

The public choice plan has had many critics, but its support by President Obama and many Democrat advocates give it at least a 50/50 chance of being included in any final legislator.

Among its critics are those on one side who think that it will become a dumping ground for more expensive, less economically desirable patients. On the other are those who see it as a sneaky incremental way of putting private insurers out of business.

Almost wholly neglected is the fact that it embraces competition as the central means of controlling costs. Whatever its other shortcomings, that is its fatal flaw.

The nature of that flaw is threefold. First, it rests on the false premise that competition can control costs and that it is a good way to run a health care system. But it is impossible to find any country in the world, including our own, that has private sector competition as its foundation.

Our own system is slightly less than 50 percent private and that portion has gradually declined over the years. With the exception of a short period in the mid-1990s, when HMOs were riding high, the private sector has never stopped steady cost increases. They have ranged from as high as 12 percent a year to as low as 6 percent, its present level.

Competition has almost always failed to make much of a cost difference in health care (whatever it might have done with cell phone and TVs). The competition among private providers in the federal Employee Health Care Benefit program (FEHBP), often cited as a model, has failed to stop annual cost increases also.

The second flaw is that proponents of the public choice idea say that, while it will be modeled on the Medicare program, it will not be identical with it. Medicare does better than the private insurance industry in controlling costs, but the difference is marginal, in the range of 1 percent to 2 percent.

It does have lower administrative costs, but not nearly enough to make it a winner by large margin. It is no more sustainable at that lower rate than the private sector is at its higher rate. With the Medicare program projected to be insolvent in eight years because of its own cost escalation, any program modeled on it will have to find ways of doing much better, much better.

The third flaw stems from the other two. The competition will have no external cost controls built into it. If it fails to hold down cost increases, altogether likely, the health care system will simply have to swallow those results.

The gold standard for annual health care cost escalation is that it be no greater than the annual growth of the GDP. Not one of the proponents of public-private competition has made a case that it is particularly suited to move strongly in that direction. The public plan and the private plans together will have to draw upon the same doctors and hospitals that are already part of the cost escalation problem, make use of the same expensive drugs and medical devices, and rely on the same fee-for-service mode of physician payment that has helped give us a cost problem.

Even if we assume that, with a reasonably level playing field as advertised, the public program will win out competi-

tively over the private insurers, it is implausible to believe that it could do so by a decisive margin. Competition will not magically confer upon it potent cost control power that it has lacked in the past. If, as the result of a truly level playing field, they come out even, we would be no better off anyway.

Other alternatives to the leading public choice model have been offered. Senator Kent Conrad, Democrat of North Dakota, has proposed nonprofit coops as a way of avoiding a government-dominated plan. Len M. Nichols and John M. Bertko of the New America Foundation have offered a plan that does not rely on the public plan's potential competitive market power to control cost growth. But both ideas continue to assume that a market-based approach, just a different kind, will control costs. There are no good historical or other evidential grounds for supposing that to be true.

The final reform prize, many believe, will go to that plan which best combines private sector market values and new

versions of government safety nets or imposed coverage mandates. Market values, principally expanded consumer choice and improved provider competition, surely have their political attractions, but they have never proved themselves in health care capable of controlling costs.

As the evidence of European systems shows, the unpleasant truth is that only price controls and other regulatory strategies can decisively work. If the private sector wants to avoid the imposition of such controls as the cost problem deepens in the future, then it is open to them to devise their own ways of doing so, and imposing on themselves various means of making them stick. That idea is no more naïve than a belief in cost control by competition.

Daniel Callahan is editor of the Health Care Cost Monitor.

COMPETITION

Defusing the Health Care Time Bomb: Lessons from the 1990s

ALAIN ENTHOVEN

AUGUST 18, 2009 > While the concept of managed competition from the 1990s fell out of favor, the “father of managed competition” describes ways that it can be updated to improve consumer choice and create incentives for more efficient health care delivery. Health care would be of high quality, but premiums would be affordable.

Health care expenditures are destroying our public finances. Last year, they drained the federal budget of \$1.07 trillion, including \$260 billion of revenue losses from the tax exclusion of employer-paid health insurance. This was about 7.5 percent of gross domestic product, and it is growing faster than GDP.

We must move effectively to get the health expenditure growth rate down to the growth rate of the GDP in a decade. To fail to do so will do huge damage to public funding for education, and to the credit rating of the U.S. Government.

We need five actions:

1. Cost conscious consumer choice of health plan

Practically nobody has a serious incentive to choose economical care. A \$2,000 deductible does not create relevant cost consciousness: the real money is in the high cost cases. The deductible may induce people with chronic conditions to skimp on needed care. Cost conscious choices do work in the annual insurance plan open enrollment where the consumer can see and consider the premiums.

Coverage should be standardized, and consumers should have information on the quality of care. Congress must cap the tax exclusion, preferably at the price of an efficient plan in each region, so that people will be rewarded for choosing an economical plan. The savings should be used to help people with low incomes buy health insurance.

The White House and Congress should resurrect the National Bipartisan Commission on the Future of Medicare, of the late 1990s, and implement its recommendations for defined contributions and multiple choices of health plans. All new Medicare beneficiaries starting in, say, 2012 should have the opportunity to save money by choosing efficient delivery systems—those that have high ratings for quality and consumer satisfaction and low premiums. Consumer choice would create powerful incentives for providers to form and join efficient delivery systems. Congress could then manage growth in contributions the way it has done in the Medicare Prospective Payment System, to control and slow the growth.

2. Organize the market for competition at the consumer level.

Most employers do not offer employees the opportunity to save money by choosing more economical health plans. *The lack of that choice blocks the growth of efficient health care delivery systems.*

Where people do have such choices, *very high percentages choose lower cost organized delivery systems.* A market could be developed to drive the transition from uncoordinated fee-for-service systems to accountable care organizations with processes to improve quality and cost.

The Committee for Economic Development (CED) recommended that an independent agency patterned on the Federal Reserve create a national system of regional exchanges through which health plans would offer coverage. The exchanges would enforce rules, such as accepting applicants re-

ardless of their health status and offering a lean standard benefit packages. They would also provide unbiased information and facilitate choice.

To prevent adverse selection, participation in exchanges must be mandatory for large classes of people. The CED recommended rolling this system out by classes of employer size, starting with small firms that need this most, making participation in the exchange a condition for receiving the tax exclusion. Eventually everyone should be in the multiple choice environment.

Through standardization and economies of scale, exchanges would drastically lower the costs of insurance administration.

3. Through market forces, transform the delivery system to integrated high performance systems.

President Obama wants to see information technology, preventive services, and comparative effectiveness put to use to improve quality and reduce cost. We need *systems* and incentives to make that happen.

Organized systems are needed for many essential functions that support improvement: to align provider incentives; to deploy health information systems; to organize and deploy infrastructure for chronic disease management; to match numbers and types of providers to meet a population's needs efficiently; to keep providers current on evidence-based practice and supported by tools (such as peer review and check lists) to overcome widespread practice variations and quality failures.

Nationally, we have more than 400 large multispecialty physician organizations, existing in every region of the country, urban and rural. With market incentives, they would transition to accountable care organizations, which would function like integrated delivery systems such as the Mayo Clinic and Kaiser Permanente. The large integrated delivery systems have shown that they can deliver high quality care at a substantially lower cost than other physician organizations.

4. Address other barriers to an efficient affordable health care.

Even if we got everyone into a model of competing systems, there would still remain a great deal of work to correct the in-

flationary bias and institutions in our health care system, including:

- Shortages of personnel, such as primary care physicians and nurses
- Provider monopolies
- The tort system
- The costs of hyper-expensive biotechnology drugs;
- Regulatory barriers to physician-hospital cooperation;
- Barriers to personnel substitution (nurse practitioners doing primary care under physician supervision, for example), created by state laws to protect providers.

We also need independent technology assessment to develop information about the benefits and costs of new technologies.

Use savings to finance subsidies for low-income people to move toward universal health insurance.

Having tens of millions of citizens without health insurance is a moral blemish and an embarrassment for our society. We ought to have reliable universal health insurance for many reasons. Without it, people lose their savings when they get sick, uninsured people burden and threaten the solvency of providers who care for them; and hospitals shut emergency rooms. People with chronic conditions need ongoing care.

The CED issued a report that recommended universal health insurance based on premium support payments for every legal resident. To pay for it, in addition to the savings proposed here, CED recommends a value added tax so as not to add to the distorting tax burden on working, saving, and investing. Eventually this should replace the flawed employment-based system.

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Health Care Reform: The Role of Hospitals and the Need for Equity

BLAIR L. SADLER

JULY 13, 2009 > A hospital reimbursement system in which every procedure and test generates a “facilities fee” and a doctor fee is in need of reform that rewards quality instead of quantity. But reform also needs to level the playing field so that safety net hospitals don’t bear a disproportionate financial burden.

President Obama makes a compelling case for comprehensive health care reform as a cure to our financial woes and because of the need to provide equal access to care for all Americans. Hospitals need to be part of the solution and, philosophically, they say they are on board. Last week, they agreed to a \$155 billion reduction in Medicare and Medicaid payments over the next decade.

But they remain concerned about the possibility of additional cuts from health care reform. When half of our hospitals are operating in the red today, this concern is hardly surprising. But to really understand the hospital component of the health care system, it seems necessary to appreciate the conflict in core values underlying American healthcare.

I believe that underlying the debate is our national schizophrenia over whether health care is a social good or an economic good. We often say the former but the reality is the latter. We say health care is a “right” not a “privilege” and we deplore that not everyone has access to health insurance.

But we also believe that there should be competition in health care and that “the market” should prevail. Because the real underlying value of American health care is “market based competition,” perverse financial incentives have developed.

In his recent *New Yorker* article, Atul Gawande reminds us that the single most expensive hospital technology is the physician’s pen. As physicians order more tests and demand more technology, hospitals scramble to provide the needed facilities and equipment. Hospital behavior is further reinforced by a reimbursement system in which every procedure performed

and every test ordered generates a “facility fee” as well as a doctor’s fee. This is not true for prevention programs that fight obesity or child abuse.

To compound matters, American hospitals are owned by a variety of organizations with different incentives. Some are public and owned by states, counties, or cities. New York’s Health and Hospitals Corporation’s network of hospitals and Chicago’s Cook County hospital are examples. Others are private for profit and are owned by individuals and may even be publicly traded. HCA and Tenet are examples. Most hospitals are “private non-profit”—tax exempt charitable organizations governed by volunteer boards of trustees on behalf of the communities they serve.

Non-government hospitals have no legal requirement to treat and admit poor, uninsured patients except for emergency care. Since Medicare reimbursement is well below commercial payers and Medicaid is well below Medicare, it is not surprising that some hospitals—including some nonprofit ones—have made a conscious “business” decision to treat as few nonpaying patients as possible.

It is the classic “mission” (social purpose) vs. “margin” (business purpose) debate and it goes on in hospital board rooms throughout America every day. It is particularly pronounced during severe economic crises. Unprecedented cuts in basic education, social, and health services are being made. Imagine operating a hospital that provides significant care to the poor being told that the state is running out of money to pay its bills. Come to California—that is today’s reality.

Market based competition has created an uneven playing field among hospitals depending on their level of commitment to the poor. The biggest solution to this financial inequity has been the federal Disproportionate Share Hospital (DSH) program, which for over 30 years has provided “supplemental” payments to those hospitals that provide a “disproportionate” level of care to patients without private health insurance.

At the nonprofit Rady Children’s Hospital in San Diego where I worked for 26 years, nearly half of the children we treated had no private health insurance. Nearly half of them were covered by Medicaid. The remaining children did not qualify for Medicaid and most of their costs were covered by philanthropy. Without the DSH program, Children’s would have not have been able to survive financially nor to fulfill its social mission of treating all children regardless of ability to pay. With no public or county hospital in San Diego, where else would sick children receive care?

Despite the dire financial conditions facing many hospitals and their key role in the public interest, there not been a whisper of “stimulus” or “bail out” funds for safety net hospitals that could close. Are banks and car manufacturers more important than essential hospitals to our nation’s well being?

How can hospitals be part of the solution to health care reform? I support a more informed use of funds that rewards quality instead of quantity and a reimbursement policy that levels the playing field so that safety net hospitals don’t bear a disproportionate burden. I believe the suggestions below describe ways hospitals can help advance health care reform.

I believe hospitals need to:

1. *Actively support some form of universal health care coverage including some type of public insurance plan and ensure its enactment in 2009.*
2. *Support the transition led by Medicare to pay hospitals and physicians for value (quality) instead of volume. Regardless of the payer, let’s really compete on patient quality in a transparent world where consumers have choice.*
3. *Support tort reform to reduce unfair malpractice litigation and reduce expensive “defensive medicine” behavior caused by the current broken tort system.*
4. *Support leveling the economic playing field to eliminate inequities that allow some hospitals to avoid providing their fair share of care to the poor.*

5. *Seek to eliminate the ability of physicians who “cherry pick” and see private paying patients in facilities that they own while caring for the poor in other hospitals.*

6. *Support comparative effectiveness research to assure that we are using only those practices, procedures, drugs and devices that are most effective.*

7. *Support reducing the widely disparate treatment patterns that exist between regions of the country and provide no benefit to patients.*

8. *Support the replacement and renovation of aging hospitals to provide facilities that help reduce health care acquired infections, patient falls, medication errors, and caregiver back injuries lifting patients,*

9. *Support new “green” energy use policies of hospitals to help reduce their carbon footprint and avoid using any devices that contain toxic substances such as mercury or harmful chemicals.*

10. *Protect the “safety net” hospitals that are vital to a healthy America.*

The time for bold action is now. We must have the courage and the will to make needed changes. Simple “across the board” cuts will fail in the long run and could cause some needed hospitals to close. Initiatives like those outlined above can be successful and help provide some balance to the “social good” vs. “economic good” tension. At its core, this debate is about our values as Americans. It is time to show the world who we really are.

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Fixing Medicare

MURIEL GILLICK, M.D.

MAY 22, 2009 > Effective Medicare reform requires implementing a coordinated, integrated approach to the management of chronic disease. While Medicare is failing to cover a variety of services that are critically important for older patients, it is simultaneously paying for an enormous amount of care that is useless and in many cases even harmful.

The Medicare Modernization Act of 2003 (MMA) was supposed to bring the Medicare program into the twenty-first century. It was going to ensure that good health care was a reality for both America's elderly and its disabled citizens. It didn't succeed.

The 45 million Americans who are enrolled in Medicare are certainly far better off than the 47 million Americans who have no health insurance at all. Some of them are better off today than they were before the MMA was passed since they now have a prescription drug benefit. In fact, for those elders who are in good health, Medicare is a model program: designed in 1965 to cover acute, time-limited illness, it does that very well. The problem is what Medicare does not do so well. It does not provide coordinated and preventive care for those with chronic illness; it favors institutional over home care; and it offers excellent end of life care only to the minority of patients willing to forgo hospitalization and palliative treatment and to enroll in hospice. And Medicare has no good way to control costs.

When the first of the baby boomers turns 65 in 2010, Medicare costs are expected to reach 3.3 percent of gross domestic product (G.D.P.); they will jump to 6.3 percent of G.D.P. in 2030 and reach a staggering 8.4 percent in 2050. Forget all the concern about Social Security—it's the Hospital Trust Fund, which pays for Medicare Part A, that is on track to go bankrupt. The latest projection by the Medicare Trustees is that Medicare will run out of money in 2017.

What Medicare is best at is treating a disease like pneumonia: the patient gets sick quickly, is hospitalized for at most a

week, and then goes home with a prescription for a few days' worth of oral antibiotics. But Medicare patients today have multiple chronic conditions: the 21 percent of Medicare beneficiaries with five or more chronic diseases account for 68 percent of all Medicare spending.

Patients with chronic medical problems need a very different model of care. They need a coordinated, integrated approach. Right now one of the few ways to get this kind of treatment is through the Program for All Inclusive Care for the Elderly (PACE), a program for the frailest of the frail—elders who are dually enrolled in Medicare and Medicaid and who are impaired enough to qualify to live in a nursing home to boot. PACE has been very successful not only in keeping such patients out of the nursing home but also at keeping them out of the hospital, while providing high quality care. But the model for addressing chronic disease in the MMA was not the capitated PACE program, but rather "case management," typically provided by an outside agency that does the medical equivalent of trying to direct traffic by phone rather than through the physician's office. Not surprisingly, these programs have in general been a disappointment.

Because Medicare is geared towards treatment of acute illness, it is built on hospital-based care, not community care. In 2006, 29 percent of Medicare spending went to hospital treatment. Much smaller chunks went to skilled nursing facility care (5 percent) and to home care (4 percent). And there are incentives for patients to be treated in institutions rather than at home. For example, patients must spend three nights in a

hospital before going to a skilled nursing facility, even though some simple problems such as pneumonia could easily be treated in the nursing facility. Similarly, there is an incentive for patients to move into a nursing home—and be covered by Medicaid—rather than to receive care at home.

One of the jewels in the Medicare crown is its hospice benefit. Enacted in 1982, the hospice benefit allows patients with a prognosis of six months or less to receive intensive services focusing on their comfort, care which in 95 percent of cases is delivered at home. The program has gotten excellent marks from families in satisfaction surveys and in formal research studies.

Hospice has grown dramatically: between 2000 and 2007, the number of Medicare certified hospices increased by 41 percent, and the number of hospice patients doubled from 513,000 to one million. But the problem with Medicare hospice is that it forces patients to make a diabolical choice. In order to qualify for the home care services most patients want at the end of life, they have to agree to forgo treatments that can offer significant palliation. Contemporary medicine can enhance the quality of life for many patients with advanced disease through relatively noninvasive treatments such as oral chemotherapy or blood transfusions. But the reimbursement structure of the Medicare hospice benefit—a fixed per diem rate—simply does not allow for these treatments.

How can Medicare do all these things—and continue to provide acute medical care? Providing additional benefits seems like the last thing the Medicare program should do: the costs of the Medicare program have already been skyrocketing, partly due to the growing number of older individuals, but to a much larger extent due to the insatiable American appetite for health care and the introduction of new, expensive technology. Fortunately, the reality is that while Medicare is failing to cover a variety of services that are critically important for older patients, it is simultaneously paying for an enormous amount of care that is useless and in many cases even harmful. In fact, when Medicare patients with heart attack, hip fracture, or colorectal cancer were followed over a five-year period, those living in parts of the country with higher spending on medical care experienced higher mortality rates.

Medicare routinely pays for burdensome, expensive treatments for patients at the end of life. Similarly, it reimburses physicians and hospitals generously for diagnostic tests and procedures of dubious benefit. And it pays for costly medications and treatments when cheaper, equally effective, treat-

ments exist. How can Medicare move from today's reality, in which it fails to provide all kinds of care it should offer and systematically encourages the use of all kinds of care it should not?

In terms of *chronic disease*, the secret to success lies within the PACE program, which provides coordinated care within a capitated system. HMOs got a bad name in the 1990s, but the truth is that only when an integrated health care system operates within a fixed budget that we can expect to see appropriate allocation of resources. With respect to *new technology*, which is the principal driver behind escalating costs in the Medicare program, the trick will be to stimulate innovation without allowing technology to diffuse unchecked.

One solution is to allow cost effectiveness analysis to enter into Centers for Medicare and Medicaid Services reimbursement decisions, not as the sole criterion, but along with other ethical principles such as preferential treatment for the most vulnerable. Finally, to provide good *end of life care* to all Medicare patients, not just those who currently opt for hospice, many of whom enroll in the program within days or even hours of death, we need to create a new benefit. This would provide much of what is currently available through hospice but allow for some hospital care and many palliative treatments in exchange for forgoing the most expensive types of care, such as major surgery and ICU care.

The current discussions of health care reform have appropriately emphasized the importance of universal access. And right now those over 65 do have access through Medicare—though median out-of-pocket health spending as a percent of income has been rising for older individuals, going from 11.9 percent in 1997 to 16.1 percent in 2005, potentially jeopardizing access. But Medicare deserves significant attention as well, both to quality and costs, two goals that are sometimes in conflict. The good news is that truly modernizing Medicare—paying attention to the most important health needs of older individuals and focusing on care that works—can actually improve quality while constraining cost.

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Cost Trends in Heart Disease, End Stage Renal Disease, Cancer, and Metabolic Syndrome

POLO BLACK GOLDE

MAY 22, 2009 > The Medicare Trust Fund is expected to be insolvent in eight years at the current rate of spending, as a result of more enrollees living longer and in worse health. Four leading medical conditions underline this trend.

The Trustees of the Medicare program recently reported that the Medicare Trust Fund will be insolvent in eight years, much sooner than their projection even a year earlier. By the end of that period the baby boom generation will have begun retiring and receiving Medicare benefits. The combination of rising costs of per capita health care for the elderly combined with the growth of their numbers is especially disturbing. More and more ways are being found to keep the elderly alive longer and longer, often in poor health, and with higher and higher costs. Four leading medical conditions of the elderly underline that trend.

Heart Disease

Heart disease has long been the leading cause of death in the United States. However, for the last 60 years, the age-adjusted mortality rate heart disease has been in decline. From 1950 to the mid-1980s, heart disease has contributed to the overall mortality rate at roughly 40 percent; since 1986 this has slowly decreased. By 2005, the most recent data from the Centers for Disease Control and Prevention (CDC), heart disease accounted for 27.1 percent of overall mortality in the U.S, at an age-adjusted rate of 222 deaths per 100,000 people.

But in stark contrast to the decreasing mortality rate from heart disease, expenditures are on the rise. In 1995, costs for heart disease totaled \$75.9 billion, according to the National Center for Health Statistics. Over \$55 billion of this was spent on individuals over 65. In 2009, our nation will spend \$183 bil-

lion directly on heart disease, according to the American Heart Association, and others are pointing out the increased utilization of interventions for heart disease among the elderly.

For treatment expenditures alone, the Milken Institute has projected an increase from \$64.7 billion in 2003 to \$186 billion in 2023, a 187 percent increase. Even in its most optimistic scenario, which assumes among other things behavioral changes and decreasing obesity, total treatment expenditures would still grow 70 percent to over \$110 billion dollars. While our spending on heart disease may claim as its success a decrease in heart disease related deaths, our expenditures to that end are not stabilizing in the least.

End-Stage Renal Disease (ESRD)

Although end-stage renal disease ranks far lower than heart disease as a cause of death (ninth, according to the CDC), expenditures for its most common and most highly-effective treatment, hemodialysis, are very high and rising dramatically. The most recent data project the number of dialysis and kidney transplant patients to increase by over 150 percent in the next eleven years, which will make it even more difficult to curtail expenditures. Through a legislative move in the mid-1970s, Medicare covers dialysis and kidney transplants for all age groups. In recent years, however, those over age 65 have become the fastest growing group of patients. Of those beginning ESRD therapy, the current adjusted incidence rate is only 2.4 percent for persons aged 45 to 64 years old, while it is 11 per-

cent for patients over 75.

Absolute costs for ESRD, for both Medicare and non-Medicare payers, have increased from \$8.01 billion in 1996 to \$33.61 billion in 2006. Medicare spending for ESRD has increased by an average of 9.2 percent annually from 1992 to 2006. Annual Medicare expenditures for hemodialysis have increased over 400 percent since 1991 to almost \$17 billion. Kidney transplant expenditures by Medicare have increased by 342 percent since 1991, and in 2006 they were over \$1.8 billion, due to a combination of rising costs for both organ acquisition and the transplants themselves.

Cancer

The cost of treating cancer, the second leading cause of death, rose to \$72.1 billion in 2004 from \$18.1 billion in 1985. As a share of overall health care spending, however, cancer treatment remained at about 4 percent during that time. But with the U.S. population growing and aging, the total number of cancer cases is expected to increase by 45 percent between 2010 and 2030; 67 percent among those over age 65. This trend will undoubtedly increase the burden on the Medicare system.

At present, lung, prostate, breast, and colorectal cancers are the leading types of newly diagnosed cancers. They account for about 60 percent of all cancers in the elderly and, in 2004, accounted for almost half of total cancer expenditures. While the incidence of colorectal cancer is declining, the National Cancer Institute projects that the cost of treating it will increase by 89 percent between 2000 and 2020. Moreover, an-

other study in *Health Economics* in 2008 concludes, “costs are more likely to increase at the individual level as new, more advanced, and more expensive treatments are adopted as standards of care.”

Metabolic Syndrome

The Metabolic Syndrome is diagnosed in a person who has at least three of the following five conditions: abnormal glucose levels, low HDL cholesterol, elevated blood pressure, high trygcleride levels, and abnormal obesity. Those with the syndrome have an increased risk of stroke and heart disease. There has been a sharp rise in recent years in treatment of conditions that make up metabolic syndrome. Significantly, “virtually all growth in Medicare spending from 1987 to 2002 can be traced to the 20 percent increase in the share of Medicare patients treated for those conditions during a year,” stated an article in *Health Affairs* in 2006. Moreover, it continued, “spending may continue to rise as increases in longevity...prolong the period over which they incur high costs year in and year out....mortality reductions resulting from improvement in chronic care may improve health...and increase spending simultaneously.” Two commentators on this trend had a disconcerting observation regarding the effectiveness of treatment for the condition: “ultimately, it will be difficult to distinguish undertreatment from overtreatment.”

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Life-Extending Treatments for the Oldest Patients

SHARON KAUFMAN

MAY 26, 2009 > The routine use of innovative life-prolonging treatments has led to an increase in interventions performed on people in their 80s and older. If we do not better define medical success and the best treatment plans in an aging society, we may find that we are wasting money at the end of life.

An explosion of life-extending interventions for older persons is changing the face of many medical specialties in the United States. Routine and innovative treatments are prolonging more lives at older ages than ever before, and the average age of patients who receive surgery and other nonprimary care interventions that extend life is rising. Indeed, octogenarians comprise the most rapidly growing group of surgical patients, and there is a growing medical literature on the justification and benefits for performing many procedures on persons over age 80. These practices are reshaping medical knowledge and societal expectations about “normal” old age, longevity and the time for death.

For clinicians, there are no longer steadfast assumptions about technological or biological limits to what medicine can do for older persons. Patients, for their part, have become medical consumers responsible for questing after their own health and longevity. Desire for therapeutics into advanced age has grown along with the aging of the population.

Four and a half million people in the U.S. are 85 years old or older. By 2050, 20 million persons will be over age 85. There are enormous pressures from multiple sources—patients, their families, the “technological imperative” in medicine, the structure of health care financing, the specter of litigation, the excitement surrounding new interventions, professional training and subspecialization, and, above all, the cumulative successes of clinical medicine—to attempt to stop the course of end-stage disease late in life. Together, the availability of more options and the normalization of life-extending treat-

ments at older ages promote the notion that aging and death are not inevitable and foster the assumption that one can and should choose to intervene. (That assumption is not as pervasive in Europe, where the limitations to health care resources are widely acknowledged.)

Examples of the expanding use of four kinds of therapies are emblematic for the rising age for interventions of all kinds. Their success in extending lives and well-being contributes to the cost challenges that accompany medical interventions in an aging society. As clinical criteria for performing these procedures expand to include older, sicker people, two accompanying social trends contribute directly to rising costs and the problem of limiting them. One trend, diminishing the risks of death by whatever clinical means available, has already become standard practice and is seen to be ethically appropriate, even necessary (for those who can access services). The other is that of ever-new biotechnological tools that create a more perceived need to intervene, in order to treat the risk of death.

Cardiac procedures

Coronary artery bypass graft surgery, angioplasty, stent procedures are now commonplace for persons in their 80s and not unusual for persons in their 90s. Cardiac valve replacement therapies are becoming more common in the ninth decade as well. Studies indicate that successful outcomes for those procedures can be obtained for select groups of patients aged 90 or older, although hospitalization may be longer and morbidi-

ty higher than for younger patients.

Advances in treatments for strokes and heart attacks have prolonged lives, although they have led also to emerging epidemics of heart failure and atrial fibrillation among the elderly. The prevalence of heart failure has been increasing over the last decade, with approximately 550,000 new cases diagnosed each year. Available interventions for severe heart failure include hospice care, the automatic implantable cardiac defibrillator (AICD), the left ventricular assist device (LVAD), and heart transplant. These dramatically distinct offerings include both ends of the intervention spectrum in contemporary medicine—from end-of-life palliation to heroic (yet only potential) life-extension. This range of treatments complicates choice because hope is always embodied in heroic interventions. A recent study shows that patients who think their chances of relatively long-term survival are favorable want aggressive therapies—despite prognostic models to the contrary.

Relatively few individuals consider and receive a LVAD or cardiac transplant, although cardiac transplant in the seventh decade is not uncommon. In contrast thousands of older Medicare recipients now qualify for the AICD device (with or without pacemakers). Use of the device is rising substantially because the Centers for Medicare and Medicaid Services in 2005 approved the expansion of the eligibility criteria to include primary prevention for patients who have never suffered a cardiac event. The device regulates a lethal cardiac rhythm, thereby reducing the risk of a fatal heart attack. In 2005 more than 100,000 individuals received an AICD, up from 48,000 in 2001.

Although a recent study shows the device to be effective in reducing mortality for older patients, opinions diverge about whether the AICD for very old individuals is appropriate. Meanwhile use of this device is on the rise because it prevents death, the treatment of *risk* itself has become important in medicine, and specialist and subspecialist referrals pave the way for its use. As devices become smaller, as techniques for implanting them become safer, and as less invasive procedures are used with greater frequency and success, physicians and the public have learned to view them as standard interventions. Reduced risks associated with all of these procedures produces a sense that life extension is open-ended.

Kidney dialysis

Since 1972, when Medicare benefits were extended to all persons with end-stage renal disease (ESRD), the earlier more stringent criteria for dialysis selection have fallen away. At the same time, advances in dialysis care mean that physicians are now more successful at treating ever-older patients with complicated disease. Many health professionals feel that it is morally unjustified not to offer dialysis to any patient with ESRD.

Projected trends for the next decade indicate an increasing proportion of new dialysis patients older than age 75. Currently, 25 percent of all U.S. dialysis patients are over 75; 14 percent are over age 80. The goals of treatment, however, have not evolved from half a century ago to reflect this shift in demographics. With few exceptions, the medical literature has not addressed the role of palliative care and the acknowledgment of the nearness of the end of life in dialysis settings, which indicates that clinicians are disinclined to discuss death with patients.

Kidney transplant

Medical evidence shows that transplantation is the treatment of choice for suitable patients with ESRD, and there is growing demand for kidney transplantation among older persons with kidney disease—both from patients on dialysis and those who would like to avoid dialysis altogether. The number of kidneys transplanted to people over 65, from both living and cadaver donors, has increased steadily in the past two decades in the U.S. In 2008 15 percent of all kidney transplants went to persons age 65 and over. Transplants are no longer unusual in the seventh decade of life and are sometimes performed into the early 80s. As the waiting time for cadaveric kidneys increases (often beyond five years), there has been greater ethical pressure on family members and friends to become living donors.

Cancer treatments

Many cancers have become chronic illnesses today, manageable and sometimes curable because of the explosion in new, specifically targeted and less toxic treatments. Older patients who in the past did not receive treatments are now receiving them for several reasons. There is an unprecedented willingness of older cancer patients to undergo aggressive and long-term treatments. Physicians do not want to deny older patients therapies that may make them more comfortable or extend life, and clinical investigators are becoming increasingly interested in including older persons in clinical trials. As a result, potentially life-extending treatments have become routine into the eighth decade, and, in much smaller numbers, into the 90s. Yet there is controversy about how aggressively to treat cancers at older ages; doctors, patients, and families are often uncertain about how to proceed.

Without medical guidelines or explicit discussions between doctors and patients about the end of life or the toxicity of treatments, many patients and families proactively choose aggressive, toxic, and costly treatments up until the time of death, even when clinicians also offer hospice care. Recent medical studies express a concern about the growing numbers

of patients who receive aggressive chemotherapy up until a few days and weeks before death.

Complicating medical success

Standard procedures are difficult to refuse. It seems against medical progress and common sense to say no, especially if interventions are immediately lifesaving or preventive, and current medical discourse emphasizes that refusing a procedure today may increase the risk later for other problems and especially for death. Success in extending older lives creates the grounds for individuals to decide whether and how to seek more time for themselves and their loved ones. These examples point to the growing difficulty of defining medical success and the “best treatment” plan in an aging society. Ethics and best practices insure that those patients who can access all

that medicine has available will be offered state-of-the-art treatments. Patients, when faced with serious disease and options about what to do, often find themselves contemplating a calculus about how much *more* time they want to live. Because the value of life is neither age-dependent nor quantifiable, their deliberations provide one reason why debates about age-rationing remain lively and unresolved.

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MEDICARE

Is Death Optional?

MURIEL GILLICK, M.D.

MAY 27, 2009 > Doctors fail to discuss the final stages of life with their patients and they keep suggesting life-sustaining treatments that have little appreciable benefit. Better training and more incentives for doctors to have honest conversations with their patients are imperative if Medicare patients are to get appropriate care, and if costs are to be controlled.

Just how far attitudes and expectations about aging have changed in the last 60 years hit home when I stumbled on an article from the *New York Times Magazine* written in 1950 called “Recharting Life for an Aging America.” The author, a physician, wrote, “To lead a long and happy life falls, for the average citizen, into the same category of irrational wishes as to be a millionaire or a movie star.” The reality, he said, is that most old people are “lonely, poor, ailing, crippled, ugly, [and] mentally and physically deteriorated.”

Today, by contrast, as Sharon Kaufman suggested in her post, elderly Americans today take the possibility of ever-increasing longevity for granted. The change in perspective is dramatic and it’s very new: while Americans born in 1950 could expect to live far longer than their grandfathers did, most of the improvement in life expectancy was due to decreases in infant mortality. It was only in 1970—five years after the introduction of Medicare—that 65 year olds could look forward to a longer period of retirement than any previous generation. By 2005, white men could anticipate another 17.2 years of life, and white women 20 years.

But is the result really that Americans today fail to accept that death is inevitable? Or do patients *appear* to believe that death is optional because physicians seldom discuss life’s final stage and continue to offer treatments, even if they are of little or no benefit? For all the lip service paid to informed consent and joint physician-patient decision-making, older patients seldom understand their likely trajectory with and without a particular treatment.

I recently came across a dramatic example of this problem in the course of a palliative care consultation at a major teaching hospital in Boston. The patient was a man in his late 70s who had been hospitalized with a devastating stroke due to massive bleeding in his brain. He was being kept alive in the ICU with a variety of high-tech interventions.

The attending neurologist told the patient’s wife that the likelihood of recovery was very small but that the full extent of his improvement might not be known for months. The doctor held out no hope of a full recovery and expected that if the patient did survive, he would require total care and would have little if any language capacity.

The patient’s wife didn’t think her husband would have accepted such profound limitations on his functioning, but she wasn’t absolutely sure. She wondered whether she should authorize further vigorous treatment to “give him a chance.”

What quickly became clear to me was that the wife’s conception of what it would be like for her husband over the next two months if she opted for attempted rehabilitation and life-prolonging treatment bore little relationship to reality. She imagined that “going to rehab” would be as benign as taking a daily vitamin pill.

I explained to her that after transfer to a rehab facility, her husband would likely suffer multiple complications, such as pressure ulcers or pneumonia. He would probably be shuttled back and forth between the rehab facility and the hospital—and after all that, he would either die or be left extremely debilitated. Once she understood both what treatment would

entail and how unlikely meaningful recovery was, she had no further hesitation: the right course of action for her husband was to focus exclusively on his comfort.

In today's medical world, this kind of discussion is rare. If Medicare patients are to get appropriate care, and if costs are to be controlled, physicians must have such conversations. But since the focus throughout a physician's training is on prolonging life, with little attention to maximizing quality of life or to deciding when to stop, medical education will need to change.

Right now, Medicare and Medicaid pay just under \$10 billion per year to hospitals in the form of General Medical Education funds to train residents. But as the Council on Graduate Medical Education observed in a letter to the Secretary of Health and Human Services in May 2009, hospitals are not held accountable for how they spend the money. Their concern is with their own labor needs, not with training the next generation of physicians to manage chronic disease. It is time to monitor and regulate the way the federal government's money is spent and require proficiency in end of life discussions alone with disease management and care coordination.

Kaufman thinks that telling patients about the trajectory of illness with different treatment options won't be good enough because patients engage in magical thinking. She cites a study in which patients who think their chances of relatively long-term survival are favorable, "despite prognostic models to the contrary," want aggressive treatment. In other words, physicians can lay out the various possible scenarios but patients will gamble that they will be the lucky ones who have the best outcomes.

My experience suggests that most patients do respond to realistic discussions about their future, but the way to deal with the minority of patients who might want to try treatments that have a vanishingly small chance of working is simply not to offer such interventions. This decision should be made at the policy level.

National Institutes of Health consensus conferences will be required to determine a new standard of care for patients with a variety of chronic conditions, such as dementia and heart failure, in the last phase of life. The Centers for Medicare & Medicaid Services (CMS) will then need to give teeth to the

practice guidelines that emerge from such conferences by agreeing to reimburse only for treatment that is consistent with those guidelines.

Perhaps the greatest challenge is that policymakers, who will need to endorse the kinds of changes I am suggesting, share the same expectations of ever-increasing longevity as other Americans. A good starting point, therefore, is to limit treatments that are burdensome, unlikely to be effective, and expensive. The next step will be to dispassionately analyze interventions that offer only a slight chance of benefit and that are expensive but not burdensome to patients.

As Kaufman mentions, some devices such as pacemakers have become increasingly acceptable as they have become smaller and implanting them has become safer and less invasive. Likewise, some cancers have become chronic illnesses because of the "explosion in new, specifically targeted and less toxic treatments," as Kaufman writes. In many instances, older cancer patients show "unprecedented willingness" to undergo treatment precisely because it isn't "aggressive" in the sense of being burdensome.

Why shouldn't patients want a potentially life-extending treatment if it comes in the form of a pill, without the nausea, vomiting, hair loss, and bone marrow depression associated with conventional chemotherapy? Ultimately, policymakers will have to take into consideration cost-effectiveness in deciding whether CMS will cover such treatments.

Far less politically charged are the steps that should be taken immediately: regulating spending on graduate medical education and limiting reimbursement for treatments that come at a high price to both patients and society without conferring any appreciable benefit.

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MEDICARE

Death by Rationing? Not Here

SUSAN GILBERT

*JULY 9, 2009 > A congregation of nuns in Rochester, N.Y., who live their last days with excellent palliative care in a supportive and stimulating environment, often choose not to have life-extending treatments. A geriatrician who cares for the nuns told *The New York Times* that they “have better deaths than any I have seen.” There is reason to believe that their care be replicated outside the convent.*

So much of the debate over controlling health care costs at the end of life is of the either-or variety: give patients access to all available treatments or condemn them to death by rationing. As Dr. Laura Carstensen, director of the Center on Longevity at Stanford University, puts it in an [excellent front page article in *The New York Times*](#), “Either we have to throw everything we’ve got at keeping people alive or leave them on the sidewalk to die.”

But the article, written by [Jane Gross](#), who created the *Times*’s New Old Age blog, gives lie to that simplistic way of thinking. “Sisters Face Death With Dignity and Reverence,” looks a congregation of nuns in a Rochester, N.Y., who live out their final days in a facility that provides excellent palliative and hospice care, along with social and intellectual engagement up until the very end. It’s not that the nuns are denied aggressive life-extending treatments; but few choose them. Sister Dorothy Quinn, for example, 87 years old and dying of heart disease, decided not to take most of the 23 medications that had been prescribed for her. She also declined to have a mammogram to determine if a lump in her remaining breast was cancerous, “understanding that she would not survive treatment,” Gross wrote.

This sort of decision-making is possible because of an environment where doctors talk to patients frankly and openly about their conditions, the likely benefit from various treatment options, and death.

The experience is in stark contrast to that of most patients dying in hospitals, which often leads to the use of expensive

and futile treatments at the end of life, as described in several posts here.

[One post](#) discussed the dramatic increase in the use of life-extending treatments for people in their 80s and 90s, including kidney transplants and dialysis.

In [another post](#), Harvard geriatrician Muriel Gillick described a man in his late 70s who had had a massive stroke and was “being kept alive in the ICU with a variety of high-tech interventions.” His wife agreed to the treatments because the doctor hadn’t explained that even if he survived the ICU, rehabilitation would be grueling and he would either die or be extremely debilitated.

“Once she understood both what treatment would entail and how unlikely meaningful recovery was, she had no further hesitation: the right course of action for her husband was to focus exclusively on his comfort,” Gillick wrote.

In the *Times* article, Dr. Robert McCann, the geriatrician who treats the nuns, says that “they have better deaths than any I’ve ever seen.”

He goes on to say, “It is much easier to guide people to better choices here than in a hospital, and you don’t get a lot of pushback when you suggest that more treatment is not better treatment.” In an [audio slideshow](#), McCann says that he uses one-third the amount of narcotics for the nuns than for his patients dying in other facilities because the nuns have less need for the drugs.

The article clearly touched a nerve. It was the most frequently e-mailed *New York Times* article on July 9, and re-

ceived dozens of comments, most full of praise for the end of life care described.

Could that kind of care take hold outside the convent, in the rest of the country? Gross is hopeful that it might. The nuns there “animate many factors that studies say contribute to successful aging and a gentle death—none of which require this special setting,” she wrote. “These include a large social network, intellectual stimulation, continued engagement in life and spiritual beliefs, as well as health care guided by the less-is-more principles of palliative and hospice care—trends that are moving from the fringes to the mainstream.”

To give that trend a push would probably require a change in Medicare proposed by Gillick in [another previous post here](#). As it stands now, she wrote, Medicare reimbursement favors “burdensome, expensive, treatments at the end of life.” It also

provides excellent hospice care, but only if patients make a “diabolical choice”—agreeing to forgo some palliative treatments that can ease their symptoms, such as oral chemotherapy.

Gillick said that a better and potentially money-saving option would be to provide hospice care along with some hospital care, but excluding the most expensive kinds of interventions, such as major surgery and ICU care.

It’s not either-or, everything or rationing. And, based on the comments on the *Times* article, it’s an option that many people would gladly choose for their last days.

Susan Gilbert is the associate editor of the Health Care Cost Monitor and the staff writer of The Hastings Center.

Reducing Regional Variations in Spending

ANTHONY MARFEO

AUGUST 14, 2009 > Regional variations in Medicare spending have long been a problem. These variations are not the disease to be cured; they are the symptoms of a health care system with some counterproductive incentives. A long-term restructuring of health care to reward quality and not quantity could organically, though perhaps not completely painlessly, reduce spending.

Regional variations in healthcare spending have been described for decades. The Dartmouth Atlas Project has spent years examining Medicare spending patterns across the country. Findings indicate that some areas spend much more than others, sometimes twice as much. Improved health outcomes do not appear to be associated with Medicare spending, after controlling for disease-severity and other factors, including age.

These studies got widespread political attention in a recent article by Atul Gawande in the *New Yorker*—President Obama called a meeting to discuss it in the Oval Office. The evidence Gawande presents point to the most emotionally compelling cause of variation: supply-driven demand, sometimes pushing deep into fraudulent territory.

This evidence has led to the disturbing observation that supply sometimes may be driving demand. Fixing the source of these variations could halt the subsidization of high-cost regions by lower-cost. The question remains: how much of the demonstrated regional variation can be painlessly reduced by politically feasible options?

Concrete solutions are hard to come by, but in December 2008 the Congressional Budget Office described 115 options to reduce health care spending. Some of these options were intended to address these variations, and their immediate economic impact was quantified.

One option called for the incremental reduction of physician fees in Hospital Service Areas that are in the 90th percentile. This would have the effect of decreasing physician fees by

as much as 30 percent in some areas, while leaving 90 percent of areas untouched. The total savings over the next 10 years would be \$5.3 billion. A second, related option calls for reducing payments to hospitals in areas with an exceptionally high volume of elective admissions. This would save a modest \$2.5 billion over 10 years.

The most dramatic option proposed would call for global reduction in payments in areas that spend greater than 10 percent more than the national average. These reductions would be scaled so that the higher spending areas receive proportionately larger reductions. For example, a region that spent twice the national average would have payments reduced by 45 percent across the board, thereby bringing total spending to the national average. These calculations assume that the volume of patients would constant, which history shows it would not.

One could anticipate a combination of effects. Experience shows that increased volume would partially make up for lost revenue. Decreases would simultaneously occur due to reduced provider participation in Medicare, and perhaps even small-scale migration of providers. The repercussions on provider availability would be enormous in the highest spending markets, leaving lower-spending areas free to continue on their current, relatively frugal tracks.

That said, if these changes were to result in real savings, the disruptions could possibly be bearable. As the CBO shows, however, the savings would be about \$50.9 billion over the next 10 years, an average of only \$5 billion per year. To put this into perspective, total Medicare expenditures in 2007 alone

were about \$420 billion. There would in all likelihood be an adverse spillover effects on the rest of our national health spending, as hospitals in heavily cut areas begin to replace revenue from other sources, namely private insurance.

As the Dartmouth Atlas researchers repeatedly state, these heavy-handed solutions are not what they envisioned. Restructuring health care delivery by emulating successful models of accountability is touted as the ideal solution. On a national scale, this would take drastic intervention that today lacks sufficient political backing. However, smaller models, such as the Mayo Clinic or Cleveland Clinic, expanding gradually as they succeed, could thrive within the frameworks

currently being proposed in Congress.

Regional variations are not the disease to be cured; they are the symptoms of a health care system with some counterproductive incentives. A long-term restructuring of health care to reward quality and not quantity could organically, though perhaps not completely painlessly, reduce spending. The difficulty lies in implementing this on a large scale.

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Cost Control in the Netherlands: Testing Market Practices

HANS MAARSE

JUNE 8, 2009 > The percentage of GDP devoted to health care in the Netherlands is expected to increase from 12 percent in 2009 to 14 percent in 2014. The country is trying a variety of market-oriented practices to control health care costs.

In Keynesian terms health care can be understood as a macroeconomic stabilizer: a financial crisis does not elicit a fall in the demand for health care and health care expenditures. Nevertheless, there is no question that the the present international economic crisis makes effective cost control in health care necessary more than ever.

A report of the Council for Public Health and Care (“Raad voor de Volksgezondheid en Zorg”) published in 2008 spelled out that health care in the Netherlands takes between 9.2 and 13.5 percent of the gross domestic product, dependent on how the boundaries of health care are drawn. Over the period 1998 to 2006, health care expenditures grew by an average of 3.7 percent a year (compared with 6 percent now in the United States). Without taking the consequences of the financial crisis into account, the Council also estimated that 20 percent of the yearly economic growth in the Netherlands is spent on health care, a figure that is projected to increase over the coming 20 years.

Some of the most notable policy measures for cost control proposed by the Council were to choose more radical competition in health care, in particular by further increasing the financial responsibility of health insurers, extending the scope of price negotiations between insurers and health care providers, and enhancing labor productivity. Another proposal was to increase private payments for care of the elderly. In the view of the Council, competition has only been implemented half-way since it was given a stronger role by the government in 2006.

Clearly, the financial crisis reinforces the need for effective cost control. In a report called “Code Red,” published in 2009 and written at the request of the Minister of Health, Gupta Strategists predicted that, due to the financial crisis, the fraction of health care of the GDP will grow from 12 percent in 2009 to almost 14 percent in 2014. Another alarming prediction was that, without effective cost control, the financial crisis might require a doubling of the premium each citizen must pay for compulsory health insurance between 2009 and 2014. The government measures announced so far to tackle the crisis are not more than a drop in the ocean. Gupta Strategists were particularly skeptical about the capability of many hospitals to improve their efficiency. If they do not perform better, about 50 percent of hospitals are expected to be in serious financial trouble in the near future. This dramatic situation might require extra government funding to avoid bankruptcy.

The financial crisis also manifests itself at other levels in health care. For instance, a growing number of health care providers are reported to struggle with deficits. Furthermore, some hospitals have difficulty financing their capital investments because of the reluctance of the banking sector to provide them with the necessary capital.

The banking sector is increasingly concerned about the hospitals’ capacity to bear the costs of rent and depreciation in future. This is to largely due to a fundamental change in the regime of funding capital investments in 2009 as part of the government’s policy to introduce regulated competition in Dutch health care, described in [Eurohealth](#) and [Health Affairs](#).

Whereas in the pre-2006 reform period hospital loans to finance construction activities were guaranteed by the government provided they had been licensed, the new regime makes hospitals responsible for their own capital investments.

As a consequence, banks no longer automatically consider hospitals a safe haven to grant a loan. In other words, the current financial crisis turns out to be an unexpected (but temporary?) obstacle to the introduction of regulated competition. Interestingly, private investors are beginning to show an increased interest in investing in health care, presumably because they view it as a growth sector not subject to any cyclical fluctuation. The consequences of this development for future health care expenditures remain to be seen.

The impact of the financial crisis on health care is far from clear yet, but one thing is absolutely certain: there is an urgent need for bridging the gap between revenues and expenditures. In this respect, one may expect, among others changes, a substantial rise in health insurance premiums, an increase of the mandatory deductible in compulsory health insurance (now 150 euros a year), and copayments as well as new reductions in the benefit package of long-term care.

Furthermore, the government will certainly require “efficiency gains” from health care providers to justify expenditure cuts, for instance, by lowering their administrative and management costs or increasing their productivity. Cuts in the salaries of health care workers are no longer inconceivable.

The crisis is also likely to elicit renewed political conflicts on remuneration between the government and doctors. Over the last 15 years, these conflicts did not play a prominent role in Dutch healthcare policymaking, mainly because of rather generous remuneration schemes. However, the government’s policy to introduce regulated competition required a substantial revision of these schemes.

A recent report of the Netherlands Health Care Authority found that the average revenues of a general practitioner had risen by 50,000 euros to 238,000 euros in 2006, the first year the new remuneration scheme had been in place. The report suggested that general practitioners had significantly benefited from the new scheme which involves, among others, a greater role for fee-for-service payment.

The Authority’s report evoked emotional reactions from general practitioners. Their national association immediately expressed its fundamental doubts about the validity of the conclusions. Its main argument was that nobody could draw any firm conclusion on the impact of the new remuneration scheme, since 2006 was a transitional year. Moreover, the Association argued that the government’s policy of substituting primary care for hospital care justified extra revenues for

general practitioners.

A second reason to predict a hot political summer is that of a cost overrun in specialist care in 2008. Due to technical failures in the new remuneration scheme of self-employed specialists (paid fee-for-service) and the abolition in 2008 of the budget constraint to their revenues, which had been in place since the mid-1990s, specialists managed to increase their revenues on average by 25 percent in only one year! Some specialists, including anaesthesiologists, medical microbiologists, radiologists and pathologists, even doubled or tripled their revenue.

The Minister of Finance announced he would claim back the cost overrun, but the specialists are not willing to do so because they dispute the validity of the government’s spending figures. Furthermore, they argue that a “contract is a contract.” They are willing to accept some revision of the scheme, but only from 2009 onward. However, such a revision will be anything but easy and can lead to new conflicts.

Interestingly, specialists were already under some political pressure because of a [report](#) published by the Organisation of Economic Development and Cooperation (OECD) in 2008. It found that specialists in the Netherlands were among the best paid doctors in the 14 countries studied. Based on 2004 data, their earnings amounted to an average of \$290,000 compared to \$236,000 for specialists in the U.S.

The most interesting question concerns the impact of the financial crisis on the government’s policy of a stepwise introduction of regulated competition. At first sight there are signs the government aims to continue its course, for instance, by further extending the scope of price competition in hospital care. Yet there is uncertainty about its future course.

The cost overruns, which are clearly associated with the introduction of competition, elicit growing skepticism about the effectiveness of regulated competition to control costs. That result may lead to a call for fixed budgets to curb the growth of health care expenditures. The general political support for delegating public tasks to the market also seems to be declining.

In conclusion, we are indeed heading into a volatile political summer to tackle the impact of the financial crisis on health care expenditures. Cost control will be again on top of the political agenda in health care policymaking.

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OTHER COUNTRIES

Cost Control in Europe: Inefficiency is Unethical

RICHARD B. SALTMAN

JUNE 10, 2009 > Many of the differences between the U.S. and European countries in health care spending are the result of stricter budgetary constraints and oversight. Can measures like government regulation of insurance premiums and coverage be implemented here?

It is commonplace to observe that European countries restrain the growth of health care expenditures more effectively than the United States. A quick glance at any data sequence from the Organization for Economic Cooperation and Development (OECD) will confirm that European systems have lower aggregate costs and often lower rates of growth. American commentators typically attribute the differences to tighter budgetary restrictions in European health systems, as well as stronger political will by national policymakers to enforce those restrictions.

Beyond the adoption of specific policies, however, if one compares both tax-funded and social health insurance funded European systems with the U.S. system, it is apparent that an equally essential element in European success at reducing expenditures is structural in nature. Looking at health systems across Europe, one can point to a range of institutional arrangements that, although they were introduced to address other issues, are often equally as important for reducing overall health system costs.

As an example, consider physician disciplinary systems. The British determine punishment for negligent physicians through a committee of the General Medical Council, while the Swedish have an impartial committee of physicians and patient representatives administered within the National Board of Health and Welfare. In each case, the decision to put this arrangement in place was taken in order to implement what was seen to be a fair procedure for dealing with patient complaints as well as to ensure the clinical and personal integ-

rity of medical staff.

Yet one key consequence has been that most patients do not sue in court for damages, and thus specialist physicians do not feel the pressure to practice defensive medicine. British, Swedish, and other Western European health policymakers never use this term, nor do they consider the practice of defensive medicine a policy concern.

In Sweden, the premium for an individually-purchased malpractice insurance policy from Salus—for all physicians regardless of specialty—is 300 kronor (\$40) per year. The point here is that the absence of this entire category of medical expense in both Sweden (whose health care costs were 9.1 percent of GDP in 2005) and in the U.K. (8.3 percent of GDP in 2005) is an unintended consequence of other, core structural arrangements.

Additional examples include:

In the U.K., most health care funds come from the national government's general revenues; therefore, health sector appropriations have to survive sharp competition from other national government departments, and are (or were, until the last Blair years) famously hard to increase.

In Sweden, 70 percent of health sector funds are raised by taxes set by the same elected body—the county council—that owns and manages health service providers. This means that before senior management can decide to spend additional funds, they themselves have to be willing to raise taxes and

then to defend those tax increases in the next county council election.

In many European countries, the same administrative entity that pays hospitals also pays for primary care services. Thus savings at the hospital level can be reinvested into expanded primary care and preventive services, which in turn will likely help reduce future hospital expenditures (quite unlike the largest hospital funder in the U.S., Medicare).

In Israel, which has a European-style social health insurance system, decisions about the new drugs and procedures to add to the service basket of its four private, nonprofit sickness funds are made by an appointed advisory council of 70 members. No new drug or procedure can be added unless there are adequate funds (raised by a national health tax) already available.

All these structural mechanisms have drawbacks as well as advantages. They increase the difficulty of keeping pace with medical innovation, and, in countries with tax-funded health care systems, they are in part to blame for waiting lists of varying lengths (up to one year in the worst case, the U.K.) for elective hospital procedures.

But they do restrain the type of runaway spending that has characterized the U.S. health care system for decades, and they play an important role in overall cost containment in European countries. (Details of the structural characteristics of European health systems are at the [European Observatory](#).)

These structural constraints, to be sure, are not themselves sufficient. Nearly all European governments remain seriously concerned about their aggregate expenditure levels, especially as their numbers of elderly continue to increase.

As a result, these governments are taking additional steps to reduce unnecessary expenditures. They are, further, closely focused on the potential (and in some Central European countries, the reality) that the current economic slump will reduce overall health sector revenues. Thus these governments are still very much in the business of designing new policy measures to help make their health systems more efficient and effective.

The following list suggests some of the more interesting policy measures that restrain the growth of health sector costs across Europe.

1. Regulating private insurers

- *Germany*: Premium rates by law cannot increase annually at a rate greater than in the average worker's wages.
- *Switzerland*: Tight regulatory control prohibits insurers from making a profit on the mandatory basic coverage, and federal government approval is required for all cost-related decisions, including building or renting new quarters.

2. Expanding Primary Care Services

- *U.K. and Finland*: To encourage first contact curative as well as preventive care, these countries have no copayments on primary care visits.
- *U.K.*: The elderly have no copayments for outpatient pharmaceuticals; this policy aims to encourage compliance and help keep them out of more expensive hospital care. Scotland and Wales, which run their own health services, have recently eliminated copayments for all patients.
- *Finland*: General practitioners are paid up to twice as much as hospital specialists, making primary care work more attractive.
- *Denmark*: GPs are paid extra for managing diabetes patients: an initial 7,500 Danish kroner (about \$1,400) for signing up a new patient and 1,000 kroner (about \$180) for providing an annual physical.

3. Supporting Home Care Services and Informal Caregivers

- *Germany*: Gives cash payments to home care clients, which can be given to family members or friends who provide in-home care.
- *Sweden, Denmark, and Norway*: Caregivers receive points in the public pension system toward their own retirement income for staying home to care for a family member.
- *Sweden*: Provides free respite care, telephone advice lines, support groups, and training sessions for relatives and friends taking care of someone at home.
- *Netherlands*: Free neighborhood walk-in centers, staffed by nurses, counsel elderly patients, give medication, check vital signs, and even have several beds where patients can be observed for several hours.

These policy measures are part of a widespread and consistent effort to give patients needed care in the least intensive and least expensive setting. In most cases, this means spending more public money on primary care or home care to reduce the demand for more expensive services, or, in the case of the elderly, to postpone the need for more expensive services as long as possible.

The benefits of these policy measures are strengthened by the major structural mechanisms noted earlier. Together, these factors help produce health care systems that are considerably less expensive than is the system in the U.S.

The policy concepts behind these measures are pursued here to a degree by leading-edge public (Veterans Administration) and private (Kaiser Permanente) providers. The central point about these measures from a European point of view,

however, is that they are part of an official national government strategy: compliance is mandatory and each measure thus represents a systematic intervention to control expenditures in a country's health sector.

The challenge to American policymakers is not just to develop ways to reconfigure European policy mechanisms for use in a pluralist federal structure with a far more diverse system of insurers and providers.

This change process will have to occur in an environment that blocks many standard European cost containment methods. It will also have to occur without the underlying legitimacy and trust that, for myriad historical, cultural, and social reasons, is generally granted many Western European Ministries of Health, but which is not part of the federal health policy-making context in the U.S.

More immediately, it is instructive to contrast current legislative efforts in Washington with the policy approach discussed by Ministers of Health and/or their senior staff from 27 European countries at a European Union Presidency meeting on Financial Sustainability in Health Systems, held in Prague on May 11 and 12. As expected, European policymakers discussed strategies for making their systems more effective and efficient.

Speakers cited the now famous dictum of Marc Danzon (head of the WHO Regional Office for Europe) that, in the current economic climate, "inefficiency is unethical." Equally, ministers grappled with how to reduce publicly funded services in order to reflect higher costs for new procedures and drugs as well as reduced public revenues from the long-term economic slump.

During the same week in the U.S., some policy measures were being considered that lead in the same direction as the

Europeans'—for example, to strictly regulate private health insurers, as in Switzerland. But most Congressional activity revolved around competing proposals to vastly expand public sector health care costs, and to concomitantly raise taxes on businesses to pay for this expansion.

Thus, in the face of extended economic disarray, countries that spend from 7 percent to 10 percent of GDP on health care are seeking ways to reduce that amount to better balance public accounts and to free up capital for investment in the broader economy. Meanwhile in the U.S., which spends 16 percent of GDP on health care, national authorities are busily devising plans to add trillions more to public health sector expenditures, arguing that this is the only effective way to expand coverage.

It is hard not to contrast these two very different approaches and to conclude that European-style policy mechanisms alone will be inadequate to resolve the basic conflict of political ideology with structural realities that now characterizes health policymaking in the U. S.

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Cost Control in Canada: Complaints of Underfunding

THEODORE MARMOR

JUNE 12, 2009 > For over three and a half decades, Canada has provided health insurance coverage to its entire population while delivering decent care. Canada continues to control costs exceedingly better than the U.S. by sticking to a budget.

Comparative commentary about health care in Canada and the United States is more unusual in 2009 than it was during the struggle over the Clinton reform in 1993-4. The contemporary reform debate is, with the exception of the *Wall Street Journal's* commentary, strikingly insular. There is hardly a mention of Germany, Canada, Australia, or the United Kingdom, in most articles on what reform strategies are substantively and politically appealing.

So, a look at Canada's health care system can provide useful perspective on our somewhat provincial health reform debate. Canada has what amounts to 10 provincial health insurance plans that fund hospital and physician services with essentially no deductibles, co-insurance, or co-payments. Think of Blue Cross/Blue Shield plans of the early 1960s, with tax funding.

The road to Canadian Medicare—the name of Canada's health care system—was extended in time: hospital coverage took place from 1957 to 1961 as the provinces gradually adopted the plan. Likewise, physician insurance came into play between 1967 and 1971.

Canadian Medicare's basic structure has remained largely intact over the past three and half decades, but Canadian confidence in the program's future dropped sharply during the mid-1990s as severe constraints on provincial budgets kept Canadian expenditures flat for at least three years. Today, there are constitutional challenges to Medicare's health insurance monopoly on hospital and physician services in at least three provinces, all following the 2005 Supreme Court decision to permit limited private insurance coverage in Quebec for elective surgeries. In short, the role of private finance is at

issue in Canada where it has long been illegal to offer private health insurance for publicly funded services.

How different this appears from the perspective of a health policy analyst looking north from the U.S. Many of my colleagues eye with envy the remarkable Canadian mode of financial medical care for all its citizens. With decades of comparative experience, the record is clear (to us). Canada has managed to arrange broad health insurance coverage for its entire population; to deliver, in general, quite decent care; and to pay considerably less (10 percent of gross national product, versus the U.S.'s 16 to 17 percent) in the bargain.

Tell American labor or business leaders now that the U.S. has the best medical care arrangements in the world and you will get a cynical laugh or a pie in your eye. The U.S. spends more than any other nation on medical care.

Interestingly, no one would pick up the U.S. story from recent rounds of Canadian commentary about U.S. Medicare and the refrain of enthusiasm, particularly from physician groups, for American levels of spending and our speedy adoption of new technology. Canadians now regularly complain that too little is spent on the public health insurance system, not that the U.S.—or Switzerland or wherever—spends too much.

“Underfunding” has become a familiar slogan, reiterated without the slightest appreciation that it is common for any professional group to claim that spending more is better. A Canadian has a bad medical experience and the language of crisis erupts.

To many informed American observers, this reaction seems quite batty. Getting good value for money in medical care is a task never completely finished. But the idea that Can-

ada faces a comparatively serious set of problems seems, from my perspective, myopic.

There is, I would argue, much confusion about the significance of managing medical care finances under public auspices and through public budgets. Some Canadians believe that everything would be better if only there were private financing—private augmentation, so to speak, of squeezed governmental budgets. The relevance of the U.S. experience is precisely that it offers an object lesson in the failure of privately based control on medical inflation.

For the past three decades, the U.S. has taken seriously the vaunted advantages of the private market model of medicine. Rightly or wrongly, the country has pursued a bewildering mix of private solutions—business coalitions at the local level, self-insurance by large firms, experiments in group practice, increases in patient cost-sharing (deductibles, co-insurance, co-payments), and all sorts of rearrangements of who can tell the doctor or the hospital what and what not to do.

The result has been twofold: a staggering growth of organizational innovations (from HMOs to PPOs and beyond) and total failure to restrain the relentless rise in American health expenditures. It is worth remembering that in 1970, the U.S. and Canada spent essentially the same proportion of GNP on medical care (roughly 7 percent). Thirty nine years later, the U.S. spends 50 percent more of national income than does Canada and, at the same time, leaves its patients with the highest out-of-pocket costs in the world.

The comparative portrait leaves the observer with both a sense of irony and questions unanswered. One example has to do with the connection between economic progress and social welfare programs.

Many Canadian business figures—like their counterparts elsewhere—regard generously funded social programs as an economic disadvantage in some sense. In the case of Canada's Medicare at least, this is precisely backwards. Were the bur-

den of Canada's Medicare funding to shift partially from the government to private payers, the economic burden would increase because overall spending on medical care would increase.

Where cost control is concerned, Canada is similar to Europe generally and the Netherlands in particular, as discussed in previous posts here. Richard Saltman emphasized that structural features of Western European democracies help to account for their relative success in cost control as compared with the U.S. (He also noted that most countries are worried about their present levels of expenditure, quite apart from their comparative performance against the U.S. standard.) Hans Maarse emphasizes the same internal concern about costs in the Netherlands, particularly in the context of the contemporary economic crisis.

What links all the comparative experience, I would argue, is the central role played by concentrated public expenditure in explaining differential levels of cost growth. Canada, the U.K., Sweden, the Netherlands, Germany—all face ex ante budget questions about how much to spend on medical care. If medical care budgets rise faster than tax income, other programs have to suffer and/or taxes must be raised. This gives political heft to steering the health sector's outlays.

No such steering mechanism exists in America's medical world. We discover what we spend after the fact and much effort is made to shift costs from one source to another. That, I think, is the comparative lesson to draw about cost control in the U.S. in 2009.

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OTHER COUNTRIES

How Nice is NICE? A Conversation with Anthony Culyer

THE EDITORS

JUNE 22, 2009 > Britain's National Institute for Clinical Excellence (NICE) assesses the relative health benefits of particular procedures. Creating incentives to invent new products that are cost effective will lead to better health and more cost containment, argues Culyer, chairman of NICE's Research and Development Committee.

Britain's National Institute for Clinical Excellence (NICE) has drawn controversy for using cost-effectiveness information to help determine coverage for drugs and medical devices. Until recently, the United Kingdom was the only country that took cost into account, but other countries, including Austria, Brazil, Columbia, and Thailand, now pay close attention to NICE as they strive to control health care costs. We asked Anthony J. Culyer, PhD, chair of the Research and Development Committee of NICE, to discuss the agency's strengths and address criticisms.

What is the role of technology assessment in the U.K. health care system?

Broadly speaking, the U.K. has two parallel but somewhat intertwined health care systems. One is financed through private insurance premiums under which insurees can receive reimbursed care either in private institutions or in public ones. The other, called the National Health Service (NHS), is financed through tax-premiums; care is received either in public institutions or private ones contracted to the NHS.

Both systems generally claim to offer only effective health care—interventions for which there is credible evidence that they work. While evidence is not itself a sufficient basis for decisions, there is considerable commitment to the idea of evidence-informed decision-making, and a good deal of evidence that is available comes from scientific studies. Both sectors take NICE's advice very seriously.

The terrible legacy of thalidomide still casts its shadow. Before the release of thalidomide in the late 1950s, adequate tests had not been performed to assess its safety, with catastrophic results for the deformed children of women who had taken thalidomide during their pregnancies in order to combat morning sickness.

How does NICE fit into technology assessment?

Being by far the larger of the two parallel sectors, the NHS takes the lead in seeking to address the question of what works. NICE is the principal agency within the NHS for giving guidance about this. NICE is not a research organization. It is, however, a major consumer of research outputs.

NICE's technology assessment procedures are clearly laid out, are publicly accessible, and were established and have been subsequently revised only after extensive discussion and consultation with all stakeholders, including industry. The general aim is to maximize the health benefits from the care the NHS provides—whether preventive, diagnostic, curative or palliative, and whether in primary, secondary or tertiary care.

The cost-effectiveness criterion NICE uses is that only technologies expected to generate a quality-adjusted year of life at a cost less than a threshold of £20,000 to 30,000 (about \$26,000 to \$36,000) will be recommended. Technologies that do not prolong life but that enhance its quality (as, for example, in palliative care) are judged by the same effectiveness cri-

terion. Costlier interventions need exceptional grounds for being recommended.

What kind of authority does NICE have?

NICE cannot ban anything. It issues *guidance*, in the form of both clinical and public health guidelines, and on the use of technologies like drugs and medical devices. The guidance specifies the technologies in question, their dosages and frequency of use, the stages of a disease at which their use is most appropriate, counter-indications, and the patient groups for which they are likely to be effective.

Local health care purchasers and providers *must* make any technology recommended by NICE available when it is required by a local physician. In this sense, NICE enables rather than commands—only *physicians* have powers to command.

To date NICE has focused on new technologies but, in response to intense parliamentary pressure, it is currently exploring the possibility of issuing “disinvestment” guidance, that is, recommendations that particular practices should be stopped or used more selectively.

What is the role of QALYs in decision-making?

NICE recommends the use of a version of the Quality-Adjusted Life-Year as its principal outcome measure (EQ-5D), partly to enable NICE advisory committees to make consistent comparisons between the many possible procedures that could be included in the “benefits basket” and partly to encourage researchers to use that outcome wherever appropriate. The QALY is not itself, a criterion. It is only the denominator of the incremental cost-effectiveness ratio.

The usual practice is to compare the QALY difference between two technologies with their cost difference, and if the cost difference divided by the QALY difference is less than the threshold ratio mentioned earlier, the most cost-effective technology is recommended. The higher a specific incremental cost-per-QALY sits in the threshold range, and certainly when it exceeds it, the greater the power of other factors needs to be to result in positive guidance.

In many cases, however, the QALY is not available or is an inadequate measure in a specific context. The presence of patients and caregivers on advisory committees is one way that the appropriateness of the QALY is assessed in each situation and for NICE to apply patient-informed other judgements in reaching its decisions.

The cost-per-QALY is at best a guide to the probable effectiveness of a procedure. It is an aid to judgment, not a determinant, always requiring the consideration of contextual factors.

Is NICE a threat to physicians’ freedom to practice? Is it a threat to industry?

NICE’s guidance to professionals is just that: guidance.

The general expectation is that most professionals will follow the finest advice and guidance that can be mustered to support their work. This seems the right approach to me—the best way to encourage best practice is to provide the best information.

With passage of time—and the likely creation of NICE look-alikes around the world—an important new determinant of research patterns in industry seems likely to emerge. For the first time, strong indications will exist about the types of research-based products entire systems are willing to pay for and which will therefore generate returns for innovators. If this generates, as it should, incentives to invent new products that are cost-effective, then that will be one significant strand in the universal striving for *both* better health *and* cost containment.

Are recent attacks on some NICE decisions evidence of some deep unrest?

This is hard to answer. Whereas industrial sponsors and patient organizations have specific concerns, NICE has to take a broader view, representing the interests of all patients.

It is inevitable that on occasion there will be clashes. It is also inevitable that the value judgments that determine, among other things, the value to be placed on small extensions of not very satisfactory life, are contestable. NICE needs to be responsive to the insured public’s views without becoming a slave to every energetic protest from a sectional interest.

There is plainly a political balancing act to be performed. It is worth remembering that a NICE failure to recommend a technology is not a ban—and local decision-makers and clinicians may choose differently. There remains, however, considerable public resistance to the significant differences in what is available according to where you live in what is regarded as a national service. The balance to be struck between local autonomy and national standards is a further inevitable point of tension.

Are any important reforms in the NICE program likely?

There is continuing pressure for NICE to speed up its decision process—coupled awkwardly with a conflicting imperative to make decisions in a consultative fashion. There is also pressure to extend NICE’s work into disinvestment guidance.

There are issues about how best to make decisions when the evidence is absent, weak, contested, or biased.

There are many issues surrounding NICE's application of technology assessment to public health measures—especially those involving non-health care agencies such as schools and municipal authorities, and measures whose principal aim is greater equity in population health. NICE is making progress with the application of technology assessment in surgical procedures, but this has, to date, fallen short of full-blown cost-effectiveness studies, not least because of the frequently poor clinical evidence base.

Another concern is how best to incorporate matters of fairness into NICE processes. Should people with rare diseases get special consideration? What about children? Or those near death? What about those with a lifetime of deprivation and disease for whom the smallest improvement ought perhaps to count for more than similar gains received by more fortunate folks?

A further ongoing concern is the effectiveness of existing knowledge translation and exchange methods. While the provision of excellent information to professionals is of critical importance, nothing of value happens if those for whom it is developed have neither the time nor the inclination to take notice of it. It's NICE work if you can get it! NICE is necessary—but scarcely sufficient.

A great feature of having a NICE is that these issues get posed in a public forum and can be addressed in the interests of the whole community and with the whole community's participation.

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Comparative Effectiveness and Rationing: Lessons from NICE

MARK HELFAND *and* LOUISE RUSSELL

JUNE 22, 2009 > American attempts at comparative effectiveness research have prompted charges of rationing. However, a free flow of information about benefits, harms, and costs through publicly funded comparative effectiveness research could improve health care in the U.S. Examining how Britain's NICE uses this research suggests potential benefits.

The American Recovery and Reinvestment Act of 2009 included \$1.1 billion for comparative effectiveness research—research that compares medical treatments and procedures to determine which ones are most effective.

Critics cry that comparative effectiveness is a code name for rationing or will inevitably lead to it. A *Wall Street Journal* editorial said “the comparative effectiveness outfit will start to ration care to control costs.” George Will declared that comparative effectiveness research “would dramatically advance government control—and rationing—of health care.” In print and online many other outlets have carried similar stories.

To support their “slippery slope” argument, the critics point to Britain’s National Institute for Health and Clinical Excellence (NICE), which uses comparative effectiveness and cost-effectiveness analysis to advise the British National Health Service on what should be provided through the service. But the critics are wrong: wrong about the sequence and wrong about the role of NICE. In fact, the British system is a case in point that demonstrates the difference between rationing and comparative effectiveness research.

Created in 1947, the British National Health Service (NHS) rationed care very effectively for more than 50 years before NICE was established, simply by setting a budget for the service each year and sticking to it. Because its budget is well controlled, the NHS has always recognized that it cannot do everything for everybody. In fact, health spending in Britain has grown faster since NICE was created than in any previous decade, the result of a deliberate policy by the Blair government.

What NICE does is help ensure that the money available to the NHS is spent effectively and fairly. NICE attempts to get the most health benefit possible from the NHS budget. One of its main goals is to counter disparities in access to care.

When NICE was created in 1999, decades of research had demonstrated persistent inequities in access to the best in medical care. Dr. Gillian Leng, a member of NICE’s Board and Deputy Chief Executive and Chief Operating Officer for NHS Evidence, described the situation this way: “While one provider was getting good results by using a state-of-the-art procedure in treating some diagnosis, the provider next door might be using an outdated, ineffective approach with less satisfactory results. It was important to develop some way to standardize treatment approaches at the highest levels among NHS providers in order to try to ensure uniformly good care. We had to eliminate what was sometimes referred to as the ‘health care lottery.’”

The health care lottery is an apt description of how care is distributed in the United States today, where geographical and socioeconomic inequities in access are even more acute than they were 10 years ago. The critics ignore the fact that care is already rationed here depending on whether patients have insurance, what type they have, whether they live in underserved areas, and whether it is profitable to serve them, as David Leonhardt pointed out recently in *The New York Times*.

Moreover, the criteria used for coverage decisions by American health plans, part D insurance carriers, and even Medicare and Medicaid are not transparent to anyone. Cost

plays a role, but the public has no idea to what extent benefit and safety have been sacrificed to save money because costs, and even the prices paid for services, are never discussed.

Critics have focused on the fact that when NICE recommends against a treatment it invokes cost-effectiveness. But they have missed two more important facts.

First, as Culyer points out, when NICE says yes, the NHS is obligated to provide that care to everyone in the country. Second, NICE is accountable to the public. Consumer groups, manufacturers, physician groups, and other stakeholders know exactly what evidence, assumptions, and other considerations led to a decision. Over time, this has led to a robust system of public comment, reconsideration and appeal as well as explicit consideration of equity and other values in decision-making.

Recently, for example, after issuing a preliminary finding that it was effective but not cost-effective, NICE approved lenalidomide for patients with multiple myeloma who had failed two or more other treatments. Critics of NICE point to the preliminary decision as “rationing,” but fail to mention how the final decision benefited patients as well as taxpayers.

For patients, NICE’s careful analysis helped define the subgroup most likely to benefit. The analysis showed that for many—those who have failed one previous treatment—it is uncertain whether lenalidomide is as effective as treatments that are already available.

NICE also pointed out that, within the fixed NHS health care budget, broader approval of the drug would have meant taking away access to other services that provide more health benefits for the money. The manufacturer, which conducted the cost-effectiveness analysis in the first place, acknowledged this point and agreed to a unique arrangement under which, for each patient, the NHS pays for the first two years of treatment and the manufacturer pays to continue treatment past that time.

In the U.S., where there is no fixed budget for health care, comparative effectiveness information cannot influence how much money goes to health care, but it can inform decisions by individual patients and physicians, affecting which tests and treatments people choose and which ones they do not. Not surprisingly, then, a December 2007 [Congressional Budget Office](#) report showed that comparative effectiveness will not cut spending by much.

Compared with NICE, the U.S. comparative effectiveness effort focuses less on cost and more on generating new evidence. At present, because of the lack of comparative studies, medical decisions are made in a cloud of uncertainty, a situation in which no one knows which tests and treatments are demonstrably better and safer than the alternatives.

For drugs and devices, for example, manufacturers conduct more research to meet the Food and Drug Administration’s regulations and less that answers patients’ and health professionals’ questions about what works best and is safest, and for whom. Few studies compare different kinds of treatments, such as drug versus nondrug alternatives, and fewer still seek to distinguish patients who have the greatest benefit and lowest risk of side effects from other patients who benefit less.

As Hal Sox, editor of the *Annals of Internal Medicine*, recently said in his keynote address to the American College of Physicians 2009 Internal Medicine meetings: “the public isn’t getting its money’s worth from our system of industry-sponsored clinical research. The public pays the costs of drug trials through higher drug prices but gets research that doesn’t tell us everything we need to know to make good decisions. We get more for our money with the NIH-sponsored trials that we support with our taxes. However, the NIH funds far fewer trials than industry.”

In fact, in the U.S. the attack on comparative effectiveness research is not really about rationing. It is about fear of the free flow of independent information about benefits, harms, and costs. Without rationing at all, publicly funded comparative effectiveness research could improve health care in the U.S. by producing and publicizing independent, comprehensive research about what works best for patients.

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OTHER COUNTRIES

NICER in the U.S.?

STEVEN PEARSON, M.D.

JUNE 26, 2009 > Although NICE has been labeled “un-American,” the U.S. may end up with an entity like it to oversee the comparative effectiveness research mandated by the stimulus legislation. However, such a body in the U.S. would not in fact be “NICER,” because it would fail to take cost into account, make clinical recommendations, or do little more than disseminate technical reports.

The day I first read Tony Culyer’s typically incisive synopsis of NICE, I was trolling my search engine’s daily serving of NICE news and happened to take note of a short article from a regional newspaper in the U.K. The article described a local campaign that had succeeded in stopping the withdrawal of drugs from patients with pulmonary hypertension, an incurable lung condition.

As the article explained, the campaign had been in reaction to a recommendation by NICE, the government’s “drug watchdog” that the National Health Service “stop the use of life-saving treatments and medication for the condition.” Sigh.

What caught my eye, however, was not the usual hyperbole, and even frank misrepresentation of NICE’s guidance that the average British man-on-the-street is now quite familiar with. It was the first two comments to the article that I thought captured much, not only about the role of NICE in the U.K., but even more about the public crucible into which the fluid metal of what we are now calling “comparative effectiveness” is about to be poured here in the United States.

Utdlass: “Why would anyone in their right mind wish to deny such drugs to people with a lung condition in the first place? Madness. It was probably all to do with money like it is when people with cancer are denied drugs to help prolong their life. Seems that there is always enough money to ensure that smacked up drug addicts get their methadone though. To sum up: Put yourself in a situation requiring free drugs and you’ve got it. Be unfortunate to suffer through no fault of your own and you’ll have to fight for your right to life saving drugs. What a Country eh?”

Yorkshireguy: “Well said, Utdlass, I cannot agree with you more.”

What this short snippet demonstrates, I think, is how fundamentally messy are our moral intuitions about allocating limited health care resources. NICE, of course, is a manifestation of supreme hubris—that out of this mess, this smouldering vat of half-baked prejudices, selfishness, and denial, a wealthy country, with a populace guaranteed health care without concern for out-of-pocket costs, and with the fantastic world of medical innovations tossed at their feet daily through the media and the internet, can somehow create a political structure and process to help its society wrestle honestly with the question of how to care for its members as a community bound to each other with mercy and justice—and do it within limited resources. The nerve.

And, of course, the most amazing thing is that, 10 years on, NICE is still standing. In fact, as Tony Culyer describes clearly, if anything, NICE has proven so resilient and respected within the English system that it is being asked on almost a yearly basis to expand the scope of its activities and take on other challenges, such as making evidence-based recommendations for public health measures. Yes, NICE is in many ways thriving.

Always under attack from some component of the physician or patient community, and frequently at odds with nearly the entire manufacturer community, but, oddly, somehow stronger and respected by countries the world over for having weathered these storms for a decade, NICE looks like a winner. Which, of course, scares the living daylights out of many peo-

ple in the United States.

The sad thing about all the lessons that could be learned from NICE's navigation of the scientific, political, and ethical minefield that all developed nations face is that most Americans will never hear anything about them.

All they will hear this summer and fall is that the English, after a long day spent killing off the weak and elderly, delight in passing their idle moments robbing all other patients of their "destiny." And that a nefarious and faceless "Board" is their main tool in this devilish pastime.

What will it be for America? Your doctor or a board of government bureaucrats at your bedside? It's just that simple. And so NICE will join the long list of foreign ideas that will be projected as "un-American." However, the only thing more surprising than NICE's survival in England is that, despite everything that can and will be thrown at the idea, the U.S. is about to embark on a similar path.

Legislation following on to the economic stimulus package will almost certainly contain a structure and sustainable funding platform for a public experiment that will attempt to shine the light of inquiry into the recesses of the American health care system in order to find out what works best, when, and for whom. How will the American version likely to emerge in legislation this year compare to NICE? And what lessons from NICE are likely to help guide the fledgling American comparative effectiveness research "entity?"

As shorthand going forward, and with a soupcon of irony, I will call the U.S. entity the National Institute for Comparative Effectiveness Research (NICER).

First of all, it is quite clear that the fundamental role that NICE plays in the English health care system will not be the goal on this side of the pond. NICER will not be charged with making specific recommendations, either in the form of clinical guidelines or of recommendations for coverage or pricing by public and private payers.

Some stakeholders will push for NICER to do nothing more than disseminate technical reports, perhaps formatted for patients and clinicians, but largely devoid of any real judgments. The goal will be framed as "globalizing the evidence and localizing the decisions" but the real agenda will be to defang NICER reports to whatever extent possible.

More likely, however, is that NICER will develop a system of rating evidence on comparative effectiveness, much as the United States Preventive Services Task Force (USPSTF) has done for years for preventive services. A transparent rating system could go a long way toward making evidence reviews more actionable for patients and clinicians; it would also be helpful to payers seeking to support tiered copayments, evidence-based pricing strategies, and other novel value-based medical policies.

The other major aspect of NICE that will not be found in NICER is the use of a cost-effectiveness threshold as the dominant method of judging a health care intervention. Cost effectiveness, or even the possibility of some version of it, is the major reason why a \$1.1 billion program for comparative effectiveness research became the target of such intense pressure within an economic stimulus package of many hundreds of billions.

Cost effectiveness as wielded by NICE is an on-off switch: new drugs or devices are either cost effective and covered in full, or they are not cost effective and not covered at all.

Debates over cost effectiveness as an element of a NICER in the U.S. have pitted, on one side, those who feel that a federal agency wielding cost-effectiveness data will ultimately be captured by the cost-saving agenda of the federal government, and ultimately use cost-effectiveness data as a single cut-point to deny coverage for expensive new interventions (even if coverage recommendations are not supposed to be allowed).

On the other side in this debate is a group of generally less vocal advocates, including health plans, some purchaser groups, and even one national physician organization, the American College of Physicians. To these stakeholders cost effectiveness need not be implemented as the dominant element in medical decisions.

Instead, as with clinical effectiveness, ratings could be developed to help clinicians and patients choose higher value options when the clinical effectiveness is equivalent; and, importantly, the additional price for very small or questionable clinical improvements could be considered in light of objective, independent evidence instead of solely through the lens of manufacturer advertising to patients and clinicians. In other words, cost-effectiveness information from NICER could help Americans better answer the question: "Is it worth it?"

Most experienced prognosticators currently believe that cost effectiveness is unlikely to survive the necessary horse trading that will occur as legislation to create NICER is cobbled together with a goal of (some) bipartisan support. This does not mean that it is impossible for there to be some arms' length connection between NICER's work on clinical effectiveness and some consideration of value, but the logistical barriers to making this work are considerable.

During the next several months we are likely to hear a lot about cost effectiveness from multiple perspectives. What is ironic is that, whether NICER incorporates cost effectiveness into its functions or not, the U.S. health care system will still have to sort out some way to handle the challenges of providing high quality care with limited health care resources.

NICE in England is not a relevant model in many ways for a NICER in the U.S., but later this year, perhaps when all the shouting dies down, maybe we'll realize something: that we

still have to figure out some way of elevating the public deliberation about caring and costs, that neither the market nor purely governmental approaches are going to suit our society; and that we could do a lot worse than mirror the courage that the English demonstrated 10 years ago when they realized they had to tackle it head on.

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Doctor Choice Abroad

RICHARD B. SALTMAN

SEPTEMBER 1, 2009 > Americans place great value on their ability to choose their own doctors, and they worry that adopting features of European health care systems would limit their choices. In practice, the amount of choice that Europeans have varies depending on the country, whether the doctor is a primary care physician or a specialist, and whether the care is paid for with public or private funds.

Choice is one of the most powerful issues in the current debate over U.S. health care reform. Americans place great value on their individual ability to choose their own doctors, and they worry that existing employer-based insurance plans might be forcibly collapsed into a new public option (or cooperative) that would limit access to their current physicians or to certain types of specialists.

Since European health systems have been notably more successful than the U.S. in extending access and in constraining costs, it may be useful to examine their levels of physician choice. In practice, the amount of choice that European patients have depends on the country, whether the doctor is a primary care physician or a specialist, and whether the care is paid for by public funds (taxes or social insurance) or privately (private commercial insurance or out-of-pocket).

Primary care

In countries with private general practitioners (including social insurance-funded systems like Germany and Netherlands as well as tax-funded systems like the United Kingdom, Denmark, and Norway), the citizen can choose his or her GP (sometimes with geographical restrictions, as in the Netherlands and the U.K.). GPs in the U.K. are known to be choosy about whom they take for new patients, however, and the patient's choice of doctor also has to be approved by the regional office of the National Health Service, which is concerned about balancing the number of patients among GPs.

In the U.K., GP offices are now required to have night and/or weekend hours, with posted times when people can drop in without an appointment. Many offices have more than one GP (some are salaried employees), so it may be difficult to see "your" GP on any particular day. In the Netherlands, private GPs are required to establish cooperative agreements among their peers to provide night and weekend coverage.

In countries with publicly employed primary care physicians (Sweden, Finland, Spain, and Italy), the degree of choice is mixed. Sweden has started a movement (again) to have registration lists for primary care doctors inside the large health care centers where these doctors normally work. Individuals are allowed onto a physician's list if there is room (there is a maximum number of patients allowed), however a patient may not be able to see that doctor on any given visit since Swedish physicians work 40-hour weeks with considerable educational and vacation leave.

Choice of primary care physician is more restricted in Finland and Spain, and it can depend on whether a visit is planned or not.

For acute care visits in Finland, Spain, and Italy, patients must see the primary care doctor on duty when they arrive (as with an HMO in the United States). In Finland, however, patients can use the separate social insurance to see any primary care doctor (including doctors who are publicly employed), with 20 percent of the fee paid by the social insurance. Patients in Finland can also see the occupational health physician at their place of work for free.

In Finland, there has been a longtime shortage of primary care doctors in the health centers (due to low pay). The problem has been dealt with in part by employing temporary doctors, especially from Estonia (attracted by what is for them is high pay).

Swedish primary health centers also have a longstanding problem with physician vacancies, and have been hiring Polish doctors to fill the gaps, particularly in rural areas. In both Finland and Sweden, people can schedule a planned visit with a particular primary care physician, but they may have to wait up to two weeks or more for the appointment.

Specialist care

The degree of choice differs between countries with tax-funded insurance systems and those with social-funded insurance systems.

In tax funded countries (the U.K., the Nordic countries, Spain, and Italy), specialists are unionized public employees. For both outpatient clinic visits and planned elective inpatient procedures, patients have to accept whatever doctor is assigned by the clinic, including junior as well as senior doctors. As both Finnish and Swedish administrators like to say, “All our doctors are qualified—we trust our doctors.”

However, if patients pay privately in a public hospital (as is possible in the U.K. and Finland), they can choose their specialist. If patients go to one of the private hospitals (available in the U.K., Denmark, Sweden, Finland, Norway, Spain, and Italy), they can choose their specialist, even if the procedure is being paid for by public funds, and even if (as in Sweden) the specialist is usually a publicly employed M.D. who is doing procedures privately in his or her off-duty time.

In Germany and Austria, which are social insurance-funded countries where specialists are hospital employees, patients may be able to choose, but choice is not guaranteed. In Belgium and Netherlands, which are social insurance coun-

tries where specialists work in private group practices on contract to hospitals, most patients can choose their doctors. The exceptions are patients who are on public subsidy. e.g., indigent and/or elderly individuals.

What this brief survey suggests is that on the question of patient choice of physician (as elsewhere in health care) what counts are the details. While it is possible to have tax-funded and social health insurance-funded health care systems in which patients can select their own primary physician (e.g., the U.K., Netherlands, and Germany), such options may be substantially restricted by governmental regulation. Conversely, patients rarely have a choice of hospital specialists in planned elective or even outpatient clinic settings, regardless of how the system is funded.

Broadly speaking and with exceptions (where there are private GPs), there is considerable tension at present in European health systems between their prior existence as a uniform public service and growing demands from a more affluent population for more of an individual service. While different countries have progressed at different rates along this trajectory, there is a clear trend toward creating more personal service within these collectively financed health systems.

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Speaking Truth to Evasion

DANIEL CALLAHAN

MAY 18, 2009 > It is difficult to have frank conversations about controlling medical costs in the U.S. Currently, a gap exists between what is politically acceptable and what must be done. Success depends on tackling these issues directly, honestly, and fearlessly.

Efforts to control health care costs go back at least to the Nixon administration in the early 1970s. Yet with only an occasional pause costs have steadily risen since then, now standing at an all-time high and escalating at a rate of 6 percent a year, a disastrous pace. Clearly, we do not yet have a political clue about effectively and decisively managing costs, despite many ideas for doing so.

We are now at it once again, and with more intensity than in the past. President Obama has made health care cost control a centerpiece of his administration, Congress is worried about it, state Medicaid programs are suffering, and the number of uninsured continues to grow, often enough because employers are finding health care too expensive to provide as a benefit. Costs are now, many would argue, more important than that of increasing access, if only because a lack of cost control could eventually sink even a universal health care plan.

But there are, we believe, some serious problems in determining how best to talk about and approach cost problems. They have troubled my colleagues and me in thinking how best to organize and edit the blog.

How much hope is it reasonable to have about controlling costs? In a May 15 *Wall Street Journal* op-ed article Peter Orszag, director of the Office of Management and Budget, set forth the cost problem in a most hopeful way. He mentioned the pledge of a number of industry leaders to cut \$2 trillion in costs over the next decade, the potential in reducing regional cost variations, the likely benefits of information technology, comparative effectiveness research, prevention and wellness

programs, and changes in financial incentives. He did not pretend it would be easy, and he did note it would take “comprehensive health care reform” to really do the job, to improve “efficiency and increase value.”

That was a welcome agenda. But anyone familiar with recent health policy studies knows that most of those ideas do not have a great cost-cutting potential. A better management of regional variations may be the most promising, but that knowledge has been around for years without a good solution in sight. The industry pledges sounded wonderful on May 11 but then a few days later the industry leaders said that Obama had overstated their promises.

Granting the value of hope, we also think there is an even greater need for candor. In 2004 the Congressional Budget Office (which Orszag previously directed) said of Medicare and Medicaid that “to finance projected increases in spending... would require tax increases of an unprecedented magnitude.... Under current policy, future generations will be made worse off by higher taxes or lower benefits.” A 2006 survey by the Kaiser Family Foundation of the full range of proposed cost control strategies concluded that “Although many of these efforts may lead to efficiency and quality gains, none would appear to be of a scale to have any meaningful impact on the overall cost picture.” Nothing has happened since then to change that picture. The former secretary of the Department of Health and Human Services, Michael O. Leavitt, said in 2008 that the growth in health care spending “could potentially drag our country into a financial crisis that would make our major sub-

prime mortgage crisis look like a warm summer rain.”

Now it may well be that those pessimistic assessments are just wrong or overstated. But I do not think it wrong to say that the public has heard little about such judgments. We believe full candor is needed even when it hurts.

A related problem is this: how far should one go in pointing out the pain and even suffering that serious cost control could entail? A common account of the problem has it that, at base, it is just a matter of getting rid of waste and inefficiency. No one can object to that goal and no political or economic interests are threatened by it. It is inherently vague, however—the shallow, warm water that soothes anxieties. But it is hard to find any solid reform strategies whose management will be anything other than painful: raising taxes and cutting benefits (reducing physician fees and hospital reimbursements), saying no to expensive treatments with only marginal benefits (but not necessarily marginal in the eyes of doctors and their patients), cost-benefit studies of new (and old) drugs and medical devices (not just comparative effectiveness studies).

In short, in one form or another, and in one guise or another, we are talking about rationing. I was told that those who played an advisory role in the Clinton reform effort in 1994 were flatly forbidden to use that dread word. I doubt that any legislator will now speak of, much less defend, rationing—they know dangerous territory when they see it. But the rest of us can, and should. Even to talk of ridding the system of waste and inefficiency is not trouble-free. In a variation on an old health care observation: to cut someone’s wasteful job is to deprive him of a salary. But once we begin to talk openly and honestly about cost control, we can then address how to do it ethically.

To be effective, our blog will have to violate some taboos. President Obama showed that he understands that when he said recently of his grandmother’s last days that a decision was made to go forward with a hip replacement despite her terminal condition, but he knew that whether “a hip replacement when they’re terminally ill is a sustainable model is a very difficult question.” That’s the kind of dilemma we will tackle in

this blog.

Our last problem is that of talking about improving access and controlling costs without hurting either in the process. An economically sustainable universal health care system will require setting limits; it can not have an open-ended budget—and all the more if those with good coverage now will have to give up something to make possible the inclusion of the presently insured. But to press that point could well scare people off from expanded access, which in itself is certain to cost considerable money.

Massachusetts now has a similar problem. Its goal of universal coverage has not yet been met, though it has been getting there. But the increasing costs of the plan stand in the way of full success, and the worry now is how to find ways of managing costs that will not alienate the various insurers and other interests in the process.

Analogous dangers are imaginable with national reform. We opt, once again, for candor about costs. We think it important to get a reform plan in place that will stand the test of time, one that has built cost control into it from the start, and that the public is fully informed about that necessity.

In principle, this country can control health care costs, and could even learn to say no to patients, doctors, insurers, and the medical industry when necessary. Other countries have done it, and with the enviable result of lower costs, better health outcomes, and higher patient approval rates. Our national dilemma comes to this: what is politically acceptable at present to control costs in the United States will not do so, and what would work to control costs is not politically acceptable. An evasion of the cost problem, or a minimizing and evading of its likely pain, will not help us out of that dilemma. Only by taking on costs directly, honestly, and with not a little nerve, can we hope to do so.

Daniel Callahan is editor of the Health Care Cost Monitor.

Ending the Cost Insanity: Some First Steps

HENRY J. AARON

MAY 20, 2009 > Fragmentation of payers, cost insulation, and an excess supply of services without research into their effectiveness have made our current health care financing system as immune as possible to cost discipline. How can talk of controlling health care spending move beyond just talk, and little else?

On May 11, the White House hosted a meeting of major players in the health industry—hospitals, doctors, insurers, drug manufacturers, and others—who collectively promised to shave \$2 trillion off health care spending in the next decade. This announcement elicited huzzahs from some bloggers and columnists. Others were skeptical. The skeptics were right. To see why, let's play a game.

Pretend you are a mad health care planner—insane, that is, not angry. You are setting out to design a health care financing system as immune as possible to cost discipline. Some of you are, no doubt, way ahead of me already. Your response is, “Why bother? The United States has built it.” But let's review the blueprint.

The first design feature would be fragmentation. You would make sure that no payer had any significant leverage over spending. And if, by chance one payer was big enough to have such leverage, you would debar that payer from using it, for example, through language such as “Nothing in this title shall be constituted to authorize any Federal Officer or employee to exercise any supervision or control over the practice of medicine.” This wording is *verbatim* from the 1965 legislation establishing Medicare.

Next, you would insulate those who use medical care from the cost of all or most of the care they use. You might even be subtly perverse, shielding patients from costs for low-benefit and discretionary care, but imposing cost sharing on the chronically ill for maintenance drugs, thereby encouraging noncompliance that results in higher costs later on.

But the overriding fact is that despite the crescendo of complaints about rising out-of-pocket health care spending, Americans who are sick pay out of pocket for only about 12 percent of the cost of their health care, about half what that fraction was two decades ago, when it was half of what it had been two decades before that. Out-of-pocket payments are a smaller share of health care spending in the U. S. than ever before—lower than in many other developed nations, including Canada.

On the other hand, the per capita cost of care is so much higher in the U. S. than elsewhere that even a modest share of it claims a sizeable chunk of income. Even so, a thick layer of insulation separates most Americans from the full cost of their care.

A third feature of this cost-insensitive system would come on the supply side. We would pay most providers for whatever they do, whether or not it is worthwhile. We wouldn't pay more than a minority of providers on salary. We most assuredly wouldn't capitate patients. To the extent that we violated these principles and paid providers in ways that encouraged them to economize, we would make sure that patients saw little of the savings. That would undercut the willingness of patients to tolerate limits of any kind, which, would deter providers from economizing out of fear they would lose patients.

The final component would be a resolute refusal to spend more than a pittance on research to find out what really works. We would funnel what little we spent through politically weak organizations that would fall prey to influential groups offend-

ed by research showing that some device or procedure was not worth what it cost. And, of course, we would compare innovations not with existing methods of treatment but with doing nothing, so that costly innovations that worked no better than old procedures would be approved.

These problems are widely known, but describing them in this manner underscores a key fact: everyone talks about controlling health care spending, but no one does—or, under current arrangements, *can do*—anything about it. Every aspect of the current U.S. health care system conspires to prevent such control.

Yet, expenditures on health care, public and private, are growing at unsustainable rates. The Congressional Budget Office has repeatedly announced long-term budget projections showing that nasty choices await us if growth of health care spending continues at, or near, historical rates.

We could raise total taxes by half, or more. If done through the income tax alone, tax rates would have to double.

We could try cutting spending other than on health care. But that wouldn't work because there isn't enough spending to cut, other than health care, interest on the debt, and such essentials as national defense.

Letting deficits happen isn't an acceptable option either. That course would result in explosive growth of government borrowing and produce a big tent calamity that would make the past financial crises in South Asia, Mexico, and Argentina seem like Lilliputian side shows.

The official projections indicate that 100 percent of the expected gap between spending and revenues can be traced to projected growth of Medicare and Medicaid. So, what should we do? I am going to list three broad recipes, two of which are, I believe, more likely to do harm than to help.

The first recipe embeds the problem of increasing health care spending in a larger challenge of an entitlement crisis. The leading edge of the baby boom has just become eligible for Social Security pensions. They will shortly qualify for Medicare, then for Medicaid nursing home benefits. Tens of millions more will follow.

The term "entitlement crisis" has been used so often and so authoritatively that anyone who denies it risks being labeled as a nut. But it is way off the mark. For one thing, Social Security doesn't really belong in the list. The Social Security gap is politically vexing it but doesn't come close to being a big fiscal problem. Over the next 75 years projected increased pension spending averages roughly one percent of gross domestic product.

In addition, most of the projected increase in public health care spending comes from the advance of medical technology, not from the baby boom. And most of those advances are a cause for celebration, not hand wringing. The problem isn't

rising spending but *wasteful* spending. And that is a problem not just of Medicare or Medicaid but of the U.S. health care system as a whole.

The second misguided approach to reining in the growth of health care spending is what I call the magic bullet approach. Adherents typically identify a single important shortcoming of the current way we pay for and organize the delivery of health care. Then, they tell us, fix this problem, and we will have controlled spending. The way to stop or sharply reduce the growth of health care spending is, variously, malpractice reform, increased use of preventive care, streamlined administration, not overtreating the terminally ill, heightened consumer cost consciousness—and the list goes on.

These proposed reforms are mostly good ideas. Many promise to improve the quality of care. Some even save money. There is just one problem—most won't save *much* money and some won't save *any*. To cut the growth of publicly financed health care spending significantly, sensibly, and in ways that do not subvert commitments to the elderly, disabled, and poor will require systemic change in the way we pay for and deliver health care.

We have been talking health system reform for decades without much progress. The difference now is that the compassionate goal of fair access for all has been married to the hard arithmetic of fiscal balance. Changing the U.S. health care system is the work of a generation, not of a single presidency. But I believe that some steps are now on the table that can move the nation forward.

The first is a lot more research on which interventions affect patient outcomes at what costs. The research will be hard and costly, but the principle challenge is political—how to insulate the entities doing this work from the political pressures that have doomed past efforts. It may not save money immediately, but it is a precondition for rational savings later.

The second step is consolidating the number of payers in a geographical area, so they have—or a single payer has—real clout. The Massachusetts Connector, embryonic though it is, could become a revolutionary innovation if businesses and individuals are encouraged to buy insurance through it and if it becomes the conduit for subsidies to make insurance affordable. Lo and behold, a financial entity capable of effecting real systemic change could result.

The third step would be the enactment of similar reforms in other states. Assume that Massachusetts is able to solve the many problems that it faces in implementing its plan. Assume that the federal government enacts legislation to encourage other state-based reforms. Assume, finally, that a few other states implement them. Were these things to happen, I believe that the debate in Washington would cease to be *whether* to enact systemic reform, and would then focus on *how* to do it. And

I ask those single-payer advocates who see state-based reform as a sellout to recall that the Canadian system began as, and remains, a provincial system.

Are these steps sufficient? I doubt it. Extending insurance coverage to all Americans, a shared goal of a majority of Americans, means eliminating even more people from any effective role in policing the cost of most health care spending. Thus, cost control can come only through collective, probably government, action, motivated by a budget constraint.

The budget constraint can come from linking payment to an earmarked tax, as with Social Security. Or it could come from competition with other government spending through an annual budget process. But until the entity that pays for health care is constrained by limits on what is spent, I believe

that talk of controlling health care spending will remain just that—talk, and little else. When such budget limits become a reality, research on what works and at what cost will provide political cover for spending limits.

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Cost Control: Where Does it Stand?

DANIEL CALLAHAN

JUNE 1, 2009 > Neither the political right nor the left are forthcoming with tough cost control ideas. Two Senate Finance Committee Reports attempted to introduce cost savings into future health care legislation, but their proposals fell short in several areas, including the use of comparative effectiveness research to make recommendations for medical practice.

The reform caldron is heating up. Legislative directions are beginning to appear. And some important government reports, from the Senate Finance Committee and the Congressional Budget Office (CBO), are bringing fresh clarity to the cost control debate.

Some areas of agreement can be discerned. Everyone, well almost everyone, agrees that rising annual costs, now running at 6 percent, pose severe, and now well-publicized threats to present and future health care. The long-term goal of control should be an annual cost increase no greater than that of the annual increase of the GDP, that is, about 3 percent, and the short-term goal is to move effectively in that direction. The main drivers of rising costs are technology, waste and inefficiency, administrative expenses, fee-for-service medicine, irrational regional costs variations...and on and on.

American culture and the commercial ethos of too much of our medicine are not a congenial setting for cost management. As one seasoned observer noted after a nationwide tour to prepare a health care documentary, he met no doctor who felt he was overpaid, no hospital administrator who believed she could get by with less money, and no patient who was prepared to give up anything. There is, as noted, some agreement on cost control, but too much of it is about what others should give up and about our medical neighbor's wasteful practices.

The politics of cost control is an old, oft-told story: liberals look to government-dominated universal care to manage costs, and conservatives to increased consumer choice and enhanced provider competition. But neither the right nor the left

are forthcoming with tough control ideas; and any hint of rationing is taken to be the kiss of death.

But the hard truth is that serious cost control will entail some pain and sacrifice, and of the worst kind: giving up some perceived personal benefits—as patients and as medical professionals—in the name of the overall well-being of American health care. As the Director of the CBO, [Douglas W. Elmendorf](#), delicately put it in spring congressional testimony in March, much health spending “contributes little if anything to the overall health of the nation, but finding ways to reduce such spending without affecting services that improve health will be difficult.” At the least.

As the physician Eric Cassell once put it in an analogous situation, “We doctors often take sick people and then make them even sicker in order to make them well.” In the long run it is perfectly possible to imagine a less expensive health care system and a healthier population, everyone's win/win dream. But there will be some misery in getting there. Before touching on some of the specific ideas in the various reports cited above, let me suggest some pertinent questions to help judge their value.

- Is it likely to be effective in controlling cost increases?
- Is it politically feasible?
- Is it technically/managerially feasible?
- Is it a slow-paced or fast-paced plan—years or decades?
- Is it likely to have a good, bad, or neutral health outcome?

While it is impossible to summarize here all the cost control ideas presented in the two reports on policy options by the Senate Finance Committee (April 29 and May 20), many of which are likely to find their way into health reform legislation, an initial point needs mentioning: although the titles of the reports seem to refer to all American health care, the proposals focus almost exclusively on Medicare and Medicaid. Does the private sector need no reform or is it that the committee has tacitly decided that the government can have no role in private sector reform and that it won't even try? Or does it expect a spillover effect from the public to the private sector, as if that might be sufficient?

The [April 29 report](#) of the Senate Finance Committee focused on payment reform, infrastructure investments (principally health IT and comparative effectiveness research), Medicare Advantage, and options to combat fraud, waste, and abuse. Most notably, some proposals rely heavily on payment incentives for good clinical practices and penalties for poor ones. Those proposals would apply to hospital quality and readmission and bundling rates, health IT, physician practices, and chronic care. Another proposal would set stricter standards for the use of imaging services.

Two features of that report are especially worth noting. One of them is that, under the earlier established congressional legislation of a Sustainable Growth Rate (SGR) for physician fees, a 21 percent reduction in physician fees is scheduled to go into effect on January 1, 2010, and with additional reductions of 6 percent a year for several years thereafter.

The SGR rule has been in effect for some years and, while Congress put the legislation in place, it regularly and almost ritualistically puts it aside. Will that happen again? The Finance Committee offers some softer legislative possibilities, but just what Congress decides to do about the present legislation and its draconian cost reductions will be a severe test of its resolve to control costs in an important high cost area.

The other feature of the Senate Finance Committee report is distressing, that of its proposal for comparative effectiveness research. "The entity conducting the research," it wrote, "should be prohibited from issuing medical practice recommendations or from making reimbursement or coverage decisions or recommendations."

Not even recommendations? If nothing else that stance is inconsistent with its quality-improvement tactics, providing for financial incentives to meet government-formulated standards. Why are quality standards acceptable to change clinical

and hospital behavior but not to control costs?

No great political sophistication is needed to spot the not-so-hidden hand of the medical industry and some physician groups behind that kind of prohibition. Their long-standing aim, going back to the 1970s, has been to neuter technology assessment efforts. Industry sees a slippery slope to price controls and physicians fear a forced use of probabilistic evidence to treat their patients; that could happen, but not necessarily, and in any event some of both could be valuable.

The public and Congress need to know the cost impact of various treatments and ways of assessing new technologies and treatments. Lacking that knowledge, cost control can only be tepid. "Cost effectiveness," CBO Director Douglas W. Elmendorf noted in his March testimony in the House of Representatives, "will yield a somewhat larger effect on health care spending" than clinical effectiveness studies." Just so.

The [May 20 Finance Committee report](#) offers a mixed package of cost control measures, mostly promising. Some are aimed, for instance, at reducing physician reimbursement for over-valued services and reducing geographical cost variations; and other are aimed at reducing costs, for example, by means-testing strategies, modifying the exclusion of employer-provided coverage from gross income for taxation purposes, and modification or repeal of the 7.5 percent income level of itemized deduction for medical expenses. All are potent ideas but all will run into political resistance, most notably any efforts to weaken employer-provided health insurance.

In recent months word has gradually leaked out from cost research that the most popular political nostrums—medical IT, comparative effectiveness research, and prevention—are unlikely to make a large difference in cost control, and that to boot it will take years for them to do much good. That knowledge does not leave many likely big winners on the horizon—at least powerful enough to reduce costs from the projected \$4.2 trillion in 2019 to, say, \$3 trillion, which would bring it close to the optimal parity with the GDP.

Is there any hope that something could make a decisive difference? Yes, if we can bring ourselves to take an open-minded look at the way European countries do it, which will be the focus of some upcoming reports in the *Health Care Cost Monitor*.

Daniel Callahan is editor of the Health Care Cost Monitor.

PREVENTION

Prevention Will Reduce Medical Costs: A Persistent Myth

LOUISE B. RUSSELL

JUNE 17, 2009 > Despite an emphasis on preventive care in some health care reform proposals, studies suggest that the use of more preventive medicine may in fact increase, overall health expenditures. With prevention, as with treatment, better health comes at a higher price most of the time.

In the debate over health reform, nearly everyone agrees on one thing: spending more on prevention will help bring health care costs under control. From Peter Orszag, the director of the Office of Management and Budget, to American's Health Insurance Plans, an industry association, there is consensus that the United States spends too much on treatment and not enough on prevention.

If more were spent on prevention, the reasoning goes, the savings in treatment would be large enough to reduce the relentlessly rising share of national income devoted to medical care, currently 16 cents of every dollar. In turn, controlling costs would help employers and state and federal governments in their struggle with the high costs of health insurance and health programs.

Unfortunately, as Mark Twain said: "It ain't what you don't know that gets you into trouble. It's what you know for sure that just ain't so." Voluminous evidence has accumulated over the last four decades on prevention's potential for controlling costs. As I pointed out in recent interviews with the *Wall Street Journal* online and *Columbia Journalism Review*, it consistently points to the opposite conclusion: despite savings in treatment, prevention usually increases medical spending.

An article in the February 14, 2008 *New England Journal of Medicine* presented the most recent and largest compilation of evidence. Based on 599 studies published between 2000 and 2005, the authors reported that spending more on prevention increased medical spending over 80 percent of the time. The situation hasn't changed since I concluded in my 1986 Brook-

ings Institution book, *Is Prevention Better than Cure?*, that prevention usually added to medical spending.

Prevention comes in many forms: vaccines; treatment of risk factors for disease, such as elevated blood pressure or cholesterol; screening to catch disease early, when it may be more treatable; programs and advice to help people alter habits like smoking or overeating, which put them at higher risk of disease.

While a few of these approaches can save more than they cost (such as flu vaccines for the elderly, when the cost per dose of vaccine is low enough), most add to medical spending. The additional spending can be modest. Smoking cessation programs cost just a few thousand dollars for each year of life they save. But in other cases the additional spending is substantial. Statins for people whose only risk factor for heart disease is their elevated cholesterol levels cost hundreds of thousands of dollars for each year of life saved. To read more about these and other examples, readers can consult my report for the National Coalition on Health Care at www.nchc.org/documents/nchc_report.pdf.

Why do people think more prevention will reduce medical costs when decades of studies show it won't? Part of the answer comes from the natural tendency to focus on the individual who ultimately develops disease and to forget about the larger picture.

If you think of the man who ends up needing an expensive bypass operation after years of smoking and untreated hypertension, it seems obvious that it would have cost less to pre-

vent his heart disease—and, of course, better for him. But it is not possible to identify that particular man ahead of time, only to identify him and people like him who are at risk of heart disease.

Prevention addresses risks of disease, not disease itself. It must be provided to all those at risk, often for many years. Yet many of them would never develop heart disease even without prevention and some will develop it in spite of prevention.

The cost per person, per year, can look low. But when those costs are summed over all the people who receive the preventive intervention, and all the years they receive it, the total cost usually exceeds the treatment savings.

How then can reputable studies claim, as some do, that prevention saves many dollars for each dollar spent? The answer is that those studies include more than just medical care spending in their tallies. They value the future wages of people whose lives and health are preserved by prevention, and even the time people would spend on treatment.

We value good health, and our time, and the estimates in those studies reflect that value. But they do not address the issue of medical costs.

A study of chicken pox vaccine provides a good example. Published in the *Journal of the American Medical Association* in 1994, the year the vaccine was approved, the paper stated that the vaccine “would save more than \$5 for every dollar invested in vaccination.” That \$5 included parents’ time, valued at their average wage rate, and children’s future earnings.

When only medical costs were considered—those of the vaccine and those of the treatment avoided because of the vaccine—the article showed that every dollar spent on the vaccine returned 90 cents in treatment savings. Not bad, but not cost-saving.

Is the vaccine worth it? Yes. It brings better health for a modest increase in medical spending. But it does not reduce medical spending.

And what about the frequent assertion that the U.S. spends only 3 percent of its health care dollars on prevention, a number so ridiculously low that it seems obvious prevention must be underfunded? Sometimes the number is put as low as 1 percent, sometimes as high as 5 percent. Researchers at the Altarum Institute have discovered that whatever the estimate, and wherever it appears, the source usually given is a report that appeared in CDC’s *Morbidity and Mortality Weekly Report* in 1992.

It is hard to tell from that brief report, a summary of a larger unpublished study, exactly what the numbers include, but they are based on data for 1988 and are now 20 years old. So the

Altarum group went back to the beginning and developed new estimates. Their estimates show that at least 8 percent to 9 percent of national health spending goes to prevention.

To put even that larger number in perspective, recall that, while treatment takes place only in the medical sector, prevention takes place throughout the economy, as it must to keep people healthy. Examples are everywhere: improvements in highway design, safety features in cars, health inspections for restaurants, water treatment plants, sewage systems, features of buildings required by safety codes, work safety measures, limits on pollutants, and many, many more. An accurate examination of the balance of prevention and treatment needs to look beyond the medical sector.

International comparisons also suggest that spending more of our medical dollars on prevention will not reduce health care costs. In 2004 the Commonwealth Fund surveyed patients in five countries: the U.S., Canada, the United Kingdom, Australia, and New Zealand. With the exception of flu shots for the elderly, where Australia ranked first, the U.K. second, and the U.S. third, the U.S. led on the use of the preventive measures examined: blood pressure checks, screening for cervical cancer, mammography, and advice from a physician on diet and exercise.

The percentages of patients in the U.S. who received these services were higher, sometimes much higher—evidence that the U.S. is already devoting more of its medical spending to prevention than other high-income countries. Yet these other countries all have longer life expectancies and lower health care costs.

Prevention is often worth doing because it brings better health. But with prevention, as with treatment, better health comes at a higher price most of the time. The best medical care is based on the best evidence. Health reform will be most likely to succeed when it, too, is based on the best evidence. That evidence shows that spending more on prevention is not the way to control health care costs.

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Public Plan Choice: A Conversation with Jacob S. Hacker

THE EDITORS

JUNE 3, 2009 > A public plan choice would enable people without employer-based insurance coverage to enroll in an affordable public insurance plan. If the plan worked, it would allow good consumer choice and help control costs through competition among the public plan and private plans to deliver value, according to Hacker, a leading proponent of a public plan.

The main aim of public plan choice is to provide people without employer-based insurance coverage the option of enrolling in a public health insurance plan modeled after Medicare. The plan would be a key feature of a national insurance exchange, which would give consumers the choice of the public plan and private plans. Competition among the plans would occur on a “level playing field.” If the plan worked, it would allow good consumer choice and help control costs through competition among the public plan and private plans to deliver value.

Jacob Hacker, a professor of political science at the University of California, Berkeley, and codirector of Berkeley’s Center for Health, Economic, and Family Security, has been a leading figure in developing and formulating the idea of public plan choice. He has described the plan in recent [blogs](#) and [commentaries](#), we posed four questions to him.

A common criticism of the public plan choice is that its real motive is to open the way to a single-payer health care system. A benign interpretation is that it is meant as a via media between a government-dominated health care system and a more market-oriented system. What are the motives behind the plan?

All of the advocates of public plan choice I know see it as a middle ground, rather than as a stepping stone to single payer. I view public plan choice as an essential security guarantee in a “hybrid” reform plan that builds on employment-based insur-

ance and existing public programs to provide all Americans with affordable, quality care. Perhaps not surprisingly, therefore, my proposal has provoked criticism from both sides. Advocates of a single-payer system worry that the public plan will be disadvantaged relative to private plans because it will be more attractive to less healthy enrollees. Advocates of a private plan-only strategy fear that the public plan will have *too much* of an advantage.

It would be glib to argue that these very different forecasts simply cancel each other out. Nonetheless, they do point to offsetting factors that will help ensure that a public plan on a level playing field will neither “wither on the vine” (as Newt Gingrich famously predicted would occur if Medicare were made to compete with private plans) nor overwhelm private plans with its superior pricing and cost control.

The public plan will have some inherent advantages—notably the lack of the need to pay profits, low administrative overhead, and the ability to gain volume discounts. But so, too, will private plans, including the basic reluctance that Americans may feel to enroll in a public plan and the enormous marketing power of the private plans.

While every effort should be made to create a level playing field, it is likely that the public plan will indeed be more attractive to higher-cost patients. That, after all, is a major reason to have it. With appropriate safeguards, however, this adverse selection should be modest and not a threat to the public plan’s success.

Public plan choice will not put private insurance out of business. (In fact, an independent analysis of my own proposal, [Health Care for America](#), indicates that more Americans would have private insurance after reform than before—through either their employer or a private plan obtained through a proposed national insurance pool.) But it will change the business of private insurance.

New rules for private insurance could go some way toward encouraging private plans to focus on providing value. But without a public plan as a benchmark, backup, and check on private plans, key problems in the insurance market will remain.

The idea of a “level playing field” has been a particular sticking point, but it seems to pose a real dilemma. If the field is so level that the public program has no built-in competitive advantage on price or quality, then why have it at all? If it has such an advantage, then why should the private insurers join the exchange? Senator Charles E. Schumer of New York has proposed a variety of means to level the playing field, but it is unclear how far such an effort can go without gutting the idea altogether. Is there a way to escape the dilemma?

I agree that at some point the public plan ceases to be an effective check on private plans and, indeed, ceases to be a public plan at all. Most leading reformers, including President Obama during the campaign and Senate Finance Committee Chair Max Baucus in late 2008, have embraced the idea of a “Medicare-like” national public plan. And for good reason: This is the simplest, most workable, most cost-effective, and most attractive model.

And it is overwhelmingly popular: In [polls](#), between two-thirds and three-quarters of Americans say they want private plans to compete with a government-administered public plan similar to Medicare.

I have been arguing that a “Medicare-like public plan” must have the following key elements:

It must be a national plan modeled after, but independent of, Medicare that fully bears the risk of medical claims for its enrollees.

Its funding should derive entirely from individuals’ premiums, employer contributions, and government subsidy payments. Besides necessary start-up costs and subsidies made on the same terms to all plans in the exchange, it should not be able to draw on general revenues for benefit payments.

It should be able to use Medicare payment and claims infrastructure, but should be free to have different payment rates from Medicare.

Its coverage and payment protocols should be fully transparent.

It should be run by a government agency housed within the Department of Health and Human Services, whose activities would be coordinated with, but distinct from, those of the Center for Medicare and Medicaid Services.

The public plan should give access to most providers across the country.

It must have the authority to use its buying power to establish fair provider rates. It should also have the authority and dedicated funding to implement delivery and payment reforms that promote value and quality.

The public plan and all private plans within the exchange must comply with the same rules and requirements, including the benefit package, regionally based competitive bidding to set premiums, risk adjustment, and enrollment.

These essential elements are consistent with Senator Schumer’s recent insistence that the public plan “should be self-sustaining,” that “officials who regulate the insurance market should be different from those who manage the public plan,” that the “public plan should be required to establish a reserve fund, just as private insurers do, for anticipated claims,” and that the “public plan should be required to offer the same minimum benefits as private plans.”

The public plan would also “pay physicians and hospitals more than Medicare” does, as Senator Schumer indicated it should. Moreover, Senator Schumer is correct that doctors should “not be required to participate in the public plan simply because they participate in Medicare.”

Competition is a major feature of the public plan choice and its means of controlling costs. But it is hard to find solid evidence that competition has held down American health care costs in any significant way. Why might competition work better with this plan than it has in the past?

I am not arguing for textbook market competition, which has about the chance of surviving in the medical sector as the proverbial snowball in hell. Rather, I am arguing for what I call “healthy competition”—that is, competition to ensure that Americans are better cared for and more secure.

Such competition requires not an endless array of choices, but rather a reasonable number of meaningfully different choices. Indeed, the key reason for public-plan choice is that public health insurance offers a set of valued features that private plans are generally unable or unwilling to provide: stability, wide pooling of risks, transparency, affordability of premiums, broad provider access, the capacity to collect and use patient information on a large scale to improve care.

On the other hand, private plans are generally more flexible and more capable of building integrated provider networks, and they have at times moved into new areas of care management in advance of the public sector.

In short, public and private plans have unique strengths, and both should have an important role in a reformed system. Healthy competition is about accountability. If public and private plans are competing on fair and equal terms, enrollees' ability to choose between the two will place a crucial check on each.

If the public plan becomes too rigid, more Americans will opt for private plans. If private plans engage in practices that obstruct access to needed care and undermine health security, then the public plan will offer a release valve.

New rules for private insurance could go some way toward encouraging private plans to focus on providing value. But without a public plan as a benchmark, backup, and check on private plans, key problems in the insurance market will remain.

Perhaps the most pressing of these problems is skyrocketing costs. Public health insurance has much lower administrative expenses than private plans, it obtains larger volume discounts because of its broad reach, and it does not have to earn profits as many private plans do. Furthermore, experience suggests that public insurance has a superior ability to control spending over time.

For all its flaws, Medicare has a substantially better track record than private health plans in controlling costs while maintaining broad access to care, especially over the past 15 years. Nearly all other advanced industrial democracies rely much more on public health insurance than the United States does, and all have lower health care costs per person, have seen their costs rise more slowly, and yet have maintained better overall health outcomes and much stronger health security for all their citizens.

While it is evident that the insurance industry is hostile to the public plan, are there are signs that it might accept it with some emendations, of the kind for instance that Senator Charles E. Schumer has proposed? What has been the reaction of the business community more generally to the idea?

I think that insurer opposition can be softened by ensuring that the playing field is level and by assuring insurers that pay providers on a more or less fee-for-service basis that they can piggyback on the public plan in setting their own prices. This idea—sometimes called “all-payer rate setting”—has echoes in the operation of the private fee-for-service plans that operate alongside Medicare today (though right now these plans are unfairly favored by a system for paying private plans that excessively subsidizes them).

Its logic has been nicely summed up by the political scientist Joseph White: “If the main problem, from the private insurers' perspective, is the superior market power of the public plan, that should be addressed by *sharing the market power among all payers*, through all-payer rate-setting.”

In practice, all-payer rate setting of this sort would mean that private fee-for-service plans within the exchange would use the same fee schedule that the public plan did. This would not stop private plans from offering alternatives to fee-for-service coverage, such as integrated HMOs—they would simply use their own payment methods. Nor would it stop the public plan from improving its own payment methods; it would only require that those innovations be shared with other plans that used similar pricing methods.

By putting the public plan and insurers “on the same side,” so to speak, it would reassure private plans that they would have the ability to compete with the public plan, allowing them to focus on innovations in care management, quality assurance, and customer service.

A less obvious but no less important effect of all-payer rate setting would be substantially reduced administrative costs. Although it is well known that administrative costs are much higher in the U.S. than other nations, it is less well known that a major portion of this difference arises because of the diverse and conflicting billing and reimbursement practices of providers and private insurers.

Finally, standardized billing and payments for a large part of the provider market would not only reduce administrative expenses, it would also facilitate the monitoring of care and of physician practice patterns—both of which are now shrouded in the fog of competing billing and reimbursement practices.

The business community as a whole has not focused much on the public plan, though it is fair to say that many employer groups are skeptical. Small employers are surprisingly receptive to a public plan as a means of covering their workers at a low cost. Large employers may not have as much direct interest in the public plan, but they would likely be supportive (or at least not actively opposed) if they felt it would restrain overall costs without shifting costs onto them—another reason why a level playing field is so important.

There is a real need to bring employers into this conversation. Although many corporate leaders were favorable toward action in the early 1990s, even more today seem to recognize that absent action, they will increasingly be caught between the rock of rising costs and the hard place of hurting their workers by dropping coverage or providing bare-bones plans.

The last decade has seen large employers pull out every trick in its arsenal for controlling costs, to little avail. Now, the only surefire way to cut expenses is to trim coverage and shift risks onto workers, which is not just unpalatable, but also likely to stoke public interest in reform.

In this difficult context, I hope that even if business leaders do not enthusiastically embrace public plan choice, many will accept that a public plan on a level playing field is an important part of ensuring that reform is workable and sustained over the long term.

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Comparative Effectiveness Research and Medicare

JACQUELINE FOX

JUNE 30, 2009 > Medicare's coverage decisions are still guided primarily by the requirement that treatments only be "reasonable and necessary." However, this principle is complicated by Medicare's inability to take costs into account.

The debate about the Obama Administration's plan to greatly increase comparative effectiveness studies is both predictable and destructive. We need such data, but many people are terrified of its collection and use and are fighting against it. This is part of the continuing fallout from our refusal to directly and honestly confront the allocation challenges presented by costly medical care.

This problem is predictable because just about all participants in the health care system in the United States have manipulated effectiveness data to further their own goals. This manipulation has poisoned the well, causing people to confuse effectiveness research with the distortions that have so often followed its collection and the harm those distortions have caused.

Done skillfully, manipulation of data can increase drug company profits, reduce political fallout from difficult resource allocation decisions, justify denials of claims for third party payers, and help avoid difficult discussions about scarce medical resources.

A good example of how we fail to confront cost directly, how this failure leads to data distortion, and how we can repair the problem, can be seen in the Medicare program. Once a treatment falls within an area of care covered under the Medicare Act, the only statutory requirement that guides further coverage decisions is that the care must be "reasonable and necessary." This language was taken from an Aetna policy that was offered to federal government employees in 1965, the year Medicare was created.

Congress has not changed the "reasonable and necessary" language since the law was passed, making it a time capsule of our health care system as it was in 1965. When patients in the 1960s filed lawsuits against their insurance companies to compel coverage of a denied claim, courts interpreted the common contract phrase "reasonably necessary" in a way that protected the treating doctor's autonomy. If the doctor said the disputed care was reasonably necessary, the court deferred to the doctor's judgment. It would have been deemed inappropriate for an insurance company to practice medicine, and this was considered to be a medical judgment.

Our health care landscape has changed dramatically since then. The federal HMO Act of 1973 allowed national HMOs and managed care hybrids to spread across the country. Laws prohibiting the corporate practice of medicine have been repealed in most states and we have grown used to the gatekeeping role of third party payers.

Perhaps most importantly, the Employee Retirement Income Security Act (ERISA) became law in the 1970s. ERISA is the federal employee benefit law that regulates employer-based pension and health plans. It pre-empts most state lawsuits related to these benefits, which means that people who receive benefits from an ERISA plan cannot sue the plan administrator for damages caused by it failing to pay for medical care.

The majority of health insurance contracts are administered without fear of any significant liability. They reserve a gatekeeping role for the plan administrator, and cost-effec-

tiveness plays a large, usually unspoken, role in the benefits a patient receives. The ERISA pre-emption has become one of the few significant health care cost-reducing laws we have. Medicare has few of the cost-saving tools these other third party payers have. The Medicare Act of 1965 has not been altered to allow Medicare a significant gatekeeping role. There is no ERISA or HMO Act for Medicare. The plan has not been altered because there is a perception of high political cost for doing so.

There are two cost-sensitive options for Medicare that frighten Congress. The first is raising taxes to pay for the increasingly expensive plan and the second is rationing health care to reduce its cost. Both are considered political suicide. This creates a complex pressure from Congress to the administrators of Medicare, as it must administer the plan in a way that protects Congress from either option.

The constant pressure to satisfy contradictory political goals has driven Medicare's cost saving choices underground. To avoid this, Medicare has repeatedly tried to make transparent, rational, ethical considerations of cost a part of its coverage decisions, but has always failed.

On at least three occasions, it has proposed regulatory schemes for making coverage decisions that take cost-effectiveness or cost-benefit analysis into account. These schemes met with thousands of negative comments, and have never been enacted.

In truth, these regulatory schemes could not be enacted because the Medicare Act, as written, does not give the Medicare administrator the right to consider cost when making a coverage decision. Congress must amend the act, changing the language discussed above, so that cost is a permissible part of the coverage determination.

Medicare has long grappled with cost. Currently, it tends to respond to expensive new technologies by limiting coverage to subgroups of patients. Rarely does it entirely refuse coverage, and then only when it is relatively clear from the available data that denial is justified. Instead, it does a political dance.

The careful manipulation of data for purposes of achieving maximal cost savings appears to be an essential tool the program uses. Consider implantable defibrillators. The data presented to CMS in the early 2000's by the device manufacturer applying for coverage showed a predictable and important usefulness for these devices in a small percentage of people across a large population of potential recipients. More data was needed to see if a narrower group, far more likely to actually benefit from the devices, could be identified.

Rather than approve the defibrillators for the entire population that the data justified, an impossibly expensive result, by 2004 Medicare was shaping a decision to approve coverage for a narrow group of patients that many commentators argued was an arbitrary subset created entirely for the purpose of saving money. Medicare subsequently required all beneficiaries who received the device to have data collected from them about the device; Medicare uses that data to continually update and refine the original coverage decision.

By not entirely denying coverage and by remaining flexible in the face of new data, Medicare manages to save money, defuse political tension, and avoid directly addressing cost concerns.

However, in the defibrillator case described above, Medicare also appeared to distort data, claiming to have initially found a significant scientific limitation on who should receive the technology where the limitation most likely did not exist. This type of behavior risks undermining the quality of care a doctor gives a patient. Private sector third party payers traditionally follow Medicare coverage decisions when they limit access to care, amplifying the ramifications of this type of decision.

Without the capacity to explicitly consider the cost implications of new technology, Medicare is in an impossible situation. Stewardship concerns for the program appear to require cheating in difficult situations. This is particularly awful for Medicare, as it is also at the forefront of promoting evidence-based medicine, constantly looking for reliable evidence to use in making coverage decisions.

Those who oppose the collection of comparative effectiveness data are worried about cost concerns being a part of medical decision-making. However, cost concerns are already a part of our medical system, and have been for decades. As counterintuitive as it might appear, we need to legally empower decision-makers to explicitly consider cost in order to more firmly define and protect the values we want our health care system to embody. By refusing to do so, we have driven cost concerns underground.

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Rationing: Why It Is Ethical

DAN BROCK

JULY 16, 2009 > The notion that health care rationing does not occur, and that if it did it would be wrong, are based on misconceptions of the true definition of rationing and a failure to understand the implications of not having a necessary level of rationing. A complete avoidance of rationing in our health care system would be irrational, undesirable, and even unethical.

Why is the prioritization of health care resources and rationing such a third rail of health care reform? Individuals are continually forced every day to prioritize their own resources, deciding what to use them for and what to forego. The process couldn't be more familiar.

Since our wants typically outrun our resources, we learn to make the choices and move on to the next ones. So why is the very idea of prioritizing and rationing health care resources so troubling and controversial?

Americans are deeply ambivalent and inconsistent about health care costs and rationing. On the one hand, many like to pretend that rationing does not take place, but on the other hand they fear being denied beneficial care, in particular payment by their health insurance plans for care they need.

Many say that we are a rich country and have no need to ration health care, but on the other hand they resist rising costs of health care, particularly when they result in greater out-of-pocket costs to them. Many say that life is precious and money should not enter into decisions about medical treatment, but on the other hand they resist the ever increasing proportion of both our national wealth and their own wealth that goes to health care. Many recognize the need to limit the use of some health care, but on the other hand resist those limits when they are applied to them or others about whom they care deeply.

Now these inconsistencies might simply reflect a perfectly common and understandable desire to have more of a valued good like health care, but not to pay more for it. For goods that

we must purchase in a marketplace, we soon learn that this is not a desire that can be satisfied—if we want more, we must pay more, and so we must decide how much that is worth to us in comparison with other uses for our resources.

Most Americans, however, do not pay out of pocket the full, or even most, costs of the health care they receive. If insurance pays, it is hardly surprising that we do not support rationing which will have the effect of denying some health care to us.

Rationing is the allocation of a good under conditions of scarcity, which necessarily implies that some who want and could be benefited by that good will not receive it. This allocation or rationing can take place by many means. The use of a market to distribute a good is one common way to ration it.

Most Americans reject ability to pay as the basis for distributing health care. They do not view health care as just another commodity. Despite this widespread view, we remain the only developed country without some form of universal health insurance, and so for the 46 million Americans without health insurance their access to health care often does depend on their ability to pay for it.

Rationing largely remains a topic that the public, their elected leaders, and many health care professionals prefer to avoid. The avoidance takes many forms. As already noted, a prominent one is just to deny that significant rationing takes place. When this denial becomes increasingly difficult to maintain in the face of the realities of the health care system, a typical alternative strategy is to condemn rationing as unjust or

unethical and so to deny that it *should* take place.

If people widely believe that health care rationing does not take place, and that if it did it would be wrong, it is hardly surprising that we have not had a responsible public debate about when and how it should be done. But both of these beliefs that health care rationing does not take place, and that if it did it would be wrong, are false.

Perhaps it is inevitable that rationing must occur if others limit resources available to physicians to care for their patients, but many deny that resources should be limited in this way. This is a mistake, however, and it is important to understand why.

As long as there is some limit to the resources available for health care, health care will have to be allocated to those who need or want it—with not everyone getting all they need or want. Allocation in the face of scarcity is inevitable.

The only to avoid scarcity in the health sector would be to provide all services to all patients who are expected to benefit, no matter how small and uncertain the benefits, and no matter how high the costs. This is clearly impossible.

Everyone might benefit from having a private physician accompany us when we travel, or from unlimited resources for research for diseases that we have or have some chance of getting. Everyone may benefit from having an MRI on the very tiny chance that a brain tumor may be causing the headache they are experiencing. Yet none of this would be possible without enormous increases in health care costs.

More important, even if possible, none of it would be rational or desirable. To avoid scarcity by providing everyone with all care of any positive expected benefit would have tremendous opportunity costs.

We would have to devote enormous additional resources to health care that produced minimal benefits when we could have used them to produce vastly greater benefits elsewhere,

such as in education or rebuilding the country's infrastructure. Even within the health sector, trying to provide all beneficial care for some patients regardless of costs would inevitably prevent us from treating other patients who would benefit more.

So the only way of avoiding the need to ration health care would be *irrational* and *undesirable*. It would also be arguably *unethical*. We would have to use resources in a very inefficient manner producing far less by way of overall benefits for the population served than if we did ration care.

And since society has other ethical responsibilities to its citizens in areas such as personal and national security, education, and so forth, failing to ration health care would inevitably result in failing to meet these other ethical and political responsibilities and obligations. How to ration health care is the subject for another blog, but that it is and should be done is undeniable. Health policy analysts understand all this—the momentous task for health reform is to bring the public to understand and accept it.

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The Limited Ethics of Rationing: A Response to Dan Brock

JOSEPH WHITE

JULY 24, 2009 > The most difficult ethical conflict in our current health care system is between those who are sick and those who profit from them. But some of the incomes in our system provide no social value at all and others are surely much higher than they need to be. Until we reduce these inflated expenses, including unnecessary overhead, then lecturing the public that it must accept rationing is a recipe for political failure, and bad policy as well.

Imagine someone took you into the woods with three other people: a young child of no particular distinguishing characteristics, a middle-aged drunkard with a family, and a 75-year-old Nobel Prize winner. The person then told you that you had to kill one of the three, and that, if you did not do so, he would go back and kill your child. How would you choose?

The child has more quality-adjusted life years at stake, multiple lives depend (not very well) on the drunkard, and the Nobel Prize winner has made huge contributions to society but may not have much longer to contribute. But there is a better choice:

Shoot the person who gave you the choice. Then your child is safe, and the rest of you can all go home.

Think about this when someone claims that reform of the U.S. health care system must involve rationing care, as Dan Brock did in his post [here](#).

The United States spends 16 percent of gross domestic product on its health care. If our financing and payment system were more like that of other countries, we could be providing the same basket of services, to all our citizens, for around 12 percent to 13 percent of G.D.P.

The most fundamental ethical conflict in the U.S. medical system isn't which care to provide. It is between the interests

of sick people and of all those who make money from the health care system. Some of the latter deserve their current incomes. But some of the incomes in our current system provide no social value at all; and others are surely much higher than they need to be. If we ignore the option of reducing the payments for care, including unnecessary overhead, then we are allowing all the people who make those incomes to tell us, essentially, "shoot the patients but keep us whole."

Dr. Brock's analysis ignores this dimension, accepts the current distribution of power and income in the system, assumes it is inviolate, and moves on to identify which patients to hurt. I don't see how that is wise or ethical.

There are situations in which discussions of relative merits of services are highly appropriate. It is necessary in triage situations. It has to be done to define benefit packages: which benefits we will promise to each other and, even more important, which services we will force some people to subsidize. But the logic of these applications is less important than the misleading implications of the common claim that ethical honesty requires that reformers admit that national health insurance requires rationing.

The extremely high costs in the U.S. are not due to overutilization. Compared to other countries, they are clearly due

much more to high prices and excessive overhead.

Can we in the U. S. reach a point where “rationing,” as Professor Brock has in mind, may be the best way to control costs? Yes, and if we do I will be extremely happy (and I should live so long). As it is, lecturing the public that it must accept rationing is a recipe for political failure, and bad policy as well.

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Dan Brock Replies

Joseph White is, of course, correct that high prices for drugs and other health care services, together with great and costly administrative inefficiencies, are primary causes of our very high level of health care spending. And, he might have added, spending substantially more of our G.D.P. on health care than any other developed country has not bought Americans better health. I do not believe, and nowhere said, that “the current distribution of power and income” in the system should remain inviolate, and I will gladly join him in supporting proposals to overturn them.

So why argue, as I did, that rationing is ubiquitous, desirable, rational, and ethical, especially when it continues to be the third rail of health policy reform? While I would much prefer a single payer system that could fundamentally change the “current distribution of power and income” in the system that both Prof. White and I lament, no alternative that would do so is on the current reform agenda.

It is widely believed in political and policy circles, rightly or wrongly, that the American people do not want and would not accept such fundamental reforms. “Would you want the government running your health care?” remains a potent charge, however, false and misleading.

Because it is widely believed that most Americans are generally satisfied with the care they get, reform proposals all leave the employer-based insurance system largely in place. Because one lesson commonly drawn from the failed Clinton health reform effort of 1993 is that the drug and insurance companies will defeat any proposal that they see as too contrary to their interests, reforms being considered do not take on these groups head on.

Current reform proposals are limited by judgments of what is politically possible, but in no small part also by trying to avoid the charge that they will lead to rationing. So we pay a price in what reforms are deemed feasible by avoiding the third rail of rationing.

There is reasonable disagreement about whether acknowledging and supporting rationing is counterproductive from a political and policy perspective. Prof. White and others, like [Jim Sabin in his blog](#), may be right that it is. Perhaps we should continue to pretend that we don’t and won’t ration health care to blunt attacks on reform and rationing.

But any reformed health care system will and should continue to ration care, and we should not let opponents of reform get away with attacking reforms on the grounds that they would lead to rationing; a reformed system will only ration in different places and in different ways than we do now. My hope, like that of Peter Singer in his recent piece in [The New York Times Magazine](#), is that if the public better understands that rationing is already commonplace in all health care systems, and that it would be irrational and unethical not to ration care, then the charge of rationing may come over time to lose some of its political force.

Opportunity Costs

NORMAN DANIELS

AUGUST 21, 2009 > In deciding to cover a \$200,000 open heart surgery procedure for heart failure, Medicare in effect denied giving that money to several more cost-effective strategies for preventing heart failure, including better access to blood pressure and lipid screening. Considering such opportunity costs as one of many factors could lead to better, more ethically sound coverage decisions.

In 2003, I and other members of the Medicare Coverage Advisory Commission (MCAC) met to consider the benefits and risks of using an implanted but externally powered pump, the left ventricular assist device (LVAD), for “destination therapy.” Destination therapy is for people with congestive heart failure whose age or other diseases make them ineligible for transplants.

The one randomized trial studying its effects showed it reduced the death rate by 48 percent, but half of recipients were dead after a year and three quarters were dead after two years. Many recipients had infections in the first three months after surgery.

The estimated cost of the device and the open-heart surgery to implant it was over \$200,000, not including costs of complications. A Blue Cross/Blue Shield estimate of the cost per quality adjusted life year (QALY) was between \$500,000 and \$1.4 million, making it a true outlier in terms of cost effectiveness. With 5,000 recipients per year—and up to 100,000 potentially eligible—costs add up to \$350 million to \$7 billion per year.

What is the “opportunity cost” of destination therapy using LVADs? What other benefits could be purchased with the cost of this procedure?

For example, if Medicare invested some of those costs in outreach programs to provide better access to blood pressure and lipid screening, plus treatment, then one could prevent many congestive heart failure cases—lowering mortality rates much more than with LVADs. In short, much more effective

and cost-effective alternatives exist than “destination” coverage for LVADs.

Unfortunately, asking this question about opportunity cost—and backing it up with evidence about cost-effectiveness—is not on the agenda for MCAC or the Centers for Medicare and Medicaid Services (CMS). Although the language in the Medicare act says coverage must be provided for “reasonable and necessary” services, it would take an explicit act of Congress to enable MCAC and CMS to consider opportunity costs and to make cost effectiveness analysis a part of deliberation about coverage. That is because no one—the managers of Medicare and the politicians in Congress—wants to face in a public way the need to consider opportunity costs. No one wants to be accused of rationing health care.

Cost effectiveness analysis is an attempt to measure the health benefit per dollar spent. Health benefit can be measured in various ways, including cases of a disease avoided, lives saved, life years saved, and health-adjusted life years saved (HALYs). Since many disease conditions significantly reduce quality of life but may not be fatal, lives saved and life years saved do not allow us to compare health benefits across as many diseases and interventions for them as we may want to.

A life year discounted for a health decrement provides a way make broader comparisons. In medical contexts, the Quality Adjusted Life Year is the construct most often used, as in the Blue Cross/Blue Shield study of the LVADs cost effectiveness. In public health contexts, Disability Adjusted Life

Years (DALYs) are used to estimate the burden of disease and cost effectiveness studies focus on the cost per DALY of reducing that burden.

Public Health Service and Institute of Medicine reports on cost effectiveness recommend that it be an input into a broader deliberation about coverage. It should not be used as a mechanical decision-making procedure. The decision process should be free to consider other ethically relevant factors that cost effectiveness by itself is insensitive to, such as distributive issues. For example, cost effectiveness is intended to help us maximize the health benefit produced per dollar spent, regardless of who gets that benefit or where in a life it goes. Yet most people are not straightforward maximizers of such health effects.

Most people want to give some priority to those who are sickest, for example; cost effectiveness give no such priority. (This point is made famous by the experiment in rationalizing Oregon's Medicaid benefit. The Oregon Health Services Commission originally thought it could simply rank condition treatment pairs by their cost effectiveness and cover them in descending order of cost effectiveness until funds ran out. But the method ended up ranking some lifesaving treatments lower than some quality of life treatments, and public outrage forced a change in methods.) Most people also want to give people a fair chance at some benefit rather than always favoring those who will benefit the most.

If, however, a decision process about coverage is structured to allow input about cost effectiveness, and to encourage deliberation about distributive or other ethical issues, then the flaws of cost effectiveness can be addressed and the valuable information it gives us can also be acted on.

For example, in thinking about the LVAD case, knowing that LVADs are far less cost effective than preventive programs aimed at reducing the risk of heart failure means that we are holding constant the seriousness of the disease. In listening to

information about cost effectiveness, but in the context of treating or preventing the same condition, we are less subject to the criticism that we are ignoring the seriousness of the condition.

Consider another way to entertain ethically relevant considerations while still using information about cost effectiveness. In England and Wales, the National Institute for Health and Clinical Excellence (NICE) has been criticized for using a particular monetary threshold—30,000 pounds per QALY—as a guide to recommendations about coverage. This threshold has only weak normative support for it, and applying it mechanically overlooks important considerations.

For example, if the only treatment for a condition costs more than that threshold, then many would want to be flexible about paying more. A public method, such as NICE's Citizen's Councils, should search for relevant reasons for flexibility. In short, we need to modify how we understand the language of "reasonable and necessary" in the Medicare law by insisting that opportunity cost be considered. Not imposing great opportunity costs on others would be one way to understand "reasonable." We could then get relevant information about the opportunity costs from cost effectiveness studies, although we would need to view those studies as but one input into a deliberative process that is ethically informed.

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Can Rationing Be Painless?

LEONARD FLECK

SEPTEMBER 8, 2009 > If we can find ways of purchasing more health good for fewer dollars—increasing efficiency, for example—then we will be able to cover the uninsured without taking away health care benefits from people who are currently well insured. But experience shows that this is difficult, if not impossible, to do.

A recent [USA Today/Gallup survey](#) found that while a majority of Americans supported the need for health care cost containment, 90 percent did not want any limits on what they or their doctors believed was necessary health care. One (disheartening) obvious implication of that statistic is that our fellow Americans do not want to have their care limited to control costs. This does not bode well for the prospects of health reform.

Is there a way to control health care costs “painlessly”? If we can find ways of purchasing more health good for fewer dollars, then we will be able to cover the uninsured without having to take away health care benefits from people who are currently well insured. Everyone gets what they want and need from the health care system.

But I will argue that this is nothing more than a tempting “moral” mirage, suitably mesmerizing of the public so far as politicians are concerned, suitably congruent with the ideology of the market and its magical powers for solving social problems, but ethically sterile as an approach to controlling health care costs fairly.

Let us consider a few examples. An article in the *Washington Post* last summer discussed the [closure of Pascack Valley Hospital in New Jersey](#) because of bankruptcy. It could no longer compete with the two other hospitals in the area. All three were quite marginal economically, so the closure strengthened the remaining two (fewer empty beds).

Surely this is what efficiency is about; surely this is a virtuous outcome. But a local restaurant owner was interviewed for

the story who, at age 58, was very troubled by high blood pressure and high cholesterol. He commented that if he were to have a heart attack he would likely not survive the ambulance ride through heavy traffic to one of the two other hospitals. He may or may not be correct about that prediction, but it is very likely that an outcome such as that will be true for some individuals who would *want and need* that third hospital closer to where they live.

So a rationing decision has been made through the “magic of the market” rather than the coercive powers of government. But the “magic of the market” is that such bad outcomes will never get public moral attention because they will appear to be merely unfortunate natural deaths. These deaths will never be identified as part of the cost of achieving efficiency and cost control in our health care system.

To be clear, if we have excess hospital beds or hospitals, we ought to close them *after we have explicitly and self-consciously assessed the morally relevant consequences of doing so*. We have no moral right to hide or ignore or deny such consequences in our quest for a more efficient health care system.

The Medicare system is predicted to face bankruptcy in about eight years. There are numerous reasons for this, but the most prominent of them would be the use of high-cost medical technologies.

We could deny the elderly extraordinarily expensive cancer drugs that yield only extra weeks or months of life at a cost of \$50,000 to \$100,000, or we could deny the elderly open heart surgery after age 85 because of the relatively long, costly

recuperation periods, but both those options represent the painful rationing decisions Americans dread.

A nearly painless alternative would be to raise the eligibility age for Medicare to age 67. The “virtue” of that approach is that no one would be denied any particular health service. That is, there would be no explicit heavy-handed rationing. Individuals with excellent health insurance from an employer would simply continue working for those two extra years.

Of course, individuals in their late 50s or early 60s who are laid off would find it very difficult to get health insurance they could afford. If they remained perfectly healthy until age 67, then being uninsured would have little consequence. But if they had a costly life-threatening medical problem, then they would be in the hands of fate. Whatever the outcome, it would appear to be (morally speaking) unfortunate, not unjust.

Efficiency can have a certain perversity about it. Removing gall bladders and repairing aged and damaged knees used to require a number of days in the hospital. But the development of arthroscopic surgery has had the medical and economic benefit of reducing hospital stays to a day or so. Surely this represents morally virtuous painless cost control.

Arthroscopy surgery costs substantially less and has fewer side effects than conventional surgery. But there has been a dramatic increase in the number of arthroscopic surgeries, and in their total cost.

When gall bladder surgery and knee surgery carried more risks and cause more pain, more patients accepted conservative medical management. But to deny patients access to arthroscopic surgery now and insist on less expensive medical

management would be seen as painful, coercive rationing.

We have seen a comparable phenomenon in cardiac care, where there has been a moderate decrease in bypass surgery but a very large increase in less expensive stenting procedures. More conservative medical management will often achieve the same life-saving goal as stenting, but at a much lower cost. But requiring cardiologists to deny patients stenting in favor of less expensive medical management would be seen today as painful rationing by both those cardiologists and their patients.

How should we assess that outcome from the perspectives of both justice and efficiency? Many new, more efficient, and less expensive medical interventions present this question. The take home message of this essay should be clear: Health care reform will require painful social choices if we are going to control health care costs fairly and reasonably. Rhetoric that invokes increasing efficiency to control costs painlessly represents an anesthetic to our sense of justice when the health reform debates require more vivid ethical self-consciousness and public deliberation.

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Single Payer: A Conversation with David Himmelstein and Steffie Woolhandler

THE EDITORS

AUGUST 27, 2009 > A single payer national health insurance system would make universal, comprehensive coverage affordable and sustainable by diverting hundreds of billions of dollars from bureaucracy to patient care and enabling rational health planning. Lesser reforms cannot realize such savings, according to Himmelstein and Woolhandler, leading proponents of a single payer approach.

One of the biggest arguments against a public choice option is that it would lead to a single payer system. Many critics frame this as a frightening prospect, a radical intrusion of government into health care. But many doctors and others regard a single payer system as the best way—perhaps the only way—to control health care costs well enough to provide coverage for all. Advantages include saving hundreds of billions of dollars and helping to reduce regional inequities in available medical services. David Himmelstein, M.D., and Steffie Woolhandler, M.D., M.P.H., cofounders of Physicians for a National Health Program, answered questions about the single payer system and why they think it is superior to a public choice option.

Why do you support a single payer health care system?

We support nonprofit, single-payer national health insurance because it would greatly improve access to medical care; ameliorate the dire financial consequences of illness; realize large savings on bureaucracy that would make a transition to universal, comprehensive coverage affordable; establish a framework for restraining the growth of medical costs in the long run; and address the regressive nature of current U.S. health care financing.

Health reform must cover the uninsured, but also address the cost crisis for insured Americans. Illness and medical bills contributed to almost two-thirds of all personal bankruptcies in 2007, a 50 percent increase since 2001.

Covering the 50 million uninsured and upgrading coverage for the tens of millions who are underinsured will cost hundreds of billions each year. A single-payer reform would make this affordable through vast savings on bureaucracy and profits.

As we've shown, administration consumes 31 percent of health spending in the United States, nearly double what Canada spends. If we cut our bureaucratic costs to Canadian levels, we'd save nearly \$400 billion annually—more than enough to cover the uninsured and to eliminate copayments and deductibles for all Americans.

Altogether, U.S. hospitals could save about \$120 billion annually on bureaucracy under a single payer system. And doctors in the U.S. could save about \$95 billion each year, which they now waste fighting with insurance companies and filling out useless paperwork.

Single payer national health insurance would also facilitate (though not ensure) rational health planning, a proven cost control strategy. Today's market-driven capital allocation mechanism has resulted in an expensive surplus of high-tech facilities in many regions, which inevitably leads to unnecessary and even dangerous tests and interventions. Meanwhile investments in underserved communities and underprovided services (e.g., public health and mental health) lag.

National health insurance would establish explicit capital allocation mechanisms, separating operating and capital funds, allowing restraints on the supply of medical resources that are keys to long-term cost containment.

In sum, a single-payer national health insurance would make universal, comprehensive coverage affordable by diverting hundreds of billions of dollars from bureaucracy to patient care, and sustainable by enabling rational health planning. Lesser reforms cannot realize such savings. While reforms that maintain a major role for private insurers may seem politically expedient, they are economically and medically nonsensical.

The term “single payer” is normally used to characterize tax-based, national health insurance systems (Canada, the United Kingdom, and Sweden). Do you think they are better than the social insurance systems (France, Holland, Switzerland)?

A single payer national health insurance has several advantages over social insurance systems—particularly those with multiple insurers. First, national health insurance is administratively far simpler and less expensive.

From the providers’ point of view, multiple payers result in sharply increased administrative costs—as we found several years ago when we studied the administrative costs of Germany’s social insurance system for the Office of Technology Assessment. Moreover, as [Hans Maarse’s recent post here](#) illustrates, the diffusion of responsibility for financing care to multiple payers makes cost control far more complex.

We are also concerned that the flat tax financing used for many social insurance programs (e.g., Medicare’s payroll tax) is less healthy than a system based on an income tax or other progressive levy, and that an employment-based system is ill suited to the current economic situation in the U.S.

Moreover, the transition from our current health financing system to a functional social insurance system would be no easier than a transition to national health insurance.

Instituting a reasonably stable social insurance system (we would not include the still unfolding experiment in the Netherlands in this category) would require a complete recasting of our insurance firms—changing their ownership, control, and regulatory frameworks. Similarly, regulation of health facilities would have to be completely revamped. It’s far simpler to establish a national health insurance payment system than to conjure up a completely revamped set of insurers and regulations for a social insurance system.

Do you consider a public choice plan designed to compete with the private insurers to be a reasonable compromise?

Unfortunately, adding a public plan option as a patch to the current private insurance system cannot correct its flaws. As long as multiple private plans coexist with the public plan, hospitals and doctors would have to maintain their costly billing and internal cost tracking apparatus. Indeed, we estimate that even if half of all privately insured Americans switched to a public plan with overhead at Medicare’s level, the administrative savings would amount to only 9 percent of the savings possible under single payer.

There’s no evidence that competition from a public plan would restrain costs, as [Daniel Callahan has argued here](#). A public plan might cut private insurers’ profits, which is why they hate it. But their profits account for only 3 percent of the money squandered on bureaucracy.

Far more goes for marketing (to attract healthy, profitable members). And tens of billions are spent on the armies of insurance administrators who fight over payment and their counterparts at hospitals and doctors offices. All of these would be retained with a public plan option.

Unfortunately, competition in health insurance involves a race to the bottom. Insurers compete by *not* paying for care: by denying payment and shifting costs onto patients or other payers. These bad behaviors confer a decisive competitive advantage.

A public plan option would either emulate them—becoming a clone of private insurance—or go under. A kinder, gentler public plan option would quickly fail in the marketplace, saddled with the sickest, most expensive patients, whose high costs would drive premiums to uncompetitive levels.

Eight decades of experience teach that private insurers cannot control costs or provide families with the coverage they need. A government-run clone of private insurers cannot fix these flaws.

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STATE EFFORTS

The Massachusetts Health Plan: A Conversation with Jonathan Gruber

THE EDITORS

AUGUST 11, 2009 > Massachusetts has the lowest rate of uninsured residents in the country, has experienced an increase in private insurance through employer-sponsored plans, and has very favorable public support. But the program has been criticized for its high costs. Gruber, a board member of the Massachusetts Health Insurance Connector Authority, discussed the state's cost control strategies.

As a result of its landmark health reform legislation, Massachusetts has the lowest rate of uninsured residents in the nation. The percentage of uninsured fell from 6.4 percent in 2006 to 2.6 percent in 2008. However, the state is struggling to control rapidly rising health care costs, which are among the highest in the nation and are projected to grow faster than the country as a whole.

Two recent developments underscore the seriousness of the state's cost problems. The legislature voted to cut back on benefits for thousand of legal immigrants. And Boston Medical Center sued the state on the grounds that its expensive universal health care law has driven the hospital into deficit. As an editorial in The New York Times said that "it will take great creativity and political will to hold down rising costs so that the program is sustainable."

Jonathan Gruber, a professor of economics at the Massachusetts Institute of Technology and a board member of the Massachusetts Health Insurance Connector Authority, answered questions about the Massachusetts plan and strategies for curbing its costs.

The Massachusetts model has been touted by some as a good model for a national health care system. Would you agree with that judgment?

I think the Massachusetts model is an excellent one for what it tried to accomplish: moving to universal coverage by building on the existing insurance infrastructure. We have a number of

noteworthy accomplishments:

We have already covered about two-thirds of our uninsured within the first year of the mandate. We have done so on budget—our costs in the first full year of the mandate were actually a bit below budgeted levels.

We have seen increased private insurance coverage, with employer sponsored insurance going up by 150,000 persons—that is, we have "crowd in" not "crowd out."

We have had near perfect compliance with our individual mandate, with 98 percent-plus of taxpayers filing correctly the very first year.

We have strong public support, with 75 percent of the public supporting reform.

An early tension felt by proponents of the Massachusetts plan was whether to give the problem of universal access a stronger emphasis than that of cost control. The latter, a difficult issue, was thought better to be dealt with later. Was that a sound judgment in light of the more recent emergence of cost control problems?

Yes, absolutely. We never would have gotten our recent report on payment reform if we had not first dealt with the coverage problem. We have a very strong and active advocacy community here in Massachusetts that was focused on expanding coverage.

Once those gains were realized, these groups quickly turned their focus to the cost controls that are required to

make this a viable long term program. That never would have happened had we not solved the coverage problem first.

How significant do you think the savings would be from the new proposal from the Massachusetts Special Commission on the Health Care Payment System to stop paying doctors on a fee-for-service basis and switch to a global payment system, which would compensate doctors for all of the care that their patients are expected to need in a give period?

Very significant. This is the most fundamental reform we can make on the supply side of medical care. Of course, the devil is in the details—but if done right this can deliver enormous savings. In particular, reimbursement must be tied to actual metrics of performance and demonstrated standards of treatments that work. The best estimates suggest that we could deliver the same level of health in the U.S. while spending two-thirds as much. If smarter reimbursement can reduce the inef-

iciency by even one-sixth, that is enough to pay for covering all the uninsured.

How do you think this change in payment structure will affect the quality of care?

I see no reason why this change will lower quality of care. We have experience with a variety of very striking changes in the supply side of medicine, from hospital prospective payment in the 1980s to managed care in the 1990s. There is no evidence from past experience that any of these changes have consistently lowered the quality of care patients receive.

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