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Brookings Briefing

HEALTH CARE IN AMERICA: HOW TO FIX A TROUBLED SYSTEM

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Discussants:
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P R O C E E D I N G S

MR. GALE: Thank you for attending this morning and welcome to the Brookings Institution. I'm Bill Gale, I'm the moderator for today's session. I'd like to welcome you to the Brookings Institution, this Tax Policy Center Event on "Your Money or Your Life, Strong Medicine for America's Health Care System."

Our main speaker this morning will be David Cutler. David wears many hats. He is currently the dean of Social Science and a professor of economics at Harvard. He's the author of the book I just mentioned, copies of which are outside, which can be purchased and autographed. He's a former staff member at the Council of Economic Advisors and the National Economic Council in the Clinton Administration.

Those are some of the tangible qualifications. The intangible qualification is that I can say, having talked to a lot of people about setting up this event that David is widely regarded as the premier health economist in the United States and we are delighted to have you here this morning to join us.

After David's presentation, we'll have three discussants. The first one is Len Burman. Len is a Senior Fellow at the Urban Institute and co-director of the Tax Policy Center, which is a joint Urban-Brookings venture. Len is a former Deputy Assistant Secretary for Tax Policy in the Clinton Administration; and he has written on many things, including, tax issues and adverse selection issues as they relate to health policy.

Our second discussant is Stuart Butler. We can dispense with all the Butler/Cutler jokes to begin with, it was not intentional. I'm sorry and I apologize for any such jokes that come up in the future. Stuart is the Vice President of Domestic and Economic Policy Studies at the Heritage Foundation. He is well known as a principled and responsible advocate for market-oriented health care reforms and other reforms.

Our last discussant will be Tom Mann. Tom is the W. Averell Harriman Chair in Governance Studies here at Bookings; and former Director of the Government Studies program for many years. He has commented on and analyzed issues all over the map, including, most recently, campaign finance reform. And, I imagine, he'll focus on the politics of health care reform.

So, what I'd like to do is turn it over to David. Then have the discussants discuss. And then all of us will come up here and we can take questions from the audience.

MR. CUTLER: Thank you for the introduction. Actually, thank you, Bill, for inviting me to come. It's always a great treat--well, it's a great treat to find out I'm still allowed to be in Washington. But it's wonderful to be here at Brookings.

And actually to see so many people. I will tell you, I'm going to have to rag to my title consultant. You know, I was writing a book, so you know, me being a fancy Harvard professor and all, I hired myself a title consultant. Okay, what I did was, I called my sister. And I said, what should I title the book. And she said, well, David, nobody's actually going to want to read your book. But if you want anyone to think about reading your book, you have to have sex in the title. And as you can tell, I wasn't very good at that. So, I'm going to have to tell her that, no, actually, there are other people like me, who will buy or think about a book that doesn't necessarily have sex in the title. So she'll be pleased with that.

What I wanted to do is to talk to you about the ideas that are in it, you know, not in sort of page-turning detail, obviously. But to kind of give you a sense of how I think one views the medical system and how to think about various types of reform. And I just kind of want to start off by giving you a sense of why I think we're never very successful at it. And then go into what's wrong with that.

So, I have what I think of as the holy trinity of health care reform--the sort of three pinnacles that everybody's driving is driving after.

Cost: the sense that we spend too much. How many people, just--since I'm empirically oriented--folks, how many people sort of agree with this that--okay, so that's the vast majority of people.

Access: we need to insure the uninsured. How many people agree with this? Okay.

Quality: the quality of medical care is uneven?

What I want to argue is that you've basically said contradictory things. And I think that most common solutions fail because they produce conflict among these.

So, if you go back to my glory years in the Clinton Administration, the goal is to save money and cover more people. Which, if you're going to save money and uninsured people are going to get more care, inherently means that those people who have insurance, typically people in this room amongst them, will wind up getting less care. And that sort of conflicts with the idea about peoples quality should improve and people should have access to high-quality medical care. So it's sort of no wonder that plans like that typically fail.

There are other kinds of plans out there. So, there's been a lot of emphasis placed on improving quality. There are things like information technology investment and other kinds of measures. The IOM had a big report on this, which then runs into the problem of, gee, that's great, but how can we afford it?

One way or another the issue of costs versus, you know, how much we spend versus what we're getting is sort of central to essentially every debate about health

care reform. You need look no further than the current flap we're having over the Medicare Drug Bill and would we have done it if the thing cost more or would we not have done it. And, you know, how do we both save money in the program and also give more benefits when, typically, most of the things we know how to do are to spend money to get stuff or not spend money, not to get stuff.

So the central questions, as I see them, are first: What do we get for increased medical spending? That is, how do we decide, as a whole, whether it's worth it or not. I'll give you sort of what I thin is conventional wisdom, although I've been out of Washington sufficiently long that I'm not sure I know conventional wisdom anymore. But I would say that the conventional wisdom is that we don't get very much for what we spend.

And the argument that I'm going to give you is that we get an enormous amount. And that there's no speed limit to spending even more, in fact, we should go ahead and spend even more. So, that's going to be the first plank of what I tell you is that the sort of common way that we approach the issue of costs in medical care, I think, is off.

And then what can would do to reform the system? I'm not sure I quite know if there is any conventional wisdom. I will note, the--I have found one item of consensus among Democrats and Republicans on health care. It may be the only item on any policy. But I found the one item, which is that--it came out the other day--when Medicare costs go up, it's universally acknowledged to be bad. So the Democrats were saying that's horrible; Republicans were saying that's horrible. So I found one item of agreement and the only problem is I think they're all wrong. So, I'll sort of tell you about that.

My answer is two-fold and I'll get to it. One, which I'll talk somewhat less about is expanding insurance coverage. I'll talk somewhat less about it because I think it's more obviously the case. And I'll just sort of mention briefly about it. And then I'll talk about value, which is the more novel part of the argument here. And the phrase that I will try to impress upon you is that to borrow from the old Clinton campaign, is that it's the value, stupid.

Obviously, the book has more discussion of these things. I will say, you know, most people find it very difficult to get truly enthusiastic about an economist pontificating on health care, which I can understand. It sort of reminds me whenever people say they're happy to hear me talk about it, reminds me of what my, thankfully former, dean said about economists--you'll realize why I'm thankful that he's my former dean--said about economists. He said if you stack all the economists in the world end to end, that would be a good thing.

So, I'll try not to contribute too much to that.

So that's what I want to do is tell you some amount of medical spending and what we're buying, whether we can do--whether we can continue that and then how one can do better.

All right, I've sort of titled this part, "The rise of modern medicine." And I want to just start off with a simple question, which is: Why on earth is the medical system bigger than it once was?

In 1950, a half century ago, the medical was extremely small; $1 in every $25 in the economy was spent on medical care. Today, it's about $1 in every $7 in the economy and it's rapidly rising to soon going to be about $1 in $6; then going to be $1 in $5. If you look at projections for the next half century, the Medicare actuaries, when they're allowed to give you their projections, will tell you that medical care will be about $1 in every $3 in the economy.

So the first basic question you have to ask yourself if you're thinking about this, which so dominates the policy discussion is: Why is that? Whenever, in any market, if you go to the grocery store and you spent more this week than last week. There are two reasons why: Either because you got more goods or because the price of the goods you're buying went up. So the fundamental question is: Is the price going up or is the quantity of services going up? And the quick answer is, we spend more because we get more.

That overwhelmingly the vast reason why we get more care--why we spend more is because the nature of what we can do is different. So, I will just give you a couple of examples.

This is the treatment for a heart attack. I'm not a doctor, but if somebody wanted, I could demonstrate a little bit how these things work. So, in 1950, the standard therapy for a heart attack was actually, bed rest. Dwight Eisenhower, when he was President, had a heart attack. The therapy was you keep him in bed, in the hospital for six weeks. You gingerly transport him home and he stays in bed for six months.

That's now known, actually, to be quite counterproductive care because you get blood clots and things. Actually they experimented on a novel form of therapy with President Eisenhower, which is, they allowed him to sit up. But the patient didn't respond very well to the therapy, so they went back to the traditional therapy.

Nowadays, you would have any number of things. You can just ask Dick Cheney, he's had most of these several times. And so, it's a lot of different things that I won't go into. What I want to note is that spending is a lot higher. Costs were pretty low in 1950, it actually not that expensive to treat somebody with bed rest. Eisenhower was a little bit more expensive, but generally, it's not that expensive.

Today a typical 45-year-old, whether or not they have heart disease; whether or not they have high blood pressure; whether or not they have diabetes;

anything like that, a typical 45-year-old can expect to spend $30,000 over their remaining life on caring just for cardiovascular disease.

Why do we spend more? Because we can do stuff now. We can give them medications; we can do surgeries, things like that. So that's the first example.

Let me give you a second example, which is care for low birth-weight infants. In 1950, there was relatively little that could be done. There were some incubators, which had kind of developed out of little chicken models. But they weren't very good, like, you know, they were sort of designed for chickens, not for little babies.

Jackie Kennedy had a baby that was about 5 and a half pounds when she was first lady. The baby died because the lungs were not very well developed and there was nothing much that could be done at the time.

Today, there are all sorts of things that could be done for the child. There would be a neonatology specialist; there would be artificial things that promote respiratory development, ventilators and so on. An the cost is much higher. I've approximated in 1950 as being about zero, which is not too far from what they were.

And, today, the costs are about $70,000, including downstream costs for infants with complications and a variety of other special education programs and things like that.

Why do we spend more? Because we can do more stuff.

The third example I will give you is care for people with depression. In the 1950s, what you want to be thinking about is "One Flew Over the Cuckoo's Nest." So people are warehoused in mental institutions; there's very little therapy for people who are not that sick. You sometimes got a lobotomy. Sometimes I think I need a lobotomy, but we don't do those anymore. Insulin therapy, which is where you give the person a lot of therapy and you produce a coma and then sometimes people get better. I think it's related to the "Three Stooges" theory of medical care, which is, if your knee hurts, you hit the guy in the head and then his knee doesn't hurt so much.

So, I think that's what's going on there. And today, everybody, of course, gets their Prozac. Costs of treating depression have more than doubled in the past 20 years. Actually not because these therapies--in this case, it turns out not because the therapies are so much more expensive, but because we treat many more people. So the number of people being diagnosed and treated for chronic depression has doubled in the past 20 years.

Is that--are we that much more mentally ill, than we use to be? Probably not. We actually don't have good data on it, but we're probably not that much more sick, we're just diagnosing things more and treating them more.

So, that's where we're spending our money. And if you want to evaluate whether that's good or bad, you have to say, what are the benefits. And there are two kinds of benefits: mortality and quality of life. Mortality is, always easier to measure. Although I should say, I'm not convinced that everybody I knew in Washington had a heart, but most people you can tell if they do and if they're alive or not. Quality of life is much more difficulty.

So, let me tell you a bit about mortality. I told you about one of the areas, which was the rise of modern medicine for cardiovascular disease, which costs about $30,000 over time. This is showing you what's happening to mortality from cardiovascular disease; diseases of the heart, stroke, things like that. And mortality is falling by about two-thirds.

The translation of this is that the average person at age 45 will live about 4 and a half years longer than he or she used to.

So, actually what the choice--what's happened is that we've figured out how to spend $30,000 per person and live four and a half years longer. Actually not all of that four and a half years is because of the medical spending. My estimates, which I won't go into, are that about two-thirds of the four and a half years results from medical spending. So, the real choice is--the real trade-off is we've spent $30,000 a person and what we've gotten is three years of live for that. And then you can--how many people think that's a valuable trade by the way? Okay, I'll make that a bit more formal in just a second.

Low birth-weight infants was the second area I told you about. Mortality rate for low birth-weight infants has fallen by about three-quarters since 1950. Largely because we can treat them better. And this is showing you a little bit on quality of life, just to show you quality of life is not getting worse. In case you're wonder, this is the share of elderly who have impairments in, basically, the ability to care for themselves. And the share is declining by about 1 to 1.5 percent per year. So people are living healthier as they are living longer.

So, here's what you want to do. You want to say, look: what are we getting for our money? Is it worth it? And on the cost side, what you have is, let's just take the cardiovascular disease case about $30,000 of spending. On the benefit side, you have three years of longer live. That seems to me--this is really what health care costs really involve. Is it worthwhile to spend more so that we get more? So, in order to say is it worth it, you have to say, what's a life worth?

Let me ask, how many people agree that health is priceless? Certainly worth a lot. It's not so clear you'd say it's priceless in the sense that we all do things that lower our health. For example, we don't all go out exercising every day. And we eat food that's not always the best for us.

It is worth a lot. Let me ask it a different way: Are you willing to pay $300 for an air bag? How many people are not willing to? Turns out that the probability that an air bag saves your life is about 1 in 10,000 people. Which means that you need to pay $300 for each of 10,000 people to save one life. Or $3 million per life. So, if you're willing to pay $3 million for life, that's about $100,000 for a year of life. So, what you've told me is that, when you think about the other uses of your money, you're happy that says I'll be willing to pay about $100,000 for an additional--at least $100,000 for an additional year of life.

I'm not the person who developed this methodology. But it's fairly common in the kind of economics and cost-effectiveness fields of medicine. Which is to say, how much, trying to attach a value to how much people are putting on being able to treat risks when they occur.

And notice that the air bag example is kind of like the Medicare example. Would you like to pay more in taxes over your lifetime so that if you have some serious incident, we will have a more sophisticated way to treat you? That's a lot like we pay to have the air bag in your car so that if you happen to have an accident, the air bag saves you.

That's the kind of question that I want to ask and say, look, how do we feel about that? And so I'm going to use a value that's about $100,000 for a year of life. That's fairly common in the field. So, as I say, that's not a novel part of the argument, but I wanted to introduce it to you.

So, if we return to cardiovascular disease with the cost of $30,000, the benefits that we've gotten, if you just take the additional longevity and you say how much is that worth in light of how much you were willing to pay for your air bag, the benefits are about $120,000.

Or the rate of return is about 4:1; that is, for every $1 we've spent we've gotten $4 back. That's a sort of corporate rate of return of 300 percent.

Now, you should think about in your businesses or in your lives, would you invest in something that has a 300 percent rate of return. The answer is, surely you would. So, every CEO you know, would be just delighted to jump at something like that. If you think of ourselves as CEOs of the economy, you say, gosh, this is something we should really be delighted about.

I've done this for quite a number of different things, not for everything in the medical system. You can see the cardiovascular disease on the left. I've looked, particularly, at fairly intensive care for people with heart attacks.

There's the low birth-weight infants, where the return seems to be about $5 out for every $1 in.

Treating people with depression, the returns are about $7 out for every $1 in.

The one area where I can't seem to find very much in the way of overall returns is breast cancer where there have been marginal improvements, but also more spending, so it seems like it's probably about a wash.

I've tried--I haven't done the medical system as a whole. What I can tell you is that if you value the improvements in health--improvements in mortality from just treating cardiovascular disease and low birth-weight infants, the benefits of that are equal to the entire increase in medical spending for everything, put together. So that's the solid part where I'm sure it's at least worth it.

And then there's a part I don't, because I haven't gone through every part of the medical system, I don't know a total amount, but it's sort of, clearly, over all.

What's going on is that people value their health highly. If you take a survey and you say, as the economy grows where would you like to spend your money. Two-thirds of people will tell you that the first or second priority is health care. Or the way that I would like to think about it is what else would you like to buy with your money? More plasma or TVs?

So, given the choice between buying sort of more consumer goods and buying more health care, people want to spend a lot of their money on health care. And that's not something we should necessarily feel bad about. I think that's why the "R" word is so unutterable, because, you know, it sort of conflicts of what people are sort of sensing intuitively is that what they really want is to get more care even if it means paying more.

And, of course what people really want is more care at lower costs. Just like what they want are more groceries at lower cost. We don't know how to give people more groceries at lower costs.

I'll tell you a little bit more about medical care at lower cost. But if the choice is between getting more and spending more or getting less and spending less, what people are implicitly telling us is that they want to spend more and get more.

So, then you can ask the question, again, before you think about making, you know, trying to selectively get rid of things--can we actually continue on this path? And the rhetoric, certainly, of the past couple of days is, oh, my gosh, no we can't possibly afford to continue on this path, you know, with the sort of commentary on the Medicare actuaries report.

I actually want to say that's not really true. There are two reasons why, there are sort of two questions you have to ask yourself, the first is will there actually be valuable things we can buy in the future. So, if we wanted to spend more, could we do

that. That's a question about what the nature of the science is going to be like, will we be able to develop ways of treating people that prolong life the ways that we've developed in the past have prolonged life?

My sense, and I am not, you know, this is sort of taking me outside of my field so I will admit to some hesitancy here. But my sense is that, yes, we are developing ways of treating people that are like the ways we've treated in the past, which are expensive, but valuable in terms of improving health.

The real question is what would we give up by devoting more resources to medical care and can we actually afford it? And what I want to tell you is that medical would take a large share of spending increases, but non-medical consumption would still rise.

The standard economic analogy is to a pie, you know, you sort of think of a pie and there's a medical care slice. And then you say, okay suppose the medical care slice of the pie gets bigger and you say, oh, my gosh, the rest of the pie is smaller. That's actually the wrong analogy here.

The right analogy is, I think, the chocolate-chip cookie. The chocolate-chip cookie, you put it on the baking pan and it gets bigger as you bake it. So that's the economy getting bigger as you bake it.

Now the slice of the cookie which is going to medical care is getting bigger, but the rest of the cookie is expanding sufficiently rapidly that the non-medical care part is getting bigger.

Let me show you that a bit more graphically. This is what our current forecast suggests the world will look like three decades from now. The overall economy will be substantially bigger than it is now. Because of productivity of growth and peoples' real wages increasing.

That's the medical care part of that, the red part would increase. But the amount left over for non-medical stuff will still increase. So it's not that we'll have to absolutely cut back on other things, just that we'll have to have them increase less rapidly than they otherwise would have.

Everyone has a different conception about what is affordable or not. So that's not an economic word that has a firm meaning--tremendously firm meaning. But when I look at that, I say, well, there's nothing about that that is inherently unaffordable for us to do.

So, if that's the case, why are we so worried? Or, let me sort of phrase it a different way. When the information technology computer sector grows as a share of the economy, we all applaud and we think that's good.

When the health care sector does the same, that's bad.

What's the difference between them? And I want to sort of talk through a little bit of the differences and sort of highlight what I think are the real problems and then sort of conclude with how to do better.

So the first worry is the government budget. When you sort of try and parse what people are telling you they say, I'm afraid the government won't be able to afford it. And it is true that at the current level of financing of the government, we would have very serious problems.

On the other hand the idea that the government's share of the economy is fixed, is just simply not the case. A century ago, the government was 4 percent to the economy, today it's a third. This is just the federal government share. So, it's about 20 percent. And the reason why government got bigger is because we wanted government to do stuff for us. So we wanted the government to get us out of the depression; we wanted that spike is World War II, we wanted the government to fight World War II for us. We wanted to have more Social Security; wanted to create Medicare and Medicaid; we wanted to have big defense.

You may agree or disagree with these priorities. The basic fact that I want to point out is that all the time we have government change size. Okay, and sometimes it gets bigger when we want it to do more and sometimes it gets smaller. So if we want to afford more public medical programs, we just have to say we're willing to do that. Maybe what we ought to have is some kind of a dedicated financing stream for medical care so that it's not coming out of other government spending. You know, I don't know exactly how to structure it, but I think by itself, this is not such a big issue.

Those left out--and I think that's the second big worry and this is a real one, which is that while incomes are rising, not everybody's incomes are rising. And so, as an economy we can afford it, but people at the lower end of the income distribution are not able to afford it. The health costs are increasing more rapidly than their wages.

One way or the other, we are going to have to cover people. Whether you think we should do it for moral reasons, because we don't like uninsured people. Whether you think we should do it for economic reasons, because the investment in peoples' health is worth it. Or whether you think we should do it because, otherwise, people are going to be so afraid of rising medical costs that they say stop it. Put caps on it. Do some other thing. One way or the other we're going to have to deal with this.

So, I told you I would tell you about reform. The first part of the reform is not very novel. But it's, I think sort of--I think about it as a different way, which is not just as a moral case but which is something about, look the reason why we're so afraid of spending more. The reason why we contort ourselves in so many ways on the cost part is because we're afraid that it prices people out of insurance.

Or to put it a different way: Suppose that we didn't have auto insurance, so that if you were in an automobile accident, you had to not only miss work and recover from that, but you had to go out and buy a new car, which you hadn't saved for. People would be very afraid of innovations that made cars be more expensive, because at a time when they might need to buy a new car, they wouldn't be able to afford those innovations. So there would be lots of pressure--gee, do we--how come those new braking systems are going in, can't the government lower the cost of the braking systems?

The reason why we don't' have that is because the car purchase has become discretionary since we have insurance. And so people can save for it and plan ahead for it. Anytime you've got something which is almost mandatory, people are going to want to make it be less costly. There's not obvious reason why this has to be made mandatory.

And so I think that's here. From my own perspective we could do this for about one-third, one-half to two-thirds of the cost of the Bush tax cuts, which, if you're like me, you enjoy doing. If you're like other people in this town you don't want to think of the trade-off, but you know, that's roughly the magnitude of what you're talking about here.

The third issue is waste. Sure it's worth it, as a whole, you say, but is it all worth it? And the answer to that is, no. And I want to talk just very briefly about how to sort of reconcile what I've told you which is, we're getting a lot of value with what you inherently think from a lot of other studies and from your own impression, which is, gosh, there's got to be a lot of waste out there.

And the biggest difficulty in health care is that waste and value go together. Or, at least, traditionally they've gone together.

Let me differentiate medical services by--along two dimensions: The first is how valuable they are, that is how important they are in improving peoples' health.

And then the second is how intensive they are. That is, kind of how much doctoring goes into them. So, up top, I have something like health promotion, which is figuring out whether the patient should be going to the doctor; calling up patients to remind them when they forget; which most patients do; figuring out that the medications actually got to the patient at the right time; making sure the doctor is aware of what the relative clinical literature suggests.

All the things that frequently go wrong, many of them are in this area, that is it's just virtually impossible for people to follow instructions. Or the way I like to think about it is most people who have diabetes have been obese for over 30 years, they go to the doctor, the doctor says congratulations you have diabetes, why don't you change your life style overnight?

Well, if people really were able to do that, they would have done that 30 years earlier. Just telling someone that and then saying get out of my office, show up in three months and be better is not really a very good way to deal with people.

So that's the first aspect and it goes with the second part, which is sort of chronic disease management. The health promotion and the follow-up are things that even I could do.

The managing of a chronic disease is something that does involve doctoring; so this is a doctor knowing to take tests and what to look for and other kinds of thing to care for. It's more intensive, oftentimes it's very high value. This is the stuff that prevents future disease.

It's not incredibly high value. What's extremely high value are things like very major surgeries; very important tests; episodic, serious illnesses of which a lot of the sort of valuable innovations are.

So, in the bottom right are many of the things I was telling you about. The development of very sophisticated surgical things and medications that really improve health a lot.

And on the bottom left are the overuse of those care. You know, when you go out and do a study and you say what share of people who get bypass surgery have a clinical condition for which bypass surgery is an appropriate therapy. And what share don't. The answer is about 10 percent of people who get bypass surgery, don't have any clinical condition for which that seems like an appropriate therapy.

So, those are people who are getting a high-tech intervention that's just not doing very much for them.

The single most-important thing I think about the medical system, is that what's done is remarkably correlated with how it's paid for.

So, if you look at what the traditional medical system did, was it reimbursed on the basis of intensity. Doctors who did a lot of intensity got paid very well. Cardiovascular surgeons, neurosurgeons would earn several hundred thousand dollars a year; doctors who did moderate doctoring, your primary care physician; your pediatrician; your family practitioner; got paid fine, but not very well. And folks who do that other stuff, didn't get paid at all.

And so what we got was a lot of really sophisticated stuff. And the really sophisticated stuff was often good but sometimes bad. And then we didn't get very much of the less-sophisticated stuff, many of which was fairly important.

So the medical system, overall, had a mixed quality record. That's exactly what you'd expect on the basis of these incentives.

What we then did is we had a brilliant idea. We said, let's stick everybody in managed care. So I think of managed care of doing this, which is making the--making it a little bit easier for patients to go visit their doctor by saying, look, we'll reduce your cost-sharing when you go visit the doctor, so it made it slightly easier for people to get that upper-level care. Although, in practice the doctors had to see patients so quickly that they couldn't actually get to see them very much. So that didn't do very well.

And it made it somewhat harder to do the fancy stuff. Not enormously harder but somewhat harder to do the fancy stuff. And if you look at what people are particularly about in managed care--what they're particularly worried about is that sort of bottom-right part which is, I'm really going to need care and it's going to be denied to me or it's just not going to be available.

And I understand there'll be some cost savings from getting rid of stuff, but that was what people are really worried about and they're right to be a little bit worried about it. The studies don't suggest it was that much worse, but people were kind of very afraid by that.

All--in essence what we've done historically is we've sort of paid more or paid less. And if you look at a lot of plans that are out there now, they basically involve more of the same. Either going back to older days and paying more, or compressing things even more, you know, sending more of the Medicare folks into managed care, in which case they'll sort of move up the way everybody else did and they'll presumably enjoy it just as much as everybody else has enjoyed their wonderful experience.

But there's nothing in the--much in the current environment that suggests it would get much better. What I think is that if you look at this, what you fundamentally want to do is to pay not on the basis of what's done, whereas someone--but on the basis of how well it's done.

Someone once put it to me, only an economist things that a colonoscopy is a benefit. The benefit is not having colon cancer. Why don't we pay a little bit more to make sure that people don't have colon cancer rather than pay so that they have colonoscopies.

So, if you think about how this would work, here's one kind of simple solution. Suppose you say, look, we're willing to increase Medicare payments a bit, I'm willing to increase Medicare payments by 5 percent, but I'm not going to increase the payments across the board the way that we always do and hope that it shows up in something good because we know what happens when we do that.

Instead, I want to put the money in a quality improvement fund. And here's the way it works. I use what the clinical literature suggests as appropriate care. So, for example, if a 50-year-old woman comes to a doctor, she should be recommended for a mammogram every so often; a diabetic patient should have his eyes examined for

retinal damages; his extremities examined for foot ulcers; whatever it is--you look at what the clinical guidelines are that are out there in the profession.

And you see how well the doctor followed them. Sometimes they would be process measures, like, did the doctor do something? In some circumstances, like, for example, at a hospital level, many states evaluate how well hospitals do in terms of mortality for common surgical procedures. So you can evaluate outcomes. Sometimes you can measure the satisfaction of the patients. There are a number of different dimensions here. And you assign points. So you might get one point for every time something goes right and you lose a point for something that you didn't do right.

You know, currently, we actually collect data on what doctors do. We collect data on what the diagnosis was and what they do. And we pay on the basis of what the diagnosis was.

So, we actually have a lot of this data already, and then you just divide up the money on the basis of that. So this is not a radical change. This is not let's tear everything down and start over, which people clearly don't want. In my past live, we learned that lesson quite well.

But this is sort of saying start from where we are and build on that. And one can think about it on the other side, as well. For example, in the Drug Bill. My sort of hidden hope was that, rather than making cost-sharing be kind of just a fixed-dollar amount, or, you know, you pay the first amount and then the government pays and then there's this donut hole where the person pays and then the government pays again. Rather than just saying, look, all drugs are drugs, why don't we say something like there's lower cost-sharing for drugs for which the patient has an indication that that drug is actually valuable.

And there's higher cost sharing for drugs for which we don't have that indication.

I guarantee you--or I don't guarantee you, I predict that what we're going to observe about the Drug Bill in a few years is that many patients are getting drugs they don't need and other patients who need drugs are not getting them. Not that overall it would be bad, but just that there will be those errors in exactly the same we see those errors in all other parts of medicine because we're not paying for quality.

And so, this is kind of the second plank of what I think about in addition to the universal coverage part.

So, I just will conclude by telling you what, at least I see as where one would wind up 10 or 15 years down the road if one started down these couple of paths.

One is that we would have less wasteful care and more valuable care. Overall spending could be higher or lower by not paying for some of this stuff for which

there is no value, we'd save money. But on the other hand an enormously large number of people are not actually getting a lot of preventive care that they could be and that paying doctors to make sure they got it would actually give them.

When you look at businesses and insurers that have really tried to push use of preventive care, what you tend to find is that in the short-term, it increases spending. And the reason is that so many people are under-treated that you spend more on them in the short-term over the longer term there may be some savings, but maybe we'd spend more, maybe we'd spend less.

That we would have sustained cost increases because we would be paying for new medical technology. We would need to make sure that the financing system is stable, so there would have to be a source of money for the government and particularly the expanded role of the government for making sure that poor people actually could afford health care.

That's in--I hate to be the one to break the news to people, but that's going to mean more government spending. So, that's something we're going to have to get used to. It insures everybody and then it sort of challenges and rewards for high value. It says that we are not going to tolerate haphazard value and we're going to put our money where our mouth is.

The final comment that I will give you is that in many ways I think of health care as being not dissimilar from other industries. They're, you know health care's brought in enormous value but also has a ways to go.

There are two industries in the economy that I know of in which you don't get paid more for doing a better job. The first is health care and the second is public schools. And we tend to worry about the quality in each of those.

And that's and so what--now fortunately in the health care case, the sort of system by default had incentives that at least gave us a lot of very valuable service use over time, so it's actually not been as bad in the school case, but I thinking about that leads one down that kind of transition path.

So, that's maybe I will stop here. That's kind of my thinking about where we are and how we make some progress on an issue that seems like, otherwise, it's going to stalemate us for another generation or two. Thank you very much.

[Applause.]

MR. BURMAN: I like this book a lot. It's very well written, readable and provocative. And it certainly provoked me to think about health care in somewhat different ways. The book makes a number of important points.

It makes the point that high medical costs produce great value; a point that's often lost in the hand-wringing about unsustainable medical cost inflation. It stresses that even though the markets for health care and health insurance embody--every market failure imaginable, there actually is a market and producers and consumers respond to incentives a point sometimes lost in the health literature.

Thus a solution to health care market problems lies in creating incentives for innovation and quality and disincentives for ineffective or wasteful care.

What's most impressive to me is David's optimism about measuring quality, risk adjustment, and especially the political process. This is really remarkable for a survivor of the 1994 health reform debacle when David was in the heart of the beast. And I suppose it's cause for optimism for the rest of us that are still recovering from that trauma.

However, for reasons that I'll explain below, I don't share David's optimism about the political process. Rather than substantive disagreements about the analysis, which I think is basically right, that underlies my concern about the policy conclusions.

I'm going to focus on the proposal for universal coverage and not on the quality improvements, which I don't have any really complaints about at all.

David proposes an individual mandate and tax credits that are adequate to insure that low-income people can afford decent health insurance. He also argues that the concern about run-away health care inflation is misplaced because the price increases reflect value far in excess of the cost. And he does that fairly convincingly.

In practice, as I said, my concerns are political. David's certainly right that an individual mandate makes much more sense than an employer mandate, if there are market reforms that guarantee that individuals can purchase insurance at fair prices and the subsidies are adequate. And those are big "if"s.

David's probably right that a political compromise to attain universal coverage would have to be based on tax credits. But it's almost inconceivable to imagine Congress now or in the near future agreeing to refundable credits of $7,000 per family, which is what David argues--I think rightly--lower income people would really need to be able to afford decent health insurance.

President Bush proposes a $3,000 credit and only for insurance purchased outside of work. David's proposal would apply the credit to wherever you purchase the insurance. The President's policy, in contrast, would undermine employment-based health insurance, while still being grossly inadequate to allow most low-income households to afford health insurance.

And, actually, even those inadequate subsidies are purely theoretical. What Congress actually enacted was health savings accounts to pay, tax deductions for savings accounts for health insurance. Those accounts are of significant value only for people who have high incomes, just like all the other tax subsidies in the health care system, which grow with income and, basically, miss the populations that most need help.

Even in the highly unlikely case that we started with adequate credits, conservatives would instantly attack them as welfare and start to hack away. Over time, if medical costs continue to grow unchecked, the cost of an adequate credit program will grow faster than the rate of health care cost inflation, for reasons David recognizes in his book and reasons I will explain below. And their political viability, whatever it is now, would just evaporate.

The consequence is, with an individual mandate, and inadequate financing, low- and middle-income people would be forced to pay larger and larger shares of their incomes for health insurance. Something that, if they had the choice, they wouldn't do.

David makes a powerful case that so far, at least, the benefits of health care innovation far exceed their costs. He also argues that future growth is affordable.

In some sense, we'd like to know the answer to this question: If we could pay everyone, every year what they spend on medical care as a lump sum, say x, and they had perfect information (or at least as much information as their doctors) how much would they actually choose to spend on health care?

In that light, David's overall conclusions might still hold, but a lot of people would want to spend far less than x on health care. Think about, if you gave somebody earning $15,000 a year, $7,000 in cash. Even if they would spend that money on health care if insured, they also have other needs, like food and housing and they would almost surely choose to allocate their money differently.

This is the standard moral hazard problem. The interesting point that I think David's making is that for high-income people, if you gave them x, they'd be willing to spend a whole more than x, because the benefit's so far exceed the cost (although they might not consume the same mix of services if it was actually their own money).

So, on balance we get more than we paid for. Basically the argument is that the costs of medical care innovation are far less than the benefits. And that the winners, who I will argue are disproportionately high-income people could compensate the losers and everyone could be better off. This is standard cost-benefit analysis.

The problem is it all falls apart if the compensation doesn't happen.

In the context of David's analysis, my point is that even if the average value, say, of a year of life is $100,000, there is a tremendous amount of variation and individuals' valuations are likely to be closely tied to income. For example, David surveyed everyone in this room and we were all willing to pay $300 for an air bag, consistent with that $100,000 valuation, but this isn't a random sample.

If you were to survey people earning $20,000 a year, you'd get a different result. They were the ones who weren't willing to pay for the air bags when they were optional.

If you think that valuation of life is proportional to income, for example, then if $100,000 is the mean, the median is probably something like $56,000. Roughly half as much. And over time, if the income distribution grows more skewed over time, the difference between the mean and the median is going to grow even larger.

So, if the winners can compensate the losers, society as a whole can be made much better off. But the problem is that the scheme isn't politically viable. The subsidies required would be quite large. If the distribution of income continues to grow more skewed, the subsidies would grow larger and larger over time and larger and larger proportions of the population would require subsidies to be adequately compensated.

Just to be clear on what we're doing here we're basically designing a system to benefit people at the top. Although there are benefits for everyone, the largest benefits go to the people who most value these health improvements—those with high incomes.

And even if somehow we could get those subsidies enacted, they are likely to crowd out other things that low- and middle-income people value, like education, food stamps, housing, earned income-tax credit.

So, I guess my argument is that the subsidy mechanism doesn't work and first for political reasons. There are also a couple of other reasons.

One is that the subsidies would eventually require immense taxes. And those taxes would ultimately prove to be a drag on economic growth. One of the assumptions underlying David's analysis is that the economy is going to continue to grow at a fairly rapid rate. But, eventually, the very, very large subsidies--especially, if they're not financed through, our concept of efficient taxes, which I think is actually a fair bet would produce a drag on the economy. So, GDP is going to grow slower over time unless health costs are checked.

Also, if the subsidies have the effect of keeping older people alive longer, then GDP per capita is going to drop, unless you can figure out a way to keep these older people in the work force.

And the other problem with targeted subsidies is that they immediately become a political target of those who don't get them. And my preference, if you're going to try and get the universal entitlement or try to get the universal coverage would be to have an entitlement that was distributed more broadly.

I have got a couple of other small points. David says in his book that if risk adjustment doesn't work, then the best option may be single-payer. I'm not sure, especially politically, that that's right.

There are a couple of other options. Although they don't work at present, but David's optimistic about innovation and maybe he can create the right incentives so that the government could bid out reinsurance services that compensate insurers for a share of excess costs and monitor the costs of services provided through audits of treatment and practices.

Can the market provided with proper incentives figure out how to solve this problem?

Another alternative would be to have a government-provided high-risk pool. The main problem with that is that it would be a large government program and it would be a political target for attack.

Finally, the one thing that I would have liked to have seen more emphasis on is that another area where there can be immense benefits is just investing in information. There are huge externalities to information about quality of care. And a lot of uncertainty about what the most effective treatments are.

One thing that struck me was that some of David's poster examples in his book, have been in the news lately because doctors are figuring out that they actually don't work the way we thought they did. For example, angioplasty and stints were in *The New York Times* on Sunday because it turns out that for something like 80 percent of heart attack victims, they're not an effective treatment because even though they deal with the plaque that caused the immediate blockage, there are all these plaque bombs all through the rest of the vascular system, just waiting to kill people.

Antidepressants, which produce huge benefits overall, may create a risk of suicide among teenagers.

Thus, there's tremendous uncertainty about treatment and standards. And that is one area where the government could reduce costs and improve quality at the same time--certainly improve quality in care. David might argue that costs might not go down because more people would get treatment that was actually efficacious, but that could still represent a good trade-off.

All in all, I think this is a terrific book and I applaud David for writing in a way that people who are not health geeks can understand it.

[Applause.]

MR. BUTLER: Thank you, it's a great pleasure to be here at Brookings, I'm an official at the Heritage Foundation, and it's not often that I get invited down here to speak at Brookings. So I feel a little bit like President Saddam must have felt when he was invited to speak to the Israelis Knesset--we agree on the broad principles, it's the details that cause us problems.

It's also a great pleasure to be commenting on David's book, which I agree as the others have done, is an excellent book. I got to know David during the Clinton health care period, where we spent most of our time attacking each other. And our relationship has improved ever since.

So, as I said, I think this is a really first-class book. It's a book that should be widely read, even purchased. I think it does a great job in explaining to the laymen, as well as to the economists, just how the health system really works and how we should think about it.

I agree broadly with his diagnosis, though I'm going to say a little bit about a couple of items. But I do have some disagreements about his prescription, and I'll say a little bit about that, too.

There are some particularly valuable insights and aspects of the discussion of the way that the system works. It does rebut very firmly the idea that we don't get value for money in health care. That is a very, very important point for people to understand. And he does an excellent job in explaining that.

It also rebuts the idea that somehow we spend too much on health care and spending on health care is bad, whereas if there's more spending on housing, or something like that, it’s somehow good for the economy. I think this is a fallacy that's been allowed to exist for far too long. And David does a great job of debunking that.

He also does an excellent job in looking a little bit more into some of the dilemmas that we feel about managed care. Managed care, which he points out and as others have done, has been the butt of jokes in movies and so on for a long time and everybody hates managed care. But as he points out, that was, in fact, a step towards beginning to bring some sanity into the organization, distribution, and spending on health care. And, to the extent that it managed to curb the growth in that part of peoples' compensation going towards health care. It may have been a significant factor in the growth of earnings during the same period. But on the other hand, people don't see that. They just think managed care is something that stopped them getting what they want and that somebody else is paying for it anyway, therefore, it's a bad thing. He does a good job in explaining that.

I do want to make a couple of observations, however, about some aspects of his diagnosis. The first concerns the issue of incentives in decision-making, the way people make decisions, and the incentive that they have. As David says, and I quote, "ultimately the medical system works the way the incentives steer it." I totally agree with that. But I think he gives less than sufficient pages to a very important factor in the incentives and the way incentives drive the system.

And that is the form of subsidy that we give to people who do have insurance through their place of work. I've written, as others have done, on the way in which the tax system we currently have provides all kinds of perverse incentives for the way decisions are made in the health care system. The tax treatment of health care, and particularly the exclusion of employer-provided coverage from one's taxable income, is like the elephant in the room that affects everything you do, but people kind of ignore it.

We spend, right now, according to the best estimates, about $180 billion a year in tax expenditures to help people obtain health insurance. But there are a couple of snags associated with this, a couple of features. One is that most of the help goes to people who don't need it. They're at the highest marginal tax rates. They get an enormous subsidy. But people who don't have employer-provided coverage, because they work for small firms, get nothing. That is not exactly what you want to do to help people get insurance who need it.

It also has another feature, which I want to touch on a bit more. It requires you to hand over control of decision-making and choice of plans to your employer. It changes the person in the equation who is fundamentally making the decisions.

That has enormous consequences for the incentive system and the way in which the health care system has evolved. It leads directly, in my view, to higher uninsurance, and hence, the need for us to be concerned about universal coverage. It hands over control to an employer who may or may not choose to provide you with insurance and many don't--in the case of small firms. So that adds to the problem.

It also adds to the illusion that health care is somehow paid for by somebody else. You know, Martians or something like that, but not me. And, therefore, why should I be concerned about cost and even quality? I'm more interested in quantity if I think somebody else is paying for it. And we see that very much in the politics of health care and in the dynamics of bargaining for health care at the place of work.

It also leads to a very different relationship between insurers and patients. I've lived in the United States for 25 years. I have never had my dinner interrupted by a phone call from a health insurance company offering me a better product. It's never happened.

I'm also an official at the Heritage Foundation and I am inundated with health insurance companies telling me how we can save money at the Heritage

Foundation. The whole incentive system is different in terms of how a normal market would operate. That leads to a lot of issues in terms of quality, decision-making, and so on.

If you think about the decisions that an employer makes, if they are dealing with insurance, they are very different from individuals.

Imagine that you are an employer who runs a small restaurant, perhaps not too far from here with a few employees. You know that in five or six years you're going to have a totally different set of employees. So what incentive do you have to organize and spend on health care that looks at the long-term interests? Why do you care about obesity, if that person isn't going to be your problem five years from now? Why would you care about making sure that your employees' children get a good start and get good health care that may not show any tangible effects for years later when your employee is not going to be with you?

Once you hand over control in that way, the whole incentive structure changes and I think contributes to the issues and concerns about the quality that David mentioned. That's why I and many other people are looking at how the health care system functions. It’s why we're so obsessed with looking at this tax treatment as the driver of perverse incentives.

I think, in addition, it's important to look at little bit more at some of the aspects about how to encourage quality sensitivity in the health care system. I mentioned why employers who control most health care for most working people don't necessarily have the incentives that we want.

But one thing I'd like to hear David say a little bit about one other aspect which I found puzzling. He argues that it's really difficult to get doctors to invest in quality-driven changes, information systems and so on, because of what he calls a free-rider problem. Because doctors work for so many different plans, he says, why would a plan invest and give resources to a doctor if they know that a doctor can gain value from that by going to some competitor at the same time.

I'm not sure that's quite the way to look at this. Washington is a city of consultants of people who work for different employers in different capacities and so on, much like doctors work for different health plans. But I don't see a big problem here in terms consultants not investing in things necessary to make them competitive and command good value and, therefore, good consulting fees in the system. I don't quite understand how that doesn't operate within the health care system, so maybe David can explain that a little bit further.

I do agree that it's very important to look at how one can change the payment systems to plans, take account of the cost and the value given. That is a perennial problem in the insurance system. A structural problem that does need ideas like insurance, risk adjustments and so on. Right now, if you're an insurer and you give

good value for money, you have a problem. I was talking to the head of an insurance company in Boston just a few months ago. He pointed out that they're doing tremendous things to deal with problems of people who have multiple illnesses and multiple problems to really organize and give them good value. I said, do you advertise that? And he said, “Good God, no, of course not. Otherwise, I would have all these sick people coming to my health plan. No good deed goes unpunished in the health insurance industry. That's why it is so important to look at reinsurance, risk adjustment and so on.

So, those are all the nice things I have to say about David.

Let me end with a couple of things which are a little bit more questioning.

The first is should we pay for improvements in health care? Of course, we should, in one sense. But David has all sorts of ideas to get business and government to do that. Now, as I said, I think there may be some other ways of thinking about how people who are now in the business sector, employed sector, where incentives might change differently, and it's important to look at those.

I'm not as skeptical as he is about the ability of people to make sensible decisions about quality if they have the control of the dollars and the control of the plans involved. I think when you don't have choice in a market, it's not a big surprise that education doesn't occur to help people navigate that market or that information systems don't develop.

It's when people actually have choices, then those kind of systems and education begin to develop. We have seen it in buying cars, in buying housing, in choosing a college for one's child -- *U.S. News*, and all this information that follows the ability to make a choice. Choice is like the "Field of Dreams" approach, "Build it and they will come."

Create choice, and you will begin to get a kind of education and information you need because now there is a value associated to it for the individual. It's not perfect, but I think it's a darn sight better than what we have today.

David is also, of course, as somebody who was involved with the Clinton Administration could be expected to be, very interested in micromanagement of everybody's lives and the economy.

[Laughter.]

MR. BUTLER: And I think David spent a little bit too much time close to Ira Magaziner when he was in the Clinton Administration. So he has a points system and various other things to try to figure out how to get things to happen in that way. But it seems to me that if you start changing the financial incentives at the beginning, you

begin to remove a lot of the need for a third party to do the kind of micromanagement that an individual would do or to would go to experts to help him.

As far as universal coverage is concerned, I'm a supporter of universal coverage. I agree with that. I agree very much in broad terms with his way of achieving it. I agree on an FEHBP, a Federal Employee Health Benefits Program-type structure for people, for all of the reasons that I encourage you to look at in his book. I agree that it should be made affordable through subsidies and tax changes. I agree with a sliding-scale tax credit system that he proposes. I even accept some form of mandate to make sure that people buy at least basic coverage and certain catastrophic coverage to protect the rest of society from free riders in the system. And I agree with reinsurance and risk adjustment, as I have said.

Paying for it, however, is a bit of a tricky problem. I think, if you look at all of the various proposals, including the ones I've developed, that try to achieve true universal coverage in this country, the numbers are large. There is a rough rule of thumb. To get adequate universal coverage, we're probably talking about $70 to $100-and-something billion a year. It may be good value. It may be the payoff is very good, but it's a large amount of money, and people are not prepared to do that. At least they show no indication of putting their hands in their pockets and paying out.

David's colleague, Bob Blendon, has pointed out on many occasions that if you ask people, "Do you want universal coverage?" they'll say, "Yes, of course."

"How much are you prepared to pay?"

"Well, maybe five bucks a month," or something like that. They're not prepared to pay much.

I think a real benefit for mankind would be that if the government created a program to make David's book available to everybody and to do television ads, as they're doing for Medicare reform right now, telling people why it's good value for them, then we may get some progress, but right now I think it's very difficult.

So what does David do? Like most people, he tried to see if there's an easy way out, and of course the easy way out is to roll back the Bush tax cuts. The Bush tax cuts are the equivalent of the peace dividend the '80s and early '90s or the surplus. Remember the surplus?

[Laughter.]

MR. BUTLER: It's basically free money that you can spend that doesn't seem to hurt anybody. Nobody thinks they're getting a tax cut in the future, and therefore spending it is painless. The problem is, there's a couple of problems, and one is the fact is the Bush tax cuts, if you haven't noticed, are actually due to be phased out and repealed in about 9 years' time. It's only a blip. It's a short amount of time that this

money is available! Also, we're talking about "only" a trillion dollars. It sounds like a lot of money, but in terms of if it's $100 billion to actually achieve universal coverage, after about 10 years you like run out of money, and then what are you going to do at that point?

So I think this notion of saying let's take something which is a short-term amount of money to pay for something which is a perpetual program, one needs to think rather carefully about that. But as I said, I'm in favor of the objective. I just haven't figured out how to persuade people to actually ante up the money to do it, and nobody else I know has managed to figure that out either. I don't think David has managed to figure it out. And until we figure it out, I think it's part of his prescription that we're really never going to achieve.

Thank you.

[Applause.]

MR. MANN: Well, the first thing I would like to do is give David the award for the best book title of any book published this year, "Your Money or Your Life." I love that title. But remember how Jack Benny responded to it when confronted by the robber, he hesitated and said, "I'm thinking. I'm thinking."

[Laughter.]

MR. MANN: Which perhaps David had in mind, certainly on the basis of discussion and commentary thus far.

As my colleagues have said, this is a delightful read, as delightful a read as it was hearing David's presentation. If we think it's a depressing problem, it's uplifting to read such a lively and ultimately elegant discussion of the health care system. And let me just say the end notes provide leads to a gold mine of research and information that you can follow up on.

It seems to me every time I get in a session like this, all of the economists become political scientists and the political scientists become economists.

[Laughter.]

MR. MANN: My colleagues have taken care of the political analysis. Let me say how much I find useful the economic reasoning about health policy in this book. The whole discussion of thinking about costs versus benefits, the importance of getting incentives right lend a sort of analytic rigor to a book intended for a general audience that is really terrific.

Frankly, I found the broad discussion of the successes of health care immensely persuasive, and that's something that just doesn't enter the public debate, and I'm delighted that it's there. I also found very persuasive the discussion about, both about over- and under-investment in health care. I think David has outlined the central

problems, and frankly I find refreshing putting the issues of coverage and quality ahead of affordability because costs dominate the discussion of health care in this country.

The entitlement problem, I mean, that's real. We ought to grapple with it, but David is taking us back to some first principles that I think are central, and he's forcing us to confront realities we don't like to confront.

Number one, society's health budget will increase, period. Whatever you say, whatever you want, it's going to happen. Moreover, he said the government's health budget should increase, and because it can't come out of other things government is doing, it means inevitably a substantial increase in the public's share of the total economy.

Well, that's heresy. David raises the question of what the economic cost of that will be, as Len discussed, and it's worth asking that question, but it isn't worth ruling out a substantial growth in the public sector's share of the economy. In effect, David is telling us, hey, it's going to happen one way or another. The question is whether we're going to get into this in an intelligent fashion.

So I just found all of that compelling, and I think you will find it compelling. And I guess what I would argue in the end is that David's contribution here, as witnessed by one of the titles he used in his presentation, is in providing a vision for the future of the health care system, rather than providing a specific plan. Because once we get into the nitty-gritty, as Len and Stewart have already begun to do, you begin to see the substantive and political hurdles that confront the suggested direction that David has in the quest to cover everyone and to improve the quality of health care.

My colleagues have discussed these items. David addresses them in the book, some more thoroughly than others, but the challenges of measuring quality, of adjusting risk, how the preferred changes relate to existing programs. David talked about the incremental change in Medicare. He didn't say anything about Medicaid, which of course has been the way in which we have tried to expand coverage for those uninsured. Are we sending them off -- away from a public program and substituting an individual mandate with full tax credits to do it?

In fact, the whole question of a transition from our current system to the vision that David has in mind is the most difficult to grapple with. I can imagine an end state that I find very attractive and reasonable. I have a much tougher time figuring out how in the world we get from here to there, in substantive policy, practical implementation, and political terms.

David talks about employer mandates and how people don't understand what economists know, which is they're paying for those health insurance benefits with lower wages. That's kind of like assuming a can opener. They don't believe that, and I don't think you're going to succeed in convincing them that this is how it works. Therefore, one of the enormous obstacles in moving off employer mandates to individual

mandates with a proper financing system built around it is that workers will believe they are losing something. There is, in my mind, no question about it.

Stuart has a lot of problems with the whole employer-provided coverage system and the perverse incentives it creates, and most of what he says makes absolute sense to me, and yet it's daunting to imagine politically how you take care of this problem of individual perceptions of benefit or loss.

David proposes that we move from the Clinton era zero-sum game, you know, more coverage, but no additional cost, to a positive-sum game, which sounds pretty good to me in, in terms of achieving it, except, as Stuart reminds us, it has to be paid for in some fashion.

By the way, I thought David was quite honest about the Bush tax cuts only providing a temporary boost to get the uninsureds on board, but quite explicit about the fact that it was going to cost much more over time, and it was going to require substantial increases in the size of government and in tax rates, which of course then undermines the idea of building a coalition of a left and right.

David hoped that universal coverage for the left and no to regulation and litigation for the right would provide the basis for a new powerful political coalition. But the reality is what separates much of the so-called "left" and "right" is our strong feelings about taxes and size of government, which becomes an enormous obstacle to achieving the objectives he has in mind.

But the very fact that he's made these issues and choices explicit and helped us understand how it is we've gotten to this point, what its benefits and costs are, and what it would take to provide something we would all value is an enormous contribution, and I, for one, have profited greatly from it.

Thank you.

[Applause.]

MR. GALE: Thanks to all of you for very interesting presentations. The only thing I found worrisome was that every time Tom had a critical comment to make about an economist, he looked at me.

[Laughter.]

MR. GALE: David has indicated he didn't want to respond formally to the comments made, so let's turn directly to the audience for questions.

Yes? There's a mike coming around.

MR. WASOW: Thank you. I feel a little bit as if we were in the former Soviet Union, where people have jammed the airwaves and told us that we live in the best of all possible worlds.

If you take an international look at health care systems and what they deliver, if you go to cases as exotic as Canada, say, you find that a share of their income going to health care is so far below us, below ours, that we could be paying for our entire defense establishment, including the war in Iraq, with the difference.

Moreover, the benefits of longer life expectancy, which David Cutler confidently presented to us, are nowhere to be found in international comparisons. If you account for differences in GDP per capita, there is nothing explained by the share of GDP going to health care. So here we are, spending nearly 14 percent of our GDP on health care, when the Group of Seven say average is below 10, and England and Japan average 6 or 7 percent of their GDP, they have higher life expectancy. How can we say we have an efficient system?

MR. GALE: Thanks. Identify yourself for the transcript.

MR. WASOW: Bernard Wasow, the Century Foundation.

MR. GALE: Just so everyone knows, there will be a transcript posted on the web in a day or two. There will be a final transcript posted in about a week probably.

David, I think that was for you.

[Laughter.]

MR. CUTLER: Let me just offer a couple of quick comments.
First, I didn't mean to suggest it as the best of all possible worlds, and the part about getting more value was directed there.

Let me just kind of give a couple of quick comments about Canada and other countries. If you say, "How is it they spend less?" one way they spend less is that doctors get paid a lot less. The average doctor in Canada earns half what the average doctor in the U.S. earns, and the average doctor in the U.K. earns half what the average doctor in Canada earns. So there is one big part there. Now, we could think about paying less to doctors, although there are other issues you face.

Second, there's lower administrative expense.
And then third is, which is a big deal, and then third is you get less services in any particular circumstance. So, if you look and say people who have a heart attack in Canada, they're about one-fifth as likely to get intensive surgical procedures as in the U.S. That latter part, generally, the better run is the government the better they are to restrict what happens to the people who really need it.

In the case of Canada, actually, they don't seem to be tremendously hurt, although it's hard to know for sure, they don't seem to be tremendously hurt by that, by not giving it to everybody. So what I infer from that, and a lot of other studies have shown this directly, is that there are a lot of things that we are doing that Canada is not doing. So Canada does better on that point.

But if you come back to the stuff that's not done very well in the U.S., like say caring for people with chronic diseases or preventive care, as best we can tell, that happens just as poorly in Canada and just as poorly in every other country.

So I sort of look at that, and I say, well, it's not the right model for me, in part, because I'm not sure we can pay less to doctors without substantial impacts on who becomes a doctor because--over time--because I think that there are hopefully other ways to get rid of the stuff that's not so valuable by, for example, paying less for stuff that's not so valuable or putting in a payment for quality.

And, third, we need to think that all countries around the world need to think about how to transition themselves towards a system that is not just paying for poking and prodding, but for actually making the patient be better off. And Canada will have to go that way as well as every other country will.

I will just give you one last point about Canada and other countries, which is, if you ask what share of Americans are basically happy with the health care system in the U.S., it's about 20 percent. If you ask what share of Canadians are basically happy with the Canadian health care system, it's about 20 percent. If you ask what share of people in the U.K. are basically happy with the British health care system, it's about 20 percent. So it seems to be a kind of universal law that no more than 1 in 5 people are actually happy with their system.

[Laughter.]

MR. : Isn't it true that the U.S. also is paying closer to the average costs for medical services and prescription drugs and other countries are basically paying closer to the marginal costs? We're basically subsidizing the rest of the world.

MR. CUTLER: For some things like prescription drugs, we're subsidizing the rest of the world. That would be a small part of the total spending, but it's a big part of what--the benefits that we provide to other countries by paying more than they do for those services.

MR. BUTLER: Can I just make a quick comment? I've lived about half my life in the United Kingdom and about half my life here. It is interesting to look at this issue of how much have we spent, and how do we measure cost and value. Mortality rates are one indicator, but of course you talk to people on the ground, it's a little different.

When somebody in the U.S. who is well insured needs a major procedure, let's say orthopedic surgery or something like that, they can generally count on that being done relatively quickly. That has two effects, compared with the U.K., where there are people who wait for years for that type of surgery. It has two important effects concerning value:

One is, of course, to the individual, and David's book looks at how you measure value and is very relevant here in terms of what you would prefer to have--what's the value of getting something done now that puts you back on the golf course or back to work and so on as an individual? There's a high value associated with that, which is not seen in the British system. In Britain, you have a lot of people who are not working, who are in pain because treatment is delayed, rationed and so on. But actual medical outcomes, from a narrow perspective, may be identical.

The other thing, of course, is that there's a cost implicit in the system that delays procedures and treatment that doesn't show up in health statistics. If somebody is not working for six months because they have angina, but they are not going to have it taken care of in the hospital for another six months or nine months, there is a cost to the economy.

These are costs here which do not appear in the health accounts. If you start looking at that aspect, then these differences are not quite so remarkable. There are enormous costs in the British system in terms of lost work, in terms of ancillary services to people who have to be cared for whilst they wait for health care or some procedure, and that's got to be built into these kinds of comparisons.

MR. GALE: Thank you.

Gene Steuerle.

MR. STEUERLE: Gene Steuerle, The Urban Institute.

David, I'm wondering if you might have pushed a little too easily on the question of what we're buying for the money that we spend. It partly relates to Bernard's question. If we do I think a major comparison of both systems around the world with the U.S., we'll find that providers in the U.S., not just doctors, but nurses and janitors in the hospital get paid a lot more, relatively a lot more, even relative to our average wages than in these other countries. If you're looking on the input side, you can at least measure some of the differences there.

And the second one, and Henry Aaron would probably scream at me--is he sitting in the room?--if I quote this, but--

MR. MANN: He's in Bellagio.

[Laughter.]

MR. STEUERLE: If you look at BEA statistics on quantity versus price of major industries, the health care industry is the only growth industry in the United States that has relative price increases over the last 50 years. Whereas, every other major growth industry, telecommunications and so on and so forth, has significant relative price decreases.

So I'm wondering if you didn't push a little too easily on the notion that what we're buying is buying significant increases in quality or in output of care.

MR. CUTLER: I can do the service of yelling at you, if you'd like.
[Laughter.]

MR. CUTLER: Both good comments.

Let me take the second one first, which is the price versus the quantity. Actually, the official statistics are very bad. So what happens is let's say you develop a newer form of whatever fancy thing you're going to do. All of that shows up as a price increase. Whereas, in the case of computers, we actually subtract out for the quality. And so the price looks like it's falling, and it is falling for computers, in part, because quality is improving so rapidly. So a real price index would actually take out on the quality side.

And when I have constructed price indices for medical care, they are much lower than the traditional ones. Indeed, they are actually, in many cases, actually declining relative to the other goods in the economy because of the quality component.

Just to give you one very sort of weird example of how it works, the old consumer price index for medical care used to price a day in the hospital. So, as a day in the hospital got more intensive because, for example, you were doing more monitoring, that showed up as a price increase. As people were in the hospital fewer days, and so each day was more intensive, that showed up as a price increase. So everything showed up as a price increase, even though it was actually more intensive care.

On the first one, the payments, the sort of wages and salaries, I must admit to sort of having kind of a dual view. On the one hand, in the past decade, we have actually lowered physician payments, and hospital and thus payments to nurses and orderlies and stuff quite substantially, sort of managed care did that.

I suspect the extent to which we're limited in our ability to do that is that the kind of skills that people who go into these professions have are transferrable to other skills. And so we sort of have to pay these professions roughly what we pay other very educated people. And in the U.S., the whole income distribution is wider. So the top of the education distribution earns a lot more in the U.S. than in other countries, which means that what you have to pay people in any given profession there is higher in the U.S. than in other countries.

So I don't know how much you get, how far you get just by saying, look, where in the income distribution are the people coming from and how much do you have to pay them? But my guess is you'd actually find that that was a reasonably large part of why the physicians had to earn more.

MR. GALE: Peter?

MR. ORSZAG: Peter Orszag, Brookings.

David, you talked about increases in life expectancy reductions in mortality rates. One of the things that has happened since 1960, though, is that mortality rates have dropped much more rapidly for better-educated, higher-earning workers, which relates to Len's comment.

I was hoping that you could provide some insight into where the benefits are really flowing and whether looking at aggregates and averages is potentially misleading here.

MR. CUTLER: Yes, another excellent question.

Everybody is living longer, but better-educated folks are living disproportionately longer. And probably the biggest part of that is that the kinds of risk factor changes that people make have been going on more for the better educated. So let me just give you one example.

In 1950 or 1960, better-educated people smoked more than less-educated people. Today, they smoke about one-third as much. So there has been an enormous decline amongst the better-educated and a very shallow decline among the less-well educated.

I think there are two ways to look at that, and they sort of came up in the differing discussions. One way to look at that is that the higher-income people implicitly value their lives more. I think it was Len who made that comment.

The higher-income people implicitly valued their lives more, and so they are willing to make these investments in better health that less-educated or lower-income people are less-willing to make. So, in that sense, you'd say, look, maybe we shouldn't be giving them all their money in health care, all the lower-income people the money in health care. Maybe we should be doing it in other ways.

The other way to look at it is that higher-income people find it easier to make these sorts of changes. So, if you say what does it mean to go without smoking, it probably means something different to a better-educated person than to a less--or a higher-income person than a lower-income person because the environment that you're in, because the access to different kinds of resources that one is in is different.

My general sense, and it sort of goes to some of the comments, is that most everybody, sort of tries to make themselves healthy, but people have differing abilities to do that. So most smokers quit 20 times a day. Most people who are overweight try a diet a week.

And, for some reason, it's sort of easier for higher-income people, either because of the resources that they have or other circumstances, and you can either sort of give up and say, "Well, that's the right answer" or you can say, "Look, we're not doing enough to help people out," and the right thing to do is to help people out.

And maybe, to come back to a comment that Stuart made, maybe what we ought to do is put a reverse bounty on helping out low-income people, that is, you get extra credit for helping low-income people change their behaviors because we know it's much harder, rather than, say, giving up on them because they sort of obviously don't want it to happen.

MR. MANN: David, your two examples were both sort of preventive health care. What about on the provision of medical services, does that account for part of Peter's differential?

MR. CUTLER: It does seem to account for part of Peter's differential; that is, if you, say, compare two people going into a hospital with a heart attack, white male is more likely to get a fancy thing happening to them than a black female.

It's probably a smaller part of the total differential, which is why I focused on the preventive part, and a lot of it is probably--a lot of it, although we're not quite sure, a lot of it seems to be related to the specific hospital that one goes to. That is, that if you take them both to the Cleveland Clinic, they're treated roughly equally, not totally, but roughly equally. Whereas, when one is going to the Cleveland Clinic and the other is going to Cleveland General Hospital, then you wind up with very different outcomes for the two.

MR. CUTLER: I just have one quick point, just that I didn't mind to imply that you should give up on lower-income people. My main point was that unrestrained health care cost increases have a disproportionate effect on people at the bottom, and unless you have some kind of a compensation mechanism, they might be better off, ultimately, with Canadian health care than with health care that they have no chance at all of affording.

MR. GALE: Let's take two more questions.

MR. MITCHELL: Thank you. Gary Mitchell from the Mitchell Report. This is a question for the author, but for others on the panel, too. I will start by saying I know you're not a doctor, and you don't play one on TV, but--

[Laughter.]

MR. MITCHELL: I was thinking about the comment of your dean thinking that it was a good idea to stack economists end-to-end, and I think we've thought that for a long time, but what seems to me is different in this day and age is that I have the feeling we're moving into an era where we think stacking physicians end-to-end is not a bad idea.

And where I'm headed with this is that I sort of want to talk about the soft side of this question, which is that, for a lot of people, it seems to me that the high-tech component of medicine is getting appreciably better, the high-touch part is not; that we're training generations of physicians who are good at treating conditions and diseases, but not necessarily as good at treating the patients.

And I'm wondering--where this is all headed is--I'm wondering if this isn't perhaps a factor that explains why, whether you ask the question in the U.S. or Canada or England, 20 percent of the people say we like the care we're getting.

MR. CUTLER: I think it is, actually. When you look at medical education sort of a decade ago or 15 years ago, that a lot of schools started moving into the idea that people were more than just organ systems, and so they started treating people as people. But that got them so far.

I think there is now another step which your question suggested, which is that should we start treating the person as a totality, that is, not just someone who comes into your office, and you give them advice or do whatever to them, but treat them as a person who needs your help and guidance and actually interact with them?

And I don't know of any real medical training programs that have gone that way, although some are starting to talk about it, but I think of that as kind of what the 21st century health care system needs to be about, and it would be nice if there were some kind of leadership on the part of those doing it, rather than sort of dragging their heels in and saying, "Well, actually, the 1960s era wasn't so bad."

MR. GALE: Charlie Schultze, last question?

MR. SCHULTZE: After the string of comments we've had, this is like kicking a dead horse, maybe a dead corpse. This goes to the distribution question, again.

A central point you make is that we're getting more than we're paying and are likely to be getting more than we're paying as health care costs increase, and I really wonder whether you can do that without distribution.

My quick visual impression of the charts you put up was that over the next 30 years, as medical care costs grow, as most project it, that look to me like that about a half to two-thirds of the increase in national income would go to paying for higher medical care costs.

Now, suppose, take two extreme ways of distributing that. One would be that everybody pays the same amount. And it seems to be fairly obvious that below about the 60th percentile, you wouldn't get willingness to do that. Whereas, above, when you get up to 80th, 90th percentile, that dollar cost is attributable compared to the increases that those people are going to be getting. So there the willingness to pay doesn't work.

Now, let's do it the other way. Suppose everybody had to pay proportionately, so we've got a big subsidy based on the distribution of income, proportional income. Then my guess is that the top end of the scale nobody is going to be willing to pay.

So that it's very hard to use that willingness to pay business to make the judgment that we're getting what it's worth, when my guess is, if you really had to allocate the costs, people would not voluntarily choose to pay a lifetime health insurance premium sufficient to cover that cost.

So I come around to the view that you may, in order to deal--we may not be getting all that we're paying for, and that it may actually be that some "beneficial" medical care might have to be eliminated if this is to make a sensible system.

MR. GALE: Thanks. David, in answering that question, why don't you also sum up anything else that you were waiting to say, and then we'll call it a day.

MR. CUTLER: This may be the first time in my life, I've been accused of being too optimistic so many times.

[Laughter.]

MR. CUTLER: On which count I plead rather guilty.

I just want to thank people for their comments, both the people on the panel and the people in the audience. I guess it's sort of or maybe I should just leave it as saying that is an optimistic view, and maybe that's what getting out of Washington does for one.

[Laughter.]

MR. GALE: All right. Well, we can all applaud that.

Thank you very much.

[Applause.]

[Whereupon, the proceedings were adjourned.]