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Health Costs Absorb One-Quarter of Economic Growth, 2000 – 2005

Recent Federal Report Unintentionally Obscures Massive Rise
Physicians' Decisions Key to Controlling Cost

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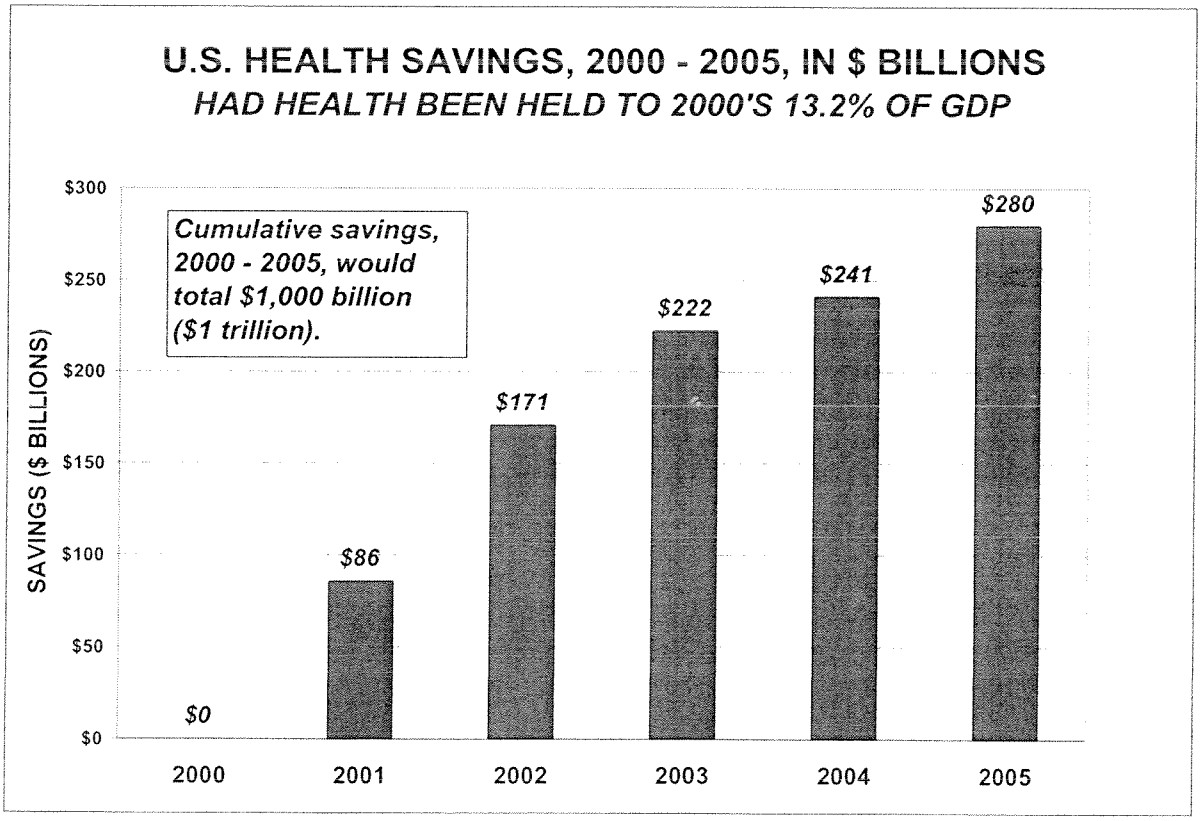
Data Brief No. 8 - 9 February 2005



SUMMARY

I. HEALTH CARE COSTS ARE STILL SOARING UNSUSTAINABLY

- The expected $621 billion rise in U.S. health care spending from 2000 to 2005, we find, will consume nearly one-quarter of the nation's projected economic growth (rise in GDP) of $2,579 billion ($2.6 trillion). *[Exhibits 8, 9]*

- This rests on a reliable federal projection that 2005 health spending will reach $1,921 billion ($1.9 trillion). That is 15.5 percent of the economy, up sharply from 2000's 13.2 percent share. *[Ex. 4, 5]*

- Had health spending in those five years grown only as fast as GDP, the U.S. would have saved $280 billion in 2005 (one-seventh of expected health cost), and $1 trillion in five years. Health spending growth averaged 8.1 percent yearly—more than two-thirds (69 percent) over GDP's 4.8 percent. *[Ex. 6]*

- If defense spending reaches $540 billion in 2005, health spending will still be 3.6 times that. Health spending is now twice education spending. *[Ex. 7, 8]*

- In January 2005, federal researchers published detailed data on 2003 health spending. That report, the press releases, and some news accounts focused on small differences, single-year changes, and other details. They missed the big-picture cost and coverage problems that concern most Americans.

- Administration officials called the findings "good news," an unduly positive view that stressed 2003's slightly slower rise in costs. Many press reports drew incomplete or incorrect conclusions. The data's main implication is that costs continue rising unaffordably. U.S. health costs suffered the third-largest percentage rise in a decade and the second-largest dollar rise ever. *[Ex.1 ,2]*

- The accuracy of federal predictions of health spending permit and oblige the U.S. to now address current costs, not 2003's much lower costs. *[Ex. 3, 4]*

- Rising health costs force many people to drop insurance and make it harder to cover all Americans. The unsustainable rise in health costs also threatens the stability of hospitals, doctors, nursing homes, drug makers and other caregivers. It burdens all who pay for care, and weakens the U.S. economy.

- Still, many caregivers and access advocates have endorsed spending more to advance their distinct aims—partly because traditional cost controls have offered little to either group. It is essential, instead, to contain cost in ways that squeeze out waste, and mobilize the savings to finance high-quality care for all Americans—while paying all needed caregivers adequately.

(continued)

II. BUT NEW STRATEGIES COULD CONTAIN COST, FINANCE NEEDED CARE FOR ALL PEOPLE, AND STABILIZE CAREGIVERS

- Traditional competitive and regulatory cost controls have failed in health care. The administration urges a new strategy, cost shifting, which it touts as "empowering consumers." By promoting underinsurance, this strategy pushes patients to deny themselves care. There is no evidence that this is clinically safe or durably contains costs. Patients are the wrong target for cost controls.

- The alternative is to engage physicians in marshaling inevitably finite dollars to care for all Americans. Doctors are key to cutting cost because their decisions control 87 percent of personal health spending. *[Ex.10]*

- One-half of health spending goes to clinical and administrative waste, excess prices, and theft. Physicians can identify clinical waste. Careful cost controls should rest on physicians' decisions about services needed by each patient. Pathology is remorseless but resources are finite, so trade-offs are essential. There are no blank checks. Trustworthy methods of paying doctors should minimize incentives to over- or under-serve. Variations on this approach have been called "bedside rationing" or "professionalism within a budget."

- It will be hard to engage doctors in this job, but their support is vital to gain backing for effective ways to contain cost and cover all Americans.

- The new Medicare law mandates a "national public debate" on how to make care affordable. But it focuses on the wrong questions, and on one crude cost-cutting tool—asking patients to gamble by excluding certain services from coverage. This process should explore other ways to cut waste and cost, and ways to foster careful physician decisions about appropriate care.

- In 2002, U.S. health spending per person was 2.1 times the average in Canada, France, Germany, Italy, Japan, and the U.K.—nations with greater elderly shares that cover all their people well. Current U.S. spending should be adequate to cover all Americans.

- U.S. health care lives on the hope that more money for business as usual will continue to flow. U.S. caregivers and payers are therefore spectacularly unprepared to economize if a serious recession were to hit. The economy's fragility makes it vital to forge a contingency plan to live with no growth in real health spending. Caregivers must work with patients and payers to develop such a plan—one that avoids serious damage to both coverage and quality.

- Winning affordable high-quality care for all requires negotiating political deals. An acceptably-functioning free market is impossible in health care, so public action is essential to contain cost and expand coverage. Political deals must offer value to patients, caregivers, and payers. Agreement will be easier to negotiate if each party accepts the principle of "one hand for yourself and one for the ship" to balance private and public interests. *[Ex. 11*

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INTRODUCTION

On Tuesday 11 January 2005, experts from the Health Statistics Group, Centers for Medicare and Medicaid Services (CMS), published data on U.S. health care spending in 2003.[1] The title of their report, "Health Spending Growth Slows in 2003," and much press coverage focused on a deceleration in the rate of rise in health spending, the first in seven years. In the CMS press release, top administration officials trumpeted the "good news." [2] The report itself was so comprehensive and described so many details that it inadvertently distracts attention from the main threat—rising health costs. We urge a broader view of the evidence.

It matters little whether the rate of increase for hospitals or for Medicare quickened or slowed a bit in 2003. It matters a great deal that total spending on all types of care, by all payers, continued to rise rapidly. It matters even more that higher health costs absorbed a staggering 24.1 percent share of the nation's economic growth between 2000 and 2005.

With the new government data showing the health care cost burden continuing to worsen, albeit at a slightly reduced pace, the administration's declaration of "good news" appears to be political posturing, misleadingly upbeat.[3]

The CMS report itself summarizes its findings with multiple mentions of "slowdown," "deceleration," and the like in the abstract (summary paragraph) as well as the title. This emphasis misses the big picture, the evidence of the intensifying cost and coverage problems that urgently concern most Americans.[4]

Starkly, the nation's continued failure to limit health spending growth to an affordable, sustainable level threatens the availability of high-quality health care to currently-insured Americans; the nation's capacity to expand coverage to protect uninsured and underinsured Americans; the financial stability of doctors, hospitals, drug makers, nursing homes, and other caregivers; the strength of the U.S. economy as a whole; and the ability of families, employers, and government to afford many other pressing needs.

As U.S. health care accelerates towards the edge of a cliff, the nation should not be distracted by discussions of how well this vehicle's air conditioning is working. Instead, we should focus on avoiding catastrophe by skillfully coordinating the steering wheel, gas, clutch, and brakes.

This brief report focuses first on evidence of unsustainably soaring health care costs, and second on how to contain cost in ways that capture and mobilize the savings to finance high-quality care for all Americans while protecting all needed hospitals, physicians, and other caregivers.

I. HEALTH CARE COSTS STILL SOARING UNSUSTAINABLY

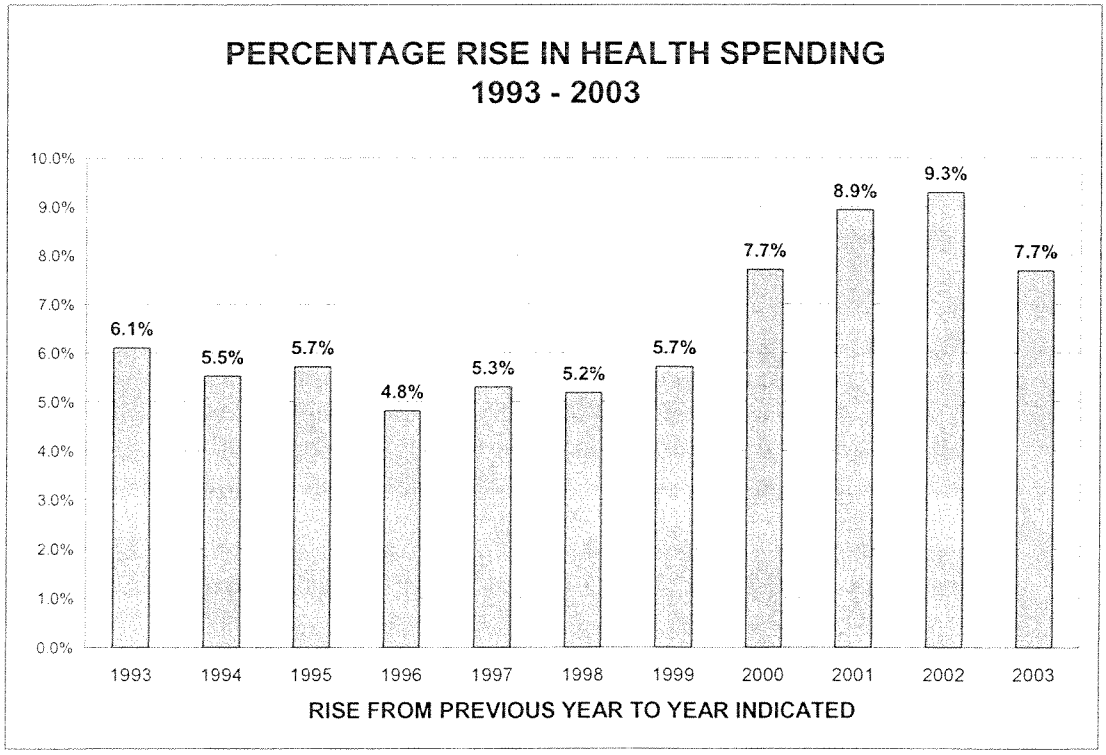
Some press coverage—apparently relying on the journal press release announcing the report—asserted that 2003's rate of increase in health spending *slowed to the lowest level* in seven years.[5] That is not so. Rather, what happened in 2003 was that the rate of increase slowed for the first time in seven years. That had to happen eventually: health care costs could not keep rising faster each year than in the previous year. Increases did finally slow in 2003.

Although the CMS press release focused on the "good news" of a slight deceleration, the first slowing in seven years may be the least important aspect of the new cost data—because it is just a slight easing in continued rapid cost increases.

Indeed, the rate of increase in U.S. health spending in 2003, at 7.7 percent over 2002, was the third-fastest percentage rise in the past decade, as shown in Exhibit 1. This holds true when health spending is measured in constant dollars.

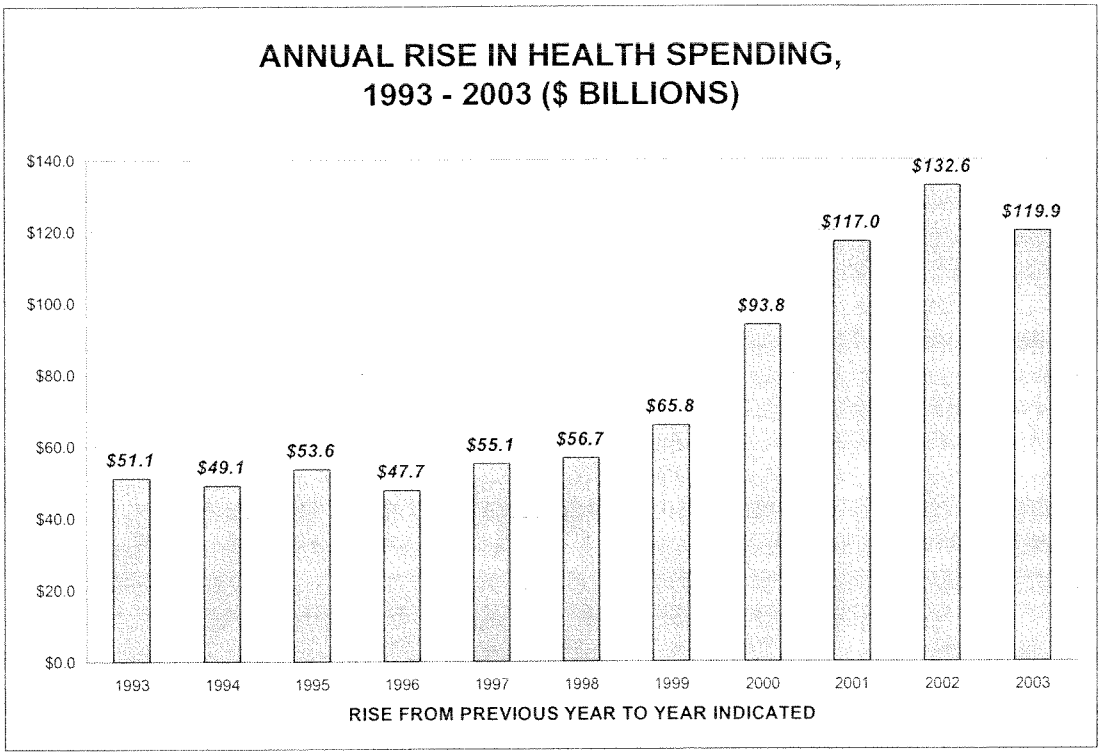
The economy experienced low overall inflation during this entire period, but it is noteworthy that the annual rise in health spending was farther above the inflation rate in 2001-2003 than in the earlier years.[6]

Exhibit 1



Worse, because health care costs have become so high, the actual dollars spent in 2003 exceeded the 2002 level by $120 billion.[7] In absolute size, this was the second-greatest health care spending increase in U.S. history. (Please refer to Exhibit 2.) Further, spending per American rose to $5,774 in 2003.[8] This burden helps to indicate and explain the growing unaffordability of U.S. health care to many citizens and employers.

Exhibit 2



The 2003 CMS report's lack of sharp focus on the big picture may partly result from the agency's understandable practice of annually releasing one additional year's data. This release has become institutionalized as the main time each year when the media cover CMS analyses of health cost trends. In striving to be comprehensive, the report risks losing sight of the forest for the trees. Also, with a focus on single-year data, it is hard to know whether a change is the start of a trend, or just a hiccup. As Exhibit 1 shows, for example, the 1996 cost increase was smaller than the previous year's, but did not portend a continued decline.

Indeed, in an appropriate caution, the report's lead author noted in *Health Affairs*' press release that " '2003 was a unique year...'" and some factors contributing to the slower spending "'are one-time in nature and not expected to recur'...." [9]

The lack of evidence of any durable turnaround in cost trends is another reason why the new data should spur worry and action, not applause for "good news."

A. TWO SALIENT ASPECTS OF THE SPENDING INCREASE

Two aspects of health spending—one that receives little attention, another that receives much—are worth highlighting, and offer great opportunities for savings.

Administration and profit. The *fastest-rising* category of spending in 2003 was "program administration and net cost of private insurance." This includes insurance industry profits along with the cost of administering public and private coverage. These costs increased to $119.7 billion in 2003, a rise of 13.2 percent from 2002, while spending on personal health care rose by 7.3 percent. [10]

Expenditures for insurance administration and profit thus rose 80 percent faster in 2003 than spending on actual care. Further, over the decade from 1993 to 2003, while personal health spending rose by 86 percent, program administration and the net cost of private insurance rose by 125 percent. This spending has now surpassed annual spending on nursing home care.

Containing these costs—and also the even bigger administrative costs in physicians' offices and hospitals—will help make health care for all Americans affordable. Simple reforms would cut the paperwork and bureaucracy that divert resources from care—for example, by replacing thousands of different insurance companies and hundreds of thousands of insurance plans with a single payer.[11]

But it will be very difficult politically to enact and implement such reforms until patients, doctors, and other parties are provided with much greater certainty about how health care would actually work after the reform is implemented. In particular, all parties need better information on how costs would actually be controlled, how caregivers would be paid, how coverage for all would be assured, what services would be provided, and how those decisions would be made. (The second part of this report begins to explore some of those issues.)

Prescription drugs. The 2003 data report a deceleration in the rate of growth in retail prescription drug spending, and this has been widely noted.[12] Nonetheless, the reported spending—on *retail* prescription drugs alone [13] —reached 10.7 percent of national health expenditures, up from 10.3 percent a year earlier, 7.6 percent in 1998, and 5.8 percent in 1993.

We have estimated *total* U.S. prescription drug spending, including drug costs in hospitals and nursing homes as well as retail. This quadruped between 1994 and 2004.[14] Even at the new, lower rate of increase, prescription drug spending will double in seven years. Total drug spending would then reach $500 billion in 2011, the year the first baby boomers pass age 65. (The new Medicare drug benefit will accelerate this rise.) Total drug spending would then reach about 17 percent of health spending. The challenge before us is to make all existing medications affordable to all Americans who need them, while spurring breakthrough research. Happily, both can be achieved.[15]

B. THE FOCUS IN 2005 SHOULD BE ON 2005 SPENDING

The health cost problem would be more real to more Americans if it were presented publicly in real time. We therefore urge focusing more attention on current-year health care expenses. This is entirely feasible because existing CMS estimates and projections have been very accurate.

The size of the recently reported rise in 2003 spending is absolutely not a surprise. Eleven months ago, in February of 2004, CMS experts published a projection that U.S. health spending in 2003 would total $1,673.6 billion.[16] The 11 January 2005 CMS report was the first to estimate actual 2003 spending using data collected after the end of 2003. This report found actual spending of $1,678.9 billion, a difference of only three-tenths of one percent (0.3 percent) from the February 2004 projection.

Indeed, as shown in Exhibit 3, national health expenditure (NHE) projections published in February of 2002, three years before the "actual" figure appeared in print, were off by only 1.5 percent.

Exhibit 3

Recent Projections of 2003 Health Spending versus Actual 2003 Spending ($ billion)

	Projections for 2003 Published by CMS in				2003 Actual
	Feb 2002	Feb 2003	Feb 2004		Jan 2005
NHE, 2003	$1,653.4	$1,660.5	$1,673.6		$1,678.9
% difference from actual 2003	-1.5%	-1.1%	-0.3%		
NHE 2003 % of GDP	15.0%	15.2%	15.3%		15.3%

The CMS experts' near-term (two- or three-year) projections for overall national health expenditures appear to have been very accurate, as Exhibit 3 indicated. They also appear stable over time.

Such projections from CMS merit greater attention and use. Public and private payers, caregivers, patients, and the public at-large all deserve current-year estimates.

We therefore suggest that it is appropriate for the media, the public, and policymakers to focus now, early in 2005, on the available projections for 2005.[17] Please refer to Exhibit 4.

It is very realistic to expect that health spending in 2005 will be about $1,921 billion ($1.9 trillion), as CMS projected in February 2004.

This is $6,477 per person. [18]

Further, CMS is shortly expected to release projections of health spending for the decade after 2003. These should offer a useful focus for further discussion of current-year costs.[19]

Exhibit 4

Recent Projections of 2005 Health Spending ($ billion)

	Projections for 2005 Published by CMS in				2002-4 Difference in Projection
	Feb 2002	Feb 2003	Feb 2004		
NHE, 2005	$1,902.2	$1,907.3	$1,920.8		+1%
NHE 2005 % of GDP	15.6%	15.7%	15.7%		+1%

New data on the size of the economy in 2004 and recent estimates for 2005 show slightly more rapid economic growth than anticipated in 2004.[20] If estimated 2005 health spending remains at $1,921 billion, health spending's share of the economy is now expected to be roughly 15.5 percent in 2005. This report reflects the recent updates in expected GDP growth for 2004 and 2005.

C. HEALTH CARE'S SOARING SHARE OF THE U.S. ECONOMY

As a share of the economy, health spending rose sharply, from 14.9 percent in 2002 to 15.3 percent in 2003. The large jump occurred despite the slight slowing in the pace of health spending growth. This is the first time that health spending exceeded 15 percent of the economy (as measured by gross domestic product).

Worse, health spending now seems likely to rise to 15.5 percent of GDP in 2005.

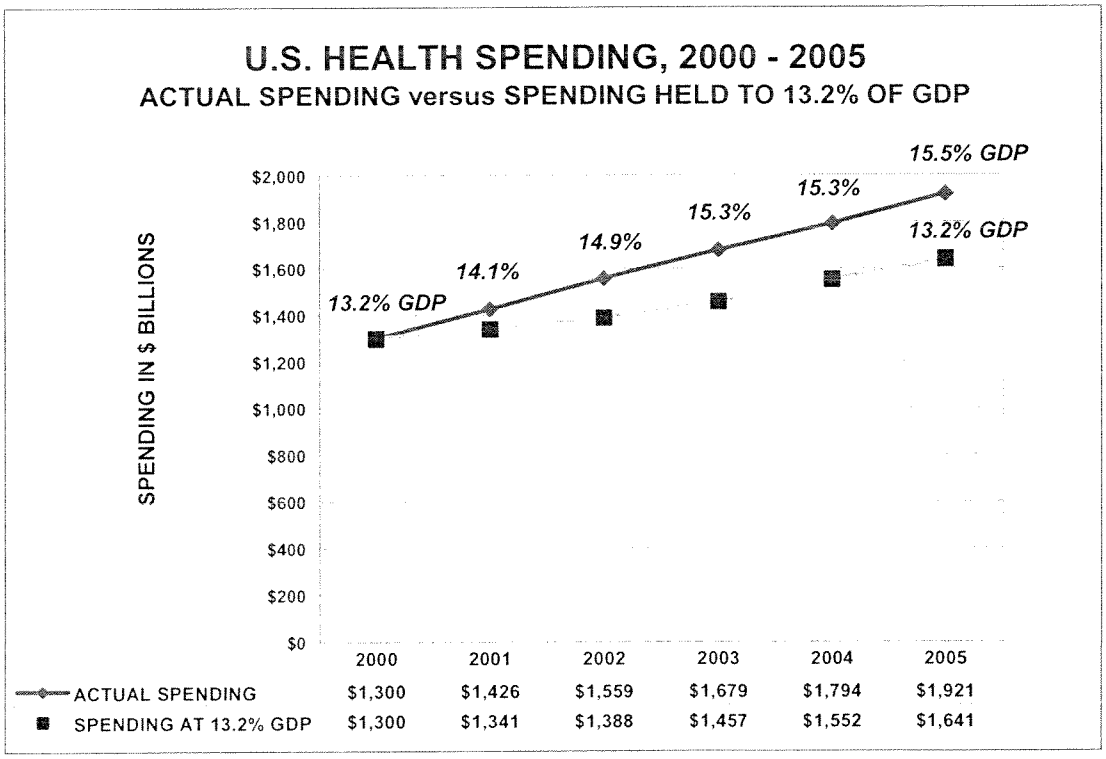
Between 2000 and 2005, health spending therefore can be expected to rise by 47.8 percent while the economy as a whole is rising by 26.3 percent.

From 2000 to 2005 health spending rose an average of 8.1 percent annually—more than two-thirds faster (69 percent faster) than the average 4.8 percent annual growth rate of the economy as a whole.

For perspective: In 2005, each one percent of the economy will equal almost $125 billion.

Exhibit 5 displays actual U.S. health spending since 2000 in dollars and as a share of GDP. It also shows how much would have been spent each year, had health costs been held to the 13.2 percent of GDP prevailing in 2000.

Exhibit 5

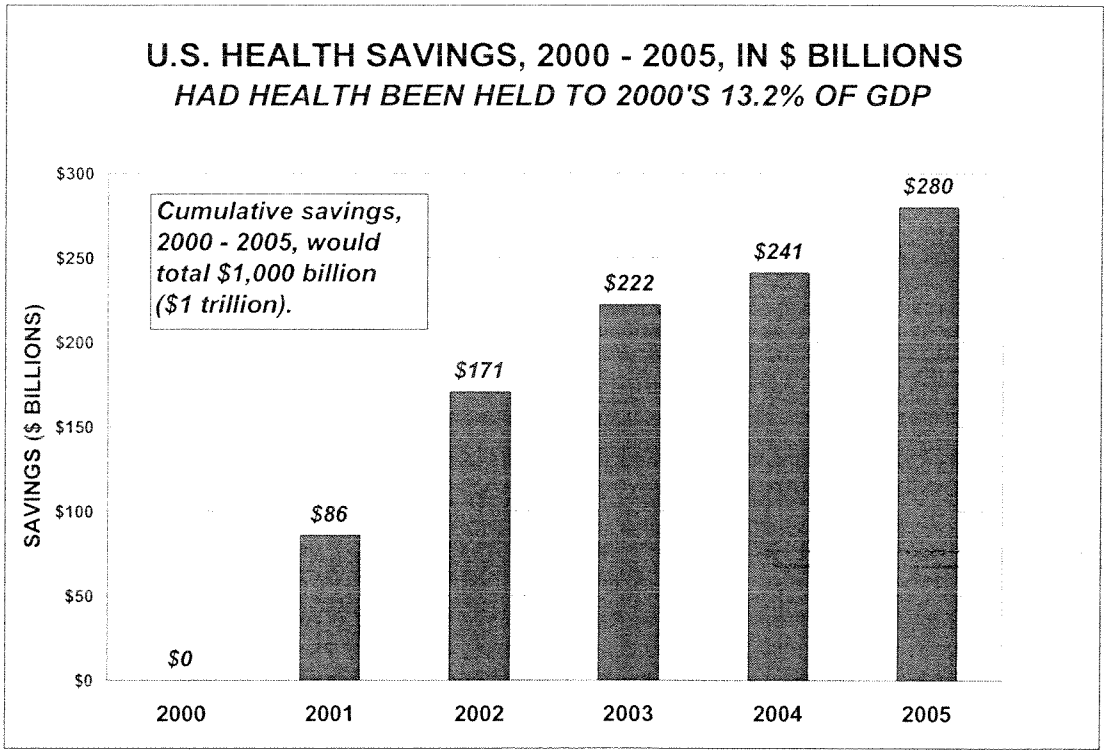


D. SAVINGS WON BY FREEZING HEALTH SPENDING AT 2000'S 13.2 PERCENT OF THE ECONOMY

The annual savings from holding health care's share of the economy fixed from 2000 onward would have been substantial. Had health spending between 2000 and 2005 grown only as fast as the economy as a whole, health spending in 2005 would be $280 billion less (14.6 percent less) than the projected level of $1,921 billion. (Exhibit 6 displays the annual savings.)

In other words, the nation would be spending one-seventh less this year on health care if we had restrained health care's share of GDP to the 13.2 percent that it consumed five years ago.

Exhibit 6



These savings would not have been trivial. As displayed in Exhibit 6, for the five years from 2001 through 2005, the sum of the annual savings would have been $1,000 billion ($1.0 trillion). If the nation had kept health spending to its 2000 share of GDP, the five-year aggregate savings of $1.0 trillion would have equaled just over one-half (52.1 percent) of the projected actual 2005 U.S. health spending.

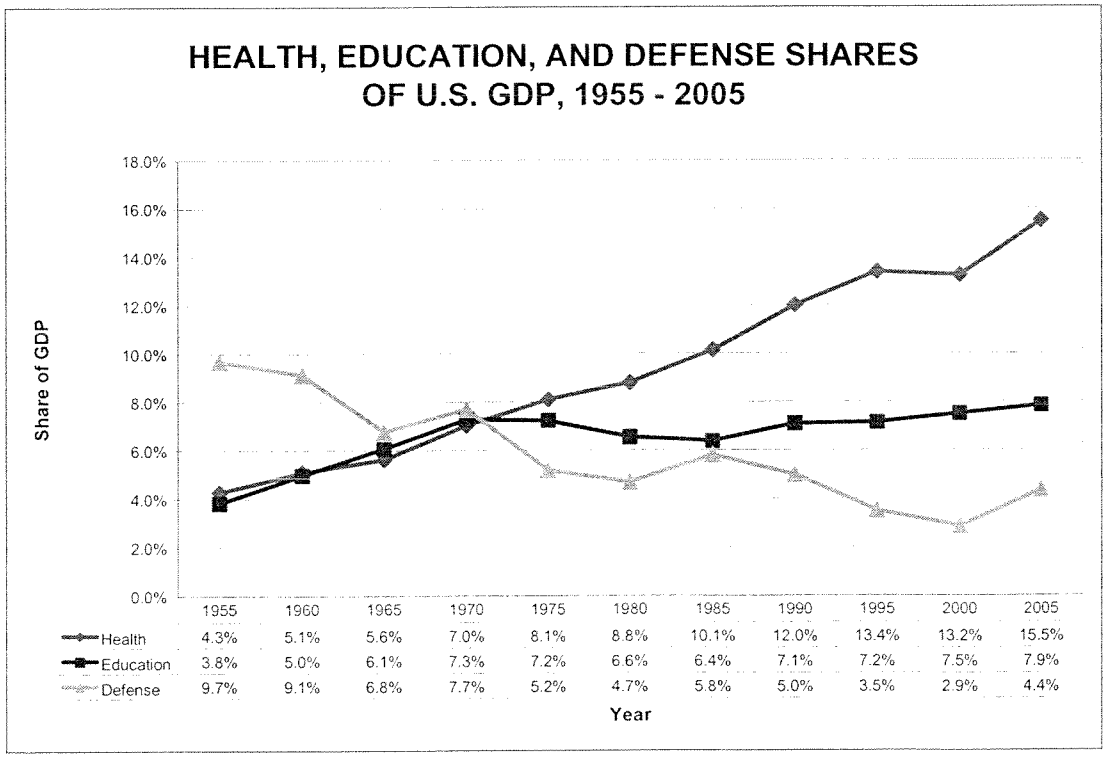
E. HEALTH, EDUCATION, AND DEFENSE

Exhibit 7 displays health care's share of GDP over the past 50 years. For comparison, it shows that health care now consumes nearly twice the share of GDP devoted to education. It also displays the defense share.

In 1985, near the height of the Reagan-era defense spending build-up, health spending was only 1.7 times as great as defense spending. [21] For 2005, even if we project defense spending at $540 billion, including supplementary spending to finance military operations in Iraq and Afghanistan,[22] health spending of $1,921 billion will still be 3.6 times as great as defense spending.

The rise in health spending of $621 billion between 2000 and 2005, shown in Exhibit 8, is itself substantially (fifteen percent) greater than expected defense spending of $540 billion in 2005.

Exhibit 7



F. HEALTH CARE SPENDING INCREASES ABSORBED 24% OF ECONOMIC GROWTH, 2000-2005

A look at the changes in health care and defense shares of GDP between 2000 and 2005 is particularly revealing. (Please see Exhibit 8.)

Exhibit 8

Health and Defense Shares of GDP, 2000 and 2005
(Dollars in Billions)

	CY	FY	CY	Percent of GDP	
Year	Health	Defense	GDP	Health	Defense
2000	$1,300	$281	$9,817	13.2%	2.9%
expected 2005	$1,921	$540	$12,396	15.5%	4.4%
rise 2000-2005					
Absolute	$621	$259	$2,579	2.3%	1.5%
percentage	47.8%	92.0%	26.3%	17.1%	52.1%
share of GDP rise	24.1%	10.0%			

As shown in Exhibit 8:

- ✓ The rise in health spending of $621 billion between 2000 and 2005 is absorbing nearly one-quarter (24.1 percent) of the expected GDP rise of $2,579 billion ($2.6 trillion), as illustrated in Exhibit 9. This large share is partly attributable to the surge in health spending and partly to relatively slow economic growth. It is reasonable to fear, looking forward, that the economy is in precarious condition. A stagnant economy is likely to lead to slower health spending growth—or even actual reductions. Today's health sector is radically unprepared to cope with even a substantial slowdown in annual revenue increases.

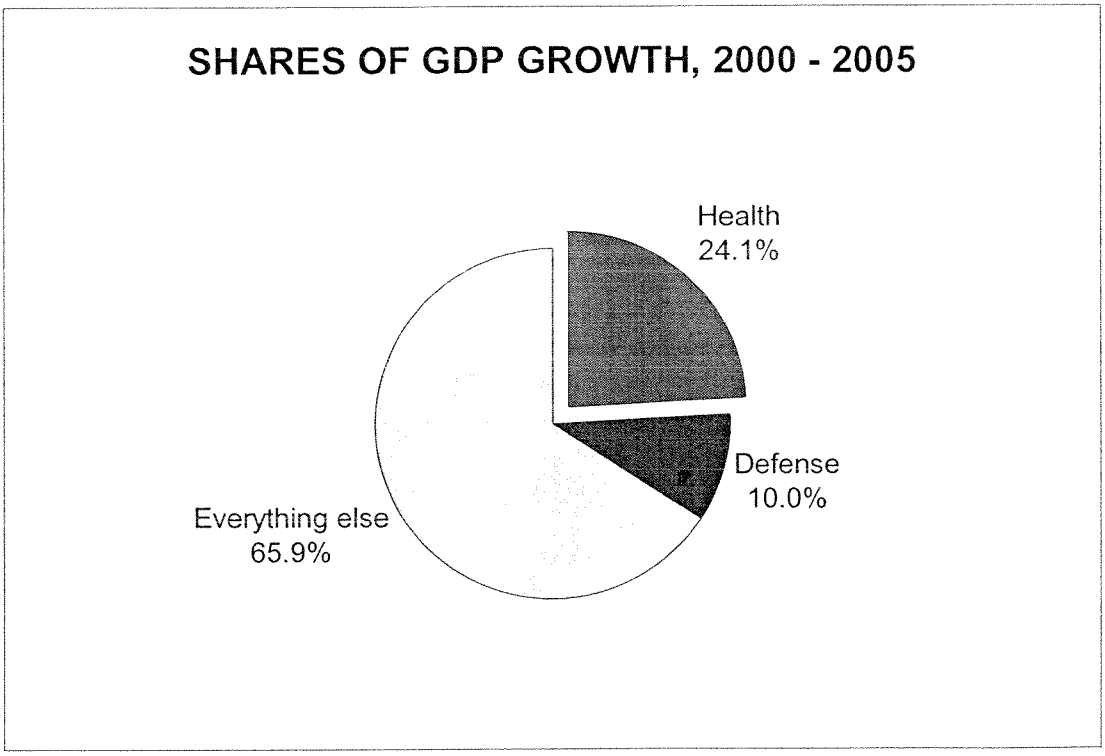
- ✓ Health spending's five-year rise of $621 billion amounts to a 48 percent increase, while defense has risen by $259 billion (92 percent).

- ✓ Health care's share of GDP rose in those five years by 2.3 percentage points (from 13.2 percent to 15.5 percent). By contrast, defense's share of GDP rose by 1.5 percentage points (from 2.9 to 4.4 percent).

So, although health care constitutes between one-seventh and one-sixth of the economy, the rapid rise in health spending has been absorbing nearly one-fourth of the economy's growth, a very disproportionate share. That limits the ability of the nation's families, employers, and government to pay for education, housing, new machinery to help rebuild manufacturing, cleaning the environment, improving criminal justice, vacations, or anything else they might hope to afford. And it hinders American businesses' ability to price exports competitively.

Exhibit 9 displays the shares of GDP growth from 2000 to 2005 that were consumed by health, defense, and all other sectors of the economy. It highlights health care's one-quarter share of the growth in the U.S. economy between 2000 and 2005.

Exhibit 9



G. HEALTH'S GROWING SHARE OF THE ECONOMY: UNSUSTAINABLE, UNDESIRABLE, UNNEEDED, BUT SEEMINGLY IRRESISTIBLE

Some economists and many health care industry groups assert that

1) continued growth in health's share of GDP is sustainable financially, [23]
2) continued growth is desirable to boost the economy itself, [24]
3) continued growth is essential to finance better health outcomes,[25] or
4) regardless of the feasibility or desirability of hiking health's share of GDP, there are few serious, effective political pressures to constrain that growth.

Many advocates for uninsured and under-insured people implicitly endorse the first assertion. Those who seek to expand coverage through higher spending apparently assume that such growth in spending would be sustainable.

But we consider the first assertion to be untrue. The growing structural weaknesses of the U.S. economy—manifested in rising federal budget deficits and trade deficits—mock these assertions.[26] In 2004, the federal budget deficit of 3.5 percent of GDP plus the trade deficit of 5.4 percent of GDP summed to 9.2 percent of GDP. The need to fill these two gaps will sharply limit the nation's ability to expand health or other spending. Recent U.S. health spending increases are unsustainable. Between 2000 and 2005, annual health spending increases have averaged 8.1 percent—69 percent faster than GDP growth, which averaged 4.8 percent, as noted earlier.

We consider the second assertion to be either short-sighted, self-serving, desperate, or silly. Although a rising GDP share for health care is often hailed by people who work in health care, it leaves business, government, and families with less money for all other needs. While it is true that some states or regions may enjoy short-run benefits by capturing disproportionate shares of the nation's health spending, those economies thereby become over-exposed to the risk of health care cuts. Employers and patients in high-cost areas are hard-pressed.

Rising health care spending is not essential to sustain a strong economy. Rather, only a strong and growing economy, would make it possible to devote a growing share of GDP to health. Even then, it would probably not be desirable.

The rapid growth in spending is especially distressing because it appears that about one-half of existing U.S. health spending is wasted (in four main ways, discussed in Part II), and that seems true of added spending also.

This enormous waste is one reason why higher health spending is unnecessary. In addition, there is no evidence that high U.S. health spending has brought commensurate improvements in health outcomes. Rather, the main benefits have apparently gone to caregivers (including makers of health care products).[27]

The growing health care cost burden further weakens the U.S. economy by making our products less competitive globally [28] and by undermining the ability of government and others to finance education and other vital investment.[29]

Yet there is little discussion of options for substantially slowing health spending increases without seriously damaging coverage or quality.

The third assertion is that higher health spending is required to finance new life-saving technologies. No. We now get cost-increasing new technologies because we are willing to pay for them. The nation could instead choose to reward new technologies and other innovations that lower cost by substituting for existing high-cost diagnostic or therapeutic interventions. When health spending is capped, the market for cost-reducing technologies will burgeon.

Clearly, though, the fourth assertion is valid—for now. There is little effective pressure for effective cost controls. Payers are burdened, but cost controls are not politically popular. The federal government's preference for trying to find ways to oblige patients to spend more of their own money on health services testifies to this. This approach promises cost control, but guarantees nothing. Failure can be blamed on the market, not on the politicians who urged its use.

Containing cost is understandably unpopular. Past cost controls have irritated but have seldom been effective. They have threatened caregivers with reduced payments—threats that caregivers have typically been able to neutralize or to game to generate still higher revenue. Past cost controls threatened to take away; they offered little in return—except the abstraction of cost control itself. The asymmetry between promised pain and promised gain was great.

(Many health care access advocates privately recognize the need to contain health cost eventually but they often endorse higher spending today as the only way to cover more people. Their reasons include the practical difficulty and political unpopularity of fashioning effective cost controls. Today's real suffering makes advocates understandably impatient to allow coverage to be held hostage to either prior or concurrent cost containment. And access advocates recognize that they can win caregivers' political support for higher coverage because those caregivers expect that more paying customers mean greater revenue.)

What might change all this? A prolonged and deep recession would boost political pressure to stabilize or even cut health's share of GDP. Creditor nations might demand that Washington cut its budget and trade deficits. Harsh federal health spending cuts might make hospitals, physicians, drug makers, and other caregivers jittery about relying on more money for business as usual. They might demand reforms. These could include less painful cost controls, such as evidence-driven cuts in clinical waste or various cuts in paperwork or excess prices. Savings could be captured and recycled to finance coverage for today's uninsured and under-insured Americans, thereby protecting caregivers' incomes.

II. TODAY'S SPENDING IS ADEQUATE TO FINANCE THE CARE THAT WORKS FOR THE PEOPLE WHO NEED IT

The growing cost of U.S. health care makes it much harder to extend financial protection to people who are uninsured. Despite continued rapid spending growth—and probably in part because of it—the number of people lacking insurance rose from 43.6 million in 2002 to 45.0 million in 2003, a rise of 1.4 million, or about three percent.[30] The new CMS report notes that "persistently high growth in per worker premiums means that fewer workers enroll in health insurance plans." CMS also observes that many states, as they grapple with rising Medicaid spending, have "tightened eligibility and restricted benefits."

Between 2003 and 2005, health spending per American is expected to rise from $5,774 to $6,477.[31] That is an increase of $702 or one-eighth (12.2 percent) in just two years. The demands of financing business as usual have had first claim on new health care dollars. These rising costs are therefore associated with cuts in coverage. How, then, can even more new money be found to cover uninsured people—or fill gaps for under-insured Americans?

International comparisons show U.S. spending should be adequate

Other nations have shown that they can cover all people at affordable costs. In 2002, we calculate, U.S. health spending per person was just over double (2.1 times as great as) the average in Canada, France, Germany, Italy, Japan, and the United Kingdom.[32] Yet these other nations cover all their people and enjoy superior health outcomes despite typically smoking and drinking more than Americans.[33] The over-65 share of most of these nations' populations is already at the level the U.S. will reach decades hence. And in public opinion polls, citizens of these nations are more likely to say they are satisfied with their health care than are Americans.

Further, most of the wealthy industrial democracies' ratios of physicians and hospital beds to population exceed those in the U.S.[34] U.S. care is more intense, aggressive, and specialized—though not, seemingly, more effective on average. U.S. physicians are more likely to be procedure-oriented specialists than their European counterparts. Teaching hospitals' share of U.S. urban hospital beds rose from 44 percent in 1950 to 76 percent in 2000.[35]

All of this suggests that current U.S. spending should be adequate to cover all Americans. There is great room for optimism—particularly because other evidence suggests that a vast share of U.S. health spending is wasted and could be better used to expand services to people who are now under-served.

Some one-half of U.S. health spending is wasted

We contend that some one-half of current health spending is wasted, that traditional wholesale cost controls have failed, and that the current crop of market-oriented efforts to de-insure patients and make them pay more out-of-pocket will also fail to squeeze out meaningful shares of this waste.

We therefore urge retail controls that rely on individual physician decisions, patient-by-patient, to provide the care that works and to spend money more carefully.

Still, just because these retail cost controls are the only way likely to work does not mean they will be easy to implement. Rather, implementing them successfully will be very difficult. But not impossible. Smart, hard, coordinated efforts will be required. These are justified by the value of the prize and by the lack of alternatives.

Some of the waste is irreducible friction but most of what is now being squandered can be identified, squeezed out, captured, and mobilized to help previously under-served patients.

Understanding the nature and causes of the four major types of health care waste shows why neither traditional wholesale cost controls nor ideological market-based deinsurance controls can work.

Caregivers have shown they can game such cost controls. If a cost control squeezes revenue in one way, caregivers discover ways to replace the lost money. For example, when certificate of need made it somewhat harder for hospitals to build more beds, many hospitals shifted capital investments into specialized programs and costly equipment that served as platforms for more intensive patterns of care. When Medicare capped cost reimbursement levels for hospitals' basic daily costs, hospitals began unbundling care and billing separately for services formerly covered under the basic daily payments. When Medicare's DRG-based Prospective Payment System specified fixed payments to hospitals for each episode of inpatient care, hospitals provided more of the inpatient admissions that they found profitable, and also shifted more care to the outpatient side. When insurers cut prices paid for each physician visit, physicians often seek to provide more visits, thereby generating the target revenues they consider appropriate. It's helpful to appreciate how much latitude physicians have about how much care to provide. An example: Surgeons in regions with more surgeons per thousand people regularly perform more surgery per thousand people.

Understanding the nature of health care waste sheds light on the impossibility of success through either wholesale or market-based de-insurance cost controls. Each type of waste exists for a set of reasons particular to that type. Each can

be reduced by addressing its causes. Because many of the wholesale efforts to shrink waste have ignored its causes, they have magnified waste.

Money is wasted in health care in numerous ways. The four most important types of waste in health care are clinical waste, administrative waste, excessive prices, and theft:

- The smallest of these four shares of waste, we conclude, is associated with outright theft and program fraud—which is not primarily by patients, but by those who earn their incomes from health care: some caregivers and insurers.

  The complexity of today's financing methods helps to make this possible. So does reliance on individual claims payment to compensate caregivers, as billions of claims for individual services must be processed each year.

  Also central is the promotion of market thinking in health care despite the absence of the conditions for a genuine free market. Adam Smith has rightly argued that free markets convert private greed into the public good, and that profit measures success in doing so. If the conditions for a genuine free market are present, this makes sense to most Americans. Theft reduces efficiency and satisfaction of consumer needs, so successful businesspeople fight theft to hold down their costs.

  But since free markets are unattainable in health care, greater reliance on markets can do nothing to reduce theft and fraud. Indeed, because—in a genuine free market—greater profits mean greater value, too many people who are not aware of the absence of a free market in health care assume that doing well financially is a sign of doing good clinically. Too often, we have allowed profit to sanctify itself. This causes delays in identifying theft and fraud. The cases of Columbia-HCA, HealthSouth, Tenet, accusations of pharmacy benefit managers' violations of fiduciary duties to clients, drug makers' conspiracies in restraint of trade, and other apparent financial irregularities of recent years seem to be examples of this.

  Perhaps most important, in today's health care world, there are too few pressures to rein in theft. Few people recognize—or have objective reason to recognize—that waste through theft or program fraud *actually kills*. That's because the connection between stealing money and reduced service to people in need either does not exist or is invisible to most who know about the theft. When money is stolen, it does not manifestly result in denial of needed care. Instead, either the stolen money is replaced (raising costs further) or clinical services are cut quietly—so the theft often does not directly and visibly harm identified patients.

If, instead, finite dollars to serve a finite group of identified patients are pooled in one place, theft or fraud of $1 million means that much less money is available to address visible clinical problems. Those who know about the theft or fraud are more likely to blow the whistle.[36]

- Waste in the form of excess prices is substantial. For example, if the U.S. paid Canadian prices for brand name prescription drugs in 2004, some $60 billion would have been saved, we have calculated.[37] But lower prices mean that patients and payers can afford to fill more prescriptions. So the $60 billion in savings could have been recycled to buy brand name drugs for the 70 million Americans who entirely lack prescription drug coverage or the dozens of millions of others with inadequate coverage. Thus, the drug makers recoup the revenue lost through the cut in prices to Canadian levels. A very small additional sum would be needed to cover the low real added cost of producing and dispensing the additional volume of medications. In that way, drug makers would have been made financially whole, with no damage to either current profits or ability to finance breakthrough research.

  Designing, negotiating, and implementing this sort of arrangement requires long-term trust-building among patients, payers, and drug makers. It can't be done ad hoc, transiently. It can't be done by payers or politicians who drop bombs on drug makers. It can't be done amidst drug makers' efforts to advertise to patients to inveigle them to buy medications they don't need, or their efforts to suppress evidence about drug safety or efficacy. Instead, a climate of trust and honesty is required.

  By contrast, greater reliance on market forces can do very little to lower drug prices. Importing drugs from Canada or other nations, while advanced as a free trade or free market solution, is neither. Rather, it is an importation of Canada's or other nations' price controls—a short-cut to avoid grappling directly with prices here. Market efforts to cut patent length or boost use of generics have had little effect on drug spending. And, if they succeed, they do reduce revenue potentially available to finance breakthrough research. Some buyers, like state government or large employers, are moving to demand that drug makers submit competitive bids if they wish to sell medications. This works for many drugs. If successful, it, too, cuts drug makers' revenues. And the savings are not recycled into expanded coverage for uninsured or under-insured patients.

- Waste in the form of administration is very substantial. This refers mainly to the administration of services and of payments to caregivers. Most of the waste is the product of mistrust, complexity, or the interaction between the two. The complexity stems in part from the need to determine whether a

patient is insured at all; what services, caregivers, and medications are covered by a particular insurer; the need to file different forms for different payers; the need to track patients' spending towards deductibles; and the like. Even more complexity stems from payers' and caregivers' mistrust of one another. Mistrust itself stems from the complicated rules that payers erect to try to hold down their obligations to caregivers—restrictions on payment per service, what services are covered, rules governing obtaining permission to serve, and the like. The consequences of each effort by payers to cut cost engender still more mistrust. For example, if a payer cuts the rate of payment per service, the caregiver is tempted to provide more services to make up for the lost revenue. They payer must then monitor volume of care as well as rate of payment per service. And so on. (This cycle probably originated largely in the early errors in designing how insurers paid hospitals and doctors. Those designs inadvertently tended to be too open-ended, effectively giving caregivers blank checks. Payers had to retrofit cost controls. This caused resentment because hospitals and doctors perceived that the cost controls deprived them of higher incomes they had gotten accustomed to and deserved.)

Covering all patients and pooling all revenue in a single trust fund or a single payer eliminates the complexity associated with multiple payers, but not the complexity associated with payer mistrust of caregivers. Mistrust will end when its actual or imagined causes end—and that will depend on establishing a trustworthy method of delivering care to all patients at a pre-set cost.

- Waste in the form of unnecessary or incompetent clinical service is the most costly type. It stems from lack of evidence about what care works to diagnose or treat an illness, uneven use of existing evidence, dissemination of inaccurate or misleading information by self-interested parties, incompetence or impairment of a relatively small share of caregivers, financial incentives to over- or under-serve associated with various methods of payment, excessively self-interested behavior by some caregivers, defensive medicine spurred by fear of malpractice litigation, demands by some patients for unnecessary care, and the like. But failure by at least as many patients to seek needed care, financial barriers associated with lack of insurance that prevent many patients from seeking care, and non-financial barriers like lack of nearby caregivers all often lead to waste also, when delayed care means costly complications.

  Making patients pay more out-of-pocket predictably causes many patients to seek less care, but—in part because they lack good information—much of the care that's cut would have been helpful. Further, caregivers can be expected to respond to lower use by some patients by doing more for the patients who do continue to seek services.[38]

Much of the clinical waste can be eliminated by better information, insurance or other financial protection for patients, better spatial distribution of hospitals and doctors, more financially neutral methods of paying doctors that reward competence and kindness and energy, and replacement of tort-based malpractice litigation with other methods of compensating those harmed and of addressing incompetence.

But the job of husbanding resources and marshaling them to do as much good as possible must rest on individual doctors' decisions about the needs of patients both individually and collectively.

Generally, the most acceptable motives for cutting costs are to keep all needed care affordable for presently covered patients, and to expand financial protection to presently uninsured patients. Cost controls must make sense clinically, financially, and ethically. Then, they will make irresistible political sense as well.

A. SOLVING THE COST AND COVERAGE PROBLEMS

Three steps are essential:

- ✓ Crafting acceptable and effective ways to contain cost. These will entail little or no reliance on wholesale cost controls or on exposing patients to greater out-of-pocket costs. Instead, they will place great reliance on physician decisions to weed out unnecessary or ineffective care. This approach is essential because, as Sherlock Holmes said, "When you have eliminated the impossible, whatever remains, however improbable, must be the truth." Building physicians', payers', and patients' confidence in these arrangements requires designing and testing acceptable and effective ways to enroll patients, establish and monitor budgets, pay physicians, organize care, and evaluate results.

- ✓ Anticipating unpleasant contingencies. U.S. health care today rests on the hope that more money to finance business as usual will continue to flow. It is spectacularly unprepared for the contingency that economic weaknesses will constrain revenue growth. This is folly. Real harm to patients and caregivers will result from a failure to prepare.

- ✓ Negotiating and testing political deals to assure affordable and high-quality health care for all Americans. Since an acceptably-functioning free market is impossible to attain in health care (with the exception of eyeglasses and contact lenses), public action is essential to limit cost and expand coverage. As long as U.S. health care continues to lack both a free market and competent government action, the nation will continue to suffer anarchic cost explosions. These explosions will be followed, in time, by equally anarchic—though possibly more harmful—revenue restrictions.

  Since economics inevitably fails in health care, government and politics are the only alternative to anarchy. Political deals will have to offer each party something important. They would be somewhat easier to negotiate if all parties accepted the principle of "one hand for yourself and one for the ship" as a way to balance selfish and selfless interests. The big, broad political decisions and deals—for example, determining how much health spending should grow—should be crafted and judged strategically. Doing this strategically means coordinating financial, budgetary, and organizational structures that liberate and oblige willing physicians to spend money in a careful and trustworthy manner. If the devil is in the details, the details should be left to physicians to address angelically, patient-by-patient. Only the big decisions should be made politically.

B. ACCEPTABLE AND EFFECTIVE WAYS TO CONTAIN COST

In the first few decades after the end of World War II, higher health spending probably seemed desirable to most of the Americans who thought about the matter at all. The federal Hill-Burton hospital construction program was designed in part as a public works program to help prevent a feared post-war return to Depression. Rapid innovation was promising to reduce illness and extend lives. In the prosperous years of the 1950s and 1960s, what better to spend money on than better health care?

Then, the U.S. economy began to weaken during the Viet Nam-era pursuit of both guns and butter, the two oil price shocks of the 1970s, and the Reagan administration's strong dollar, which undermined domestic manufacturing. Rising health costs were seen as an increasingly serious problem.

Beginning in the early 1970s, payers have worked episodically to contain health costs. In the watershed year of 1972, Congress first took serious legislative action to slow the rise of health costs by trying to set limits on cost-reimbursement payments to hospitals. That year, U.S. health spending of $90.4 billion amounted to 7.8 percent of GDP.[39]

In subsequent decades, payers tried both regulatory controls like certificate of need constraints on hospital capital spending, resource-based relative value scales for paying physicians, and competitive controls like inter-hospital and inter-HMO competition by price and quality. These traditional broad or wholesale controls have failed.

Since the early 1970s, Congress has massively changed methods of paying both hospitals and doctors under Medicare, promoted use of competing HMOs by Medicare and Medicaid, sought to limit hospital capital spending through certificate of need, tried to encourage training of more primary care physicians, cut payment rates to hospitals and doctors, and taken a host of other steps to try to slow cost. Private employers, insurers and Blue Cross plans, managed care organizations, and others have employed these and other techniques.

Still, in 2005, only 23 years later, health's share of GDP has almost exactly doubled.

We can safely draw several lessons.

First, reining in health costs is a hard and complex job--financially, politically, clinically, and organizationally. Cost cutters have often adopted short-sighted, uncoordinated, or untested approaches. Failing to appreciate the difficulty of containing cost, they have failed to do so. Episodic, desultory cost controls and clever political slogans don't substitute for sustained engagement.

Second, caregivers have often been ingenious in legislatively defeating some proposed cost controls or in hamstringing other proposals that later passed in enfeebled, complex, and unworkable forms.

Third, caregivers have often been able to game cost controls that were passed, relying on various combinations of superior clinical knowledge and mastery of billing to serve patients and seek payments in ways that protected or actually increased revenue.

Fourth, all this is understandable politically because cost controls were seldom linked to a larger benign and highly visible end, such as durably financing needed health services for all Americans, or expanding coverage to previously under-served people. Instead, any savings won were actually designed to disappear like a desert stream that sinks into the sand. Few potential beneficiaries could perceive gain, so why should they fight for what they viewed as the abstraction of cost control? Many caregivers would potentially be harmed, and they had every reason to oppose cost control. They could threaten that the controls would harm patients.

Fifth, actually limiting health care cost increases will require buy-in from caregivers (particularly doctors), employers, other payers, and especially patients. This buy-in can in be sought in three ways. The first should rest on a combination of building a shared understanding of the unaffordability of continuing to rely on more money for business as usual, and of the need for compromise among caregivers, payers, and patients. The second should rest on robust political deals involving each group of caregivers. The third requires demonstrating that it is possible to build practical, coordinated, and workable ways to contain cost and assure coverage for all Americans, and that doing so will put U.S. health care on a durably affordable foundation. In summary, acceptance of cost controls will be much easier to obtain

- if cost controls are accompanied by a commitment—and by actual mechanisms—to recycle savings to cover more people and expand access for the under-insured,
- if all parties see that more money for business as usual is starkly unaffordable,
- if caregivers are promised adequate and secure revenue, and if cost controls target actual waste or fat.

It is vital to involve caregivers centrally in cutting costs. Even with today's far-from-perfect information, doctors and other caregivers know where much or most of the waste is located. So to cut unneeded services and other waste, we must rely most

- not on the bludgeon of HMO/insuror regulations (which failed),

- not on the risky pass-the-buck policy of requiring high patient payments, and forcing patients to deny themselves care,
- not on the gamble of omitting coverage for certain services,
- but rather on the scalpel of careful decision-making by physicians (paid in ways to minimize incentives either to under- or over-serve).

C. PATIENTS ARE RARELY CONSUMERS, AND FORCING THEM TO PAY MORE OUT-OF-POCKET CONSTITUTES A REGRESSIVE TAX ON BEING SICK

Patients are not the key to containing health costs. It is mistaken to consider patients "consumers." Consumers in a genuine free market require good information about price and quality of products being bought. That information is usually lacking or very difficult to acquire in health care. The great majority of patients depend on doctors for information, inevitably.

Yet today, in what appears to be the most widely-touted strategy for containing the cost of health coverage, many private and public payers are requiring higher patient co-payments, co-insurance, and deductibles, and dropping certain benefits entirely. But as discussed below, this appears likely to put patients at risk, while doing more to shift costs than to contain them overall.

CMS found that out-of-pocket spending grew faster in 2003 than in recent years, and attributed this to the higher patient payments required in employer-sponsored insurance and to the rise in the number of people who are entirely uninsured. CMS's January 2005 report considered likely responses to rising health care costs. It forecast further cuts in private and public coverage, and more employer cost-shifts to workers, with little hint that other options are available.

One account of the new cost data summed up aptly by noting that the slower rise in U.S. health costs appeared attributable to "Policies that make it harder for the poor, the elderly and the disabled to get treatment...." [40] As a result of such cost-shifts, a recent study concluded that in 2004, 14.3 million Americans under age 65—most of whom were insured—spent over one-quarter of their incomes on health care.[41] Patients' obligations to pay for medical care, other recent analyses have found, account for a large share of all personal bankruptcies.[42]

The president and his allies advocate further expanding use of high deductibles and related measures to make sick people bear a larger share of health care costs, to increase their attention to costs.[43] But forcing sick people to pay more—trumpeted as "empowering consumers"—constitutes a reckless, buck-passing policy that actively promotes under-insurance.

By diminishing the broad sharing of costs through public or private insurance, "patient cost-sharing," as it is called, moves us backwards, increasing the numbers of people under-insured and uninsured. Worse, requiring people who need care to pay more is a tax on the sick. This sickness tax is regressive, because sicker people tend to have lower incomes—and poorer people also tend to be sicker.[44]

Reducing coverage by requiring more patient payments will doubtless reduce use of care by average Americans, and encourage patients to try to second-guess the tests and treatments that their physicians prescribe.

But there is evidence that these changes are ***not*** clinically safe, and no evidence that they cut costs overall.[45] Non-physicians cannot readily tell whether care is needed.

Requiring higher out-of-pocket payments puts all patients at risk. People with high out-of-pocket costs who are poor and sick are especially likely to forgo care—both vital and inessential care—and thus to needlessly suffer pain, disability, even death.[46] Under these circumstances, de-insuring patients and then asking them to decide what care they need is a little like asking them to serve as untrained kamikaze pilots in the war on health costs.

Further, the financial result is often higher cost for delayed treatment.

The potential for savings is reduced in another way. Notably, patients use fewer services as out-of-pocket costs rise, resulting in a drop in caregivers' incomes. In response, caregivers can be expected to raise their prices or to treat their remaining patients more intensively.[47]

(Therefore, if requirements for higher patient payments were to reduce total health spending, they would have to be applied so as to have equivalent use-reducing effects on all patients, as one analyst suggests. Doing so would be difficult, given patients' varied circumstances and preferences—not to speak of the huge variety of coverage plans that exist today.[48] Likewise, rules for required patient payments for different types of health services would have to be calibrated carefully to avoid prompting patients and caregivers to substitute other services, simply shifting or even raising costs.)

Some physicians and other caregivers may support high-deductible insurance plans today because they hope to charge full undiscounted prices to patients with health savings accounts (HSAs). But it is not clear that these higher prices will offset the revenue loss caused by the drop in the number of well-insured patients. Physicians may also be demoralized by pressure to do still more for well-insured or higher-income patients and to do still less for patients who can pay less.

Many low-income patients will simply forgo needed care (rather than trying to persuade doctors, hospitals, or pharmacies to forgo collecting the increased out-of-pocket share). When higher out-of-pocket payment requirements pose a barrier to care for patients, many or most caregivers will simply cease to serve them. Today's policies neither expect nor encourage caregivers to absorb those costs.

Some caregivers may continue to serve people in need who cannot pay. So policies that shift more costs to patients may wind up financially burdening the caregivers who serve them, especially in poorer communities. For example, public hospitals, some non-profit teaching hospitals, and health centers will struggle to continue serving their patients when states slash Medicaid's scope of benefits, and when private or public insurance plans set co-insurance, deductibles, or benefit caps that leave patients unable to pay for needed care. Some pharmacies in poor areas may previously have forgone collecting Medicaid patients' $1-2 co-payments but must face turning patients away or suffering intolerably large revenue losses when states raise patients' co-payments further (rather than tackling drug makers' prices).

Indeed, boosting patients' required payments may be especially dangerous for public hospitals, health centers, and other caregivers who serve many low-income patients. This policy could jeopardize the very survival of those vitally-needed caregivers. Controlling costs in other ways will therefore be especially important to those caregivers.

Most important, requiring higher patient payments cannot work to control costs because it aims at the wrong target. Designers of successful cost controls must recognize that a relatively small number of seriously ill people account for the vast majority of health spending—69 percent of health costs in 1996 were for 10 percent of non-institutionalized Americans.[49] The costs incurred for seriously ill people largely reflect complex treatment decisions by their physicians, and may be little affected by requiring higher co-payments and deductibles. A patient's main decision, it has been said, is whether to initiate the process of care by visiting a physician.

Many well-intentioned people may today accept the argument that Americans must be educated and encouraged to weigh value of services and their cost before using care. This is dangerously misguided—and not only because good cost data are not generally available, and because the bulk of the population contributes little to the nation's health costs. We cannot turn patients into mini-MDs who know enough about the cost and clinical pros and cons of tests, treatments, and caregivers to safely second-guess their physicians' decisions. Time for patient education for health maintenance and treatment is often scant, and will diminish further if patients must focus on cost comparisons. A huge share of patients—especially those needing the most care—will simply never be able to investigate and grapple with detailed efficacy and cost information. Hearing and vision problems, cognitive difficulties, language barriers, and low literacy are obstacles for a great many Americans.[50] Pain, anxiety, and often a need for fast decisions compound these difficulties. Forcing ill people to focus on weighing efficacy and cost is unhelpful and irresponsible.

(We suggest that many of the experts who call for boosting patients' out-of-pocket costs—in hopes of spurring patients to make better medical decisions—are themselves related to physicians, live next door to physicians, or otherwise have speedy access to reliable medical information. Most Americans lack that sort of access. When illness or injury hits, most Americans are worried, pressed for time, and can find it hard to identify and weigh the voluminous and often-conflicting medical information available on the web and elsewhere. Don't we ask physicians to complete four years of college, four years of medical school, and multiple years of residencies and fellowships so that they can learn what care we need?)

Health care consumerism: An ideological smokescreen and an abdication of responsibility

No other nation relies heavily on patients to contain health costs. A nation that devotes $1.9 trillion to health care should not turn to patients to contain cost. This is a reckless gamble, one unsupported by evidence.

Caregivers and payers are increasingly embracing evidence-based clinical medicine—just the opposite of putting patients at greater financial risk in order to encourage them to carefully try to figure out what care is worth the money. Similarly, rather than letting ideology drive policy, government should pursue evidence-based health policy and financing.

Calling patients "consumers" is a smokescreen for abdication of political responsibility in favor of a theoretical free market. This offers the appearance of cost containment. It allows federal or state governments to abandon responsibility both for cost containment itself and for the health the American people. It is doomed to fail politically, financially, and medically. But many people will suffer unnecessarily before the smokescreen is dispelled, and before the myth of a free market in health care is discredited.

Lazy romantics and free market ideologues hope that forcing U.S. health care to function like a free market will finally contain costs. Past cost controls haven't worked, so why not a dose of the market? It knocked down the Berlin Wall.

This won't succeed. Containing health costs is hard and complicated work. It requires an understanding of the realities of health care, not the theory of the market. It requires addressing how doctors spend money now and what they need to spend it better. It requires better ways to pay doctors. It requires more evidence about what care works and which patients need it. It requires ways to set budgets and liberate doctors to spend money to do as much good as possible, while serving all of us. It requires making tough political deals with doctors, hospitals, other caregivers, patients, and payers.

Doing these things requires testing and evaluating what actually works. That means hard work, not slogans. The looming economic crisis should spur us all to find ways to craft durably affordable health care. A "spirit of one hand for yourself and one for the ship" may help to encourage all of us to make good compromises to keep U.S. health care afloat.

The romantics and ideologues will be disappointed, as always. We can offer them a solace. If the big, strategic decisions in health care are made carefully—a commitment to limiting cost and covering all people, physician agreement to spend finite dollars as carefully as possible, building robust budgeting and management methods, greater use of evidence, paying caregivers in trustworthy ways, and the like—health care can then regulate itself from day to day. The new arrangements won't be perfect. But they will be real and they will work.

D. DOCTORS ARE THE KEY

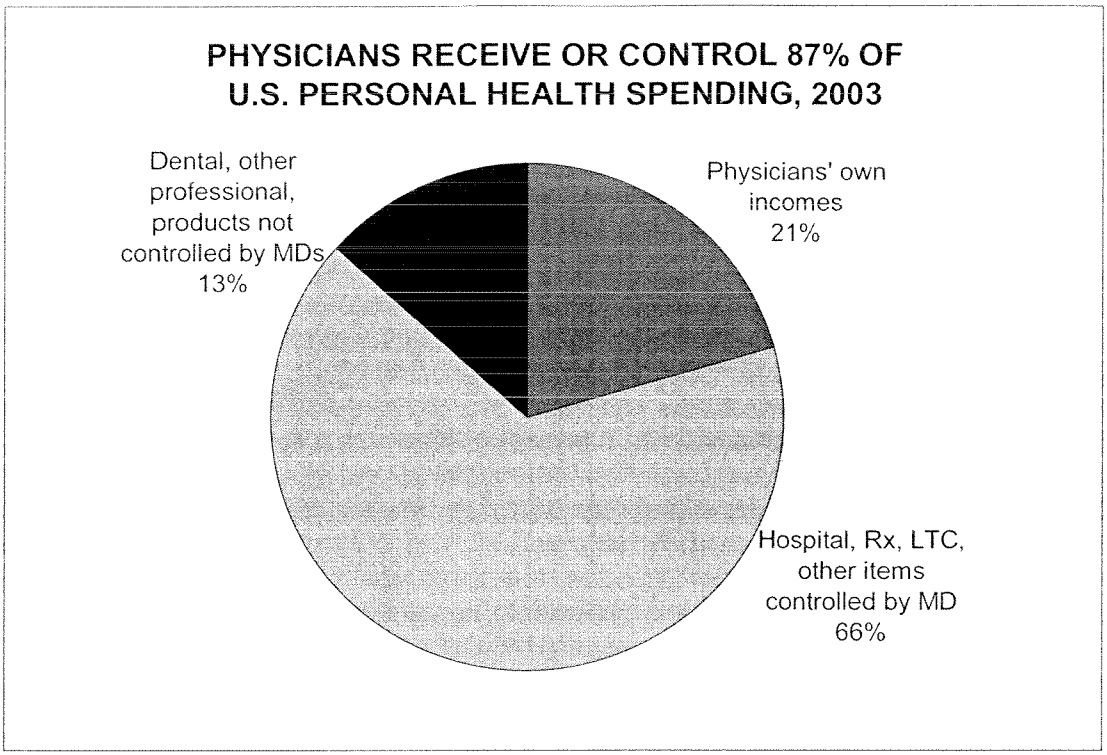
Desperate to contain health costs—or perhaps anxious to appear to be trying to do so—some policy-makers are trying to force patients to deny themselves care by requiring them to pay more out-of-pocket.

The major alternative to de-insurance has not been adequately pursued. Costs can indeed by cut patient-by-patient in a safe and effective manner, but not by patients themselves. To be effective, this type of retail, patient-by-patient cost control would have to be implemented by physicians. Doctors will decide what services are needed and effective for each patient. Each decision will need to take into account the inevitable limits on the money available to spend.

One reason is that, as shown in Exhibit 10, it is physicians' decisions that control fully 87 percent of the personal health care dollar.[51]

While physicians' own incomes represent approximately 21 percent of personal health care spending, physician decisions also determine patients' use of hospitals, prescription drugs, long term care (LTC), and many other health care goods and services. These amount to an additional 66 percent of personal health spending. Only the remaining 13 percent of personal health spending is neither physicians' income nor controlled by physicians' decisions.

Exhibit 10 [52]



When we note that physicians' decisions control these types of spending, we do not suggest that physicians act unilaterally or arbitrarily. They do increasingly rely on evidence and clinical guidelines whenever possible. They do consider patients' and families' preferences. Still, it is individual doctors who admit individual patients to hospitals, order tests, perform surgery, prescribe drugs, and the like. Their guidance, advice, and pressure are generally decisive.

One reason, then, to focus on physicians' decisions is that they control most spending.

The second is that many physicians already know where much of the clinical waste is located. If not, they could be given better information about what care works, and for whom. Further, they know which of their colleagues are incompetent or actually dangerous.

The third—and most important—reason is that improving doctors' individual decisions offers the most careful, clinically effective, and humanly acceptable method of slowing U.S. health cost increases—and of doing so in a way that liberates the savings to finance coverage for all Americans. A related benefit is a drop in administrative costs engendered by mistrust.

The fourth is that when physicians oppose a reform, they can frustrate and undermine it. Consider the single payer example. Even though a number of studies have shown that single payer plans could finance coverage for all Americans while substantially cutting both administrative waste and overall health spending, [53] these plans have gone nowhere politically.

Addressing uncertainty about the effects of reform

One reason is opposition from physicians. This stems mainly from worry about incomes and outcomes—fear for their incomes and uncertainty about what their lives and their abilities to care for their patients would actually be like after implementing reform.

Were individual physicians to favor a certain health care reform and then to tell their patients that they were confident that this reform was likely to contain cost in ways that protected coverage and quality of care, the general public's hesitations about this reform would dissipate rapidly.

(Some HMOs and insurers might continue to oppose reform because it threatened their role and profit, or eliminated them entirely, but these organizations are not influential enough to block valuable change once physicians, patients, governments, and employers are generally on board, we judge.)

The great uncertainty concerning single payer is, what will the actual delivery of care and methods and adequacy of payment for services will be like after implementation. Single payer advocates have not yet been able to describe these in ways that are sufficiently concrete, specific, convincing, and attractive to physicians or patients.

The great advantage of single payer is that, by greatly simplifying and cutting the cost of administering payments, the nation (or individual states) could free up very large sums for actual care.

Some studies of single payer assume that spending on actual health services will be held to a certain level simply by legislative decisions, such as by establishing a budget ceiling for most or all health care.

How that ceiling would be enforced is not yet clear. Therefore, it is essential to describe how doctors, hospitals, and other caregivers would behave to allocate available resources under the ceiling, to actually serve all patients.

If the ceiling on actual health spending is set only by an act of a legislature—if it is not made real by doctors' actual decisions—the ceiling will probably be exceeded and costs of care will continue to climb. (Alternatively, if the legislature

is determined to enforce a ceiling, it would have to act forcefully by cutting fees, incomes, or other things. These acts would probably infuriate both patients and caregivers.) Then, single payer's success in cutting administrative waste would amount only to moving health care a few steps back on the cost escalator. That is no small achievement, but it is not sufficient.

Designing methods of slowing that escalator are essential. Other factors, especially payment methods that reward caregivers for doing more, would continue to move health care spending upward, seemingly inexorably—to slam into the ceiling.

What, then, will shape doctors' behavior? The challenge is to change health spending patterns from today's open-ended practices, to avoid repeatedly hitting that ceiling, forcing constant debate over whether to raise it, or forcing legislatures to enforce the ceiling in peremptory ways. How would health budgets actually be implemented in the U.S., and how would budgets affect decisions about what care is provided?

It is essential to answer this question convincingly and with doctors' participation. Only doctors' active support can discredit the inevitable successors of Harry and Louise, the television actors whose commercials did much to undermine the Clintons' health reform plans of 1993-1994.

Designing and testing new arrangements

Advocates' descriptions of a single payer future are not yet convincingly specific because they cannot yet describe—have not yet designed—the actual mechanisms for organizing services and paying caregivers under single payer. This is not a criticism of the single payer advocates themselves. Designing and testing these mechanisms is a lengthy, complicated, and expensive job.

When single payer reformers and others design and test payment methods that doctors understand and accept—and when a political deal between doctors and payers is successfully negotiated—doctors will urge their patients to vote for reform.

This process of designing and testing of payment methods and related arrangements —seeking trustworthy ways to channel inevitably limited resources to meet a defined population's health care needs—is a vital stage of reforming health care. To win physicians' and the public's confidence, much of that testing will probably have to come before passage of national legislation, rather than after. Indeed, actually enacting single payer legislation may well be one of the later steps in the process of health care reform, not one of the first.

Because current arrangements are crumbling around us, and because careful testing could not be done amid economic collapse or medical meltdown, *starting testing now is crucial*—to try different arrangements for enabling and obliging cooperative physicians to marshal finite budgets to comprehensively serve a defined community.

Arrangements to support physician decision-making

Implementing retail-level cost control solutions will entail encouraging more careful decision-making by physicians about what services are needed and effective for each patient. Because pathology is remorseless but resources are finite, each decision will need to take into account the inevitable limits on the money available to spend. Variations on this approach have been called "bedside rationing"[54] or "professionalism within a budget." [55]

Consider the opportunities and options if health care were on a budget, and all Americans enrolled in one of many organizations that hold those budgets. Savings gained by eliminating ineffective—even harmful—over-treatment and care of marginal value would remain in the budget and would have to be used to help finance care for all patients. Arrangements like these have long been in effect in traditional prepaid group practices, like the Kaiser HMOs, that pay physicians by salary.[56] Looser networks of office-based physicians could be employed as well.

It is important to include both options because, over the past three decades, most patients have shown that they do not wish to change physicians to take advantage of new financing or delivery arrangements, and most physicians have shown that they do not wish to be paid by salary. (This might change, depending on the adequacy of the salaries, physicians' comfort with new organizational arrangements, and the feasibility of sustaining fee-for-service practices. Some physicians, especially in poorer areas where fewer patients can pay, and in many rural areas, might actively prefer the more secure income a salary would provide.) Therefore, it is important to design and test methods of inducing non-salaried physicians to mirror the behavior of their colleagues in salaried prepaid group 0practices by accepting responsibility for spending money carefully on behalf of groups of patients. Physicians in other wealthy nations seem generally to behave as if they are doing this.

Supply constraints have proven successful in other nations.[57] It appears that some U.S. physicians adopt needlessly intensive and costly practice patterns because they are rewarded financially for doing so, because of the lack of good information on what care works or which patients need what does work, and because the nation's physicians and hospitals are excessively specialized. Some work in settings that encourage or at least facilitate elaborate practice patterns—with unnecessary testing and the like—because the unnecessary

services are so readily available. Patients are more likely given unneeded specialist visits, tests and procedures, because of the large share of U.S. medical care provided in hospitals (instead of in community physicians' offices), and the large share of hospital care that is in teaching hospitals. Unnecessary care is also facilitated by the nation's over-specialized and maldistributed physician supply, which gives some geographic areas a physician surplus and (from the physicians' view) a patient shortage. Modulating fee-for-service and other payment methods that now reward unneeded services would help to reduce unnecessary services, but addressing supply issues may also be necessary. We also must address our medical culture and attitudes in the broader society which give more prestige—as well as financial reward—to more aggressive interventions and services than to careful history-taking, counseling, preventive services, rehabilitation, and the like.

Physicians may be essential to careful containment of U.S. health costs and to covering all Americans, but that does not make it easy to involve them. Evidence about the usefulness of many medical interventions is lacking. Physicians often don't know the costs of various services. Many physicians prefer market-driven cost containment methods. Accustomed to today's clinical patterns and financial incentives, it will not be easy to persuade physicians to take on larger roles. Accustomed to independence—what some might call freedom without responsibility—physicians may be reluctant to accept financial limits, let alone take on the job of allocating resources.

Physicians understandably have criticized skimpy insurance policies that deny coverage for services essential to many patients, or that impose burdensome bureaucratic requirements for physicians to obtain prior approval and the like. The alternative to such external constraints, however, is to take responsibility for wisely using available resources—operating within a budget—to achieve the maximum benefit for patients.

Creating physician-directed retail cost controls and enabling them to work will probably require eight main things:

1. paying physicians in ways that reward competence, effort, and kindness, that markedly reduce incentives to over-serve or under-serve, and that therefore make it clear to each patient that care will be denied only when it is ineffective or when another patient has greater need of the resources;
2. providing physicians with increasingly valid and clear evidence about the clinical value of all important diagnostic and therapeutic interventions, and simple information about the marginal cost of each;
3. educating and orienting physicians to use this information to offer—or deny— care with one eye on the needs of the patient before them and the other eye on the needs of all other patients;

4. developing simple, fair, and sturdy structures for enrolling patients and administering budgets;
5. ensuring standards of equity of patient care by gender, race, ethnicity, religion, age, disability, sexual orientation, and other characteristics;
6. organizing doctors to empower them act as more capable, effective negotiating partners, and to provide them with skills needed to act collegially;
7. encouraging physicians to work more cooperatively with nurses and other clinicians, and with administrators who will help them manage budgets and spend money more carefully;
8. persuading doctors that taking on the job of cost containment—rather than leaving such decisions to insurors—is essential to their long-term economic well-being, to their professional self-esteem, and even to making health care durably affordable for all Americans;
9. educating and supporting physicians in sharing decision-making responsibilities with patients and families as appropriate; and
10. in all these ways, encouraging, empowering, rewarding, and educating physicians to take on the role of fiduciaries, holding in trust the prime responsibility for marshaling the available resources to serve all Americans.

Seeking services to cut is the wrong focus of public debates

One way to advance such reforms is suggested by the scheduled discussion of how to afford the "Health Care that Works for All Americans." A series of hearings and reports will be organized over the next two years by a "Citizens Health Care Working Group" created under the 2003 Medicare law.[58] Unfortunately, as currently framed, the process is likely to be a dead-end.

The law's mandate focuses too narrowly on one option: seeking savings by developing visible, public rules that deny insurance coverage for certain services. This appears in part inspired by Oregon's experiment with prioritizing services to develop public, bureaucratic rules for what Medicaid will cover, and by numerous other recent expressions of interest in rationing by public lists—a form of wholesale cost control, albeit a more intelligent one.

The "Health Care that Works" section of the law begins by calling for "an informed national public debate to make choices about the services they want covered." This is the wrong focus for several reasons.[59]

First, citizens cannot be expected to guess what care they will need and want when they get sick. Forcing citizens to choose, for example, among covering radiation for brain tumors, counseling for mental health, nursing home care for Alzheimer's, medications for stroke prevention, and rehabilitation for stroke treatment is like telling people to play Russian roulette. Second, a category of

services or a particular service may be pointless for some patients, yet essential for others.[60] Cutting the scope of covered benefits is a crude, inflexible tool—a meat-axe approach. What is needed instead is a scalpel wielded by well-informed physicians empowered to determine what is appropriate care for individual patients. Third, it's vital to develop and provide caregivers with much better information about the effectiveness and actual costs of many specific health care services and medications in specific circumstances, but that is a substantially technical process, not primarily one to conduct in hearings.

Fourth, and most fundamentally, the full range of strategies for cutting cost and waste in health care must be weighed, to have a constructive debate on how to make care affordable. That requires considering such tools as negotiating drug prices for Medicare and other payers; cutting health care marketing and advertising to prescribers and patients; changing payment incentives for physicians, hospitals, and other caregivers; addressing the supply, types, and distribution of physicians, hospitals, costly equipment, and other care; simplifying the administration of health care financing; giving secure flexible global budgets to hospitals while obliging them to serve all in need; and more.

The nation indeed needs a wide-ranging debate on how to make health care affordable to all, with easy opportunities for input from the general public as well as organized stakeholders. The process that is now planned, however, focuses on exactly the wrong questions. It is the big questions of system design that should be the focus of public debate—how much to spend, how to minimize caregivers' incentives to over- or under-serve, and many more. But such a process cannot effectively micromanage care or technically assess the value of countless specific services for individual patients.

The most essential step is to select robust and simple ways to structure health care financing and care delivery so as to encourage and aid physicians in making careful decisions about what care is effective and cost-effective for which patients.

Public debate and practical testing: Incrementalism, not ideology

We are not suggesting anything like a centrally planned approach to doing this. No one even knows how to plan this centrally. Instead, we are suggesting a combination of public discussion and practical testing. Each informs the other.

Practical testing means carefully devising and trying a variety of arrangements to enroll patients, monitor budgets, spend money carefully, learn more about what care works and how needs it, learn more about how best to provide physicians with this information to guide but not control their decisions, involve patients and families in clinical decision-making, and the like.

Some such arrangements might be tested in large group practices and other networks of caregivers. Further, varied approaches to covering all citizens affordably—and the implementation arrangements that those polices require—ought to be tested in different states. We must encourage states to devise and foster efforts to try different policies and practical arrangements, and to carefully evaluate their success.

The U.S. is a nation of incrementalists and tinkerers, not of ideologues. That is why we need a great variety of new approaches and techniques—a de-centralized market of practical ideas and careful tests. This is at the other end of the spectrum from the single, simple, and naïve idea of de-insuring patients through higher out-of-pocket costs, and then asking them to try to spend money more carefully. That idea is not one of citizen empowerment. Behind the rhetoric, it amounts to telling sick Americans to play in traffic.

E. CONTINGENCIES

The data in the January 2005 CMS report on 2003 health spending, and the solid projections for 2005 make it clear that the nation is oriented toward continued increases in health spending to finance business as usual. The political constituency for controlling cost is weak.

But what if the economy slips into a deep recession? The nation is unprepared. Years of relative financial insulation have fostered the illusion that money for business as usual will continue to flow. This leaves our caregivers, payers, and patients spectacularly ill-equipped to economize.

The challenge before the nation is, therefore, contingency planning—to anticipate that a weaker economy may well make our growing burden of health care spending intolerable. That would oblige doctors, hospitals, and other caregivers to work with patients, taxpayers, business, and government to shape ways to finance and deliver needed, high quality health care equitably and affordably to all Americans. To avoid a crisis, or reduce its destructive impact, we must together begin the work of putting health care on a sound footing now.

Deep recession could make for a financial meltdown in health care, one that could include 100 million uninsured patients, 1,000 more closed hospitals, and 100,000 physicians driving cabs. After such a meltdown occurred, political pressure for change would finally grow to persuasive levels.

But *action cannot be deferred until such a crisis hits*. The associated political panic and inadequate preparation would make that the worst time to design, test, and implement workable reforms. Now is the time— perhaps in the states more easily than nationally—to test and evaluate a wide range of possible reforms, uninhibited by dogma. Health care is too important to tolerate politically or ideologically motivated handcuffs.

Imagine that the economy unexpectedly rebounds strongly and durably. Imagine that de-insuring patients and other market-like forces slow health cost increases to affordable levels. Then, there's no need for anyone to have read this report—or for us to have written it.

But imagine that we're right. That contingency deserves reasonably serious consideration. Consider Pascal's bet about believing in God.[61] Consider further the low cost for preparing to cope with the strong possibility of a weak economy and unaffordable health care, as described earlier.

F. POLITICAL DEALS, NOT ECONOMIC DELUSIONS

Without a functioning free market in health care, containing cost and covering all people will require some public—and therefore political—intervention. This intervention should be limited to the big decisions. These include deciding how much money is available to spend on health care, and requiring that all people are financially protected. Additionally, political decisions will be needed to spark, design, finance, and test, a wide variety of administrative mechanisms to create and monitor the budgets that doctors will need to spend carefully. The ones that work should be selected for wide dissemination.

Making this real will require much more than goodwill. It will require a political deal that addresses the needs and issues troubling each sector. Here, for example, are the outlines of several illustrative deals:

- Physicians could be assured free medical school tuition, relief from most of the administrative costs they now bear, and relief from tort liability if they agreed, in return, to manage inevitably finite dollars on behalf of groups of patients using better evidence, and the like.

- All needed hospitals might agree to be paid revenue guaranteed to cover the cost of efficient provision of needed types and volumes of service, in exchange for cooperating with one another to identify patient needs and avoid duplication. Flexible budgets, adjusted for case mix, might be employed to generate needed revenue.

- Drug makers might agree to accept much lower prices in exchange for guarantees that revenue lost from price cuts would be replaced by payments for the resulting higher volumes of prescriptions. Drug makers could be persuaded to innovate by the lure of very large payments for success. Payments for a new drug might be keyed to both its clinical value and the money it saves by displacing existing costly therapies. Consider the value of a very effective medication to prevent Alzheimer's.

Years of rich financial rewards to caregivers, rising health spending, and assertions that selfish behavior is justified by Adam Smith's invisible hand (which does convert private greed to the public good) have eroded some of the spirit of cooperation and public service that was once more common in U.S. health care. Without a free market in health care to convert private greed into the public good, pursuit of private or individual self-interest does not affordably advance the nation's health.

There will be much more elbow room to craft good political deals to address the real needs of each group of caregivers, payers, and patients; to contain cost; and to cover all Americans if greater goodwill and willingness to compromise are present. Recognition of the huge sums spent on health care already, and the

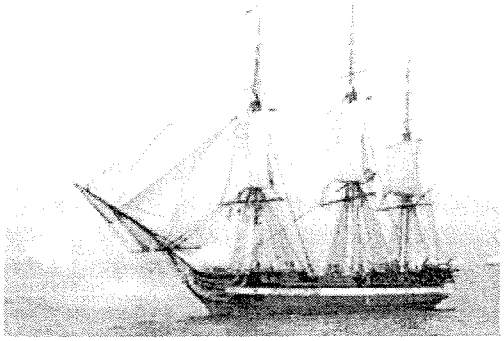
huge share that is wasted, will help spur willingness to compromise. So will the worry that health care business as usual is unsustainable. One other thing may help.

"ONE HAND FOR YOURSELF AND ONE FOR THE SHIP."

Exhibit 11 is a picture of the U.S.S. *Constitution,* which was launched in 1797 and is now moored in the Charlestown district of Boston, Massachusetts.

Its mainmast is 220 feet (67 meters) high. To furl and unfurl the sails, sailors would climb rope ladders and edge out on the yards (horizontal timbers attached to the masts) and tie and untie knots. They did this in storms, when the ship was rolling and pitching wildly, in total darkness, and in rain or snow. Discipline helped sailors do this. So did professional pride and group cohesion. Perhaps most important, sailors knew that the ship could easily be destroyed during storms if the sails were not adjusted properly. Accordingly, the sailors' motto was "one hand for yourself and one hand for the ship."

Exhibit 11



Understandably, each stakeholder in health care fights for its own interests. Caregivers seek more money for business as usual. Each payer tries to pay less or to shift costs to another payer (especially, today, to patients). Advocates of improved financial coverage seek higher spending to advance their aim.

This strategy has worked reasonably well for most parties until now. It may work a little longer, but probably not much. Each stakeholder therefore needs to give much more serious thought to what is essential to its own long-term self-interest and to ways to reconcile that self-interest with the needs of other stakeholders—and with the nation's need for affordable and high-quality health care for all Americans.

Unaffordable health costs and the fragile U.S. economy pose great risk of a medical meltdown, which would cost tens of millions more Americans their coverage, and drive huge numbers of caregivers out of business, destroying invaluable medical resources and leaving all Americans vulnerable. The nation is unlikely to avoid such a medical meltdown unless physicians, hospitals, drug makers, and other caregivers recognize the value of securing financial stability for themselves—and for health care across the country—in return for wholeheartedly taking on the job of covering all people with the dollars available.

Years of institutional, financial, and other rivalries have spurred inter-hospital competition. It has probably hiked costs, duplicated equipment, and distorted patterns of patient care toward profitable services and away from uninsured patients. Hospitals should think more about the needs of the people who live nearby, and how to address them. They should be paid for doing so.

Many drug makers have learned to make very high profits while investing less than they should in high-risk innovative research. They have instead adopted conservative strategies of boosting revenues through the three M's—marketing and advertising, mergers and acquisitions, and me-too drugs—along with price increases on existing medications. Who can blame them? They have a well-founded fear of price controls because they are victims of their own financial success in quadrupling revenues garnered in the U.S. over the past decade—revenues that today amount to one-half of their world-wide totals. They should make a commitment to ensuring that all Americans obtain all appropriately-prescribed medications in return for added payments that simply cover the added (though surprisingly small) incremental cost of manufacturing the additional pills.

Many payers have learned to make money by avoiding costly patients, shift costs to other payers, and other techniques. They should instead move to pool their expertise to sponsor a wide variety of alternative methods of organizing physicians to contain cost and boost appropriateness of care.

Doctors' role in spending money carefully has always been central. At the same time, it is enormously difficult to inform physicians, create appropriate incentives for them, and configure physicians' practices, budgets, and responsibilities to groups of patients.

The nation must avoid burdening patients, politicians, payers, physicians, and other caregivers with yet another generation of irritating, infuriating, and demoralizing traditional wholesale cost controls. It will be hard for physicians to take responsibility for controlling costs carefully, but other strategies either do not contain costs, or do so by cutting quality and access.

Most physicians won't want to change how they do things. They are naturally conservative, like most of us. But the alternative is intolerable. To avoid radical

external controls, physicians may have to conclude (to paraphrase Pogo) that "we have met the solution and it is us."

Every other nation has figured out how to cover all people and enjoy better health outcomes in a more or less satisfactory manner—so there is good reason to be optimistic.

Still, some may think that all this is just too complicated. Too many elements must be identified, analyzed, adjusted, and coordinated. That might be true. On the other hand, reshaping many aspects of the actual delivery of the 87 percent of personal health services that is controlled by physicians might be much easier to accomplish if improvements in a number of areas are coordinated. Physicians who work with better evidence; who are liberated to focus mainly on clinical need, and less on financial incentives; who are the trusted fiduciaries and principal guardians of the nation's health; who have much less paperwork; and who can't be sued might just enjoy their jobs much more.

Since careful physician allocation of budgeted resources is the only open path to making care affordable for all, this nation and its doctors should start along that path quickly.

Throughout, patients and physicians—along with nurses and other clinicians—should recognize, as they usually do, that pathology is remorseless and resources are finite. Immortality is not an option, so medical care has never saved a single life. It does delay death, relieve pain, and overcome disability—and that is why we are devoting $1.9 trillion to medical care this year.

It is therefore useful to set for U.S. health care a clear, honest, realistic, and achievable goal, one commensurate with human and medical realities. We suggest that the goal should be "medical security," which offers to each patient well-justified confidence that he or she will receive needed and effective and competent medical care in a timely manner without having to worry about the bill.

Appendix Exhibit

SELECTED HEALTH SPENDING ESTIMATES AND PROJECTIONS, 2002-2005

	Actual		Projected
	2002	2003	2005
National Health Expenditures ($ billion)	$1559.0	$1678.9	$1920.8
Personal Health Care	$1342.9	$1440.8	$1651.5
Prescription Drugs (Retail)	$161.8	$179.2	$233.6
Coverage Administration + Insuror Profit	$105.7	$119.7	$134.7
NHE per person	$5,414	$5,774	$6,477
NHE % of Gross Domestic Product	14.9%	15.3%	15.5%

Sources:

Estimates, 2002-3: Cynthia Smith et al., "Health Spending Growth Slows in 2003," Health Affairs, Vol. 24, No. 1 (Jan.-Feb. 2005), pp. 185-194.

Projections, 2004-5: CMS, "National Health Care Expenditures Projections: 2003-2013," 6 Feb. 2004, www.cms.hhs.gov/statistics/nhe/projections-2003/highlights.asp.

NHE per person: Calculated by Health Reform Program using Census Bureau population data.

Notes

[1] Cynthia Smith and others, "Health Spending Growth Slows in 2003," *Health Affairs,* Vol. 24, No. 1 (January-February 2005), pp. 185-194.

[2] CMS's own press release was headlined, "Health Care Spending in the United States Slows for the First Time in Seven Years." *CMS News*, 11 January 2005, http://www.cms.hhs.gov/media/press/release.asp?Counter=1314. It quoted administration officials describing that slowing as " 'good news' " that came because, " 'The Administration and the Congress have taken important steps in recent years to contain costs....' "

[3] We distinguish between the accuracy of the collection and analysis of the underlying data, and how those findings are treated in a federal press release. Some areas of federal health care policy, and federal science policy more broadly, have been subject to unusual politicization recently. However, we have seen no reason to expect that collection, analysis, and reporting on the national health expenditure data themselves have been politicized. (For evidence of politicization in other areas, see, for example, on suppression of HHS actuaries' cost estimates for Medicare Modernization Act, see U.S. Government Accountability Office, "Department of Health and Human Services Chief Actuary's Communications with Congress," GAO B-302911, 7 September 2004, http://www.gao.gov/decisions/appro/302911.htm. On revisions to a report on racial and ethnic health disparities, see, for example, Bureau of National Affairs, "HHS Issues Original Version of Report That Highlighted Disparities in Health Care," *Medical Research Law and Policy*, 3 March 2004, http://subscript.bna.com/SAMPLES/mrl.nsf/0/447ee44eeb70916d85256e4c00004473?OpenDocument. On appointments to science study sections and advisory committees, see, for example, Donald Kennedy, "An epidemic of politics?" editorial, *Science*, Vol. 299, Issue 5607, 625, 31 January 2003, http://www.sciencemag.org/cgi/content/short/299/5607/625. On numerous other investigations, see "Politics and Science" website of U.S. Rep. Henry A. Waxman, ranking minority member, Committee on Government Reform, http://democrats.reform.house.gov/features/politics_and_science/index.htm. Access to all of the above URLs confirmed 2 February 2005.)

[4] A recent survey documented the public's declared interest in containing health costs (63 percent) and improving coverage (57 percent). See Kaiser Family Foundation, *Health Care Agenda for the New Congress,* Washington: The Foundation, January 2005, http://www.kff.org/kaiserpolls/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=50263, access confirmed 27 January 2005.

[5] "Health Spending Grows At Slowest Pace In Seven Years," press release, *Health Affairs*, embargoed to 11 January 2005, http://www.healthaffairs.org/press/janfeb0501.htm; Kristin Reed, "Health Spending for U.S. in 2003 Rose Least in Seven Years," Bloomberg News, 11 January 2005; Sarah Lueck, "Rise in Health-care Spending Tempered by Federal Pullback," *Wall Street Journal,* 11 January 2005; Lee Bowman, "Spending on health care grows at the slowest pace in 7 years," *Seattle Post Intelligencer*, 11 January 2005; John Strahanich, "Health Spending Slowed, to little effect," *Boston Herald*, 11 January 2005.

[6] This table permits comparing annual health care spending increases with calculated annual increases in the Consumer Price Index.

General Inflation and Health Spending Increases, 1993-2003

	Annual CPI	Inflation (rise in annual CPI)	Rise in health care spending
2003	184.0	2.3%	7.7%
2002	179.9	1.6%	9.3%
2001	177.1	2.8%	8.9%
2000	172.2	3.4%	7.7%
1999	166.6	2.2%	5.7%
1998	163.0	1.6%	5.2%
1997	160.5	2.3%	5.3%
1996	156.9	3.0%	4.8%
1995	152.4	2.8%	5.7%
1994	148.2	2.6%	5.5%
1993	144.5	3.0%	6.1%
1992	140.3		

Consumer Price Index data are for all U.S. urban consumers, all items. (U.S. Bureau of Labor Statistics)

[7] See Appendix Exhibit.

[8] NHE per person calculated by Health Reform Program using Census Bureau population data.

[9] "Health Spending Grows At Slowest Pace In Seven Years," press release, *Health Affairs*, embargoed to 11 January 2005, http://www.healthaffairs.org/press/janfeb0501.htm.

[10] See Appendix Exhibit.

[11] A Blue Cross Blue Shield official has reported, for example, that their firm alone has "17,000 different plan designs" just in Chicago. Quoted in Robert Kazel, "Blue Crossroad: Insurance in the 21st Century," American Medical News, 20 September 2004, http://www.ama-assn.org/amednews/2004/09/20/bisa0920.htm. (Noted in Don McCanne, "Quote of the Day," 13 September 2004, which observed, "The only reason to offer 17,000 plan designs is to allow the healthy to avoid funding care for the unhealthy.")

[12] Robert Pear, "Nation's Health Spending Slows, but It Still Hits a Record," *New York Times, 11 January 2005;* Kristin Reed, "Health Spending for U.S. in 2003 Rose Least in Seven Years," Bloomberg News, 11 January 2005.

[13] See Appendix Exhibit.

[14] Alan Sager, *Affidavit in Support of Governor Blagojevich's Petition to the FDA to authorize the State of Illinois to import prescription drugs from Canada*, 8 April 2004, http://www.affordabledrugs.il.gov/pdf/SagerAffidavit.pdf and www.healthrformprogram.org.

[15] Alan Sager, "Winning Durably Affordable Innovative Drugs: A Few Lessons from the Arguments over Importing Drugs from Canada," Symposium on U.S. and Canadian Pharmaceutical Policy, University of Connecticut Law School, 29 October 2004, www.healthreformprogram.org. See also, for example, Alan Sager and Deborah Socolar, "Lower U.S. Prescription Drug Prices Are Vital to Both Patients and Drug Makers—But Instead, U.S. Prices Have Been Rising Rapidly Relative to Those in Other Wealthy Nations," Data Brief No. 3, Boston: Health Reform Program, Boston University School of Public Health, 24 July 2003, www.healthreformprogram.org.

[16] Centers for Medicare and Medicaid Services, "National Health Care Expenditures Projections: 2003-2013," 6 February 2004, www.cms.hhs.gov/statistics/nhe/projections-2003/highlights.asp, access confirmed 12 January 2005. See also Stephen Heffler and others, "Health Spending Projections Through 2013," *Health Affairs* web exclusive, 11 February 2004, www.healthaffairs.org.

[17] At this writing, it appears that CMS's latest projections, for 2004 – 2014, are likely to be released later in February of 2005.

[18] NHE per person calculated by Health Reform Program using Census Bureau population data.

[19] As noted earlier, we distinguish between the accuracy of the collection and analysis of the underlying data, and how those findings are treated in a federal press release. Some areas of federal health care policy, and federal science policy more broadly, have been subject to unusual politicization recently. However, we have seen no reason to expect that collection, analysis, and reporting on the national health expenditure data themselves have been politicized. (For evidence of politicization in other areas, see, for example, see U.S. Government Accountability Office, "Department of Health and Human Services Chief Actuary's Communications with Congress," GAO B-302911, 7 September 2004, http://www.gao.gov/decisions/appro/302911.htm; Bureau of National Affairs, "HHS Issues Original Version of Report That Highlighted Disparities in Health Care," *Medical Research Law and Policy*, 3 March 2004, http://subscript.bna.com/SAMPLES/mrl.nsf/0/447ee44eeb70916d85256e4c00004473?OpenDocument; Donald Kennedy, "An epidemic of politics?" editorial, *Science*, Vol. 299, Issue 5607, 625, 31 January 2003, http://www.sciencemag.org/cgi/content/short/299/5607/625; "Politics and Science" website of U.S. Rep. Henry A. Waxman, Committee on Government Reform, http://democrats.reform.house.gov/features/politics_and_science/index.htm. Access to all of the above URLs confirmed 2 February 2005.)

[20] Bureau of Economic Analysis, Gross Domestic Product, Table 1.1.5, Last Revised January 28, 2005 http://www.bea.gov/bea/dn/nipaweb/TableView.asp#Mid, access confirmed 28 January 2005. Congressional Budget Office, *The Budget and Economic*

Outlook: Fiscal Years 2006 to 2015, Table 2-1, http://www.cbo.gov/showdoc.cfm?index=6060&sequence=0.

[21] Department of Defense outlays, as reported in Office of Management and Budget, *Historical Tables, Budget of the United States Government, Fiscal Year 2005,* Washington: U.S. Government Printing Office, 2004.

[22] This $540 billion figure for FY 2005 represents $430 billion in initial Department of Defense (DoD) funding plus $25 billion and $90 billion in supplemental budgets. The DoD budget request for FY2005, as reported in March 2004, included $429.6 billion in FY 2005 DoD outlays. (See "National Defense Outlays," Office of the Under Secretary of Defense, *National Defense Budget Estimates for FY 2005*, March 2004, p. 8, Table 1-5, www.dod.gov.) To this must be added the president's May 2004 $25 billion supplemental budget request for initial FY 2005 financing for military operations in Iraq, which Congress approved in August. A February 2005 supplemental request is also expected, designed to provide most FY 2005 financing for the Iraq war; recent press reports indicate that the "administration is asking Congress for at least $80 billion more in military spending this year," so we include $90 billion. (Roger Runningen and Tony Capaccio, " "Bush Seeks $80 Bln More for Iraq Spending (Update 5)," Bloomberg News, 25 January 2005. See also Bryan Bender, "War funding request may hit $100 billion," *Boston Globe*, 15 December 2004.)

[23] Chernew and others assert that a one percent excess in health growth over GDP growth is feasible. See Michael E. Chernew, Richard A. Hirth, and David M. Cutler, "Increased Spending on Health Care: How Much Can the United States Afford?" *Health Affairs*, Vol. 22, No. 4 (July – August 2003), pp. 15-25. Also see Ellen Lutch Trager, "Who Will Pick up the Health Care Tab?" *Boston Globe* op-ed, 10 August 1999.

[24] See, for example, the discussion of "An Economy at Risk," *We Care! About Health Care*, Winter 2004/05 Edition, Burlington, Massachusetts: Massachusetts Hospital Association, p. 1. The economy considered at risk is health care itself. And it is asserted that "a vibrant health care sector in Massachusetts . . . is essential to the state's economy and overall quality of life."

[25] Charles Stein, "As healthcare progresses, so does the cost," *Boston Globe, 30 January 2005.*

[26] Elizabeth Becker, "U.S. Trade Deficit Hit Highest Figure Ever in November," *New York Times*, 12 January 2005. See also, for example, Associated Press, "Economy Slowed in 4th Quarter, U.S. Report Says," 28 January 2005, which stated, "The deceleration seen in the fourth quarter from the previous quarter mostly reflected a drag on growth from the nation's swollen trade deficit."

[27] See, for example, Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs,* Vol. 22, No. 3 (May-June 2003), pp. 89-105.

[28] See, for example, Jeffrey McCracken, "Business pressures: Health care crisis at automakers' doorstep, Government may have to step in, Dingell warns," *Detroit Free Press*, 19 January 2005, www.freep.com/money/autonews/dingell19e_20050119.htm;

Eric Mayne, "Health costs could drive investment overseas," *Detroit News*, 20 July 2004, http://www.detnews.com/2004/autosinsider/0407/20/c01-216906.htm; Kirsten Downey, "A Heftier Dose to Swallow: Rising Cost of Health Care in U.S. Gives Other Developed Countries an Edge in Keeping Jobs," *Washington Post*, 6 March 2004, http://www.washingtonpost.com/ac2/wp-dyn/A34899-2004Mar5.

[29] See, for example, Erin Madigan, "Medicaid Increasingly Heavy State Budget Burden," www.stateline.org, 3 January 2005; Robert Tanner, Associated Press, "States Press Bush, Congress on Medicaid," *San Jose Mercury News*, 19 January 2005, http://www.mercurynews.com/mld/mercurynews/news/world/10682836.htm.

[30] Carmen DeNavas-Walt, Bernadette D. Proctor, and Robert J. Mills, *Income, Poverty, and Health Insurance Coverage in the United States: 2003, Current Population Reports,* P60-226, Washington: U.S. Census Bureau, August 2004.

[31] NHE per person calculated by Health Reform Program using Census Bureau population data.

[32] Calculated from data on Total Health Spending per Capita, adjusted for purchasing power parity, Organization for Economic Cooperation and Development, *OECD Health Data, 2004*, 1st edition, http://www.oecd.org/document/16/0,2340,en_2649_34631_2085200_1_1_1_1,00.html, Table 9, access confirmed 12 January 2005.

[33] See, for example, life expectancy data from Organization for Economic Cooperation and Development, *OECD Health Data, 2004*, 1st edition, http://www.oecd.org/document/16/0,2340,en_2649_34631_2085200_1_1_1_1,00.html, Table 1, access confirmed 13 January 2005. See also 2004 estimated infant mortality rates by nation, U.S. Central Intelligence Agency, *World Factbook*, "Rank Order – Infant Mortality Rate," http://www.cia.gov/cia/publications/factbook/rankorder/2091rank.html, access confirmed 18 January 2005.

[34] See, for example, data from Organization for Economic Cooperation and Development, *OECD Health Data, 2004*, 1st edition, on practicing physicians (Table 4), and on acute care hospital beds (Table 5), http://www.oecd.org/document/16/0,2340,en_2649_37407_2085200_1_1_1_37407,00.html, access confirmed 31 January 2005.

[35] Alan Sager, "Urban Hospital Closings: Race Matters but Efficiency Does Not," National Health Law Program, 2004 annual conference, Washington, D.C. 6 December 2004.

[36] Alan Sager and Deborah Socolar, "Vast Sums of Money Are Stolen from What We Spend to Delay Death, Treat Pain and Overcome Disability," *Newsday,* 3 August 2003, www.healthreformprogram.org.

[37] Alan Sager, *Affidavit Supporting Illinois Governor Blagojevich's Petition to the FDA to Permit Prescription Drug Importing*, 8 April 2004, http://www.affordabledrugs.il.gov/pdf/SagerAffidavit.pdf; www.healthreformprogram.org

[38] M.C. Fahs, "Physician Response to the United Mineworkers' cost-sharing program: the other side of the coin," *Health Services Research*, Vol. 27, No. 1 (April 1992), pp. 25-45.

[39] Barbara S. Cooper, Nancy L. Worthington, and Mary F. McGee, *Compendium of National Health Expenditures Data*, Washington: Office of Research and Statistics, Social Security Administration, January 1976.

[40] Birgitta Forsberg, "Health care costs see slower growth; Disadvantaged lost benefits, report says," San Francisco Chronicle, 11 January 2005.

[41] That was a rise from 11.6 million in 2000. Analysis by Lewin Associates for Families USA, as cited in William M. Welch, "Health costs rising faster than incomes, study says," *USA Today*, 27 September 2004, http://www.usatoday.com/news/health/2004-09-27-healthcare-usat_x.htm.

[42] Many people with insurance are vulnerable to bankruptcy. See David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, "Illness and Injury as Contributors to Bankruptcy, *Health* Affairs web exclusive, 2 February 2005, www.healthaffairs.org.

[43] See, for example, Michael A. Fletcher, "Bush Promotes Health Savings Accounts," *Washington Post*, 27 January 2005, http://www.washingtonpost.com/wp-dyn/articles/A39782-2005Jan26.html; Ricardo Alonso-Zaldivar, "Healthcare Overhaul Is Quietly Underway," Los Angeles Times, See also, for example, Newt Gingrich, "Conservatives Should Vote 'Yes' on Medicare," Wall Street Journal, 20 November 2003. Discussing Health Savings Accounts, for people under 65 to use with high-deductible insurance, he urged "shifting away from the failed...third-party payer model and back to a market-mediated...model, where the customer [pays] his own first health dollars...."

[44] Also regressive are proposals to reduce Medicaid coverage for poor people to free up money in order to expand coverage for people who are less poor. (See, for example, Robert Pear, "Bush Nominee Wants States to Get Medicaid Flexibility," *New York Times*, 19 January 2005.)

[45] For a substantial survey of the evidence on both the barriers to needed care and the effect on costs, see M. Edith Rasell, "Cost Sharing in Health Insurance -- A Reexamination," [Sounding Board], *New England Journal of Medicine* 332 (27 April 1995), pp. 1164-1168.

[46] See, for example, Robert H. Brook and others, "Does Free Care Improve Adults' Health? Results from a Randomized Controlled Trial," *New England Journal of Medicine* 309 (8 December 1983), pp. 1426-34.

[47] M.C. Fahs, "Physician Response to the United Mineworkers' cost-sharing program: the other side of the coin," *Health Services Research*, Vol. 27, No. 1 (April 1992), pp. 25-45.

[48] M. Edith Rasell, "Cost Sharing in Health Insurance – A Reexamination," *New England Journal of Medicine*, Vol. 332, No. 17 (27 April 1995).

[49] M.L. Berk and A.C. Monheit, "The Concentration of Health Care Expenditures Revisited," *Health Affairs*, March-April 2001, pp. 204-213, Exhibit 1.

[50] Other barriers to gathering information are financial. Many patients cannot afford a computer, some cannot even afford a home telephone, and some lack the time needed because they must work multiple jobs. Many observers and policy-makers suggest that patients should get health care price information on the internet, but a spring 2004 survey found that a financially-based "significant digital divide could leave those most in need with less information on which to base important health care decisions." Of the 64 percent of seniors with yearly household incomes below $20,000, less than one-sixth (15 percent) have ever used the internet, the survey found. See Kaiser Family Foundation, "Online Health Information Poised to Become Important Resource For Seniors, But Not There Yet: Digital Divide Puts Many Seniors At Disadvantage," news release, 12 January 2005, http://www.kff.org/entmedia/entmedia011205nr.cfm, access confirmed 1 February 2005.

[51] Personal health care spending finances the services received by individual patients. It therefore excludes sums spent on research, construction, government public health activities, coverage administration, and insurance company profits.

[52] Health Reform Program analysis of CMS 2003 health spending data.

[53] Congressional Budget Office, *Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates,* Washington: Congressional Budget Office, April 1993; Robert Brand, Deborah Socolar, David Ford, and Alan Sager, *Universal Comprehensive Coverage: A Report to the Massachusetts Medical Society,* December 1998 (an updated version is posted at http://dcc2.bumc.bu.edu/hs/sager/110100/UHC%201%20Nov%2000%20FINAL.pdf, access confirmed 25 January 2005); John F. Sheils and Randall A. Haught, *The Health Care for All Californians Act: Cost and Economic Impacts Ana*lysis, Fairfax, Virginia: The Lewin Group, 19 January 2005, http://www.healthcareforall.org/lewin.pdf, access confirmed 3 February 2005.

[54] E. H. Morreim, "Fiscal Scarcity and the Inevitability of Bedside Budget Rationing," *Archives of Internal Medicine,* Vol. 149, No. 5 (1 May 1989), pp. 1012-1015.

[55] Joseph White, "Markets, Budgets, and Health Care Cost Control," *Health Affairs*, Vol. 13, No. 3 (fall 1993), pp. 44-57.

[56] Steve Lohr, "Is Kaiser the Future of American Health Care?" *New York Times, 31 October 2004.*

[57] See, for example, Brian Abel-Smith, "Cost Containment and New Priorities in the European Community," *Milbank Memorial Fund Quarterly*, Vol. 70, No.3 (1992), pp. 393-416.

[58] Based on a bill by Senators Hatch and Wyden, Section 1014 of the 2003 Medicare law Act is entitled, "Health Care that Works for All Americans." The section's language is posted at http://wyden.senate.gov/leg_issues/legislation/wyden_hatch_healthcare.pdf. The Comptroller General, designated to name the Citizens Working Group members, recently said these appointments will come by late February 2005. Thereafter, the Citizens Working Group has a mandated series of activities—hearings, reports, community meetings, and recommendations—with a two-year deadline, and with specified questions to consider at each stage of the work.

[59] See also Sidney J. Socolar and Deborah Socolar, "Hidden in the New Medicare Law: How the Health Reform Debate is To Be Re-shaped," 12 February 2004, posted at www.rekindlingreform.org.

[60] This legislation appears to have been inspired by Oregon, which a decade ago adopted the strategy of listing all health care services, establishing relative priorities, and funding all those above a certain level for Medicaid. The nation clearly must develop more and better evidence on which care is effective and cost-effective under what circumstances. In analyzing the Oregon experience, however, Oberlander and colleagues noted that

> Excluding entire categories of services, regardless of individual circumstances, puts policy-makers in the uncomfortable position of insuring medical care for patients unlikely to benefit from covered services, while denying care to patients requiring services that are not covered. Such a policy not only makes little sense, it is also, as the behaviour of physicians in Oregon indicates, difficult to implement.

See Jonathan Oberlander and others, "Rationing medical care: rhetoric and reality in the Oregon Health Plan," *Canadian Medical Association Journal*, Vol. 164, No. 11, 29 May 2001, p. 1583, http://www.cmaj.ca/cgi/reprint/164/11/1583.

Similar problems undermine the effectiveness and equity of efforts to cut back Medicaid to some level of "basic benefits," as the incoming HHS Secretary proposes. (See, for example, Robert Pear, "Bush Nominee Wants States to Get Medicaid Flexibility," *New York Times*, 19 January 2005.)

[61] Blaise Pascal, *Pensees,* discussed in Alan Hájek, "Pascal's Wager", *The Stanford Encyclopedia of Philosophy (Spring 2004 Edition)*, Edward N. Zalta (ed.) http://plato.stanford.edu/archives/spr2004/entries/pascal-wager, access confirmed 4 February 2005.