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The Challenge of Rationing Health Care:

Can We Say No?

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C O N T E N T S

P R O C E E D I N G S

MR. REISCHAUER: [In progress] —by rationing health care in the American context, in particular around Henry Aaron's new book, The Challenge of Rationing Health Care: Can We Say No? I thought this was an easy one, that we've said no for many years to rationing, so I read the book with great interest.

As all of you know [technical interruption] we're going to start off with Henry Aaron who is the MacLaury Senior Fellow here at the Brookings Institution in the Economics Studies Program, a program that he directed for a number of years. Henry is a member of the Institute of Medicine, he's Chairman of the Board of the National Academy of Social Insurance, he's a former Assistant Secretary for Policy and Evaluation at HEW, and on another boards, as well as a prolific author on topics ranging from health care to welfare.

He will be followed by Michael Chernew who is a Professor at the University of Michigan in the Health Management and Policy Department, as well as the Economics Department. Michael is also on the Commonwealth Foundation's Commission for High Performance Health Care System, and a co-editor of The American Journal of Managed Care and on the editorial boards of Health Affairs, Medical Care Research and Review, and Health Services Research.

Last but not least is Mark Pauly who is a Professor in the Department of Health Care Systems at the Wharton School at the

University of Pennsylvania, as well as a Professor in the Economics Department. Mark was a member of the Physician Payment Review Commission, a predecessor of MedPAC, has been the leading authority in this country on moral hazard, and is the co-editor of the International Journal of Health Care Finance and Economy, and the Journal of Risk and Uncertainty.

With that, let me turn this over to Henry for the initial presentation.

MR. AARON: Thank you very much, Bob. I note that he referred to a panel of four, now three economists, and if you look up here you will actually see four economists. Bob did not include himself in the fraternity.

I'd like to begin by having two thank-yous. First to the Robert Wood Johnson Foundation for helping to support this project. Secondly, with whole-hearted enthusiasm to Melissa Cox, a co-author of this book, who is now at Yale University editing the Journal of Health Policy, Law, and Ethics, I think I've got that, and whose contributions actually really made this book possible. So, thank you to Melissa Cox.

I want to stress that I am not up here advocating health care rationing. I'm up here to emphasize that I think we face a choice. The choice arises from the intersection of a series of events. We know that technology has increased total spending on health care, and not just on health care, but wherever technology advances rapidly, total spending

increases, if you think about all the great scientific revolutions. We're an aging society. That's pushing up health care costs. And we know that well-insured individuals have every economic incentive to want any service that yields a benefit greater than the cost they bear, which in the case of well-insured individuals is either zero or close to it for the great majority of health care that people consume. That combination of influences is what has been driving the increase in health care spending, there is no sign whatever that it is abating, and every prospect that spending will continue to grow.

There's a bit of a paradox here, not so much a paradox once one takes a close look, but on first glance. Careful analysis has shown that the total benefits from the increase in total health care spending are enormous. In fact, the study by Kevin Murphy and Robert Topel of the University of Chicago indicates that the benefit from increased health care status over the last 30 years or so, not all of which but much of which is attributable to improved health care, is worth as much in terms of improved welfare as that from all economic growth from other sources combined. So we're talking about a first-order magnitude improvement in welfare from improved health status. So the total bill is worth paying. But at the margin, and it's a pretty wide margin, we spend a great deal of money on health care that really isn't worth what it costs that yields benefits that are very small if beneficial at all. What that means is as health care spending grows, in total we're getting a good return, but it

means we're wasting a growing amount of total resources as that spending increases.

Here are some projections by the CBO of what lies ahead if historical trends continue. We're looking at health care spending taking an every larger share of GDP, reaching a third or more by sometime around 2040, Medicare and Medicaid spending quadrupling over that period, and federal outlays in total growing to be more than a third of GDP with the implied requirement of humongous increases in tax payments. It's either that—that's one possibility if policies do not drastically slow the growth of health care spending—or I am going to argue it's rationing. Which we will choose remains unclear, but choose we must.

The problem is understanding what rationing means, and I think it's frequently misunderstood. Normally, the market system causes people to balance benefits and costs when they buy something. In the case of health insurance, it is calculated precisely to anesthetize, to remove that discipline from the decision at the time of illness about what health care to consume. If rationing were ideal, it would do what the market system does which is to limit the availability of health care to those cases where the benefits exceed the total cost of providing the commodity, but designing, even imagining how such a rationing system would function is very, very hard to do. What the burden of my

presentation this morning and the book is, is that we'd damn well better start thinking about how to do that.

To gain some insight into what rationing choices result in, what kind of decisions they impose, the study that I'm reporting on looked at a number of health care technologies used in Great Britain and in the United States. We compared the relative use of these different procedures focusing on high technology because it's expensive and much of it is new, and one of the ways that rationing occurs is through delays in the introduction of new and costly procedures, so one has a better metric, a more sensitive test, for detecting rationing here in those cases than with respect to very well-established procedures. I want to stress at the outset for those who are looking for statistical rigor, you can stand up and head for the door. You're not going to get any today. What you're going to get is a study that probably is more anthropological in character. It's a careful examination of a few case studies about which I then attempt to tell stories, and you will have to judge whether those stories make sense or don't make sense. Let me move ahead with the list of the studies that we looked at. This is not a complete representation of what modern medicine has to offer, but most of the items in here do involve discoveries that have been made in some cases within the last decade or two, and certainly in all cases, in the last three or four decades.

What are the relative levels of provision? In some cases, the level of provision is almost the same in Britain as in the United States

despite the fact that they spend only about 40 cents for each dollar we spend per patient. Total spending in Britain per capita is about 40 percent of what it is in the United States, so you know they're doing a lot less of a lot of things. But in the case of treatment for hemophilia, they spend about as much as we do, and there isn't a material difference in the epidemiology of the condition.

Hip replacement may come as a bit of a shock to those of you who are familiar with the poster child for rationing in Great Britain which is the enormous queues that used to exist for hip replacement in Great Britain, and I'll have a bit more to say about that in a minute. But the key point is, the Blair administration has been increasing expenditures and those waiting lists have come down enormously, and I think it's fair to say if they stay on track they're on process to if not being eliminated then reduced to a level that's a tiny fraction of what they were in the past.

In the case of stem cell transplantation, there once was no difference. Twenty years ago there was no difference between British provision and U.S. provision. Today we do about half again as much as the Brits do. Not a huge difference, but a significant one.

Now come the eye-poppers, the ones where there are really large differences. In the case of dialysis, 2 to 1, and if you don't get dialyzed when you get chronic kidney failure or have a kidney transplant, your prognosis is simple, short and final, so this difference has real

implications for patient survival. In the case of ICUs, the difference is enormous. It was about 10 to 1, 20 years ago, it's still 5 to 1, and ICUs have increased, so the absolute gap has widened. In the case of coronary revascularization which is the physician's summary term for coronary artery bypass surgery and angioplasty where a balloon is threaded into an artery and enlarged to open it frequently now with the insertion of a metal mesh tube to keep it open, the differences were 10 to 1, now 5 to 1, but once again, the absolute gaps have widened enormously because the frequency of the procedure has increased. And in the case of diagnostic radiology which fundamentally now in this case means CT scans and MRI, there's about a 4 or 5 to 1 difference in the number of procedures performed. The question is why? What explains the fact that they do as much as we do of some things, a little less of some others, and a whole lot less of still some other procedures?

I'm going to present a set of hypotheses. I'm not going to read them to you, you can look at them, but I think each of them has intuitive plausibility based on total cost, visibility of illness, the degree of patient knowledge, and there's something that's evolving with the Internet, how new the procedure is, whether the population is old or young, whether the procedure depends on specially dedicated equipment and personnel: if you don't hire the surgeon who is the only one who can perform that surgery, you don't do that surgery, if you don't have the machine that is required to do that procedure, you don't do it. So if a

procedure depends on specific inputs, it's easier to ration. If when you don't treat somebody it's very inexpensive as in the case of some of these conditions, that's a factor. And then there's the issue of whether patients and providers get mobilized. Actually, the nature of the illness influences the likelihood that patients and patients and providers will be able to mobilize. The maintained hypothesis throughout all of this is that similar procedures would operate here in the United States.

How do the procedures play out for the particular cases that I've described? Let's start with a no rationing case. Hemophilia is just a devastating disease. If you don't treat, people really suffer very obvious and extremely painful episodes of illness, and it's costly to maintain them. In the case of hip surgery, there is an interesting story. The Brits always did nearly as much as we do, queues notwithstanding, so why were there queues? The answer is, hip patients don't die on you, they just suffer. And consequently, if you have a shortfall of provision relative to the requirements for care, you build up a backlog, the patients remain with you and you build up a waiting list over time. So even 20 years ago the Brits were doing 80 to 90 percent as much hip surgery adjusted for population as we did. Today they're doing basically as much as we are doing.

In the case of stem cell transplantation, 20 years ago there was no gap, but it didn't cost anything to speak of because it was a procedure that could be used in only a very small number of conditions,

and the total cost was so small it didn't make a dent even in the British health care budget which is tightly constrained. As the menu of interventions where it can be used has lengthened, cost has become an increasingly important consideration and lo and behold, a gap has emerged.

Now let me look at the large gaps. In the case of treatment for coronary disease, the total cost of treating at U.S. rates would be enormous. There are also differences in national attitudes and differences that pervade the whole health care system with respect to the likelihood that heart disease will be detected. As one British physician told us, we just don't do screening examinations. People go to see a doctor when they get sick. That's not quite the attitude that prevails in the United States.

I want to stress that point a bit. I'm going to look at three statements by British physicians, two British physicians, one by an American physician practicing in England, on what factors come into play in the treatment of coronary disease. I'll just let you read these. They sort of build as we'll go down the page. This is, you go to doctors when you're sick. The next one suggests that resources, yes, they do come into play. It isn't just attitudes. And finally, an American physician who helped staff a for-profit hospital that was opened in Scotland. Here is a case where somebody comes from outside the system who is not accepting of resource limits, who is acutely sensitive to the

choices that inevitably will get made if you're providing a procedure at 20 percent or so of the rate to which you're normally accustomed.

Another gap where the ratios are 4 or 5 to 1 is diagnostic radiology, and once again I'm going to give you three quotes that build from it's not much of a problem, to it really is. Here is one British radiologist who says, there's a bit of an inconvenience because we don't have as much CT or MRI capacity, and so we substitute but we get through. The next one acknowledges that there are differences in the way patients end up experiencing and that it's inconvenient. You could be faster if you only had more equipment. And finally, the statement from a British radiologist who is now practicing at the University of California, San Diego. He left the country because he was upset at the situation. The point here is that national traditions matter, that resource limits feed back to influence what those national traditions are. Also that physicians in varying degrees will or will not be accepting of the decisions that are imposed by resource limits.

I want to go a little deeper into the diagnostic radiology case because it's really a hard one. How do you know whether the Brits are doing too little, we're doing too much, both, possibly neither, neither if given limited resources they are saving money where they should, and given more available resources we're spending it where we should? In the case of the use of MRI for diagnosing a certain form of brain tumor, here is a list of questions that were put together by radiologists who

wanted to classify studies as to what question they were answering, and they are arrayed from starting with the most abstract physical or engineering measures, on down through how does it affect patients and is it really cost-effective.

As it turns out, if you are a nation thinking about resource allocation, what you really care about are those bottom two categories, right? If would be nice if you can take sharper pictures, but you really want to know if it has an impact on how patients do. Here is a count of the number of studies of each type that were done. It's real easy and it's kind of fun to look at how sharp and fast and really terrific new radiological equipment is. If you want something to knock your socks off, I'm sure Melissa Cox and I had the same reaction, we visited the Fairfax Hospital's radiology facility. It is really an eye-popping experience. What can be done now is extraordinary. But if you're a resource allocation decision maker, what you care about are the answers to questions 5 and 6 and you don't get any help at all.

You also discover a lot of studies are done of just one procedure used for one condition, and if you really want to make resource allocation decisions, you need to have studies of all kinds of different procedures or conditions and comparison of different techniques that were used. We're not close to having that information. What that means is right now the Brits are guessing, if we had resource limits, we would be guessing.

Finally, in the case of renal failure, 20 years ago we were doing twice as much as the Brits were doing at the time. One British general practitioner told us why they did so little, and I have this quote here, everyone over age 50 is a bit crumbly. I'm looking at a lot of crumbly people here right now.

[Laughter.]

MR. AARON: Honest to God he really said that. I was younger then, actually.

What's the story now? The U.K. is doing 5 times as much as they did, and we are doing about 5 times as much as we did then as well. So the gap is actually in percentage terms even a little wider than it was, in absolute terms it's enormously larger. The Brits are not doing any age cutoffs at the present time, but there are limits that are imposed in determining whether patients in general go ahead for treatment.

What explains these trends with respect to treatment of kidney disease? The increase in the numbers is due to these four factors, and I might add, both British and American nephrologists are scared out of their wits that they're going to be overwhelmed by increasing numbers of cases over the next 5 to 10 years because obesity causes diabetes, causes kidney failure, and we are, I am, overweight and that is a national health problem.

Why do the gaps persist? In Great Britain regarding treatment, here are three factors at work. Once again, in item 2 I have a

quotation from a British nephrologist. The third item is kind of interesting, the third reason. It turns out modern dialysis procedure requires the services of vascular surgeons to implant what is called a fistula to enable long-term access to the veins in order to do hemodialysis. What has happened is that vascular surgeons in Great Britain to a much greater extent in the past have opportunities to practice privately outside the national health service. Those of you who love competition can see how a mixture of competition with a controlled system can produce very unintended consequences. So given these opportunities to make a lot of money outside, they're just not available to the dialysis centers to perform the needed surgery, and that is a bottleneck in the system.

I don't know whether we're going to ration, I don't know if we ration how we're going to do it, but I do know that if we do not ration, we are going to be spending a very great deal of money on health care services, an increasing absolute amount of which is not going to be worth what it costs society to provide. I think I know that deductibles or other forms of cost-sharing, as my edge toward today's political debate, is not going to do the job of controlling spending because the great majority of health care spending occurs during episodes that cost far more than any deductibles now under discussion. Just as a number, about 80 percent of health care spending occurs for patients whose annual outlays exceed $4,000 a year.

Finally, the one thing I know for sure is that we don't know now how to ration health care in a rational way.

I think there are some obstacles that we're going to have to overcome. The first is to recognize that rationing is not a four-letter word. Properly done it accomplishes without the use of prices something that approximates what the price system is supposed to do. We lack evaluative research today to base sound decisions on that. We need to think real hard about how a controlled system would allow patients with particularly intense demands for health care some degree of wiggle room. We are not going to ever in the United States I am convinced put a flat cap on spending. We need to think hard about malpractice reform not in the sense that it is now being debated, but in the sense that malpractice principles that are coherent under a system that does not have resource limits become incoherent under a system that does. The principle of malpractice is if according to current medical standards a prudent doctor would have done this and this doctor didn't do it, then malpractice occurs. Under a resource constrained system, one is likely to see different standards of resource allocation in different areas and what constitutes a prudent doctor's practice is going to lose clear definition.

We need to realize that our current health care costs and our problems and our future ones are not the result of villains. It isn't the drug companies or the insurance companies that are euchring the rest of us, and we're going to have to realize that a whole range of single-factor

fixes aren't going to work such as computerization, HMOs by themselves, consumer-directed health care.

Instead, what we're going to have to face is that we need to acquire a great deal of knowledge, that the nation is going to confront a set of choices that I believe will strain the democratic fabric of our nation because of the emotional content and the economic stakes involved. We've only begun to see the cutting edge, the leading edge of this debate, and I think it's time that scholars, and after them probably, elected begin to acknowledge the importance of this debate and the fact that we're going to have to engage in it.

So at that point let me stop and we can hear from the others. I misspoke a bit when I implied that the panel wasn't balanced, because while there were four economists on it, that seems a little unbalanced, in another sense it was quite balanced, we had two crumbly presenters and two noncrumbly ones, but unfortunately Len crumbled, so we're down to one. Michael? Give us the perspective from the under 50 set.

[Laughter.]

MR. CHERNEW: Boy, that's hard. First I'd like to thank Henry for both inviting me to be here and for writing this book. His analysis, I'm not going to comment directly on a lot of things that are in the book, but I will tell you that I believe it is, A, basically right, and B, on what may be perhaps the most important question that we're going to face as a country over the coming decades because the numbers are so

daunting and the issues, as Henry said at the end and almost stole some of my thunder, the issues are so emotional, the distributional consequences are so important, that we really need to just think more broadly about how to address the problem. So having books like this I think are crucial.

The title of my talk is say no, but we're not really saying no, we're sort of saying yes but less often. So things aren't to get worse, they're just not to get as much better in some ways than they otherwise would. So they still get better, just less better than they otherwise might. Again this is one of these complicated things where we would think rationing is bad, everyone is going to get a lot less stuff. No, people will get more stuff, but we'll just get less more stuff. I try not to say less more in my class. That's not really the way to get through to your students, but that's basically what we're trying to talk about.

I want to start with one sort of algebraic or maybe this is geometry, I'm not sure which, I guess I'm presenting it as a picture, there's an important distinction to make between the rate of growth and the level of growth. System 1, I won't call that the United States, but if system 1 was spending more and growing at a certain rate, that might be the higher spending trend line that I have there. If system 2 were spending 80 percent of system 1, you would get a picture that looks something like the lower line system 2 that's less money. Now I'm going to ignore for a minute the fact that there might be difference in health

outcomes which matter enormously so as an economist I feel guilty, I'm falling into everyone's stereotype of economists, I'm ignoring the health part, but just looking at the money part, system 2 is less, spending 80 percent less or so, but it turns out it's growing at the same rate. So if Britain is spending 40 percent of what the United States is spending but always spending 40 percent of what we're spending, they have the same problem we do, they just don't have it yet. Again, they're saving a lot of money particularly if you're not getting the health benefit, you'd much rather be spending less than more, but the problem isn't a uniquely American problem. Simply rationing, spending 40 percent of, 60 percent less, whatever the number happens to be, still doesn't solve the problem because you have to really change the slope a lot to change the rate of growth. So a lot of these sort of solutions, and I'm not going to talk about particular ones, I'll talk about a few at the end, even if they can convince you that we save a lot of money which is a good thing, that's shifting you down on the line, not necessarily changing the rate which was the line is rising. In the long run, what's going to matter is the rate with which the line is rising because exponentiation is really a powerful thing.

This is my version of some of Henry's numbers, but they're really meant to convince you of the importance of this. This assumes that the rate of health care spending grows 1 percent greater than GDP. So there's a 1 percentage point gap, a 1 percentage point difference

between health care spending and GDP growth, and the first row of real numbers here tells you how fast would that impact nonhealth care spending is going up, and with the 1 percent gap you see that for the entire period between now and 2075, roughly, this was based off an earlier base but if you take the earlier base, you still have some spending growth in nonhealth care stuff. You're not spending less, you're just spending less more, if that makes sense. I hope so.

But what's more pressing from the political point of view is the amount of increased growth that we have every year, every year we're richer, the share of that that goes to health care becomes higher and higher and higher. So, for example, between 2050 and 2075, roughly two-thirds of the increase in national wealth would go to health care. That's dramatically out of line with what we've seen in the past decades. So there's are a lot fewer big-screen TVs incrementally, of course, we probably won't have big-screen TVs by then, but whatever other great stuff we're buying that we can't even envision.

With a 2 percent gap, and this is closer to the historical average, a 2 percent gap between national health care spending and GDP growth, you see that by the time we get to 2050 we're spending almost 90 percent of our increased wealth on health, and once we get much past that, we're actually losing. The amount of nonhealth care spending is going down. What that means pictorially is, this is the spending in nonhealth care goods and services. The zero percent gap means health

care costs are going at the rate of GDP, the 1 percent gap is the growth, if it's growing, at 1 percent more than GDP, nonhealth care spending is still going up. Eventually it will turn down because the earlier point, mathematically you can't have that gap forever, but you can actually have it for a long time.

The 2 percent gap is just crushing for a whole range of reasons. You actually begin to see a downturn in the amount of nonhealth care spending. The fundamental question is going to be how do we put on the brakes. There was a slide that Henry had, in some ways he should have just left it up there, we all could have walked out, taken a deep breath, come back and really try and grasp what it means, because there is this tradeoff between enormously large spending and some form of rationing which is crucial to how we think about that, and the process by which the brakes get put on is really what the challenge is going to be, and I think we need to think through what that is. What's more, and I'm not going to talk about it a lot now, but I hope you ask me and then I'll feel less comfortable about not talking about it now, but the distributional consequences are enormous because when we talk broadly about what happens in the U.S. or in Britain or in managed care or fee for service, we sort of talk for the society as a whole. But the distributional consequences of how that's being played out are really important from the policy implications and the distributional consequences I think are going to be crucial.

Here is going to be my little spiel about addressing rising health care costs. The first thing, if you talk about technology being the driving of rising health care costs and if you say that to a technology industry group, they hate you, and they begin to tell you things like this, and you can see articles in really great magazines about wonderful technology and it's always incredibly cost-saving. And they will tell you a story, this story that I'm about to tell you has been around for a long time, which is when you don't know much about health care systems, you get bad outcomes, but it's cheap. Then over time, when you learn about treating disease, it becomes more expensive and you get better outcomes. But when you learn even more, you can actually get better outcomes and spend less money.

An example would be something like polio. There was a period of time when we spent a lot on polio; we don't spend nearly as much on polio now because we've learned so much, we can prevent the illness. It's just a matter of getting over the top, and if we would just spend more on technology, we would save tons more. We're just at the top. So the question is, are we at the top of the U? The answer is we don't know for sure because all the empirical evidence is backwards looking, we can't really look forward. If you see some of these studies that look at specific diseases that say we're spending a ton of money on disease X, a little more investment and we'll cure that disease, we won't have that problem, that might differ from the aggregate level because I'm

not a clinician, but I will say that if you don't die from one disease, you'll die of another, and you're not going to like it as a general rule. That's the whole thing about the crumbly part is we don't like that part.

There is really not much evidence that we're at the top of the U. I'm incredibly skeptical of these sort of very optimistic views that if we just investment more in medical technology and treatment, we will just save tons of money and we don't have this problem. I just think that there is very little evidence that would happen, and if does, hopefully I'll be wrong.

Then you often hear this notion that information technology will solve the problem because it's going to make things much more efficient. In my view, I'm a big fan of information technology, I should say that, I think it can make us a lot more efficient, I do think it actually will be part of whatever solution we have, but we're not spending a lot more now than we were in 1980 because we have a lot worse information technology now. So I'm a little skeptical that information technology is going to solve the problem because it certainly wasn't the cause of the problem, and actually the cause of the problem has been fundamentally we get sick and we don't like it so we want to spend money. So I don't think that technology is going to get us out of the problem, I think it's going to continue to contribute to the problem.

The next thing that you hear a lot and that I hear all the time is we can solve this problem just by staying healthier, so we can put you

into disease management programs and they can manage your chronic illnesses. I don't know what chronic illnesses you have, but I'm sure we all have a lot of them, soon at some point anyway. But we can put you in diabetes disease management, congestive heart failure disease management, asthma disease management, some whole body disease management that will manage every disease you could ever want to have. And not only will you then be healthier, but in fact it will be cheaper because you will be healthier and we don't spend money on you if you stay health which is true, but still you will die and you won't like it.

[Laughter.]

MR. CHERNEW: And there is very little evidence that disease management works. Or we could pay doctors to do a better job which also is an important thing because I don't want to do them a bad job, and so we could then get people healthier because we're paying them more when the physicians are now doing the right things as opposed to not the right things, and in my other version of this talk I will have the slides that say we only get 50 percent of the right care, the right care is delivered 50 percent of the time, and we could pay them to give us a greater percentage of the care that's correct, and I think that would be a good thing, but I see no evidence that's going to save us money. So Henry's basic challenge I think still remains true, and I think these notions of doing things that are good for our health is important, we should do things that are good for our health. My mother tells me that all

the time, do things that are good for your health, I just don't think it's going to save a lot of money.

The next part is about behavioral modification which in today's world is typically a comment about we should eat better, because I drink a lot of Mountain Dew and eat a lot of Hostess products, I love Hostess products. I wasn't paid to say that, but it's true.

[Laughter.]

MR. CHERNEW: And then there would be less obesity and we'd all be healthier because obesity is driving up health care costs, and it might be true that if we were healthier we would spend less money, but of course we smoke a lot less now. On balance, I'm not sure that actually our health behaviors are that much better. Still, even if we were eating a lot better and there was less of an epidemic of obesity, I don't think that fundamentally would solve our problem because you're still going to get sick and you're not going to like it, and we're going to try to spend money to prevent it. That's sort of the point about the human condition.

I'm going to conclude by saying there's little evidence that all of these things fundamentally will change the dilemma that Henry raises in the book. We're going to have to face this problem, and just arguing that we'll drink less Mountain Dew and we'll tax sodas or whatever isn't going to be a solution to the dilemma that Henry raises, although we might want to be healthier. So don't leave saying Chernew says we should drink Mountain Dew.

Now I want to talk about this issue of cost-sharing which actually comes up a lot. It's certainly somewhat in vogue now and I have to admit as an economist I'm loosely an advocate for markets, although I recognize that health care markets create some problems, and I think there's been a long sense in which people have tried to solve the market failures in health care in a range of different ways, managed care being one of them, I'm going to talk a little bit about cost-sharing.

The first thing I'll say is, cost-sharing we know affects the level of spending, there is much less evidence about whether cost-sharing affects the rate of growth. We don't know that quite as much. I actually think you might need substantially more cost-sharing than we have now to get there, and Henry's point which is exactly right on, it matters a lot where you put the cost-sharing. If you have a lot of cost-sharing up to $3,000 but then none, that might not be the smartest way to use cost-sharing if your goal is to control health care spending growth.

What I'm going to talk a little bit about going forward is that cost-sharing may lead to health outcomes being worse, we may get worse health care when we charge people to do things because they won't do things that they should do, and I think that's a big problem. What I think is also crucially important to address from a policy point of view is cost-sharing will generate disparities which is my nice way of saying we will have greater tiers and access to care and use of care if we rely heavily on cost-sharing because the market, as wonderful as people might think the

market is, doesn't give us the most equitable outcomes, and we might care about that, and I'll just leave that hanging out there.

I want to talk about the benefit-based co-pay which is something my colleagues and I have been talking about, and it's really a relatively simply idea, which is basically adjusting the co-pay for the clinical situation, reducing the co-pay for patients with high potential benefit from treatment and charging more when the expected benefit is lower, which would fit into exactly Henry's case. If you take the hemophiliacs who would have a very inelastic demand and you shouldn't tax them a lot, they would use a lot of stuff and that would work fine. Areas where you think there's a lot of elastic demand or where you think there should be a lot of elastic demand if people were perfectly informed, you might want to charge people more. So you would never deny them, you would just make them pay more to get more stuff. The co-pay would then depend on clinical traits, but the key point is, in order to make this work you need some clinical nuance. Try not to use the word nuance, but you need the clinical nuance or sophistication here because the problem in the system is there's both underuse and overuse, and so you want the co-pay system to discourage underuse. You want people to do the right thing in terms of taking their blood pressure medication, all the disease management, pay for performance stuff, but you don't want to charge them when they're getting a whole bunch of other things that you might not think are as valuable.

In my little graph of this, if a service is truly cost-saving, or which I think there are very few, ACE ARBs for diabetics might be one which is actually cost-savings if you've read the article on giving diabetics ACE ARBs, you might actually want to not charge people, in fact, you may consider actually paying them to encourage them to do this stuff. Certainly, we don't pay them directly, but we pay other people to call them up on the phone and say take your medications. If something is cost-effective but not cost-savings, we might want to not charge people very much or charge them minimally. We want people to be healthy; we don't want to charge them a lot.

But if something is not cost-effective, we want to charge a really meaningful co-pay. Of course, the beauty of being an economist is I don't have to numbers on those lines, I don't have to put services on those lines, I can just hit the return button and I move on to the next slide. But I do want to say that's really not what's going on now. We have a study that's coming out that looked at co-pays for pharmaceutical products for people who are inside disease management programs. These are people who are getting services where they were paying a lot of money to have someone call them up on the phone and say take your medication, do this, do this, things that people clinically thought were very important which is what disease management programs try and encourage, with co-pays in those systems versus outside of those systems, and they're basically the same, and if I showed you the other chart from

the paper, you'd see they're rising at the same rate. We're charging people more because we believe in cost-sharing to do the same things we're paying people to encourage those people to consumer. So we're charging people more for their blood pressure medication, at the same time we're paying people to call them up and say take your blood pressure medication. That's not necessarily a synergistic way to design your health care benefit scheme.

When I advocate this, people say you can't do it. The information technology systems are too crude, you can never figure out what's needed, what's not needed. Any rationing system is going to have to make some important clinical knowledge tradeoffs, so this is my way of saying in the business community people are trying to move towards these evidence-based things. So there is one article in The Wall Street Journal in June 2004 actually being done by some folks at Pitney Bowes. They're not doing the most sophisticated thing in the world if you look at what Pitney Bowes has done. Pitney Bowes, they make postage stuff, but they actually had a relatively innovative benefit-based co-pay-like system where they were charging less for things that they thought were really important, and they made it work. There is another example of a large employer, Marriott, they're doing the same thing with very complicated information technology where they're through elaborate clinical detail trying to make some of the decisions about when co-pays will be higher and when co-pays will be lower, and they have an elaborate system for

communicating that. It may be a disaster. I don't know. I will tell you this; it is physically running without an enormous amount of hassle. How well it works and stuff I think remains to be seen.

So here is what I'll say loosely are the merits of some type of BBC approach, benefit-based co-pay approach. The first is, rationing becomes market-based, it's consumer-centric. You can ration a lot of different ways and the market is certainly one way to ration. One of the challenges we have in this country I think is not do we ration, but who rations. Do we do it by money or do we do it through some other mechanism of controlling the amount of resources that go into this? I think that is a fundamental philosophical question about how we're going to address Henry's problem. I do think that that's worthy of some debate and there are a lot of people that advocate the market-based approach, it's just I think that the current market-based approaches don't use cost-sharing as intelligently as they perhaps could, but if you use prices, you do have a more consumer-centric approach if you care about that. There are issues about information and do people make the right decisions which we'll have to talk about later.

It allows you to ration health care more than you ration health. The basic problem is we want to ration health care services, but we don't want to ration health, so we want to give you things that give you a lot of health so we care about that, and so it reduces the negative health consequences of rigid cost-sharing because it reduces how much

you have to pay for things we really think are important, but it makes you pay for things that we don't think are quite so important. It allows more efficient subsidization of care, the insurance industry isn't lowering the price on everything, only those things you think are valued, it could be used synergistically with disease management or pay for performance which is what we've been advocating, and then I will say we are a very long way from doing this well. There is strikingly little ability right now to do this well, but we can do it some. I told you Pitney Bowes is doing it and I know a few other companies that are doing it. I can tell you, if you spend any time talking to benefit consultants, employer benefit consultants, the EBCs, they're all struggling with this. The National Business Group on Health is an evidence-based coverage initiative, the National Business Coalition on Health, they have an initiative in this area. There is a range of things going on in the actual benefit provision area where people are trying to do this. Will it work? I'm not sure.

What we really need is we need more and better research. We need research to understand what's valued versus not valued care, we need research to understand how well these systems basically work, we need much better information technology because all of this is going to require more information technology to sort of ration, if you will, in a more clinically sensitive way. And I think in the end what I'd like you to leave here saying is Chernew was advocating clinically sensitive rationing, which I think is probably what Henry would have advocated,

too, we certainly want to be clinically sensitive, but in order to do that we're going to need a little bit better information technology, I think we're going to need better communication with patients in order to let them understand what's going on, and better communication in general with and within the industry with health plants, employee benefit consultants and the PBMs which actually are doing a reasonably good job of at least trying to put in some of the information systems to do some of this stuff.

My bottom line is basically this, I actually think the choice that Henry puts up is put up for a particular reason, but I hope it motivates you to understand that it's really not going to be tenable. At some point we really are going to have to make some decisions about rationing, and more, we have to make decisions that are actually stronger than simply we'll give you 80 percent of what we can do, because if the only decision is we're going to give you 80 percent of what's possible, we're going to have the same problem and we'll just push back the day of reckoning a little bit, sort of like the budget cycle, but a lot longer.

We have to actually think about that even in a deeper way to try and understand not just do we ration, but how, and I actually say more than how, whom, by what system, fundamentally how much do we rely on the market, how much do we rely on nonmarket systems to accomplish this goals? And I think that really is the fundamental debate that's going to have to be faced because cutting how much we pay to hospitals, that

will save money, I don't want to argue about whether we should or shouldn't cut money to hospitals or physicians, that will save money, too, I don't want to argue about that, but that's only going to save money for a short period of time. We'll stay on the same trend, or potentially stay on the same trend, unless we pay really, really little, and then we're going to have this again and again and again.

This is a problem that faces all countries, not just the two discussed in Henry's book, and one of these things that really blends sort of the economics of what's going on with the ethics of what's going on, and I think that's really the fundamental question. Again, thank you.

[Applause.]

MR. PAULY: When I got up at 5:00 in the morning this morning to come down here, and let the record show I took public transportation to this meeting, I put on this suit that I hadn't worn since last Wednesday and I found in the pocket for a chest film because last Wednesday when I wore it my wife told me I needed to get a physical, so I did because, after all, the insurance paid for it, and then got it at the clinic run by the University of Pennsylvania near our house, Penn Medicine, and I got an order for a chest X-ray. And when I went over to the radiology department there was a long line, it was a little bit like the U.K. on the Main Line, and so I decided I'd come back later when they weren't quite as busy. And I guess I'm actually planning to go back for that chest X-ray, and I don't want to feel guilty about it, so I'm going to

try to explain why rationing might not be such a big or agonizing deal at least for some people in some circumstances, but then because we have to have some comparisons and contrasts here, maybe not in other circumstances. I'll give you the answer first, and I guess we may be a bit rationed in terms of time so I'll probably truncate or ration the complete story.

Is health care rationing a big deal? By big deal I mean in a sense kind of what Henry and Mike are both talking about, and I actually should say I quite agree with them, things that we need to think seriously about, ponder importantly, wave in the front of policy makers' noses when what they really want to hear is what's your plan that will lower cost and not do any harm to anybody and we don't have that, we don't have MBAs, I guess that's why, but I don't think anybody really has that, I'm in favor of all of those things. I guess the main distinction I would make here is that both the need for a discussion of rationing and in a sense the psychological agony that probably necessarily accompanies that discussion is going to be much greater for public spending, and then this is more of a catch-all, other matters subject to collective choice, and not necessarily for the market, although I call it the somewhat fettered free market here because it's not worth talking about the hypothetical unfettered free market in health care that has never existed and never will, and I'm mostly going to talk about how the market might deal with rationing in ways that are a little less agonizing and also perhaps require

less attention from the collective choice mechanism than some of those others. Mostly the population of the U.S. I'm talking about are the non-poor, non-old. That's going to be my target clientele here.

Having said all that, I'm sorry that Len isn't here because part of what I prepared was in a sense my reaction to a very interesting talk he gave up at Penn in the fall dealing with the issue of how markets are working as you kind of move up and down the income distribution for which there are some problems.

Some theoretical points. There are two kinds of rationing that I could think of, and I'll speak my normal language of economics here, cross-sectional or time series. One kind of rationing we think about, maybe we worry about, is what might be called cross-sectional rationing. Some people get more than others. Mostly I'm going to think about that in terms of income, high-income people are rationed less than low-income people. Then the other is time series. That's kind of what Mike and Henry mostly talked about, that over time we have been spending more in real terms on health care, getting more real health out of it, but nevertheless spending more. So what's the story?

A few theoretical points. In the cross-section, according to the classic model that is sometimes called Purgatory for health economics graduate students developed by Mike Grossman, it is rational and in a sense normatively efficient for some people to be healthier than others, and I wrote down here, less rationing for rich athletes. I didn't write

down less rationing for rich people generally because the concept in Grossman's model which is the part of it I buy is that a reason why it's in a sense maybe a desirable thing and maybe an inevitable thing that some people will be healthier than others, is more strongly related to the wage rate of people than to their income. So it makes sense for an athlete to want to stay healthy, of course, they get banged up every Saturday and at least the carnage is over for a while but I guess it will happen again next fall, because if they are unable to perform their line of work, they lose substantial wages and it's less important for someone with a lower level of income.

Grossman actually found once you control for wages and then ask what's the effect of windfall income on people's health, this is I think poetic justice, it actually in his data made people sicker. This is the wine, women and sing Paris Hilton version of the impact of income, but nevertheless.

Second, the demand curve sloped downward and to the right. That means that user prices do work to ration and they're not the work of Satan. I agree with what Mike had to say, that if you had the knowledge and you were willing to pay the administrative cost, you'd probably want to deal with a much more subtle version of user prices than the brute force method than is currently going on, and I'll talk a little bit about how I think that might play out in the market.

I also need to make 2 cents' worth of comments on Henry's deprecation to some extent of user prices. It is true that most insurances, for people who have insurance, the user prices are only turned on at the low end of the spending distribution. There actually are some insurances now that people are talking about called minipolicies where you turn the user prices on at the high end of the spending distribution, but theoretically we don't like this. And need to say I'm not a big fan of health savings accounts myself. I think they're a fine thing for people who like that sort of thing. Having said all that though, I feel the need to say that even for those expenses which are the bulk of medical expenses that occur above a deductible, it is plausible to imagine that having to pay the deductible may deter the person from initiating the episode of care, picking up that most lethal medical instrument, the telephone, or maybe not the computer, if you got online you could email for an appointment, so—will have an effect.

In the time series, the theoretical point here is no good can be a luxury good forever. A luxury good in economics, although this is not sanctified by the gods of economics theory terminology as some others, but at least the informal version of a luxury good is a good with an income elasticity greater than 1, that's economies for when you get 10 percent more income, you're spending on this thing goes up by more 10 percent, and if you think about it, if your income is growing or if a country's income is growing which we hope it will continue to, any

product where every time you get an increment in your income you spend a disproportionate share on—

[End side A. Begin side B.]

MR. PAULY: [In progress] —like that forever because eventually if you extrapolate you'll be spending 100 percent on that product. And the demand curve is inelastic over the whole range; there must be a price high enough to cause a quantity to fall to zero, so at least there is some need for limits there. Growing income leads to more spending even if the marginal cost of health is rising which it probably is, if technology offsets, and that I think is pretty much what we've seen. So at least in the short-term at least my interpretation of what's been going on is that for the average person in the United States and, for that matter, in most other countries, the U.K. here may be an exception, and somewhat related to the points Mike was making, because technology probably has lowered the quality adjusted price of health across the board, people have rationally responded by saying I want to spend more on health care. So I don't think we ought to try to whip inflation in health care as long as the inflation really does mean better health care and better health for people.

The empirical evidence such as it is is the following. Higher-income people do tend to be healthier than lower-income people and spend more. The increment at least in terms of quantity of medical care and level of health is not enormous. It's not that Donald Trump is

100 percent healthier—in fact, to look at him he doesn't look that healthy at all—but 100 percent healthier than the janitor at Trump Tower. The spending tends to be a little bit more responsive to income because one of the great things we do in this country is permit the foolish rich to waste their resources on health care. I suppose that was what was happening to me at the clinic as well, at least based on what I actually know about physical exams, but I couldn't convince my wife, but there is definitely a positive relationship. This I think is the crucial point.

In the present circumstance, and I think this is even true of relatively high income people, demand is not unlimited. Use is constrained either by rules if you're in a managed care setting, or by incentives, meaning use prices, and the key idea of how this to some extent does work and perhaps should work is that people do in various ways, maybe not to well, but do, and maybe should be offered greater opportunity, to choose themselves in the market how they're going to ration, so that's what I call self-rationing.

I could pick if I wanted a health savings account. When I got my last gas bill I kind of thought about it might be a good idea to pick a cheaper health plan that would ration me more strictly than my current slap on the wrist PPO does. That would be a choice I could make. Or I could go with the Rambo HMO, you know the one that only has doctors on its panel that are not in the best parts of town or whatever it might be and that requires you call that 1-800 number for almost

everything. I could do that, or I might not. And I guess my perception is, and maybe my rationalization is since I've been fortunate enough in life to have the privilege of paying relatively high marginal tax rates, I would prefer not to choose a use-constraining health insurance policy, rationing is an inferior good, and it can't go on like that forever, but it can go on for quite a while.

We could sustain today's level of real care, this was kind of the point Mike was making so I won't say too much about it, in a growing economy. It's the addition that's the key problem, not the current level, and so in a sense, things that may slightly improve the efficiency of the current level of spending aren't and cannot be the answer.

The real issue is this technical change, and the trend of technical change means that spending per capita grows, and I've actually been with Mike so I can tell you that he and I and a lot of other health economists agonize about what is exactly going on here, and I guess the key question, it's the chicken and egg question, is the rate of increase the rate of improvement in technology which allows us to spend more and get healthier, is that endogenous, meaning as our real incomes rise we sort of give orders or signals to the biotech industry and maybe even to the National Institutes of Health, please invent something even if it costs me more money that will make me healthier and make me a little less crumbly? Or, alternatively, are there just discoveries that happen that then nobody can pass up, what Fuchs calls the technological imperative?

I guess the prudent conclusion here would be it's probably a little of both, but we surely would like to know. And the idea that people are spending ever increasing shares of their income on health is consistent I think and not particularly worrisome, if health is a luxury good, if they have preferences, as I put it here, to spend their increased income on improving life, not on consumer electronics or some other thing that they could have spent their money on.

The real issue is can things go on like this forever, and I think for the average person, by that I mean the person with the average income, I think the answer is yes, for quite some time. This was also the point Mike was making, the rate of growth must eventually fall, and here Bob mentioned the iron law of algebra, that the rate of growth of spending on something cannot exceed the rate of growth of income forever, it will eat up an entire income. But I guess the main point I want to make here is that I think what people perhaps value and what maybe we ought to think in terms of is not so much that percentage figure. As analysts we sort of naturally gravitate to thinking about it, but maybe what really matters to people is more real quality and quantity in the health care they receive, and it is certainly possible for the foreseeable future as long as real income in the U.S. growing, and we certainly hope it will continue to do that, for people to get more real health care and improvements in health year in and year out forever. It's just that, I guess this is the less more that Mike was talking about, the

addition, has to be within a particular range, and I keep wanting to say and the rate of growth has to be cut, but the rate of growth has no particular cosmic significance I guess is my main point here. In some ways I think we're kind of trapped by our own propensity to think of things that way, but if we just told everybody you can have more and better health care every year and maybe even plotted out the path, and instead of talking about percentage rate of growth just told them all the great stuff they'd get every year, maybe people would say that's fine, I'm willing to settle for that and that would be all we would need to say.

So that's I guess my main point, that there doesn't seem to be some intrinsic imperative that the rate of growth need be maintained. There probably is both an imperative and a very strong and passionate desire on the part of people to have health care be a little bit better every year or at least better every year, but we could accommodate that.

If we do need to slow the rate of growth, it would be easier to do it if the technological change slows down beforehand. The most agonizing thing would be if there's a great discovery and not everybody can get it or it's really expensive. And if we could begin the rationing at the level of discovery both of new technology and of ways of using existing technology, in a sense what you don't know won't hurt you might be a good strategy to try to implement here. I'm not sure I'm in favor of defunding the National Institutes of Health, although if I were God, I would actually tell them to direct their research toward kinds of

investigations that are likely to discover those new technologies that improve health and lower costs, other things equal.

So I actually think a soft landing possible, I'm not offering any guarantees here, but I think to be optimistic, that's a little hard for an economist, it's a little bit of an oxymoron, but the optimistic economist in my says a soft landing may be possible in private insurance. It probably will be packaged with self-rationing, and I suspect the final policy will be one with managed care and cost-sharing and hopefully purposeful or reasonable cost-sharing as Mike was talking about.

Is there a benign perfect storm brewing? I told my students, I've got good news for you, kids. The rate of introduction of new chemical entities has been dropping precipitously in the last 10 years. Isn't that great news? Because now drug spending growth is slowing down. Well, it is actually slowing down, and not to extrapolate too much, but maybe it will be time to close down the Patent Office because everything useful that could be discovered has been discovered. We're not sure what we hope for here, but it may be that's what's happening.

A key interaction that I think is worth worrying about, and this is the one Len talked about, is even if things could work out reasonably well, a soft landing, not to worry, not to lay awakes nights, not to wake up screaming, I wake up screaming about Medicare but not about the private sector, the closer I get to Medicare the more I wake up screaming, but the other interaction and sort of problematic situation I

think is even if the person of average income can accommodate the way the health care system is making new technology available and is willing to sacrifice a chunk of their income growth, what about people with incomes below the medium or below the mean, what about lower-income people? And that I think is where the real problem is, that the new technology that I'm in a way happy to pay a big chunk of my raise for that still leaves me with enough to pay my gas bill, that may not be affordable by people with incomes less than I who are still the tweeners, not poor enough to go on Medicaid or are not categorically eligible.

Economists worry about this. Shouldn't there be a health plan that offers a different form of addition of new technology that would be more appropriate for those people? I've for many years—trying to get investors in a health plan whose slogan will be, Last Year's Technology at Last Year's Premiums, but if somehow I don't get any bites even from low-income people, but that would be the idea, there are apparently some spillovers. So in a sense even those of us who are not poor or are not uninsured may want to care, so the market may not work perfectly even if we could get it to create separate programs for adding new technology for people at different income levels.

I did notice, though, however, that the percentage rate of growth in benefits which primarily includes health benefits, although not entirely, was the same for white-collar and blue-collar workers over the last 20 years which would imply that the real benefits that were added

were actually differentiated somewhat by income. So I think it's not hopeless to imagine that a system could emerge, and then again I'm not sure I really like to hear myself saying this, but that could emerge that would provide the new technology that could be accommodated by lower-income people as well as higher-income people.

Where the problems remain: The real problems I think are the public programs. As Bob mentioned, I was on the Physician Payment Review Commission before it was merged out of business. We didn't really do that much rationing there. I tried myself, but the only thing that really got rationed was the tri-color pasta salad because in a way the view was we actually had this report every year, the Study of Access to Care of our Medicare Beneficiaries for Physician Services, and the report would say every year with a few exceptions, mostly those people who didn't have supplemental MediGap insurance, but with a few exceptions there are almost no problems of access to care for Medicare beneficiaries. They can go to any doctor or any hospital. My reaction always was, well, we must be paying too much then, and in fact, we're starting to see perhaps a little bit of rationing. To an economist that's not necessarily bad, but to a gotcha journalist, even one with crazy hair, the idea of rationing seems unspeakable, and so that's probably the kind of discourse that Henry wants us to engage in.

There is also the fiscal illusion, of course, that when the government is paying for it, why shouldn't it pay for everything that's

good for everybody and tax the guy behind the tree? But sooner or later somebody has to pay that tax. Then, I think this Alan Greenspan's nightmare, if marginal tax rates get high enough as they are projected to do for Medicare alone, eventually perhaps being at marginal rates just to pay for things for old people at 33 percent or more, it's not only that our kids may disown us at that point, it's that the distortions that would be imposed on the economy by this high rates of taxation, what economists call the excess burden of taxation, is going to be bad for all of us.

With the public discourse, I guess my last kind of philosophical point on this is most of the problem with that interaction is of course because some people have high income and some people have low income, and we have a kind of schizophrenia, and probably this is differential between the U.S. and the U.K. Here at least we tolerate, I called it a misdistribution of income, personally I actually think it is, although that's a value judgment, but at least we tolerate a fairly uneven distribution of income with some with high incomes and some with low, and then we get all upset when the people with low incomes can't consumer as much medical care as the people with high incomes. I think perhaps the debate and the discussion we may have to have is one not only about rationing medical care, but the more fundamental one that I think we ought to have about the appropriate distribution if income. Thank you.

[Applause.]

MR. REISCHAUER: Thank you. I will ask Henry at the end of this whether he has any reactions to the presentations, but now let's turn to your comments and questions. I will give preference to those of you who are non-economists. Why don't you stand up, first of all, wait for the microphone and identify yourself and your institutional affiliation, if any?

MR. LOVELL: I'm Mack Lovell [ph] with George Washington University.

Obviously, from what all of you have said, there is not any one solution to this. It calls for a wide variety of strategies. But one which I didn't see emphasized very much was to bring medical care into the marketplace a little bit more.

I had an experience a while ago where I was sent to a periodontist and he looked at it and he said this is worse than I thought; it's going to cost you $2,000. And I went home online and looked up periodontal.com and put in my Zip code and it came up with a whole bunch of costs for that kind of thing which were around $600. So I went back and made a copy of it and he looked at it says, absolutely ridiculous, but he cut the cost in half.

But it seems to me the doctor I go to refers me to a number of other doctors and you know, they're all on the same floor, and that's probably a coincidence with the doctor I went to before that. They weren't all on the same floor; they were on the same building. But there

is no real competition and the culture of medicine is that you honor the doctor so much that you don't question their judgment or their costs. And I just wonder whether some ingredient to bring medical care into the market economy could be achieved.

MR. REISCHAUER: Let me ask Michael who did talk a little bit about prices to answer that.

MR. CHERNEW: I hope I say something that fits in with what the group of us economists would say. It is clear that one of the biggest distortions in the system is what the actual prices are, and not necessarily the prices the person pays, but the prices paid to the provider. And there's a challenge every year in how we set that price in the government system, and there is certainly a challenge in how the private system, the market works in generating those prices.

I think one reason why we might advocate greater cost-sharing is because it gives people greater incentive to shop amongst their physicians, and the extent to which they will shop will depend a lot on the nature of the service, the nature of the culture, and the nature of the information, and the nature of a whole range of things. My grandmother always brags about how expensive her physicians are. Crazy.

[Laughter.]

MR. CHERNOW: But I think your point is generally true, that in any system we come up with, figuring out what people should be paid for services is a challenge. The market system, and I'm sure Mark

would agree, has a particular way in which that happens. It's not clear that that always happens well with our current system, with more cost-sharing there might be a better way of that happening. People for a long time have advocated managed care systems arguing that you can't do the right shopping, and you can't figure out if the $600 person is good or not, but if you buy a health plan that can then credential that person, they will shop for you and then you can have sort of a buyer's aid if you do that. I think all of that is true.

I think most of that will be reflected on the reduction in the level of spending, but it's not really a reduction in the trend of spending, or I should say more accurately, I haven't seen evidence that that greater cost-sharing even lower prices reduces the rate of growth in spending, it simply would make things cheaper which is a good thing.

MR. : [Off mike.]

MR. CHERNEW: And it's still over the rate of growth, conceivably that would fit with your analysis. Some of the differences in convention are specialties as well.

MR. DAVID: David Glass [ph]. You bring Britain versus the U.S., but in Britain people are born into the national health system and die in the national health system, where here insurers are often in the position of not wanting really high-cost people in their plans and designing benefits that therefore would attract the healthier people versus

the sicker people. So how could the same form of rationing work in those two systems?

MR. : I think you're putting your finger on an absolutely central question which is that the U.S. system is [off mike] Medicare has the power but for a host of political reasons, Congress does not want them to use that power.

[END OF TAPED RECORDING.]

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