THE BROOKINGS INSTITUTION

OUR LOOMING MEDICAL COST CATASTROPHE:

WHAT'S TO BE DONE?

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Welcome and Introduction

GREGG BLOCHE
Director of the Center on Health Care Financing and Organization, O'Neill Institute for National and Global Health Law at Georgetown University

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TOM DASCHLE
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Director of the Congressional Budget Office

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Moderator

JASON FURMAN
Senior Fellow, Economic Studies

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Chair and Director of Health Economics, Finance, and Organization, RAND

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DAVID HYMAN
Professor of Law and Medicine, University of Illinois

BRADLEY HERRING
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PATRICK HEALY
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MARK HALL
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P R O C E E D I N G S

MR. BLOCHE: Let's get underway. Everybody please be seated. Welcome; thanks all very much for coming. On behalf of Georgetown Law Center and the Brookings Institution, which are co-sponsoring this event, I welcome you. My name is Gregg Bloche.

We gathered here today because of the remarkable and growing ability of our medical technologies to improve and prolong our lives, but this also poses an amounting threat to our capacity to pursue other aims.

You all know the numbers. Health spending is projected to rise to 25 percent of GDP a decade and a half or so from now, and to 50 percent of GDP later in the latter part of this century.

This is, of course, unsustainable. Somehow push is going to come to shove. Controlling medical costs would be simple were we not passionately convinced that we get something profoundly important in exchange for what we spend on health care.

We could just stop spending and do something else with our $2.1 trillion a year. We're gathered here today to try to preserve the immense value that we gain from health care, while moving our country toward a medical spending track that's financially sustainable. We have an extraordinary group of speakers, beginning with Senator Tom Daschle in a few minutes, but first some full disclosure. There's an elephant in the room,

or more precisely, there are both elephants and donkeys in this room. It's presidential primary season. Some of you may have noticed it, it's still presidential primary season.

We didn't think it would be when we picked this date, we were very proud of that. We thought we could talk about substance, free of all that. And some of today's speakers, including yours truly, have been advising candidates in the race.

I'm on leave from my appointment at Brookings while I do so, and this event was planned before I, and I'm pretty sure my fellow elephants and donkeys, became involved. We're all here representing our own views. This is a non-partisan event. Perhaps to the consternation of the campaigns that have consulted some of us, at least what we say may well be perhaps to their consternation.

In the best tradition of Brookings and the Georgetown University Law Center, which is co-sponsoring this event, we're going to do our best to shed some light on a problem that's defied solution for several decades. And it's critical to our country's future. And it's, frankly, not been discussed, dare I say this, in a particularly insightful way in political campaigns and in the public space.

We're deeply grateful to Brookings and to the O'Neill Institute for National and Global Health Law at Georgetown University for their co-

sponsorship of this conference, and for the book that will follow at the end of this year.

And I also want to thank Henry Aaron and Martha Blaxall and Bill Gale, Vice President and Director of Economic Studies at Brookings, for their support and encouragement. And I'd like to thank John Monahan, Director of the O'Neill Center at Georgetown, and Alex Aleinikoff, the Dean of the Law School at Georgetown, for their support.

And most importantly, this conference wouldn't be happening without the tireless and extraordinary efforts of Kathleen Yinug here at Brookings, who made all the logistics happen.

I'm going to turn things over now to Leslie Meltzer, Greenwall Fellow in Bioethics and Health Policy at Johns Hopkins and Georgetown. And Leslie is going to introduce Senator Daschle.

MS. MELTZER: Thank you, Gregg. And let me also offer my warm welcome to all of you. We're very excited to have so many of you here today. It's with great pleasure that I introduce our morning speaker, Senator Tom Daschle. As many of you know, Senator Daschle has had a lengthy career in public service. He was a congressman in the U.S. House of Representatives for eight years before his election to the U.S. Senate in 1986, where he became the only senator in American history to serve twice, as both majority and minority leader.

What you may not know about Senator Daschle is that he was a guest last evening on John Stewart's Daily show. I unfortunately missed that presentation, but I heard it was terrific.

Today Senator Daschle is an advisor to the law firm of Alston and Bird, where he provides strategic advice on public policy issues such as climate change, energy, health care, trade, financial services, and telecommunications.

He's also the co-creator of the Bipartisan Policy Center, as well as a co-chair of the One Vote '08 campaign, which aims to address health and poverty in the developing world in a more aggressive way. In addition to these tremendous accomplishments, the Senator has written a new and greatly acclaimed book entitled Critical, What We Can Do About The Health Care Crisis, which I have to add the plug for Senator Daschle, will be on sale for all of you later this afternoon.

The book has been called a must read by Jerome Grossman, the Director of Harvard Health Care Delivery Project, and right on target by former Senate Majority Leader Bob Dole. Given the theme of our conference, we couldn't be more delighted to have the Senator here. Without further adieu, please join me in welcoming him.

SENATOR DASCHLE: Well, thank you very much, Leslie, for that generous introduction, and thank you for your warm reception this

morning. In politics, you're always introduced in interesting ways.

I remember the time a while back, I was introduced as a model politician and a model legislator and a model United States Senator, and my wife showed me the word "model" as is defined in the dictionary, and there it's defined as a small replica of the real thing, so Leslie chose not to use that word, and I appreciate that very much. I also want to thank Brookings and the O'Neill Institute for an extraordinarily timely conference. And with the array of speakers that you have today, I'm truly honored to be a part of the program and to be a part of the discussion this morning. This is a critical issue, and I'm delighted that it is getting the attention that it so justly deserves.

I think that it is going to be one of the prominent issues to be debated in the next administration, regardless of who's elected, simply because necessity will dictate that agenda.

I would also want to point out that my co-author in the book, Critical is here, Jeanne Lambrew, she's been a terrific partner, and I'm very pleased that she and her class from the LDG School is also here.

I wanted to talk, if I could, about a couple of things this morning, and then, as I understand it, we can entertain some discussion and questions. But obviously, I want to talk about cost.

But for those of us who were involved in the last great effort to

move meaningful health reform, the '93/'94 period, I'd like to discuss to a certain extent what I think are the lessons learned from that experience.

I had the good fortune to be the Chairman of the Senate Democratic Policy Committee at the time, and that was really one of my first assignments, and I have bittersweet memories of those times. Extraordinary opportunity to be baptized, if you use that term, in health and legislative policy, but at the same time, terribly disappointing in the way it all turned out. And I think we can learn a lot from that if we're going to apply lessons learned to the next opportunity presented to this country as we consider meaningful health reform in the future.

With regard to cost, I'd like to start by making four assertions that I would hope would not necessarily be even arguable. The first assertion is that cost is the largest of all the components of the health care debate, and by far the most politically potent.

If you look at the three categories of issues that I believe we have to address, cost, access, and quality, I think it's been a little bit of a mistake in the past for us to put most of the attention on access, as important as it is.

As I travel the country, as I talk to business, as I talk to individuals, as I talk to institutions, regardless, government leaders, everybody brings it to me in the context of cost, and I think we have to

recognize the potency of the cost dimension of this debate.

The second assertion is that many, as they talk about addressing cost, really end up talking about cost shifting rather than cost savings. And I think we have to really draw a clear distinction. Those who argue, for example, that really we can address cost with changes in tax treatment are really talking about cost shifting.

There are only three components, only three ways with which we pay for our medical care in this country or in any country, it's taxes, premiums, and out of pocket expenses. So if we reduce the overall tax consequence, as we pay the overall medical bill, we're going to shift the premiums and out of pocket expenses. It doesn't go away just because we've shifted the components. And I think it's very important for us to realize that.

I hear so many people in politics today talk about the importance of bringing costs down with some new tax treatment. Well, frankly, that doesn't do anything, and we have to recognize cost shifting when we see it.

The third assertion is that it really isn't cost at the end of the day that matters, it's value. And I think we have to apply value to our definition as we talk about how to address cost. Cost and value are interchangeable to a certain extent, but value is really a function of all three

things. It's a function of cost, but it's also a function of access and quality, and the interrelationship, and the intricate interrelationship of all three is really what we need to be aware of and cognizant of as we address this cost question. How do we arrive at the best value, and that doesn't necessarily mean how do we bring down cost most precipitously.

And then finally, I think it's very important to understand how interrelated these are. There are those who have argued that we can just address cost and find solutions, and I'm sure throughout the day there will be many offered as we consider ways to address it, and I've got my own list that I'll share with you in a minute.

But I don't think it's possible to address cost alone without also effecting the other components, quality and access in particular. So understanding that brings me to the conclusion, and I would hope everyone in the room, that the only way to address meaningful health reform today is in a comprehensive way, that is, with everything on the table, because of this intricate interrelationship.

Cost containment is certainly an opportunity rich environment. In our system, we pay $7,500 per capita now, that's going up dramatically, it could exceed $8,000 this year we're told, 40 percent more than the second most expensive country, and yet we aren't getting the outcome, we're not getting the value, we're not coming close to the performance level of almost

any other industrialized country in the world today. So what is it we need to address? And I think that there is great debate about how we get better value today.

But I won't elaborate on each of these because we have some extraordinary experts who are far more qualified than am I to talk about specific ideas with regard to cost containment. But here would be my top ten list; first, I think we have to have universal coverage to end cost shifting and to make the system more efficient.

I don't think there's any way that we can address this if we don't involve everybody. The more we leave people out, the more inefficient we're going to be in addressing cost containment. So I believe counter intuitively that at the end of the day, in the longer term, involving everybody, health care for all, provides us with the mechanism, the framework within which we can address costs effectively.

Secondly, no one can deny that we can do a better job with administrative costs. I've seen various ranges, and it is debatable, granted, but anywhere from 25 to 35 percent of our costs are spent on administration. That is money not spent on health care. IT, the information technological world that exists out there certainly can address part of this. But we have to go beyond IT. IT is not a silver bullet.

I think there are many opportunities for us to acquire a far

greater administrative savings than most people appreciate. But clearly, as we look to other countries and how they've done it, efficiency in administration can ring out a lot of savings, and when we're talking about the $2.2 trillion, if we could simply bring down administrative costs by five or ten percent, it would be a dramatic improvement. But that would be number two for me.

Employing best practices, we don't do that in this country, largely systemically, and I think that's a big mistake. The more we can employ best practices, the more likely it is we're going to exact savings of significant margin.

Fourth, we've got to address proprietary medicine, that's a real sacred cow. I don't see how we can begin to address the larger questions of cost and spending if we aren't prepared to put proprietary medicine on the table.

Fifth, our reimbursement for procedural care is a huge mistake. I'm on the Board of Trustees for the Mayo Clinic, and every meeting we have, that conversation comes back. We are making up in volume on procedures what we lose as we reduce the reimbursement costs.

Yesterday we just passed physician reimbursement in the Senate and the Congress, and as part of the budget instructions and reconciliation, and I'm going to come back to that in a minute. But again,

we're exacerbating the problem by simply compounding the reimbursement schedules that we have through the DRG system.

I think we've got to look at episodical care, and I don't think there's any question that the more we can look at the larger context of health care delivery and get away from this procedure reimbursement practice that we're in, we're going to be in a lot better position to address meaningful cost containment.

Sixth is pooling; we don't do nearly enough pooling in this country. We've shown what value there is in pooling, and I believe that collective resource management is one of the key areas for which there has to be a good deal of discussion. Chronic care management, undeniably an opportunity for us to address meaningful health care. I would say that negotiating drug prices has to be on the table. Other countries have shown what a dramatic improvement we can bring about in cost containment and negotiating drug prices will provide that.

Good primary care, clearly, we're the only country that doesn't put the emphasis on wellness and primary care that ought to be provided. And while there are skeptics regarding that assertion, I think at the end of the day, when one looks at dentistry, when you look at cancer screening, when you look at all of the preventative efforts made today, we're only beginning to appreciate the magnitude of the savings that could be generated.

And also, when one looks at the cost of obesity in our society today, the fact that younger generations have a lower life expectancy than we do, in part, because of obesity, is something that has to be addressed.

And then finally, better use of providers. We don't use nurses, we don't use physicians assistants, nurse practitioners nearly as effectively and efficiently as we should. I would love to see a system that employs a far greater emphasis on alternative providers than what we allow for within our system today. All of those, that's my ten, there are many more, I'll limit it to that, and I'd love to go back if you have specific issues or concerns about some of the ones I've mentioned. But I think it's fair to say that every single one of those has a significant degree of opposition somewhere within the health delivery system today, and it's why I feel so strongly about the need for a federal health board, a board similar to the federal reserve system, which allows the autonomy, the political authority, and the real expertise to bring to bear to health decision-making that we can't today.

I don't believe, having been in Congress for 26 years, that Congress has the capacity to deal with all of these specific issues and to deal with the politics and the tremendous political pressure that is brought to bear every time one of these questions comes up, which is why we never really get to the answers that you're looking for in this conference today.

We never really close out one of these questions simply

because it goes on and on, in large measure, because of the political environment within which these decisions have to be made. If you would ask Congress on a monthly basis to evaluate the need for raising interest rates and expect them to raise interest rates if they had to, you can only imagine how long it would be before we got that job done. Well, that is exactly what's happening in health care today. Decisions are delayed, decisions are never made, in large measure because of the political pressures that are brought to bear on members of Congress.

There is a lot of discussion, obviously, about the need for substantive agreement. And I doubt that this audience would come to agreement on the ten cost saving measures that I've just quickly mentioned.

But whether we did or not, and I would hope we could at the end of a conference like this, the real question is, how are we going to get it done? What is it that we can do to improve our prospects for success when this issue comes before us again?

And I realize that there may not be -- I may not be looking at a room full of activists here, there may be people who are very satisfied with tinkering with the status quo, and that's an understandable position. But for those of us who believe that we really need meaningful, comprehensive health care reform in the United States soon, there are lessons to be learned about what went wrong the last time, and how we can address those

shortcomings as we look to a successful effort at legislative strategy the next time. First, I would start by destroying the myths. It is so frequently stated that it has become almost fact that the United States has the best health care system in the world. We start with that myth; well, the fact is, we don't have the best health care system in the world. If one looks at outcomes, one looks at life expectancy, one looks at infant mortality, by virtually any criteria, we don't have the best health care system in the world.

Now, there will be those who perpetrate that myth. Sometimes we interchange the best system in the world for the best technology in the world. Certainly we have the best technology in the world, but that hasn't translated to the best system in the world.

We have some of the best institutions in the world. I sit on the board of one of them, but there are many, Johns Hopkins, Cleveland Clinic, and I could go on. We have islands of excellence in a sea of mediocrity, and those islands of excellence are ones that draw people from around the world.

But if you're on an Indian reservation in the state of South Dakota, where the per capita health expenditure is $1,900, and you have a life and limb test, it has to be your life or limb in danger before you get care, that's not the best health care system in the world. If we come in 29th in infant mortality in the world, that is not the best health care system we can

produce. Again, we have to come back to value. And it is so critical that those of us who care enough about the issue try to destroy that myth before the next debate begins.

The second is that, as I said a moment ago, we have to recognize how consequentially cost is driving this debate. And unless we have some consensus among us, not unanimity, but consensus about how we bring down cost, then I think we might as well forget reform, it isn't going to happen.

When people say to me, and I get this question all the time, well, with all the things you're talking about doing, how much more is it going to cost; well, our answer has to be, if it costs more, we have failed in the solution. We've got to find a comprehensive solution to cost containment, whether it's my ten ideas or the ten that you've got to offer sometime during the day. But we have to move reform using the cost vehicle in a very compelling way or we will fail.

The third is that I think we failed last time to build -- and by the way, I'm going through these as examples of mistakes or shortcomings in the last debate. We didn't destroy the myth in '93 and '94; we didn't emphasize cost in '93 and '94; and we didn't bring about the kind of constructive coalition back then. I think we excluded too many people, we didn't include the kind of bipartisan coalition adequately in the Congress itself, so the lesson learned

for 2009 is to build a better coalition, to reach out to desperate groups and to recognize within that coalition will come our success.

Fourth, let's stay away from 1,300 page bills. Let's understand that details kill, that the longer we wait in the weeds, the more likely it is we're going to get lost and never be seen again. It is really important that we stay away from the weeds, that we understand how dramatically we compound the problem with too much detail.

I would love to see this streamlined approach to legislative strategy on all legislation. But clearly, when it comes to health care, it is absolutely essential, which is, again, a reason why I believe the health board is important.

Massachusetts called it a connector; but if we're able to say, well, look, this isn't a decision we're going to make today, it isn't going to be found on page 723, paragraph four, line six, it's not going to happen that way, we're going to delegate these decision-making responsibilities to an organization that has the capacity to make them in a way that shows the real expertise and authority that they should have. So we will delegate these responsibilities as we should have the first time.

Next, I think it's important that we stay on the offensive. Every time reformer efforts have been made in the past, it's been the reformers who have been on the defense. Well, I think advocates of the status quo

ought to be on the defense, not advocates for change, and that's going to be a battle.

But every single time we've lost, trying to explain why this isn't socialized medicine, why this isn't rationing, why this is better than the current system, and that will be a challenge. But if we, again, find ourselves on the defensive when it comes to meaningful reform, we will lose.

Finally, I think we have to have single minded focus. By that, I mean we have to learn the lesson that we should have learned as a result of what happened in the '93/'94 period. If you'll recall, when that bill was laid down in October, it had broad based support, great support, people were enthusiastic. You had republicans and democrats saying, it may not be this bill, but we will have a bill, it will happen. What happened? Well, Somalia, NAFTA; all kinds of other legislative ideas and challenges and priorities came up. The bill languished from October to March, and by the time March rolled around, people had a different view, Harry and Louise were household words, and the bill was dead. We had lost the momentum, we had lost the focus, we had lost the consensus, we had lost our opportunity to make meaningful change. And we have to take that lesson to heart.

The last piece of this, and we're probably running out of time, I don't want to elaborate; are we okay on time? Okay. The last piece of this has to do with legislative strategy, and this may be a little -- I mean legislative

procedural strategy, and I don't want to get too wonky here, but there was another decision we made that I think was a huge mistake in '93 and '94. We had a very big internal debate on whether we ought to use the reconciliation process to pass meaningful health reform.

The reconciliation process, as you know, comes from the 1974 Budget Act. Reconciliation is a term used to describe how we reconcile the budget with the spending in the country overall, and it has two levels, two phases. The first phase is the budget instructions that the budget committee instructs the Congress to employee as they pass the budget resolution. And then the actual implementation of those instructions take place later, and that is actually in the form of a piece of legislation that requires a presidential signature.

I believe we've had 18 reconciliation measures that have passed, three have been vetoed since 1980, when it was first employed, and the Carter Administration. But one of the great advantages, the course to reconciliation has accelerated consideration, and the fact that one cannot filibuster.

So it brings the threshold per passage from 60 to 51, but it does something else. If opponents know that they can't beat the bill, then you create a legislative environment where real give and take and partnership and exchange of ideas occurs in a much more meaningful way.

If you know you can stop a bill and you've got 60 votes, there isn't any compromise, there isn't any negotiation. And I can say with ample experience over and over, good pieces of legislation died, in large measure, because there was never even an opportunity to negotiate compromise. So this would really force all sides to come to the table, to negotiate, to consider procedurally how we might move forward, and I think that it's so critical for us to do that in this case.

And to those who say, well, reconciliation and process, examples are such that we really are abusing the budget, well, I would say that we've already set a precedent that goes all the way back to 1980, when it was used as a trade mechanism, but we've used it for SCHIP, we've used it for any one of a number of important issues.

It was used a couple of years ago for Anwar. Anwar failed, but nonetheless, it was brought up under reconciliation as a budget measure. Just yesterday, it was used in the budget instructions for physician reimbursement. So there are plenty of precedents already employed in the last 20 years. And so I believe that it is critical for our congressional leadership to come to that realization early on in this process. With 51 votes, we can get this job done.

I would finally just end by saying this; in a republic, it's one of two factors that will bring about major change, either crisis or leadership.

There have been many cases where we've seen crisis driven decision making. 911 was a perfect example of crisis driven decision making, some of it good, some of it not. But in every case, if we didn't have leadership, you simply don't have the capacity to address this in a meaningful way. Nothing could be more true about health care reform than that.

If this is going to get done, it's going to require a president of the United States to say, I'm going to exert the leadership, I'm going to show the focus, I'm going to put the priority on this issue early in my career as president, and we're going to get this job done working with both republican and democratic members of Congress.

I would love to see that level of leadership, that level of commitment. I'd love to think that it isn't going to take a crisis to bring us to that point. But if we fail to address this challenge in the year 2009, it won't be long before it will be a crisis driven decision.

I'm hopeful that your conference will move us closer to a collective response to the tremendous challenges we face in bringing that about. I thank you for your participation, your interest, and your leadership, and I look forward to a discussion this morning. Thank you all.

MS. MELTZER: Thank you, Senator, for your very thoughtful comments on this. We'd now like to open the floor to your comments. Yes, sir.

MR. VANDEWOOD: I'm Paul Vandewood from the National Academy of Social Insurance. I'd actually like to ask, if I could, two quick questions. First, in using -- you talked about trying to build the less detailed, and you also talked about using the reconciliation process; how do those two fit together given the necessity and the reconciliation process of producing cost estimates which generally require some degree of specificity to legislation?

My second quick question, you used the federal reserve as a model for an organization, but most experts and government instructors think that the federal reserve is a really unique thing that isn't a very good model because it's not transparent, it's not accountable, it doesn't provide any sort of due process.

The connector in Massachusetts is actually very closely tied into the executive branch, the governor and the attorney general appoint the majority of members, the chair is a member of the governor's cabinet, the governor is actually weighed in, it's critical moments to make sure that the new reform effort actually works, so, you know, shouldn't we actually consider an agency which is really, you know, a normal part of the executive branch?

SENATOR DASCHLE: Well, in answer to your first question, which was a very good one, I think that the difference, the distinction I would

draw between delegating and defining is found in the report language, the legislative history, all of the accompanying documentation that is required in a budget resolution. So much of that doesn't fall within the resolution itself, it falls in the supporting documentation, and that's what I would suggest in this case, as well.

It doesn't have to be written in the law to have the value that good documentation and good support materials can provide. And the legislative history, of course, is, by far, the most important of all of the supporting documentation. So you can spell it out without having to articulate it specifically within the pages of the bill itself, and that's what I would suggest.

With regard to the FED, your point is so well taken with regard to transparency in particular. I would hope, and I didn't address this, and I -- it was an oversight on my part, I think one of the biggest problems we have in our health care system is the total lack of transparency. I would argue that it's the least transparent of any dissectors of our economy today, and that is one of the problems. You can't fix the problem if you don't know what it is. And we don't know the degree to which these problems exist in large measure because access to good information is very, very difficult, especially relating to performance.

So we need transparency, and I, as we say, Jeanne and I say

in the book, we don't believe that the federal reserve model, in every detail, is the perfect model, but the concept of having an autonomous board that has the expertise, the authority, and the real responsibility to address these decision-making questions in a more timely and effective way is something we have to have.

You can call it something else, I wouldn't call it the federal reserve board, I'd call it the federal health board, but you have to delegate this responsibility to somebody with the ability to make a decision, and unfortunately, we don't have that today.

We also don't have an integrated management of really two systems. About 45 percent of the people in this country get their care from one of the public programs on the federal side, federal or state government; 55 percent get it from the private sector. So we have a public/private system today, we don't have a -- that's another myth that I didn't describe in my earlier comments. The myth is, we have a private system; well, we don't have a private system. We have a public/private system. We have people that get their care from Medicare, from Medicaid, from IHS, from the VA, and any one of a number of federal governmental programs. So somebody has to integrate, somebody has to find a way to make this mesh better than it does today, and I believe a federal health board could do that.

MR. GREENBERG: Warren Greenberg from George

Washington University. Senator, you described so well the political process and the difficulties using the political process. But may I say something as a researcher? I'm looking at the enemy and it's us.

When it comes to issues like free trade, 95 percent of the economist wants to have free trade, what happened, we had to knock the bill, yes, there was some -- When you ask economists about the regulating industries, 95 percent said we should deregulate, what happened, the airlines and others were deregulated.

When you ask economists about Wal-Mart, and Wal-Mart can have lower prices and have a bigger share, yes, this is exactly what's happening with Wal-Mart. When you ask the people in this room, when you ask colleagues what kind of health care system should we have, there's immense disagreement. We haven't yet come to any conclusions ourselves about the role of government, the role of rationing, the role of the market in this industry. So I would -- and I have for a while put the blame on ourselves, and then we'll let Congress then tackle it after that. But, Senator, it was a great little talk.

SENATOR DASCHLE: Thank you, Warren, for that endorsement, that compliment. I'm overwhelmed by your generosity. Let me just -- if I could just say, that just takes me back to my last point. I don't think we have a consensus, in part, because, frankly, I don't think we've seen

a lot of leadership here, and I put myself in that -- part of that condemnation.

You need a president of the United States, and there are plenty of examples of presidents who have stepped up to do this on other issues. You mentioned NAFTA; NAFTA wouldn't have passed if President Clinton hadn't taken on some of his base to say we're going to get this done. And a Treasury Secretary, Bob Rubin, who said, you know, I know that this has great opposition, but we're going to get this done. Now, whether it was the right decision or not, I happen to believe it was, but it's still debatable today, as you can see from presidential campaigns elsewhere. But, you know, it requires leadership. You've got to have leadership. And we need leadership in this case or it won't happen.

MS. MELTZER: Yes, sir.

MR. BINDER: My name is Richard Binder, I've been a physician for 40 years, and I think the focus on costs follows the curve, I think the focus has to be on changing practice, and without changing practice, you're never going to change cost, and that starts with education.

I think we have a great parallel in the country. Our education system is broken, our health care system is broken, and as much money as you throw into it, until you change and reform the practice of education, the practice of medicine, you're going to get no where.

SENATOR DASCHLE: Well, somebody made that point to me

just a couple of days ago, that, he called it culture, we have to change the culture, and I think there is a lot of truth to that, that I -- I made my point that it's cost access and quality, and he said, well, I'd add a fourth leg, it's culture, and that's basically your point, a lot of which falls outside of our health care system, per se. You know, why we have gotten away from physical education in schools, why we continue to have issues of nutrition in schools is beyond me. I don't understand how it is that fast food and junk food could be so much a part of the diet of young people today, but that is driving a big part of the culture, or I should say the culture is driving a big part of the choice there. But I think your point is well taken.

MS. MELTZER: Sean.

MR. TUNIS: My name is Sean Tunis, and I remember being a lowly fellow on the Hill actually working with Mark Childress in '93, when the Clinton reform plan was underway, and one of the things that particularly made me nervous then and actually, you know, made me wonder if it could possibly work was the comment that I heard that, under that plan, everyone was going to have as good or better care than they have now for the same or less money.

And it seems to me like, if you really want to expand access dramatically, the impact of that will be people who have good care now will probably pay more for less good care, so that everybody -- so that more

people can have some care, and that seems, to me, very hard to sell politically, which is, you're going to have to pay more money possibly for care that isn't as good now at least in the short term. So my question is basically, do you agree with that premise, and if so, how do you sell that notion politically?

SENATOR DASCHLE: Well, I think it is misleading to say that somehow we can have all of this and not have to change our ways, not have to sacrifice in some way. But I go back to my -- so I think in the short term the answer is yes, we'll probably have to -- there are going to be additional costs. As I said, taxes, premiums, out of pocket expenses will change.

But in the longer term, if we can't show that we can bring down cost, then I think we fail. And I would make that same case here. I don't think, in the longer term, a more rational health care system has to cost more. There's no rational explanation for a 30 percent administrative cost in our system.

I don't think there's a rational explanation for why we don't use best practices today. I don't think there's a rational explanation for why we haven't put greater emphasis on wellness and prevention. I mean there are so many different pieces that are omitted from our system today, all of which could have significance cost containment. I mean this propriety medicine, I know that's a hot issue, but is that something that we ought to continue to

promote? I mean there are just a lot of things that I think have to be addressed, and at the end of the day, if we address them, I would hope that our quality would not be 35th, if that's what it is, I would hope that it would be first. I would hope that we could bring down infant mortality and increase life expectancy. And in a better system, that's exactly what we could bring about. And I would hope that our per capita cost would come down.

So at the end of the day, and it is the end of the day, like ten years, or 15 years from now, I would hope we could achieve exactly that, so that, in essence, the ultimate goal of health reform would be to do what was said probably not so artfully in the early '90's.

MS. MELTZER: David.

MR. HYMAN: David Hyman; you used the term proprietary medicine a couple of times and neither Bill nor I can figure out what you mean by that. So -- well the rest of my comment is if you could just explain exactly what you mean by that. Are you talking about for profit hospitals or private practice in medicine, group practice, individual employees?

SPEAKER: I know David is setting you up with this one.

MR. HYMAN: I'm just asking you to define your term.

SENATOR DASCHLE: Okay.

MR. HYMAN: I don't know if Bill wants a disassociation of that.

SENATOR DASCHLE: Well, I use it as a reference largely to

the practice of owning equipment that -- equipment, facilities, the whole array of health delivery mechanisms that we have, and prescribing care with an appreciation of the profit derived from that particular prescription. So I'm not saying that all of it is bad. And if you'll note, I didn't condemn it categorically. I'm just saying it ought to be on the table as an appropriate review, as an appropriate opportunity for us to review cost savings.

I think it would be impossible to argue that every single provider in this country never takes into account what profit could be generated from a particular health setting when he or she owns the equipment to which they are prescribing care. And I think that, as I said, there are times when it's necessary, but there are times when I think it adds to cost.

MS. MELTZER: Bill had one point he wanted to make and then we're going to take the last question in the back before we wrap it up.

MR. SAGE: I'm Bill Sage from the University of Texas. Actually, I wanted to sincerely compliment you, that I thought this was the best key note on health care from a political leader I've ever heard.

SENATOR DASCHLE: Thank you.

MR. SAGE: So I wanted to compliment you on that. The question I --

SENATOR DASCHLE: Thank you very much.

MR. SAGE: -- the question -- I work with Jeanne, so maybe I'm a little bit of a set-up there, I'm partial. The question I wanted to ask was actually about the National Health Board, only in terms of the federal reserve analogy. For me, the FED has a couple of tools it uses at a very macro level and has a pretty clearly defined mission, and I was just wondering if you could say for your National Health Board, what would be the tools and what would be the mission?

SENATOR DASCHLE: The tools would be, first, primarily, it would be the administrative capacity over all federal -- all public health care, but we would also access -- we would give as a choice -- part of the plan, I didn't explain all of the details of it, but we would create sort of an FEHB system in our health care. We would set minimum benefit standards on the government side, but we would allow everybody to have access to Medicare if they wanted to choose Medicare as their option. And the Federal Health Board would regulate all of that, providing access to public programs, but make it a matter of choice for patients.

They could choose a private plan or they could have a public plan, it would be their choice. We would manage the whole public side of it just as the FED manages the discount rate.

MS. MELTZER: The one final question from the gentleman on the right side of the room.

MR. PETERSON: Chris Peterson; actually, I'm almost done with your book, and it's very good, parts two and three are my favorite. But my question is this; if you look back at the only time where health insurance premiums have actually declined was in the mid '90's, because of managed care, and so the way that I think about that is, that occurred essentially because people were told no, either you can't have this care or you can't go to that provider, and we know what peoples' response was, that backlash. And so my question is this in thinking about the board, as you define it in the book, trying to look at comparative effectiveness and saying, you know, this treatment is not as good, for somebody in a non-partisan way to make that declaration. But at the end of the day, somebody still then has to say no; is that going to be the doctor, and then what is their protection from malpractice, is it going to be the plan's, what is their protection?

And then in a competitive market where these plans are competing, if one plan decides to say no to certain things and another one doesn't, then based on previous experience, does that mean everybody is just going to go to those other plans? And so it makes me question the extent to which the cost savings will actually occur when there are these disincentives to finally say no to people.

SENATOR DASCHLE: Well, that's a very good question. I would say that the -- first of all, I would start with my assertion that episodic

reimbursement is so much better than procedural reimbursement in that -- this would be another function of the board, is to decide what episodic reimbursement approaches we might employ, and also setting out best practices. I think that other countries have employed best practices very effectively, and I think that it's so critical for us to employ best practices in our system, too, so you start with that. My own feeling is, and I only speak for myself, I don't speak for Jeanne in this case, but I believe that if a doctor employed best practices, was reimbursed for episodic care, was sued for malpractice, that he would have immunity from the lawsuit, but that we would have an insurance compensation fund set up to address the payment of malpractice claims, relieving the doctor of that particular requirement, therefore, shifting away the concern that physicians have had all too long about defensive medicine, testing excessively and other things that have produced cost.

So I think it's this intricate interrelationship with all of these things that I think would bring down cost. Ultimately, I do believe it's the doctor who has to make the decision.

The problem that managed care got in the '90's, I think, was that you had administrators making a lot of these decisions, and more and more authority and autonomy was taken away from the provider himself or herself, and we've got to get -- put the decision where it belongs, and that is

with the provider and not with the administrator, so long as best practices and this episodic reimbursement can be provided.

MS. MELTZER: Please join me now in thanking the Senator.

SENATOR DASCHLE: Thank you all very much, thank you.

MR. BLOCHE: Our next speaker will be Tim Jost, who is one of America's leading scholars of health law and its interface with health policy. And, now, Tim is going to get us all depressed, because he's going to offer a history of our failed attempts at cost containment and perhaps some lessons from that dismal history of 40 years or so of trying without succeeding.

Tim holds the Robert L. Willet, I hope I pronounced that correctly, Family Professorship of Law at the Washington and Lee University School of Law. He's co-authored one of the leading case books in health law, used in lots of law schools throughout the U.S. that have health law courses.

And he's also the author of Health Care At Risk, a critique of the consumer driven movement, and a recent article on Health Care Coverage, Determinations. And he has written numerous articles for many, many different kinds of audiences in addition to law review audiences on both health care regulation and comparative health law and policy in different countries. Tim, thanks a lot.

MR. JOST: Thank you, Greg. In 1927, a distinguished group of physicians, health economists, and public health experts were convened as the Committee on the Costs of Medical Care. By 1932, the committee had published 28 volumes of reports, including its final summary report, Medical Care for the American People. They -- of a committee of experts convened under this title, Our Moment of History, when we are spending over $2 trillion a year on health care would be obvious.

But in 1930, the United States spent only about four percent of its GDP on health care. And the primary concern of the committee was, in fact, not that the country was spending too much on health care, but that it was spending too little, that needed health care was not being provided.

A primary reason why provision fell short of need in the view of the committee was the skewed distribution of medical costs. The report stated no one fact is more clearly demonstrated to the committee than this one, that costs of medical care in any on year fall very unevenly upon different families in the same income and population groups.

Because of this skewed burden, the committee concluded, household budgeting for health care was impossible. The consumer driven system of payment for health care that existed in the United States up until that point had failed. The solution to the problem facing Americans was some form of risk sharing, and more specifically, the committee concluded

group health insurance.

In the two decades that followed, the nature of health care financing in the United States changed radically as first Blue Cross, and then commercial insurers replaced out of pocket payment as the standard form of health care finance.

By 1965, the year that Medicare and Medicaid were adopted, the vast majority of Americans had private hospital insurance. But as health care coverage expanded, so did national health expenditures.

At first expenditures grew gradually, but after the introduction of Medicare and Medicaid in 1965, expenditures grew much more rapidly. From 1965 until 1970, personal health care expenditures grew at a rate of 12.7 percent per year. This rapid growth provoked for the first time in the United States public policy initiatives to control health care costs. The most extensive and coordinated cost control strategy of the 1970's was health planning aimed at controlling excess capacity. Health planning originated earlier in the century primarily as a solution to the problem of poor distribution of health care resources. Over time, however, the rational with health planning changed to cost control. The economic justification for health care costs -- through supply planning came to be known as Romer's Law, named after Milton Romer, who stated, "the more hospital beds are provided in a community, the more days of hospital care will be used."

In 1974, Congress adopted the National Health Planning Resources Development Act, which mandated the establishment of a national system of regional health systems agencies to control capital investment in health care institutions, and thus, health care costs.

A second strategy that originated in the 1970's was utilization review. The first major utilization review program was the Professional Standards Review Organization, or PSRO program, established in 1972.

The task of the PSRO program was to review Medicare and Medicaid finance services to determine whether the care was consistent with professional standards, medically necessary, and in certain cases, impossible to provide more economically in an alternative setting. The third federal cost control strategy of the 1970's was President Nixon's signature Health Maintenance Organization program. Prepaid health care that existed for decades and had from time to time been proposed as a model for health reform in the health care system.

Paul Elwood, a rehabilitation physician from Minnesota, persuaded policy advisors to President Nixon that prepaid health organizations which he rechristened, Health Maintenance Organization, could both improve health by focusing on preventative care and save money by providing health care more economically.

The federal HMO legislation adopted in 1970 pre-empted state

laws that placed barriers in the way of the formation of federally qualified HMO's, required some employers to offer HMO options for their employees, and provided federal grants, loans, and loan guarantees to encourage the formation of HMO's.

These incentives, however, were only available to federally qualified HMO's. Federal certification requirements became increasingly onerous as Nixon's legislation worked its way through Congress, significantly diminishing the attractive of participating in the program.

HMO's did not have a real impact on the health care system until a decade later, when market conditions rather than a regulatory program stimulated their expansion. The fourth cost control strategy of the 1970's was hospital price controls. President Nixon's economic stabilization program, which imposed price controls throughout the economy, was modestly successful, holding hospital expenses as a share of GDP fairly steady.

President Carter, who succeeded Nixon in 1977, proposed the Hospital Cost Containment Act. While Congress never adopted the legislation, its threat provoked a voluntary effort on the part of hospitals, which also, for a time, had a dampening effect on cost increases.

The 1970's also saw the beginning of the enforcement of anti-trust laws against health care providers. In 1975, the Supreme Court held the anti-trust laws applied to professionals who were not previously thought

to have been engaged in interstate commerce.

In the years that followed, the Supreme Court upheld a number of anti-trust enforcement actions in the health care industry. Perhaps most importantly, the anti-trust laws played a role in weakening organized medicine's opposition to pre-paid health care, which, in turn, made possible the managed care revolution of the 1980's and '90's. Finally, in retrospect, the most important health policy initiative of the 1970's seems to have been the Employee Retirement Income Security Act of 1974. ERISA was, of course, adopted as a pension reform statute, not as a health care cost containment measure. It contained, however, a revolutionary provision pre-empting state laws relating to employee benefit plans.

Supreme Court cases in the 1980's further expanded ERISA pre-emption to allow removal of cases asserting ERISA claims into federal court and to supersede state remedies supplementary to ERISA. ERISA was adopted at a time when the states were beginning to take the initiative in health policy generally, and in particular with respect to cost control.

By 1979, half of the states had adopted some form of mandatory or voluntary hospital rate control programs. Several of these programs, however, were challenged under the pre-emption provisions of ERISA, and although these challenges were ultimately rejected by the Supreme Court in 1995, by then, the rate setting programs of the states had

circumed to the anti-regulatory mode of the 1980's.

In 1980, Ronald Reagan was elected president with promises to shrink the role of government in the American economy. National health insurance, which had seemed almost inevitable in the 1960's, vanished from the health policy agenda, and the aggressive cost control efforts of the 1970's went into full retreat. The PSRO program was the first to fall, being replaced in 1982 by the leaner PRO program, which focused more on quality and less on cost and offered less comprehensive oversight of medical practice.

Four years later, the federal health planning law was repealed. Within the next half decade, about a dozen states repealed, and more scaled back their state certificate of need programs. Most states also repealed their rate setting programs.

While the federal government in the 1980's abandoned attempts to control the costs of the health care system generally, it refocused its attention on its own programs, and in particular, on Medicare. The most important change came in 1983, with the imposition of DRG hospital payment.

Hospitals had previously been reimbursed by Medicare on a cost basis, which had proved disastrous. Hospitals suffered no consequences if they raised their operating costs or invested in additional

technology or beds. To stanch the flood of Medicare funds flowing into the hospitals, Congress created the DRG Prospective Payment System. DRG PPS did cut the rise in hospital costs for a time, but primarily -- but it only controlled in-patient hospital costs, and its primary effect was to drive care out of the hospitals into out-patient surgery, long term care, and rehabilitation facilities often owned by the same hospitals whose in-patient consensuses where shrinking.

The most dramatic change in the American health care system during the 1980's, however, was primarily driven by the private sector rather than by government, the emergence of managed care.

Managed care appeared at a time when costs were growing faster than ever, 10.3 percent annually between 1985 and 1990. It responded effectively, as one of our questionnaires pointed out earlier today. Between 1993 and 1999, hospital health care costs increased at an average of only 5.6 percent per year, about half that of the previous decade.

Many factors came together to contribute to this cost moderation. There was considerable excess capacity in hospitals allowing managed care plans to drive down prices. Managed care organizations were able to negotiate aggressively with physicians by establishing tight networks and experimenting with provider incentive programs. Traditional insurers competed aggressively for business as they saw their market

positions challenged by the emerging managed care organizations. By the mid 1990's, however, a backlash against managed care was building. One way in which it manifested itself was through restrictive state legislation, supported by public opinion which increasingly reacted against managed care's abuses.

Initially, these state laws ran up against the barrier of ERISA pre-emption. In the mid 1990's, and particularly in the early 2000's, the Supreme Court, in a series of cases, loosened up ERISA pre-emption.

The court finally drew the line by rejecting tort suits in state courts against ERISA plans in 2005; but by then the court had greatly widened the permissible scope of state regulation.

Managed care faced not only hostile state legislation, but also pushed back from the health care industry. A flurry of hospital mergers and closures in the 1990's consolidated the bargaining position of hospitals allowing them to withstand pressure from managed care plans. More importantly, the booming economy and the tight job market of the late 1990's encouraged employers, and thus insurers, to yield to consumer demands for broader networks and looser utilization controls. And Gregg Bloche has written an excellent article on the relationship between the market and the law in managed care backlash in this area. As private managed care organizations backed off from the cost controls in the late 1990's, however,

public programs were tightening the screws.

Arguably, the most significant federal health legislation of the 1990's was the Balanced Budget Act of 1997. While the BBA embraced managed competition for Medicare and managed care for Medicaid, its most effective strategy was to ratchet down the administered prices paid through Medicare's prospective payment systems while extending prospective payment to virtually all Medicare providers not covered by it.

Medicare expenditures increased by only one-tenth of one percent in 1998, and one percent in 1999, a situation not duplicated before or since in the public and private sector. If you want to look at how to control health care costs, look at the BBA.

Medicare's ability to control costs was aided by increasingly effective enforcement of fraud and abuse laws against providers who were billing Medicare and Medicaid illegally or abusively. By the late 1990's, the government was routinely settling Medicare false claims cases for millions, and in some cases hundreds of millions of dollars, and health care providers were billing much more conservatively, further constraining Medicare cost inflation.

Just as the mid 1990's saw a market push back against managed care, however, the end of the 1990's and early 2000's saw a political push back both against the BBA's stringent limits on Medicare

provider payment and the ambitious fraud and abuse enforcement efforts of the OIG and Department of Justice.

A series of budget reconciliation acts ratcheted up provider payments back to the levels at which they had been before or higher. And as cost control efforts flagged, the cost of government programs dramatically increased, with Medicare program cost increases even exceeding private insurance premium increases over the last couple of years, as the cost of Medicare advantage managed care plans have continued to explode while the new Medicare drug program has taken over drug costs from both the private sector and Medicaid programs. As the costs of both private and public programs climbed in the middle of the first decade of the 21st century, policy makers have turned in a new direction in the hope of controlling health care costs to the health care consumer. Since at least the 1960's, some health economists have asserted that the root cause of high and rapidly growing health care costs was moral hazard.

The solution to this problem was to greatly increase consumer cost sharing, a strategy that came to be known as consumer driven health care. The 2003 Medicare Modernization Act represents the triumph of the consumer drive strategy as liberal tax subsidies were enacted for consumer driven products.

It's too early to tell yet whether the consumer driven strategy

will have an actual impact on health care costs or whether it will end up in the graveyard of other cost control initiatives.

There is growing evidence, however, that lower income persons with high deductible policies are not getting medically necessary care and are encountering financial difficulties.

In fact, if high deductible accounts really caught on, we could find that we have gone full circle, retreating to the situation described by the Committee on Costs of Medical Care. If we end up with health care cost inflation moderating, but with many Americans unable to afford medical care because of high cost sharing, will we really have made an advance in health policy? What lessons can be drawn from our experience with health care cost control? First and most obviously, the United States has never succeeded at controlling health care costs for the long term.

At various times, health care cost increases have dipped briefly in response to specific policy initiatives, and the most successful have been managed care in the private sector in the 1990's and the controls on administered prices in the BBA in 1997.

But the share of the GDP devoted to health care has continued to grow, from 5.2 percent in 1960, to 9.1 percent in 1980, to 16 percent in 2006. Neither market nor regulatory strategies have succeeded in holding down health care costs in the long term.

Second, it is clear, however, and here I turn to a lot of work I've done in comparative health policy and my book on Health Care At Risk, which is cited in the materials, goes through a lot of this information. But my conclusion is that other countries have been more successful in controlling health care costs. Health care costs have continued to increase throughout the world. But other countries with developed health care systems have, over time, held health care cost growth to lower levels than the United States. Most other countries have controlled costs through government regulatory strategies such as health care budgets, negotiations with providers, or price and profit control.

We at the United States have lacked the political will or capacity to control health care costs through government regulation. The pro market anti-regulation ideology that has dominated U.S. politics for a generation rejects regulation as a viable strategy.

Moreover, with a health care system as fragmented as that that we have in the United States, with the majority of expenditures in the private sector and public sector expenditures divided between a multiple of state and federal programs, it is difficult to imagine a regulatory strategy that would work.

But no country in the world has successfully controlled health care cost through simple reliance on market forces. This is true for a simple

reason; markets can only bring health care to those who have the resources to pay for it. Public resources are necessary to provide health care for the rest. And with government financing, it seems to me, must inexorably come at least some level of government oversight. Well, the task of my talk here today was to provide a history of cost control in the United States. I believe this history confirms that we have not yet found a solution. That, I assume, is the task of the rest of the speakers today. Thank you.

MR. BLOCHE: We have time for a few or several questions.

MR. DEYOUNG: Thanks; I'm Eric Deyoung, I'm a geriatrician here in D.C. caring for elders. My question for you is about how doctors induce demand, and how do we address that in kind of the payment system, because doctors ultimately, in addition to moral hazard, are the ones who decide what to do, but doctors can induce their own demand because they can decide exactly what will pay them more, for example, and do more of that, and how do we address that?

MR. JOST: Yeah, well, I mean I'm not an economist, and there are lots of people in the room who are, but I'll give you my take on that, and that is that doctor induced demand is debated, but I think is fairly well established as existing, but I think it's a product of a fee for service system, and so I think what you need to do is to change the incentives, move to capitation, move to some other way of doing it. I'm working together right

now actually with a project on trying to change financing in traditional Medicare with a number of health organization people, Steve Shortell and Larry Casalino is who I'm working with most directly, and they have some very interesting proposals for changing the form of Medicare reimbursement so that we focus more on quality, focus more on cost control, retain a fee for service element, but try to de-emphasize that and try to balance out the incentives so that physicians have as much to gain from improving quality and controlling costs as they do from increasing demand.

And there's a lot of changes that would need to be made in the Medicare program to bring that about, that's what I've written a paper about. But there's some good ideas out there. I don't know that there's solutions, but there's some good ideas out there on how to address that. Yes.

MR. GOLDMAN: Dana Goldman; you mentioned there was an attempt to lower cost and it was successful for a while to deal with fraud and programs, and I found it interesting, when we talk about administrative costs, and there's a lot of discussion about it, people point to Medicare spending maybe five percent, and private plans center national spending maybe 25 percent, but what you're suggesting is actually that we should be spending more on administrative costs, for example, trying to fight fraud in the Medicare program, because it actually would lower the rate of growth and health care spending; is that correct?

MR. JOST: Yeah, I've written about this, and I mean I think the question is, what is productive administrative cost and what is unproductive administrative cost. If a doctor has to have three billing clerks in his office to deal with 100 different insurance forms and coding systems, that's unproductive administrative cost. If a health insurer is doing some sort of useful utilization review and there's a question as to what that means, that might be productive administrative cost.

And one argument I've made is that we have such low administrative costs in the Medicare program because we essentially pay every claim that's submitted and we don't screen them very effectively.

On the other hand, at the back end, we have this system that says if we catch you with your hand in the till, we're going to hit you with $100 million fine and maybe throw you in jail. And in terms of rational deterrence theory, that should make sense. If you have huge penalties and a relatively low likelihood of getting caught, then, you know, people will maybe pay attention to that. I'm not sure it's the best way to do it, and I think probably Medicare should be spending more on administrative costs. A big part of the problem there, and I'll say this briefly and then shut up, is the way in which Medicare is financed, which is that on the service side, it's, what do you call it, it's mandatory spending, it just goes right through the budget, whereas CMS's administrative costs have to be in an appropriation act every year,

and so Congress gets all worried about are we spending too much on Medicare. And they could probably spend less in terms of Medicare reimbursement if they'd spend more on administration, yeah.

MR. CALFEE: Thank you; Jack Calfee, AEI. How do you know when cost control has been successful, is it when it's a stable proportion of GDP, is it when it's -- the growth rate is no more than that of median advanced economy, is it when additional spending no longer provides benefits equal to the value of what you get with the spending or what?

MR. JOST: Yes.

MR. CALFEE: It's the latter?

MR. JOST: I would say that when the costs are not -- when further costs are not justified by increase in value, yeah, I mean that's the way I would define it. On the other hand, I would think that one rough proxy for that is growth in the GDP proportionate to other developed countries, because developed countries, wealthy countries spend, as you know, a lot more of their GDP on health care than poorer countries, and the United States is no exception. We're the wealthiest country in the world, and therefore, we spend the highest proportion of our GDP on health care.

On the other hand, if you chart it, there's almost a direct line linear correlation between the wealth of countries per capita and the

proportion of their GDP that they spend on health care, except for the United States, which is way off the chart. And incidentally, I think Luxemburg is way below the chart, I don't know about that. But the United States, for some reason, we spend far more, and I think that's a pretty good indication that we're spending too much. Okay.

MR. BLOCHE: Thank you, Tim. And now our first panel or group of several folks will come on up. And I'm going to introduce the moderator, who is Jack Calfee. Jack Calfee received his PhD in economics from Cal Berkeley, and he then went to work for the Federal Trade Commission, in the Bureau of Economics, and worked on the Economics of Consumer Protection, and also looked at the tort liability system and tobacco. He later taught at two business schools, marketing and consumer behavior at University of Maryland, College Park, and Boston University. Then he spent a year here a while back as a visiting senior fellow at the Brookings Institution. And since 1995, he's been a resident scholar at the American Enterprise Institute here in Washington.

He has focused in recent years on the economics of the pharmaceutical industry, and on medical innovation more generally. And he's been quite critical in his writings of what our legal system had to say and what it's done in these realms.

He's written numerous articles for academic journals, and has

published several monographs with AEI. And he's also written a number of -- pieces, including pieces, a number of pieces for the Wall Street Journal and the Las Angeles Times. And, Jack, you're in charge.

MR. CALFEE: Well, thank you, Gregg. It's a pleasure to be here. I'm a late addition to the program. And my introductions will not be as elaborate. I'm introducing three people. But we're going to begin with Leslie Meltzer, who is a lawyer, having gotten her JD from Yale Law School, and this is one of those years, because it's an election year, a presidential election year, in which we are constantly reminded of the prominence of graduates of our leading law schools, and this is no exception.

Leslie also has a master's degree from Oxford University in medical history, and she feels very strongly that her educational qualifications are still rather weak, and so she is now obtaining a PhD in ethics at the University of Virginia, and at the conclusion from that, she will have achieved what my aunt asked me whether I would ever achieve when I entered my second PhD program, although I didn't finish the first one, and when she asked me, Jack, are you ever going to get educated.

And Leslie is just getting started in her career, but she is at John Hopkins. You have a joint appointment at Hopkins and Georgetown; is that right, which is already impressive. And her work is in bioethics, and that, I think, is what you're going to talk about.

MS. MELTZER: That's right.

MR. CALFEE: Thank you.

MS. MELTZER: Thanks, Jack, both for agreeing to be our moderator and for that kind introduction. I've always thought that the longer I stay in academics, the better I am able to assess whether a basic benefits package is any good. The nation's last -- into major health care reform, the 1993/'94 Clinton proposal, collapsed for many reasons, as Senator Daschle alluded to.

The decision to exclude Congress from the process, instead handing them 1,000 plus pages of fully informed legislation and expecting swift passage -- you know, we actually just lost battery power on our computer, so I'm going to break for one minute and see if there is a way to get that back up and running, if you don't mind.

(Pause)

MS. MELTZER: We lawyers don't usually use PowerPoint presentations, often times thinking they're the spawn of the devil, but I've actually found them to be quite useful in talking to a mixed audience.

I'm going to go ahead while that's loading back up. So as I was saying, there are a number of reasons that the 1993/'94 Clinton proposal collapsed, one of which was the decision to exclude Congress from the process, instead, as I mentioned, handing them a 1,000 page plus

document of fully formed legislation and expecting swift passage. One was the failure to anticipate, and I think effectively defend against strong conservative opposition, and another was the deep opposition of the medical industrial complex, which makes millions, if not billions of dollars, I think, in profit off the system.

But perhaps nothing was so effective in dooming the Clinton proposal as the infamous Harry and Louise ads. Funded by the Health and Insurance Association of America, they featured a middle class couple seated at a kitchen table full of bills, worrying over medical expenses that were covered under their old health care plan, but were denied by their new plan under what was dubbed Hillary Care by its opponent.

It was a factitious scene that played upon a very real fear, that serious attempts at cost containment will inevitably force us to make, to use Guido Calibrazi's phrase, tragic choices about what medical care will be covered under a national system.

The ads helped to convince Americans, the overwhelming majority of whom already had health insurance, that they had something big to lose in this battle. In the aftermath of this debacle, it might be astonishing that any presidential candidate will even whisper the words, cost control, in the context of health care reform. But with the specter of 1993 looming large today, the candidates in this presidential campaign have turned cost control, I

think, into what we might call the Atkins diet of health care reform. The nation can simply continue consuming all of the health care that it wants, but still be able to trim substantial costs out of the system.

In the public debate, cost control has come to mean an easy, pain free, quick way to reduce expenditures, things like stamping out waste, eliminating fraud and abuse, utilizing information technology, and one of the favorites, enhancing prevention.

But there is an 800 pound gorilla in the room. Any serious cost containment proposal will have to wrestle with sometimes tragic choices about how to value life. Perhaps carrying the obesity epidemic will help our gorilla drop a few pounds, but my sense is that he'll still be in the room.

This is obviously a topic for a much longer discussion. And so what I'd like to do here is spend my time talking about the three ethical conundrums that I think any cost containment proposal faces, and then present you at the very end with some values that we might use in evaluating serious cost containment proposals. The first is how we evaluate interventions that improve health, but also increase cost. Now, there's a common believe, I think both among the public and certainly among the presidential nominees, that health promotion and prevention are magic bullets in the effort to contain health care costs.

Hillary Clinton suggests that we focus on prevention, wellness,

not sickness. Barack Obama says that we spend too little on prevention and public health. And even John McCain has argued that public health initiatives must be undertaken with all our citizens to stem the growing epidemic of obesity and diabetes and to deter smoking.

Now, on their face I don't see anything wrong with these statements. In fact, preventable causes of disease are responsible for 40 percent of the total year mortality rate in the United States. And some measures that reduce mortality, like the flu vaccine, do so cost efficiently, or even at cost savings.

But as Joshua Cohen and his colleagues pointed out three weeks ago in the New England Journal of Medicine, it's misleading to suggest that preventative medicine is always a good value. Although some preventative measures save money, in fact, the vast majority do not. Now, a study by our colleague who's here, Dana Goldman, in 2006, who's speaking on the next panel, I think is useful in illustrating this point. He and his colleagues simulated four interventions, hypertension, diabetes, smoking, and obesity control, to see how those would effect medical expenditures for the 180 million Medicare beneficiaries who will enter the program between 2005 and 2030.

The study assumed that hypertension, diabetes, and smoking could be 100 percent effective, and that obesity control would lead to a 50

percent reduction in obesity, basically reducing it back to its 1980 level.

The study examined how much each intervention would reduce the burden of disease, but also what effect it would have on health care costs. Disease burden was measured using disability adjusted life years, also known as DALY's, which account for the benefit of any intervention in terms of the quality and quantity of life it grants. And then they looked at the health care costs measured in 2000, near $2,000.

Now, as this graph shows, and I, again, encourage you to actually reference Dana's article, which I think gives much more comprehensive information and, in fact, much prettier graphs than I could produce. The study found that hypertension prevention would result in 75 million additional disability adjusted life years, and would also lower medical spending by $890 billion. Diabetes prevention proved even more effective, increasing DALY's by 90 million, but it also was more expensive. Health care spending would be $246 billion higher than under the status quo.

Smoking cessation would save 32 million DALY's, but it, too, would increase costs by $293 billion. Finally, obesity prevention yielded the lowest increase in DALY's, meaning it didn't change quality of life nearly as much as the other measures, but the cost savings were enormous, $1.2 trillion, so much that even though Goldman's study actually focused on the elderly population, both of the two democratic nominees for president have

used this information to argue that this is one of the greatest ways in which we can achieve cost savings through prevention, is to focus on obesity control.

The ethical question is how we should evaluate these interventions, like diabetes control and smoking cessation programs for the elderly that reduce the burden of disease, but actually result in increased health care spending. And creating a health care plan should be privilege intervention that improve health outcomes or privilege those that decrease cost. To answer these questions depends on the ethical value that animates our system. But before we get to the value discussion, let me highlight a second related ethical conundrum that we face in any cost containment proposal, and that is, how much are we willing to pay for improved health.

Any effort to contain cost will require us I think to make important moral judgments about how much we're willing to spend to save an additional year of life. This is the harsh reality of limited resources. We can't avoid these explicit conversations about how much certain lives are worth.

Now, for the moment, let's assume that we're willing to spend $50,00 per life year saved, which is the conventional benchmark. Some preventative measures, like the flu vaccine for toddlers or a one time colonoscopy for men age 60 to 64, actually improve health at cost savings. These are the rare freebies, though.

Now consider the following data drawn from a 2007 report of the National Coalition on Health Care on the cost effective myths of cholesterol lowering medications known as statens for men at varying risk for heart disease. For men age 45 to 54, at low risk for heart disease, the cost of statens is about $400,000 per health year gained in 2007 dollars. For men that same age who smoke and have high blood pressure and poor cholesterol, the cost per healthy year is much less, $85,000. And finally, for men in category three, with heart disease, statens are the most cost effective, less than $15,000 per healthy year gained. Again, this is the sickest patient population.

Now, in a system that set its benchmark for spending at $50,000 per life year saved, statens will only be provided to men in this third category, despite the fact that statens are known to improve, and in some cases, save the lives of men in the other two categories. This is just one example, and I have to say, a rather easy example for people because it's in the area of prevention as opposed to in the area of treatment.

But nevertheless, it forces us to look at what to do in a system that sets a price on life years, as any cost containment proposal must. Many interventions that are currently covered in our system will just turn out to be too expensive. And is this a fair outcome? Again, it depends what values animate your health care system.

Now, I want to address one more ethical conundrum that I think any health care cost containment proposal must face, and that is what costs count. Insofar as certain interventions extend life, they may also increase dependence on the social security system and other features of the welfare state. Consider how the interventions simulated in Dana's study effect the life span of the elderly population. Under the status quo, the number of people with Medicare parts A and B coverage who will reach age 65 or older by 2030 is 72.6 million people. With the exception of obesity control, each of the methods in Goldman's study increased the Medicare beneficiary population. Diabetes control increased the population by four percent or 2.9 million people, hypertension by three percent or 2.1 million people, and smoking cessation by two percent or 1.1 million people.

It turns out that while weight reduction is good for the rest of us, it actually is a -- it's good for older people to have a little bit of fat on their bones. So, in fact, obesity control actually decreased the beneficiary population there by 0.6 million people or one percent.

The available data suggests that increased longevity does not itself add to Medicare costs. However, a larger aging population certainly results in increased public spending on things like social security benefits. Now, Goldman and his colleagues in that study do not conduct a welfare analysis, though Dana told me this morning this is on their current agenda.

We can't be sure at the moment as to the extent to which these increases in the Medicare beneficiary population will increase costs outside of the health care sector.

But what I do think is that in a world of limited resources, the question cannot just be whether a health care intervention is cost efficient in that sphere, but whether it might be cost efficient across the entire budget. Containing cost will require us to engage in moral parsing about what costs count in any cost containment strategy. Now, what I hope I've illustrated is, first, that there's no moral free lunch here to be had in cost containment; and secondly, that before we implement new cost containment strategies, we need to articulate what social bulls or moral objectives we want to achieve in our health care policy.

As important as health care cost containment is, it still remains only one of many valued social goals. Let me suggest briefly, because I think there's only a few minutes here, that there are at least five other moral objectives and probably others you might articulate during the Q and A session that follows that we could consider in formulating health care policy. These are alternatives, they're not meant to be mutually exclusive, and they are certainly trade-offs between them, but they set the stage, I think, for a conversation that will hopefully prove productive in a little bit.

First, the value that we place on health outcomes matters

insofar as it effects individual health. This has been the traditional focus of bioethics and medicine. But just how much we value individual health is unclear. It seems to me that we value it differently over the life span; in other words, we often want a basic benefits package to include preventative medicine for infants and toddlers, we're less clear about how many of these preventative methods we want included in a package for adults.

Some people argue, for example, that in the case of individual health care, adults need nothing other than catastrophic health insurance. Secondly, aggregate health outcomes for the population, how should we consider things, for example, like indicators of population health from life expectancy to burden of disease and infant mortality. These are the indicators, in fact, that we're rated on as a nation when we look at the percentage of GDP that we spend on health. How well are we doing in protecting our population as a whole, not just the individuals in it? Third, respect, and here I mean respect at a minimum as something in which people are treated as equal moral beings with equal moral concern, that we're committed not only to improving the case of those without health insurance and those who are the worst off among us, but also those who are the wealthiest. In other words, we look at health care equally for all people.

Finally, individual economic well being, and here we think again about protection from economic catastrophe. Any health care cost

containment plan we might say, at a minimum, ought to offer people enough economic security that they're not so afraid that in the case of a dire medical catastrophe, they have no resources at all.

And finally, our national economic health. In 2005, and these are numbers that you may hear over and over again today, total national health expenditures rose 6.9 percent, two times the rate of inflation. Total spending was $2 trillion or $6,700 per person, and represented what we can now say was only 16 percent of the GDP.

But now U.S. health care spending is expected to increase at similar levels for the next decade, reaching $4 trillion in 2015 or 20 percent of the GDP. How should we count national economic health in relation to these other values? In any health care policy or health policy, there will be conflicts and there will be trade-off. We should engage, I think, in an ongoing discourse about the inner play of these values and others, like responsibility for personal health and choice for one's health care plan, for one's doctor, and for one's life.

These discourses need to occur across diverse communities with transparency and revision, but there's no doubt that we've entered a morally dicey landscape and one that I look forward to discussing further with all of you.

MR. CALFEE: Well, thank you, Leslie. We are going to have

a question period, but not now. We're going to wait until all three speakers have spoken, and then we will have a little bit of a round table her and then have questions from the audience. We're not quite following the sequence as listed in the program. We're going to turn now to Daniel Wikler, if that's okay with him.

And Professor Wikler was, as you noted from his bio, the first staff ethicist at the World Health Organization, where he discovered and explored a large number of ethical issues which arose rather quickly in the context of the World Health Organization and their work, especially in the international burden of disease. He's now the merry -- Professor of Population Ethics in the Department of Population and International Health at the Harvard School of Public Health. He is -- Professor Wikler is what I guess you might think of as an ethicist.

He's been prominent in this field starting at a time when it was a very narrow area that had not received a lot of attention until the present day, when -- an increasingly broad area, tracking a great deal of attention even from people like me, the economists, and he's a widely published researcher on ethics and health, and I think it's fair to say the bulk of your work, at least most of it, is in the context of international health.

MR. WIKLER: Thank you; and that's true, in recent years, my interests have turned to international health, and although I was tangentially

involved in domestic debates about 25 years ago, it's been quite a different -- it's been a much broader train that I've been active now. But I hope that that will -- that offers a perspective which, turned back on the domestic scene, might offer one or two ideas that will be of value even if they're at some level of abstraction. Twenty-five years ago, a little over that, I received a call when I was -- had just gotten tenure at the university, and a distant acquaintance said, listen, I've been set up as the executive director of the new presidential commission on ethics and health, it's called the President's Commission for the Study of Ethical Problems in Medicine, and we have been asked to put out a big report on access to health care in America, stressing equity and fairness, and so why don't you come to Washington and be my staff philosopher, which was -- I was at loss, and which allowed me to have the only business card in Washington, I have the presidential seal in one corner and then the word staff philosopher under the name, and I would pull that out, as everyone does in the hand shaking routine, and people would laugh and say, now let's see your real card.

When we got there, you know, we took up the question, we realized immediately that to talk about access in an era in which the main determination in Congress seemed to be to avoid any new entitlements was to introduce rationing, and so if there was going to be an ethical issue, it was going to be rationing, and we -- about it, and we had lots of consultations and

so on, and before we actually sent any drafts up for approval, the word came back that our word must never appear in your report. But since that's what the whole report was about, we thought, what are we going to do. And that actually became our main pre-occupation for a long time. And finally we realized that we just had to -- we didn't have a universal search because it was all done on selectrics back then, but we painstakingly replaced our word with the word allocation, and everything was fine.

Now, it's clear, I think Leslie's talk was excellent in making this point that, of course, our highest wish is that we'll have a painless, relatively painless method for cost containment.

And Senator Daschle offered his top ten measures, most of which the fairly painless, if they could be made to work. The main obstacles are political and overcoming impinged interest, but as to whether these would be good if we could do them, sure.

And one of the great things about most of these efforts is that they wouldn't involve any rationing. And so if we can pull off some of those, no question, those are the first things to do.

Now the question is, suppose that we reach the limits of feasibility, and if there's going to be any further cost containment, then we're going to have to pull back, somebody is not going to get something that might benefit them. What then? Well, the title of this session, which Gregg

dreamed up, which I think is a very good one, it's how to square the obligation of social stewardship with the obligation of fidelity to patients. And the nub of the problem, in my view, is that social stewardship is an obligation of the system as a whole, and fidelity to patients is mostly seen as an obligation of individual care givers.

And so that inevitably is going to be produce a conflict, because there's no way the individual care givers can take on part of the responsibility that really is much broader than their's alone, so how do we manage that conflict.

When we did our work on the our word back in -- I don't expect any of you to ever have read that report or heard of it, there are millions -- there are dozens of those reports generated in Washington all the time, and ours was not one of those notable ones, but when we did the work on that, that was, I think, the first government report that was specifically addressed to the ethics of this problem.

And at that time, it was much harder than it is now to find a medical student, let's say, who would tell you that what they're taught in ethics class or the ethic that they absorbed through consultations on rounds and so on would permit them to recognize stewardship resources as an obligation of their's. It was we fight for the patient and we have to fight against the people who think it's their job to be stewards of resources, and

anything other than that would be a violation of our sacred honor and duty.

And over the next 25 years, medical education, medical training has changed. Conservation of resources, stewardship and so on is not breathed in along with the other fumes in medical schools, and it's understood that it's not fully professional behavior to squander resources even if you think there might be a marginal benefit to your patient. So in a sense, that battle has been at least partially achieved. But, still, the tension remains, and especially the tension arises when we come to benefits that we think may be more than just marginal.

Now, should we expect patients in the United States to roll over and play dead and to say, because we have the insupportable costs, and we need to do something about them, we simply must accept the idea that our personal physicians are going to look at us and think, yes, I can help you, but is it worth it, and by worth it, I mean worth it to you or even to me, I mean worth it to America. That will be the day, won't it. Now, before going on, although I do want to address this question, I think one can make out an argument for saying that we shouldn't arrive that day, that any patient who accepted this and rolled over and played dead would simply be an uninformed and insufficiently aroused patient, and all they have to do is look at the total that America spends on health care, which has already been noted this morning. What we spend is so much higher than what others

spend.

Suppose that you took the difference between American health expenditures and those of the National Health Service in England, and you took the percentage of excess, and you went to the NHS and you said, look, you know, your places are really kind of grungy here, you've got some waiting lists, there are times when you know that if you could give a referral of a patient to a, you know, more highly trained specialist, things would go better, and yet you don't do these things for reasons of the economy. We're going to give you increases in your budget so that you don't have to compromise in any of these ways.

Well, according to some ways of telling the total, they could double their budget and still not reach what we have. Now, what would the NHS do with all that money if they could double their budget? They'd have to put people out on the streets with sandwich boards saying, won't you come in, please, and absorb some high cost health care. All the other problems we've got, I mean no rationing, as far as I know, there would be -- it would be very hard to find ways to ration. All the problems that they identify as rationing problems have price tags for their resolution that are far below the level that they would reach if they wanted to match the United States.

So an American patient who knows that, if their doctor came to them and said, look, you know, on behalf of, you know, as a patriotic

American, I owe it to you to stint on health care that would really benefit you, why shouldn't they say, look, first, become as efficient as -- or some of our other counterparts are, and then come back to me, and if it's still true, then I'll talk to you about it.

Now, of course, we can't -- the powers are entrenched, and whatever it is that's keeping those costs so very high, and I wouldn't presume to enumerate them, whatever those causes are are not going to go away. And so the ethical issue facing us is not how we'd ration if we had our costs more in line with those of our counterparts, because they're not, it's what we do in the world we actually live in. So I do think this caveat that I just mentioned ought to be mentioned first, and every year that Professor Anderson publishes his studies of cost spending, it reminds us of the primary importance of this question for any discussion, the ethics of rationing, which is why I always cite it, but in the end, we have to take the costs as we can make them rather than as they might ideally be.

So when we come to deciding then who might get less if we had to contain costs by offering less, consider the following progression. These are criteria, or these are the basis on which one might decide to allocate a resource in the American health care system.

So first of all, this intervention, by which I mean a procedure or a drug or whatever, this intervention is desired by the patient, and

presumably endorsed by the physician.

Secondly, this intervention actually works, it's effective to deliver a benefit. Thirdly, the cost of this intervention is moderate, not terribly high priced. Fourth, the benefit of this intervention in relation to its cost is sufficient. And then fifthly, allocating resources by providing this intervention would satisfy a combined cost effectiveness/fairness criterion. Now, let's go back over this list and ask where are we and where should we hope to be. The first one, obviously, is fuel for budget busting. If every patient got everything that they wanted to get, their doctors would agree to go along with, provide -- the sky is the limit, so everybody knows that we don't want to be there. So how about finding out that whatever it is that they want actually works.

Well, in some respects, as I understand American policy, that's sort of where we are, at least with respect to whether the government will reimburse a drug or a procedure in Medicare. Whether it works for somebody to some degree is really the crucial thing, and that's what you try to prove when you do clinical trials.

Now, coming to three, the cost of this intervention is moderate, that's a different thing, of course, because when we introduce questions of effectiveness without looking at cost, then what we get are interventions that might actually deliver a benefit, and you can't deny that they did deliver a

benefit, at least to some patients, but the costs are simply unsupportable.

So if we introduce the question of cost, that would be a step forward, but of course, it would naturally -- to number four, which is that we look at cost in relation to benefit. And so that's a question of cost effectiveness, it's worth -- the cost is moderate relative to the benefit that it produces. Now, if we move to a system of allocation of resources or rationing, that was moved very hard on -- that pushed very hard on cost effectiveness, would this be an ethically defensible system?

And I'm sure it will come as no surprise to almost everybody in the room that the answer to that is certainly no, we'd know from looking at the effects of cost effectiveness in guiding health care allocations that in instance after instance, following that particular route, leads us into ethical blind allies.

And we find that it generates patterns of allocation which any -- which, first of all, almost everybody rejects, and secondly, which, on reflection, scholars who work on this stuff, like me, also reject, not that that means all that much, but I'm going to add my voice to that.

This was first noticed, of course, in the pioneering work by the Oregon Health Services Commission, which was trying very hard in its first iteration, first priorities list to push cost effectiveness above all. And at that time, when they were trying to generate that list, it may not be terribly well

remembered, they were being advised by somebody who was quite knowledgeable about how to do a cost effectiveness analysis. And he told me that he warned the commission before they started up, look, you're going to run into a notorious aggregation problem, there are going to be items that deliver fairly trivial benefits, like tooth caps, and they're going to wind up way high on your priorities list because they're so cheap, so -- and then there will be other items that save a life, like an appendectomy, and they're going to wind up way low on the priorities list because they're so expensive, and you're going to get a situation in which, if you just compare, you know, item to item, it looks like your priorities are insane, but if you're doing it on the basis of cost effectiveness or you sum up the total gain from the small expenditures on these items like tooth caps, then they're going to buoy up to the top of the list, and you have to be prepared for this, and I said yeah, yeah, yeah.

Well, then came the day when they were going to push the button on the computer and spit out the priorities list, and someone asked, do we have to do this in public, and the public spirited member of the commission said, yes, this is -- we have a sunshine wall here, so not to be outdone, and another person said, we'll not only do it in public, we'll invite the New York Times, so oh, that's great, you know, really in the Oregon spirit. So they invited in the support for the New York Times, they press the button,

out comes this list, tooth caps way above the line, appendectomy below the line, not to be offered, you know, low priority, front page of the New York Times the next day subject to the ridicule, the members of the commission almost quit, and that would have been the end of the Oregon plan. Now, how about this guy who had warned them that this was a predictable result, they fired him, so that was that.

Now, this aggregation problem is one of the most notorious ethical conundrums that comes up when we try to go beyond mere cost effectiveness to achieve what we think is a genuinely fair or ethically defensible allocation.

There's a long list of other ones, each of which is studied fairly intensively by people who work in health economics and in my field and so on. We often think that we should give priority not only to large gains over small gains, which is what this aggregation thing is about, but also to people who are in grave need of care as opposed to the people who are doing fairly well. So this is priority to the worst off, speaking of worst off as the sickest. But, of course, that's all -- this is all understood to be keeping one thing constant, which is the amount of benefit. Priority to the worst off, where you pull resources into someone who's only going to get marginally better, but not actually take priority under this principal. But as long as the amount of benefit is the same, we want to redirect -- we want to direct the interventions

to the people who are doing worst.

We also might want to give priority to the young. I'm working on a project with the government of Thailand now on who can be -- who ought to be saved by kidney dialysis given that they can only cover half of the need for it. And it's terribly tragic, but people who are not going to get dialysis are just going to die.

So the question is, should you say that the people who have not had the chance to live anywhere close to a normal life span, they should be top on the list so that they can get their -- or should we have some notion of equal access that would take dominance over that.

And then I'll just mention one more which is kind of priority to the worst off, interventions that reduce health care disparities seen on a population level. If we have some groups, whether it's the poor, the uneducated, or ethnic groups who, in the aggregate, have much worse health statuses than the rest of the population, you're choosing between two interventions, and you can choose one that would narrow those disparities significantly versus another one that might actually increase them, then what should you do? A classic case of this was the study of the cost effectiveness of hypertension screening in a large city, and what they found was that the need for hypertension screening, because of the incidents of -- the prevalence of hypertension, was among urban blacks in the city core.

But it wasn't cost effective to screen them, because they didn't have doctors, they couldn't afford the drugs, and their lives generally were too chaotic to permit them to engage in the kind of rigorous habit changing, you know, lifestyle changes that would breed hypertension most effectively.

If you really wanted to use your hypertension screen money cost effectively, you'd go out to the suburbs, maybe go to the country club and find some junior executives, you know, and you know, say, can we take some blood pressure readings. You wouldn't find many of them who had a hypertension problem, but every one of the ones who you identified would get it fixed, and that's the cost effective way to use your hypertension screening. Now, to present that is to sort of answer the question, should we pursue cost effectiveness as the model for equitable rationing, and it looks like in this case, since it's so wildly out of kilter with the need to do something about health care disparities, the answer would be no.

So all of this is to say that as we move away from what we might think of as naive, where we allocate according to preference toward one that stresses cost, and then finally cost effectiveness, we also want to move beyond that. We want to move to one that looks at cost effectiveness modified by a whole host of fairness considerations.

And an important intellectual task, I think, in the years ahead is to try to work out what these things are and to figure out what the right

methodology for working this out should be.

Now, before I close, I want to say that actually I don't think that that's the last stop at all. It seems to me that what comes next after that is more important. And I'm going to pick up here on points that I've already heard this morning, but maybe not quite in this guise. If we came to this point, where we thought, okay, we're going to try to control cost, we can't avoid reallocating, although avoid is our word, but, you know, we have to allocate with a mind toward cost control, it's not just painless, and we want to do it in the most ethically defensible way, which means stressing cost effectiveness, but modified by these -- by a rather lengthy list of fairness considerations.

Then something else might occur to you. Putting it this way says that what ethics does, or ethical allocation or rationing does, is to whittle down the list. We start with the stuff we're paying for, for which we think the cost isn't supportable, and we think, what can we not do so we can save some money.

But that's really not the right question, because what we're trying to do is achieve when we allocate in a way that's cost effective and fair, that uses this expanded notion of allocation take takes -- marries cost effectiveness to these other considerations.

What we're trying to achieve is what's overall the most ethically

defensible mix of interventions. And it may be that the problem here is not just that we have some that shouldn't be on the list, of course, there might be a whole lot of services that are not now being provided that should be, and of course, people who should -- who are not now served who should be. And if we think that way, then it might turn out that what this perspective on cost containment instructs us to do is not necessarily cut out this or that high cost, low benefit service that's now being provided, and pocket the money or reallocate the money out of health care, but rather to use it for something like a public tobacco control program or something else that might address people who currently are not well served at all in that way and who don't even identify themselves as patients.

Now, if we did that, then what we might try to do, coming back to Gregg's title for this talk, the tension between, I think it really is a good title, the tension between the stewardship of resources as an obligation and fidelity to patients as an obligation, which I said was an especially wrenching dilemma because the first one is social and the second one is individual, what we might try to do is to understand the fidelity of patients in a more social way, fidelity to populations.

We think of the doctor as a part of a health care team that's trying to make populations healthier. And I think this is in line with some things that Leslie was saying. It's not how we do usually think, but it's -- if we

do approach it in that way, it might redirect us so that we would see the -- that what doctors, and everybody else is pulling the train in health care should be doing, is thinking about how to make the populations that are served as healthy as possible, and this is going to be a mix of interventions with the people who are now being addressed, and, of course, the people who are not.

Now, does this mean that the only way that we could produce an ethically defensible system of cost containment would be within a single pair or even government run health system? It might sound like it from the way I've been talking, but I think the answer is emphatically not. And I want to use as an instance or as a kind of case study something that looks very different from this, the recent proposal by my colleague, Michael Porter, I'm sure many of you know his book, Redefining Health Care.

Now, you don't have to endorse his ideas in that book, and I'm not endorsing any of the ideas in that book, but I think it's interesting for the present discussion in one respect. Porter is Mr. Competition, he wants to increase competition in health care enormously and sees that as the way to bring down cost, also to improve care. And I won't sketch out his elaborate proposal, but basically he's -- the way he understands the task is to find out who's doing the best work, and he thinks that the best work is usually the cheapest work for the unit of benefit. And so you get money by providing

benefits, so it's -- performance done at large.

Now, as I read through Michael's book and heard him speak, I thought, okay, very interesting, not entirely unique, but very interesting. But then he also has a few pages in this book on what he thinks health policy should look like, you know, what kind of coverage people should have, and he says two things which seem to me offer an interesting corollary that he doesn't bring out actually when you marry it to his other proposals.

The first thing is, he thinks that everyone should be covered, and the second thing is, he doesn't think this should be a two class system of care. So three elements, one is competition, private based system, much more than that, private based system, a one class system, and everyone is covered.

Now, think about what this actually would make profits rest on. Let's suppose that, as he insists, that all of the competition is made by regulation to carry their share of unmet burden of -- and to take in the uninsured and the people who have special needs and so on on an equitable basis, and we pull that off, we're going to be in heaven here, but let's suppose that you could do that. Now, the result is this; you probably -- I'm sure most of you have seen the movie, "Sicko," the Michael Moore movie, which let me just say, I didn't like very much, but I want to refer to one image that was the image I think he took from television, he didn't shoot it, of these

vans coming out of one or more hospitals in Los Angeles, I'm not sure I remember which one it was.

They would take poor patients who had come in and they couldn't dump, they would fix them up, stabilize them, maybe even treat them, but there's no discharge, these people were homeless to begin with, so where are they going to put them, and they didn't want to turn it into a convalescent home.

So they just put them in a little van and took them to skid row, and then they had these photographs because of some -- I think some newsmen got this, you know, the door opens in the back and the ramp comes down and someone on a wheelchair comes out and the van drives away, and that's the end of their episode of care with this hospital. Now, if I were a public relations officer at the hospital, I would say, look, you know, in many of these cases we delivered the care that -- we went further than we had to statutorily because we didn't just stabilize them, we actually treated them, but, you know, there was no place to discharge them to, that's why we put them back there.

But I think it was the single most effective image in that film, it makes you think, what the hell kind of country is this. Now, imagine that we adopted something like Porter's plan or any other plan that has those features, what would happen then?

Well, it would turn out that this lowly throw away person, and remember, you know, the health burden is always skewed downward in the socioeconomic pecking board, but that's -- the need is at the bottom.

This lowliest person is -- he is the key to profits for the highest and the mightiest and the wealthiest. They can't get paid unless they get their health statistics up for the group that they're serving, and he's the main problem, he's dragging everybody down.

So they would rush to this skid row, and they'd say, sir, how can we help you, will you cooperate with us, we're not going to make any money unless we make you as healthy as we possibly can, you're the obstacle to profit for us, we have to keep you alive and we have to keep you healthy, and what a wonderful inversion of things that would be. So if we take a more population oriented view, this is my general thesis, if we see things more in the population health terms, and we see that -- we remember the Julian Tudor Hart's wonderfully phrased inverse care law, some of you remember from college physics, the inverse square law which I won't explain right now, but the inverse care law, very simple to state, throughout history and everywhere in the world, the amount of health delivered is inversely proportioned to the need for it, and the very simple reason is that the lower you are down in the pecking order, the more you need health care, and also the fewer resources you have to pay for it, and the care generally goes to

those who can command resources.

Now, if we adopted something like this population focus, even in a hyper competitive privately based system like Porter's, we would essentially be repealing the inverse care law. And if we wanted an ethical approach to cost containment, it seems to me we could do a lot worse than that. Thank you.

MR. CALFEE: Well, thank you. We're going to move on to Bill Sage, who has both an MD and a JD, which I think is a dangerous combination, but I think any advanced degree when combined with a JD is a dangerous combination, even if it's a PhD in economics, it goes along with it. It is no surprise that Bill works on topics like medical malpractice. He's taught at Columbia Law School, he is now at the University of Texas, at Austin, where I gather you have more or less -- you have campus wide appointments, a Vice Provost for Health Affairs, a chair and faculty excellence.

As I understand it, most of the faculty at that very large institution have to keep an eye on you. And you do teaching and research, widely published in the areas, roughly the ones that one would expect, which is health care law, including such related topics as anti-trust; Bill.

MR. SAGE: Thanks, Jack. Now, depending how you read the program, either I stand between you and lunch or between you and the

Congressional Budget Office, so I'll keep it in mind either way. I think we've all complimented Gregg and Leslie on the title for this session, I will add that compliment, I think the social stewardship versus fidelity of patients is a good way of looking at it.

By way of introduction, and my talk is going to be relatively brief, I do want to observe that health care value seems to be in vogue this year. I find this miraculous. My story is, I worked in 1993 in the Clinton White House on health reform then, and then I went back home to California and worked for a very nice woman, Kathleen Brown, Jerry Brown's sister, in a hopeless run for the governorship of California. I was her volunteer health care advisor.

And working with me was a very bright woman who's now a partner at McKenzie Global Consulting, and we came up with this platform for Kathleen around health care, and it was value for money. And we aired it with her political team, who were no dummies, and they laughed us out of the room. They said, nobody thinks of health care as value.

People, especially on the democratic side, want to think about it as access and want to think about it as quality, forget cost, and certainly forget value, because that's just not the image people have.

Well, all the people who are now running for president and for other high offices are, once again, discovering value, and they are no political

dummies, and they're doing it because politics I think has very much changed around this issue as cost has increased. There are significant ambiguities, and that's what this session really focuses on. Value for money sounds good until you think about value to whom and whose money. And neither of those have been flushed out. And I love Leslie's list, which I wrote down, and I hope she makes it the centerpiece of her written product here, which was, think about the problems of individual health, health outcomes for populations, respect, personal economic security, and national economic health, and I think you have a perfect list of the different types of value and the different sources and uses of benefits of money that you could have in the system. And they all apply to the subject that I was assigned for today, which is medical malpractice. So think of those as we go through this topic, as well.

So, you see, my title here is, you know, both symptom and disease, not malpractice and health care costs. We may think of costs as consequence of malpractice exposure. We may think of malpractice exposure as consequence to changes in health care that are constant increasing, as the original cast of Saturday Night Live was wanting to say, it's both a floor wax and a dessert topping. It is both symptom and disease here.

So, you know, here's the -- it's a disease, this is -- it's all the lawyer's fault, you're used to this. Now, you may be surprised that we have a

session on medical malpractice at all in 2008; you wouldn't have been surprised in 2003/2004. This tends to be an episodic issue linked to malpractice insurance crisis. So this is malpractice is the problem, it's all about we're patients, lawyers, it's all about greedy patients, it's all about large numbers of claims, high jury awards, exorbitant insurance premiums, and the like.

And in times of malpractice insurance crisis, when premiums for liability insurance, distinct from health insurance, are high, and when it is hard for doctors to buy coverage, it is very easy to sell this view of malpractice because there is the notion that doctors will quit if something is not done, that something being usually traditional tort reform.

And then you have to account for the persistence of this view in the times that you have not an insurance price, when malpractice insurance is widely available and relatively affordable. And then the theory in this camp tends to be defensive medicine.

It's that malpractice is highly cost increasing, and even when your doctor is not about to quit, you're paying huge numbers of dollars in the aggregate for medical behavior whose primary, if not exclusive purpose is to reduce the likelihood of being sued or being held liable, note, I do not say guilty, I say liable. So that's the top priority view. The opposite view is the tail wagging the dog view associated with a bunch of academics, largely

including, for the most part, myself, you know, I have to in some sense be dragged kicking and screaming to give a presentation on malpractice when the subject is health care cost and there's so many pressing issues of health policy to be considered that I think are more, in many ways, important than malpractice, and it says, look, you know, at the end of the day, not many patients sue, even fewer are awarded compensation.

We have way too many medical errors out there and way too many uncompensated injuries. The process stinks, we know that. The insurance system is lousy. But at the end of the day, add up liability insurance premiums and self-funded reserves, you get one, maybe two percent of national health care spending. Is defensive medical real? Yeah, I think it is, but I can't disentangle it from all the other sources of medical inflation, and that's the tail wagging the dog view.

But then there's a third view which I actually think is nearest the truth. This, for those who, you know, don't get out of the beltway, is Britney Spears and Anna Nicole Smith. Malpractice is an absolutely fascinating issue. Everybody is totally taken with this. We can't drag our eyes away, it's the crash on the side of the road. We just can't take our eyes away from this stuff. At the end of the day, we may know it's not very important, but we still can't take our eyes away from this.

So, you know, a year ago I was talking about malpractices, the

Anna Nicole Smith of the health care system, you know. So David Hyman provided me with this slide last minute, I'm very grateful. In the court of public opinion, you know, you ask people, what are the reasons for rising health care costs, and they tell you about profits of drugs and insurance companies, and malpractice lawsuits, and greed, and waste, and if you ask on the right hand column what people think is the most important source of health care cost, you know, number of malpractice lawsuits hits number two.

And there is not an expert in the country, even ones well paid, who would say this is, you know, truly number two on the list. But that's not my point. My point is not to tell the public the public is wrong. I think a really terrible way of engaging health policy in a democracy is to go around telling the public the public is wrong. You have to work with the perceptions that are out there, because perceptions drive behavior. Perceptions actually do in this area become reality. Physicians have for many generations now been preoccupied with medical malpractice. It's a terrible, very personal threat to their self-esteem and to their reputation.

And the public responds to what they see and what they hear from physicians. And they're not necessarily wrong, this is what they feel and their behavior changes. And defensive medicine is a reflection how physician behavior changes and patients behavior changes, as well.

And my bottom line here, and I'll sort of distill this for you in a

few areas without going into excessive detail, because I would like to leave a little time for discussion, is that the environment by which malpractice is both symptom and disease, by which perceptions of this as a dominant issue become reality as actual behavior changes, creates some inflationary pressures in medicine, I would say particularly around things like diagnostics and imaging for low risk conditions in young people who visit emergency departments or in women who undergo a mammogram, but mainly malpractice just reinforces many characteristics of the health care system that are cost inflationary. And I'll put them into the useful categories for you without trying to go through the detail. When I write this up, I'll include the detail. So the basic exercise is, how do you map the malpractice system onto the various cost drivers in health care. So I divided them into some categories.

Number one, health care delivery factors. You know, when I wrote in the Health Affairs 25th Anniversary book, it was about delivery system reform as being a top priority this go around. It's the delivery system -- that's got to be the mantra and the connection between the delivery system and public health.

So let's start with the delivery system and malpractice. Note, all of the things that we say are cost inflationary about our delivery system, high technology, high prices, incredible variability in practice, fragmentation

of health care delivery, doctors separate from hospitals, doctors separate from other doctors, service side separate from product side, and then the lack of transparency and poor communication all either have manifestations or self-reinforcing manifestations where malpractice liability is concerned.

Many people have written negligence laws. Sort of the underlying legal principals of medical malpractice is about technology, it's about technologic change, changes in public expectation, and responses to the harms that are associated with the technologic successes. And here the basic message is that we have malpractice liability because American medicine at a technological level has been wildly successful. And the price of that success, technologically, not systematically, is malpractice liability.

Variability, think about the notion of a malpractice standard of care. We like to think that this is some very demanding standard applied to doctors and through what physicians often call the retrospective scope, meaning, in hindsight, sometimes it is. But by and large, this is a highly variable and arbitrary standard set by physicians through their expert witness determinations, and it really doesn't demand very much in the statistical sense of performance in the system.

Fragmentation, doctors get their insurance separate from hospitals for liability coverage. Doctors are considered the responsible party even for things they really can't control. Moreover, there is tremendous

suspicion in the liability context of coordinated corporate behavior. Think about the managed care experience, think about any corporate defendant. It is much easier to paint those in conspiracy terms as, you know, something that the courtroom has to defend against the predations of. All of the things in fragmentation of the system that we know are major cost drivers and waste inducers in health care.

Many of them are self-reinforcing with the malpractices, as are issues around communication, which is poor because of fears of liability, and transparency, which is also poor, because the type of scrutiny that malpractice provides is the sort punitive scrutiny that nobody welcomes in their area of expertise.

Demographic factors, other cost drivers, we've heard about the burden of preventable disease, and we should think about the Asian population. The lesson here basically is that malpractice about liability is a distraction from these.

We don't think about these major issues in the malpractice system. Malpractice focuses on salient, acute care events that can be attributed to discreet causes who might be held financially responsible. We are oblivious in this sense to the community basis, the preventable basis, the individual accountability, even the primary care basis of most medical costs in that the liability focus is on the salient, in hospital high dollar event. And

population aging, one of the tragedies of the malpractice system, in my view, is it provides absolutely nothing to people over 65. If you really look at the Medicare population, they have no claims. Their claims do not generate the types of cases, the amounts of damages that attract lawyers to help them.

We looked with Texas data over a decade, of the top 100 judgments and settlements and malpractice cases in Texas, only one of those 100 involved someone over age 65. These people are really shut out of the system.

But these are long term pressures. We don't -- our view of health care that's driven by malpractice really doesn't take account of preventable disease or aging. There's another list of reinforcements that one can derive in terms of health care financing, I'll leave those alone.

I will point out, however, that consumer financial exposure, which I think is really the great growing issue to change the political dynamic, as well as the policy in health care, the financing of personal health care expenditure does play very much into the malpractice system, where, you know, motivations for suit often have to do with the financial dislocations that are consequent to unexpected illness, particularly unexpected illness for which no good explanation has been offered. And in that sense, the early offer programs that a few provider groups and insurers have structured, such as the kopeck program of early offer and early non-release compensation in

Colorado, those are often thought of by doctors as offering a bone to the greedy patient or lawyer. It's not that, it's not if we give you some money for your injury, you'll feel better, it's that by virtue of having been injured, you can't pay the mortgage, or you can't get someone to drive your aunt to the doctor, or you can't do your child care, it's dealing with the consumer financial exposure.

And uninsured noticed that the people who truly don't have access to health care never get the health care that could generate the malpractice liability. And if we think about this as a malpractice system, we just ignore those.

And then there are a host of political factors in terms of how malpractice has divided us between state and federal control, between judicial system control and legislative control, how anything that smacks of a liability component gets into judicial committee jurisdiction and legislatures, which is very distinct in its politics and implications from the health side, and ultimately, malpractice feeds the search for billings. We want to blame those greedy insurance companies, those greedy pharmaceutical companies, those greedy lawyers, or those greedy doctors, or whomever. But when we think about this in the malpractice imagery, it very much feeds our sense that there must be an accountable party.

This is going to be a big challenge as we move into new

models, whether they're new delivery models, new financing models, or new prevention and public health models, we're going to have to deal with it.

And here's what I really want to leave you with; I want to leave you with a concept, and this is borrowed fairly freely from a European scholar of insurance named Francois Ewald, who talks about the insurance imaginary, and talks about insurance as, in some sense, a social construct rather than merely an economic or business phenomenon.

And I think there is truly a malpractice imaginary that has a very significant role in the way we think about our health care system. It is an image of what I call relational dominance, an image of determining everything in our system through the lens of one doctor treating one patient who has a serious medical condition, and I think that is an extraordinarily limited way of viewing the types of value and the types of benefits that society can get from health care. I think it is ultimately a very poor fit for health policy. It doesn't talk about collective value, it doesn't talk about aggregate social or economic productivity. And yet if you take nothing else away from my remarks, I hope you'll take away this notion that the malpractice imaginary has incredible salience and power in the overall debate over health care, regardless of whether you think that malpractice itself is technically important. Thanks.

MR. CALFEE: Thanks, Bill. We do have a schedule, there's a

noon lunch, it's the kind of thing that cannot be pushed around time-wise, and we're scheduled now for a break at 11:45. We have time for a few questions. I had a list of questions I was going to ask in order to really puncture straight to the heart of all the presentations, incredibly insightful questions, all of which I have -- almost all of which I -- so I'm just going to ask basically one question and then we're going to turn it over to the audience.

The item that kept popping up in my mind during Dan's talk, but also the earlier talks was prices versus expenses. I'm sure you all are familiar with the work of Jerry Anderson and others, and he may have been the one that you referred to, I'm not too sure, in which a number of studies have found that when you compare American and European health care expenditures, et cetera, what you tend to find is not that we spend a lot more time in hospitals or see a lot more specialists than they do, but we just pay so much more.

And if you're worried about the allocation of resources, and if you don't have a tremendous amount of faith in the market basis of relative prices in this economy versus out of economy, it makes you wonder whether the resources are being misallocated here as opposed to prices being all screwed up, and I was just wondering what anyone, but especially Dan, think about that?

MR. WIKLER: That's what I meant.

MR. CALFEE: You agree, okay. That was a quick answer. It's nice to have quick answers.

MS. MELTZER: In the interest of time, I was also going to mention that Jerry Anderson and his colleague, Brad Herring, who's here, are going to be speaking in the afternoon on precisely this point, so if you're here this afternoon, you'll be able to get even further answers to Jack's very pointed question.

MR. SAGE: I can make just one comment on the pricing. One of the interesting things is, when you take the physician sector, which makes only about -- accounts for only about ten to 15 percent of health care expenditure, and through the operation of liability precept, you saddle it with accountability for two-thirds or so of health care spending, because as people know, you know, doctors ordering behavior generates roughly about a percentage of aggregate expenditure.

If you ask for a 15 percent party to effectively ensure the adverse consequences of a 70 percent system, you are creating a very large dollar gap in the financial management of liability and injury in the system, and that's one of the price drivers that comes from malpractice.

MR. CALFEE: Got it; I just found out from Gregg, we do have a few extra minutes before we break for lunch, so I want to ask just one more question which will elicit, I hope, quick answers, maybe not always as quick

as Dan's first answer.

But in the discussions about ethical issues and so on, the one thing that I kept wondering about, I guess because I'm an economist, is where the role -- what roles played by individual preferences, willingness to pay, that kind of thing. I mean I keep thinking of people, whether you're talking about anti-psychotics, anti-depressants, back pain, a lot of other things, in which you could have really quite diverse differences in what people want, what they're willing to pay for, and since we have a party private system, I can even imagine situations in which some patients might be willing to pay quite a bit more, they would pay it out of their own pocket, you know, it doesn't necessarily misallocate resources at all, it does raise the issue of disparity -- I was just wondering what you all think about that.

MR. WIKLER: I figure you're looking at me, so -- okay, just say a couple of words. The colonel of my talk was that we should organize our ethical thinking on this issue around the population health focus.

Now, population health focus doesn't ask for a depressed person, how much is that person willing to pay, it's what allocation of resources is going to relieve the burden of depression on this population the most, so it doesn't really have room for that.

But there's no reason why that can't go side by side with a lot of individual variations and what people get that is determined by market

considerations. So if the allocation that came about for population focus was it will do this, but you decide it's, given the resources that are available to you, that the extra benefit you might get by doing something else or something in addition was worth it to you, then, of course, you go for it. So it's not to say population and health focus would have no room for cosmetic surgery, sure you have market for cosmetic surgery, it's just that the allocation is done according to the market.

And so there's kind of a division between the areas of concern here in which a market allocation is perfectly appropriate and the ones that are driven by your considered opinion about what the -- fulfilling your ethical responsibilities toward the population health goal would be.

MR. CALFEE: Bill, did you want to --

MR. SAGE: The question that comes to my mind is that, you know, if you ask about willingness to pay and preference, my question back is always, how do you propose to use the information. And I think there are parts of the health care system that can productively be left, at least for the time being, to the exercise of individual market preferences, backed by individuals own money, for those individuals relatively short term benefit, but that only gets us to some of the system, and a lot of the system, you're talking about using willingness to pay information to then feed back into collective calculations, and I think it really becomes important to know what

universes we're measuring cost and benefits within and what discount rates are being applied.

MR. CALFEE: Very tricky.

MS. MELTZER: And the one thing I wanted to add to that, which I think shaped this slightly differently, is that autonomy has long been the central value of bioethics, that is, most of us who also study population ethics know autonomy is a value of luxury for those who can afford it.

If you don't have the money to be able to make a choice, choice actually isn't relevant in your moral landscape. So to the extent that we're thinking about cost containment, we need to think about how to, in population aggregate terms, actually increase choices for everyone.

MR. CALFEE: Okay. Audience questions, we'll start right there on the aisle, yes.

MS. POPLIN: Hi, my name is Carolyn Poplin, I am also an MD JD, and I practice law, and I practice medicine. My law degree is from Yale also. I wanted to bring up the question of malpractice, because having practiced medicine, general internal medicine for 15 years, I think malpractice is very important in two respects. First of all, there's no question that it drives medical practice because standard of care is what we do. And what we have done up until now is, if an intervention could be beneficial and isn't going to cause much harm, we do it, or at least we recommend it

whether it's paid for or not. And so defensive medicine isn't some sort of marginal thing. I think it's absolutely central to practice, that's on the one hand.

On the other hand, I think there's a tremendous amount of malpractice that goes on every day, things that if they went to court, if you went to court, if there were a bad outcome, any reasonable jury would hold the doctor liable, for example, not looking things up, not checking doses, not checking allergies, it happens all the time, leaving a tertiary care hospital in the charge of inexperienced residents overnight with no staff on hand, that's just insane in this day and age.

And it's very interesting that in the medical literature, these things are called medical errors. What they really are is malpractice, and the malpractice system won't change until these kinds of practices, which doctors think are perfectly normal because that's how things have always been done, but a jury of normal, average citizens who would hear about someone relying on his memory of a lab test instead of looking it up, his memory of the correct treatment without looking it up, they would lose, and we're not going to change our malpractice system to go to health ports or something else.

MR. CALFEE: Okay. Bill, maybe you can answer the question that comes over and over again; why is it that everyone who's ever

looked very carefully at medical practice has concluded that there's a huge amount of undetected and unindicted, unlitigated med mal, why is there so much, why is it --

MR. SAGE: It's the delivery system. I'll leave off the last word. Just to keep this in the context of what we're really talking about, which is national health care costs and national health care reform, understand that we all have in our decision making either a general satisfaction with what we have because we don't use it too often or a general satisfaction, in Garis and Teller terms, because we think we're all above average and we think our care is all above average.

And it's -- we can usually content ourselves with those images, either our insurance is fine because we haven't used it much, or our doctor is great even if doctors as a whole are not so good. We also do orient to the salient technologies which provide wonderful success stories. At the end of the day, we just do not interrogate the overall structure of the system very carefully. And I think the project is a delivery system project. Senator Daschle said it, and I was just hoping that all of you truly heard it. Because a lot of people are saying it, but the people who listen are still in the debate over financing, mandates, budgetary costs, and the like.

And so, you know, I think the malpractice inclusion in this conference should be just to say, take this image that we have and

understand we have the image of the good medicine, the understanding now, thanks to the IOM and others, that there's a lot of bad medicine out there, and it's an invitation to really look at how health care is delivered.

MR. CALFEE: Richard.

SPEAKER: -- at the University of Chicago. I agree with much of what Bill said about most of the -- most of the serious forms of malpractice are kind of dumb errors, at the sort of low level and maintenance, and that's what you ought to target.

What I don't understand is the relationship between the control of error and the centralization of the entire management system. I mean when I heard ex Senator Daschle speak about this problem, it was somehow going to put this into a massive sort of board and essentially have more centralization with respect to the control and the operation.

And for the life of me, we think that the appropriate way in which you're going to have some degree of responsibility would be a separation and a division of the system, competitive operation of various kinds of firms, and yet what I'm hearing from the panel is that when we have this particular problem, we have to go to a mechanism of control, which as best I can tell, doesn't work anywhere particularly well, only works for the Federal Reserve Board in virtue of the fact that it's trying to determine one number every two months, which is the discount rate, as opposed to trying to

determine 500 million thousand different things moving at the same time.

So the question I wanted to ask is, let's suppose that it is the delivery system stupid, I think that was the word you left off, what do we do about the delivery system in order to eliminate the errors? I mean at this point we're long on indictment, but I think we're somewhat short on cures, as least as I understand the problem.

MR. CALFEE: Anyone who has a cure is welcome to --

SPEAKER: First of all, Richard, I completely agree with you. I am troubled by the National Health Board proposals, because it's never clear to me what mission, what powers, and what enforcement. And I think that the one thing we've learned about a trillion dollar system is, you don't change it through a centralized decision making process unless you're very clear on what decision is being made.

And it's interesting to look back over 25 years and say what most changed the delivery of health care in the last 25 years, and I think it was DRG's. And so you say, well, Dana, what was that as a policy leaver, how did it work, how did it happen, and does it -- is there a DRG equivalent perhaps better designed to deal with the public health and prevention side and to deal with the non-acute care side.

So I am very skeptical of the National Health Board proposals. How do you do delivery system reform? It is largely decentralized, guided

very much by the right financial incentives given to the participants in the system. But as I think Senator Daschle and others have said, in my opinion, it's opening up to new forms of practice, including the retail clinic based -- retail store based health clinics, it's considering new work force models, it's looking at community based care in ways we haven't. It's not necessarily medical homes as we all imagine they might be, it's medical homes the way that future generations might actually want to access them, which may be through information tools and other settings and not actually a walk in clinic with a trusted nurse or doctor there.

But this is not an easy project, but I think it's where, you know, going back to Senator Daschle's remarks, it's where the leadership comes in, it's where someone just says, let's keep our eye on the ball, and where we can make progress here, we will.

MR. CALFEE: We've run out of time; is that right? Okay. Ten minutes to 12:00, and lunch is at 12:00. Thank you very much to the panel.

(Recess)

MR. BLOCHE: Okay. We are very privileged to have Peter Orszag with us to speak over lunch. And I was reminded of Peter's talk as I saw these chocolate chip cookies outside. More specifically, Peter reminds -- Peter's talk -- the topic of Peter's talk reminds me that it would be patriotic of me to eat this chocolate chip cookie while Peter makes his remarks so that I

can reduce our likely Medicare liability by buying the farm. It's doctor's speak for passing on by buying the farm at a younger age. So you should all feel free and encouraged and, you know, invited to go back and finish up all these cookies. There are many more where this came from.

Peter Orszag is the seventh Director of the Congressional Budget Office. His term began a bit more than a year ago with the new Congress, in January of 2007. Before joining the CBO, he was here, he was the Joseph A. Pechman Senior Fellow and Director of the Hamilton Project and many other titles at Brookings, too numerous to name.

And back during the Clinton Administration, he served as Special Assistant to the President for Economic Policy, and he was also Senior Economic Advisor at the National Economic Council, and other positions too numerous to name.

Peter is a summa cum laude graduate of Princeton, and also he holds a PhD from the London School of Economics. And he is -- he was something of a boy wonder at Brookings, and now he is the boy wonder of the Congressional Budget Office. He's also the Paul Revere health care spending, warning, making use of the podium he has now at CBO to warn the whole country and certainly warn Congress that, in the words of Henry Aaron, it's health care stupid, it's more than social security, more than the other entitlement issues that the country faces. That's the huge threat to our

budget in the many decades ahead. Peter, thank you very much.

MR. ORSZAG: Thank you for having me. Whenever I receive an introduction that seems disproportionate to what I've actually done, I'm always reminded that my kids refer to CBO as the Congressional Boring Office and that seems to put me properly in my place.

Let me talk to you a bit about health care and the federal budget. And I was able to catch the very end of the previous session, and I think some of the same themes may come up to some degree in my talk.

If you look back over history, the rate at which health care costs have been rising compared to income per capita has averaged something between two and two and a half percentage points per year, and that so called excess cost growth has been a key driver of health care costs, not only in Medicare and Medicaid, but in the rest of the health system also. And, in fact, one of the key themes that you should be able to see pretty quickly even from this table is that the rate at which health care costs grow tend to be at least broadly similar in the different parts of our health system, which is not surprising given that doctors are seeing Medicare and non-Medicare patients, Medicaid and non-Medicaid patients, et cetera, to the extent that practice norms and the flow of technology are similar in different parts of the health system, and one would suspect that they would be.

You tend to get similar cost trends over long periods of time.

And so those who present the underlying cost trouble or cost problems as being, you know, exclusively occurring in the private part of the system or in the public part of the system miss the point that those things are highly correlated and being driven by the same underlying forces.

As you look out over time in the future, it is reasonable to suspect that, in the absence of policy changes, some positive excess cost growth will continue, and a key conclusion from this chart is that the rate at which health care costs grow is the single most important determinant of our nation's physical future. You can infer that from the fact that the same demographic forces that are effecting Medicare and Medicaid also effect social security, and yet the dark blue part of that curve rises much less than the light blue part of the curve. Even the same children who refer to CBO in the manner that I just described can tell from this graph that Medicare and Medicaid are the key drivers to our future.

And furthermore, when you explain it, I think can also understand that there's something different that's happening in those programs than is happening in social security, and that should be a clue that the rate at which health care costs grow is the key factor.

If you then take Medicare and Medicaid and try to isolate the pure effects of demographics on the programs, so take that projection I just showed you in which Medicare and Medicaid spending at the federal level

rises from about four and a half percent of the economy today to about 20 percent of the economy by the end of our 75 year projection window, with various stopping points along the way, like 12 percent of GDP by 2050 and so forth, and ask how much of that is due to an aging population, given how much attention is given to that phenomena in the popular media. So one way of answering that question is to say, let's take health care costs per beneficiary as it is today and then age the, in real terms, age the population so that older beneficiaries cost more than younger beneficiaries and that drives up cost, how much does cost rise as a result. The result is that dark blue part of the curve. And I think you can immediately see that that's a very small contributor to the overall projected increase.

Now, there's an interaction effect. The fact that health care costs per beneficiary is not going to actually stay constant, but rather, will be rising, gets magnified, because in the future, we will have more and older beneficiaries than we do today.

So that interaction effect is the light blue -- or I guess the medium blue part of this curve. And how one should parse that part depends on your sort of philosophical outlook. But even if you attribute that interaction effect to demographics, it is still the case that as you go out over time, the impacts of demographics are significantly smaller than the rate at which health care costs per beneficiary are growing.

It is stunning to me that relative to this curve, the vast majority of the description that continues to be presented to the American public about the nature of our long term physical problem is roughly and adversely proportional to that light blue area relative to the dark blue area. That is to say, the ink spilled about the real, but nonetheless relatively smaller demographic impact relative to cost per beneficiary growth seems to be flipped relative to the underlying facts.

If you combine that spending path with various alternatives on the revenue side, you get the typical result that the nation is on an unsustainable fiscal course, and this just shows you debt as a share of GDP under the projected spending for the programs that I showed you, which, again, are driven primarily by that cost per beneficiary growth, combined with two different assumptions on the revenue side.

I won't go into the details, but suffice it to say under either path, we wind up with an exploding level of government debt compared to GDP, and this will not happen. This will not happen because it can't happen.

Anyone who has any experience in the financial world will immediately recognize that if we actually had debt that was 400 percent of GDP, we might have a little difficulty selling each additional bond at that point, and therefore, this will not occur, but it, nonetheless, illustrates the path that we are on and it will require policy changes in order to prevent it from

occurring. You can collapse things, just to give another metric of the nation's long term fiscal picture, you can collapse that spending path into a present value number and combine it with a present value of revenues and say what is the difference in present value over the next 75 years between projected spending and projected revenue, which gives you what economists call a fiscal gap.

The fiscal gap just measures the size of the change in spending or revenue relative to GDP that would be required today and then required to be maintained over a given period in order to avoid an unsustainable increase in government debt.

If one takes the tax parameters of the tax system as exists today so that the alternative minimum tax does not take over the tax code and the marginal tax rate structure that we have today is perpetuated out over time and combine that with the spending path that I showed you before, you wind up with a fiscal gap over the next 75 years of seven percent, 6.9 percent of GDP. That means that we have to cut spending by seven percent of GDP or raise revenue by seven percent of GDP today and hold it there for the next 75 years to avoid that exploding debt path that I illustrated before. Given that both of those things, spending and revenue, are about 20 percent of GDP, another way of saying that is, we have to cut spending, total spending, by about a third, or raise taxes by about a third in order to avoid

that outcome or some combination thereof.

And for those of you who are saying that that seems, from a political economy perspective, totally implausible, I would just say that illustrates the gap between the size and nature of the nation's long term fiscal imbalance and the policy response that has been forthcoming thus far. I won't go into that.

Let me turn to -- well, okay, fine. So this is just another way of saying that of that fiscal gap, most of it is not due to demographics and aging, this is just another way of making the same point that I made before, with the direct effecting aging and then the interaction effect, the vast majority of that fiscal gap is not explained by population, aging, and demographics.

And again, as a policy community, I think we have spent far too much time analyzing and evaluating that issue and far too little time with the light area of that bar, which has mostly to do with cost per beneficiary growth. And we really need to be tackling that much more aggressively, and that's a lot of what we're doing, or at least trying to do at CBO, and I'll describe that in a little bit more detail. So I typically get to this part of a talk, and as Gregg had said, I'm supposed to depress you more, but I don't actually want to depress you, because despite the fact that we have misdiagnosed the nation's long term fiscal problem, and it's really big, and it's

really complicated because the key variable has this complicated interaction with the rest of the health system, I think there's actually a very exciting and potentially quite large opportunity embedded in that central fiscal challenge to improve efficiency, that is, to reduce cost without harming health outcomes.

And it is striking to me, I have this panel of health advisors, I believe at least one of whom is in the room, and I've asked them, what share of health care costs do you believe could be reduced without harming health outcomes, and the answers range from, well, one or two people said what a stupid question, I'm not going to answer it, but the people who answered it, because I said leave apart political economy constraints, and some people didn't want to play that game, but leaving apart the political economy difficulty of capturing the opportunity, trying to calibrate the size of the opportunity, what share of health care costs do you believe could be reduced without harming health outcomes; the answers ranged from five to 50 percent, with the modal answer being 30, which, by the way, happens to be consistent with some of the information being provided by the Dartmouth folks who are amply represented in the back of the room.

Thirty percent, if we apply it to overall health care spending of 16 percent of GDP, is five percent of GDP. There is not a single academic study that I can think of on all the other topics that we talk about, the distortions from marginal tax rates, the efficiency losses from impeding

international trade, the problems associated with product and labor market restrictions and hiring and firing restrictions, and all the other things that economists tend to bemoan as being problematic from a macro economic perspective, none of those, when you actually look at the academic studies, generates efficiency losses anywhere close to five percent of GDP.

You tend to get like a half a percent of GDP or one percent of GDP or something like that. You don't get five percent of GDP. Or another way of putting this, instead of this being a triangle, this thing is a rectangle. This is much bigger than -- or another way of putting it is, I can't think of another academic, credible academic, and I guess I'll say John Skinner might be a credible academic, credible academic who's willing to say that there might be something anywhere approaching a five percent of GDP efficiency gain in other sectors of the economy that I can identify.

Why is that occurring, how is it occurring, what evidence do we have suggesting that it's occurring? And before I get to all of that, I'd just say, given the size of that opportunity, it remains striking to me that we are doing so little thus far to try to capture it.

And when you start to think about it more and more, it's hard to imagine what else could be more worthwhile in terms of economic performance than trying to capture that opportunity, because it's at the heart of our nation's long term fiscal problem, it's at the heart of the difficulties that

many states are facing because rising Medicaid costs are eating up a larger share of state budgets, and by the way, it also has spill over effects on those very researchers who are doing some of the research, because at the state level, higher Medicaid costs are increasingly crowding out state support for higher education, and the result has been actually for public universities, a very significant decline in spending per student, and salaries for new assistant professors relative to private universities, and I could talk more about that, and it is effecting worker anxiety to a degree that I think is unappreciated.

Most workers, I increasingly think, have absolutely no idea how much take home pay they are foregoing in order to obtain their employer sponsored insurance. And if they knew how much their take home pay was being reduced because of that insurance, and we know that that offset occurs, I think there would be more demands for efficiency in the health system.

So the lack of salience of employer -- in fact, just to pause on that for a second, you hear so much discussion about out of pocket expenses and co-payments and deductibles, a popular discussion of that; out of pocket expenses, something like 15 percent of personal health care spending, employer sponsored insurance is a much more dominant form of financing of health care, and you hear much less about the reduction in take

home pay that is associated with that, even though it's much bigger. And I think it, again, is because of salience, it's not as transparent. And that, by the way, I'm going to continue with this in a second, but that, by the way, I think is also a broader lesson that especially economists need to really underscore, given how much influence economics seems to have over various aspects of public policy.

In area after area, I think, at least with regard to consumer behavior, individual behavior, and provider behavior is different, but with regard to consumer behavior, we have way exaggerated the impact of pure financial incentives and way under appreciated the impact of ease simplicity, default, and salience, and you see that in area after area with opt out 401K's.

The kick you get from automatically enrolling workers and allowing them to opt out rather than having them sign up is far larger, you go from 20 to 30 percent participation rates up to 80 to 90 percent participation rates, even for low income new workers, which are the hardest to enroll, which is far larger than any kick you can get from even providing 100 or 150 percent match or a 200 percent match. There's not a direct financial incentive in the world that can get you that kind of kick. It is striking to me, and I'm not licensed to practice politics, but the vast majority of American households, something like three quarters, pay more in payroll taxes than in

income taxes. I believe you -- I think it's a fairer description of the popular discourse to say there's more discussion about the income tax than the payroll tax, which is not what you'd expect given financial burdens. But, again, I think the payroll tax is less salient than the income tax.

There's evidence now that tolls that you pay on a highway have less impact on behavior if they're collected from the EZ pass than if you pay out of your pocket, which, again, flies in the face of sort of simple economic theory.

And in example after example after example, I think we are learning that that stuff has a bigger effect on behavior than whether the co-insurance rate is 20 percent or 25 percent or the match is 50 or 75 percent and what have you, and that is a perspective that needs to be brought much more to bear on this question.

And on that point, I would just note, before I get to documenting and trying to explore the opportunity, that on this question of how much workers are foregoing in wages for their employer sponsored insurance, I was actually back at Brookings last week and was intrigued, I won't mention their names, but there were three Harvard professors, two economists and one law professor, all of whom are well known, very smart, very knowledgeable. The first Harvard economics professor admitted that he had spent 30 minutes on the Harvard internet trying to find information about

how much Harvard University contributed for his insurance, was only able to obtain what he thought was misleading information, before realizing that he actually wasn't covered by Harvard's plan because he was on his spouse's plan. It gets better.

Harvard professor number two says, oh, don't you understand, Harvard is providing that information on its pay stubs now, you get these paper pay stubs, and it tells you, like many firms are doing, what the employer contribution for your health insurance is as a sort of informational item.

Then the third professor says, yes, but don't you realize we don't get paper pay stubs anymore, they've moved to electronic pay stubs -- electronic payments, that information is not provided, and you have to sign up for the paper pay stub in order to obtain that information.

And then there was a debate about whether that was or was not true. This whole thing went on for about 30 or 40 minutes, and I'm still confused about what information Harvard does or does not provide. But I think that may illustrate the point, that there's not a lot of transparency in terms of foregone wages in exchange for health insurance. And that is one, although I don't think the key, but that's a facilitator of this significant inefficiency in the health system.

So what is this inefficiency in the health system and what's the

best evidence in favor of it? I am increasingly relying on the good people at, what I will correctly refer to as Dartmouth College, and the work that they do on regional variation.

In fact, I use the regional variation map so much that we decided we were no longer willing or it was not fair to continue to ask the Dartmouth folks to make the maps for us, so we now have the IT infrastructure at CBO to make our own maps, which is a really big advance.

And this reflects CBO's map based on the work that the Dartmouth Group has done with Medicare data. I'm sure it's nothing new to anyone in this room, but I am struck that when I walk around Washington and I walk around with this map, it's still the case that people find it exceedingly intriguing, unless they've been to my talks five times, in which case they're bored. As you all know, there's very significant variation across parts of the United States for reasons that really cannot be explained based on the underlying characteristics of the regions or of the patients involved. I note a few things, maybe this is a little more information content provided. CBO recent did an analysis, which I forgot whether it's in here, no, on regional variation.

It is striking that the variation in Medicare spending has decline quite substantially over time, which, frankly, I was surprised by, mostly because of reduction in hospital costs, which itself may be tied to changes in

the payment system that has been adopted for part A of Medicare.

The regional variation in Medicare is now about the same as it is in the rest of the health care system, so basically Medicare has been coming down, the total has been constant, and they're now about the same, whereas two decades ago, Medicare was substantially higher than other parts of the health system.

The regional variation in the United States, perhaps not surprisingly, is higher than in Canada or in the United Kingdom. But surprisingly, the regional variation in Medicare is not higher than it is in the VA system, and one might have thought that that was the case. So we're doing a lot more work on this variation. As you all know, the variation, at least on average, is not associated with improvements in health outcomes. There is one study suggesting that, with regard to emergency room visits across different parts of Florida, there might be some evidence that the higher spending regions generate better health outcomes for emergency room visits than the lower spending regions. But there have been questions raised about that paper.

In any case, it may turn out that these results, which are obtained on average, don't hold in each and every type of medical care delivery system, and there are reasons to suspect that emergency rooms may be one of those things, possibly, again, I think the jury is out, where the

higher spending regions do better, I don't know. But I'll just mention that that's the one counter example in terms of this, if anything, inverse relationship between spending and quality.

The variation often occurs more dramatically in those areas where it's less clear what should happen, like in imaging and diagnostic tests. So if you're on the vertical line here, there's no variation, and that map would all be the same color. If you're off the vertical line, there's more variation, and the color differences would be more dramatic. The speed and intensity with which new technologies are adopted in settings where we don't actually know that they work better than other things is, in my view, one of the key determinants or factors that effect this regional variation and that open up the opportunity for improvements in health outcomes while reducing costs.

It is also striking, people like to say, and both glib and deep at the same point, that the darker blue areas of the country disproportionate have the nation's leading medical centers, which is true, and those provide the best medical care in the world.

But it's also true that, if you look across our nation's leading medical centers, there are very substantial differences that can't be explained by quality differences or that generate better health quality indicators across them. If you compare UCA Medical and the Mayo Clinic,

you see that, if anything, quality is higher at the Mayo Clinic, costs are $50,000 per beneficiary, for Medicare beneficiaries in the last six months of life at UCA Medical, $26,000 at the Mayo Clinic.

At UCSF, Mass General, and a few other places, they're more in the $40,000 range. But there is a very substantial variation even in our top medical centers that don't seem to translate into improvements in health outcomes. Elliott Fisher likes to say, how can the best medical care in the world cost twice as much as the best medical care in the world, and what I find striking is that we tax payers are paying for this. We are paying for that $50,000 care relative to the $26,000 care, and we really don't know what we're getting in exchange for it.

And when you stop and start to think about that more and more, I think it raises some very deep questions about why that persists and what can be done about it.

Let me pause and say what I think might help, and there are obviously lots of things that need to be tried and evaluated. I would also say, before I get to that, the typical framing of the nation's long term fiscal problem reflects a full set of options that are consistent with the world in like social security space, so -- where you have a menu of options, and the typical framing of the nature of the nation's long term fiscal problem is, it's one generation versus the other, and the way we need to get to policy enactment

is to lock policy makers in the room, don't give them any food, not let them out until they've reached agreement. And that actually might be an insightful way of looking at the demographic piece. I don't think it's that insightful with regard to this stuff, because, frankly, we just don't have enough information yet to be making precise policy suggestions or recommendations or options. I think there are sort of thematic things and there are -- there's infrastructure building that we can do, but in terms of making -- or another way of putting it, we don't have a -- I've never seen a plan, if anyone has it in the room, let me know, a plan to restore long term balance to Medicare and Medicaid that has been scored by credible sources as succeeding in that objective.

And in the absence of that, you can lock the policy makers in the room, but I don't know what they're going to talk about. We have not done enough to try to fill out the options on what might help bend the curve.

So let me just give you four buckets of things that might help narrow this variation and improve the efficiency of the health care system. The first is clearly more information.

We do far too little testing on what works and what doesn't, and the value of various different kinds of interventions compared to other things, and that has to be the basis for many other things that people are talking about. If you favor consumer directed health approaches, consumers need that information. If you favor a single payer, this all knowing single

payer is going to need that information. If you favor something in between, then a combination of insurance firms, Medicare, and Medicaid, employers, workers, state governments, what have you, are going to need the information. Any way you cut it, I don't see how you can be improving the efficiency of the health system without knowing what works better than what doesn't.

The second -- and by the way, as part of that, the medical profession is going to, I think out of necessity, there's an irony, out of necessity, rely more on panel data econometrics, perhaps based, one would hope, on a broader array of electronic health records and a health information technology backbone, than it does on randomized control trials, because it is implausible to me that you're going to be able to conduct all of the kinds of studies that are required in any cost effective and timely way based on randomized control trials, and the resistance that you feel among medical professionals for that is going to be a key question in terms of the degree to which any expanded comparative effectiveness or information effort translates into improved medical practice. I find that ironic because the economics profession, after struggling with the imperfections, which are real, a panel of data econometrics for decades, is yearning and undertaking more randomized trials, exactly the opposite of what I think has to happen in the medical profession, but I think that's something that has not been discussed

enough, and, in fact, it may turn out that the biggest return to health information technology is not, in fact, I'm increasingly convinced of this, is not the internal efficiencies that some studies from RAND and others have suggested, which, by the way, we have some questions about, but rather, by providing a more comprehensive data base that could be used as part of an increased effort, however organized, to study what works and what doesn't, so that's the first bucket.

The second bucket is incentives. To a first approximation in health care, I believe we get what we provide financial incentives for providers to provide. So we have strong financial incentives for high end technology, we get a lot of that. We don't have strong financial incentives for the provision of preventative medicine, we don't get a lot of that. The incentives right now are for more care rather than better care, and that facilitates this variation in health care spending, because in the more interventionist areas of the country, the more interventionist approaches get financed and accommodated, even though we're not sure that they're actually generating any improvements in health outcomes. And, indeed, if you wanted to pay for better care rather than more care, you need to know what the better care is. That brings us back to the need for that first bucket.

The third bucket involves delivery systems, and I heard a little bit about -- I heard a little tail end of the discussion, and I think there are

questions about, even if you had better information and changes in incentives, whether there are additional structural changes, whether it's -- well, I won't go into all the details, but exactly how care is delivered, and I think there's some debate about whether, if you just got the information and incentives right, the delivery system would take care of itself, or whether there are additional steps that are required in terms of sort of direct operation on the delivery system.

And then the fourth bucket, in my mind, involves behavior, health behavior, and also the behavior of the doctors. And this is where a lot of the behavioral economics I think comes in. Not only with regard to improving health outcomes, which, of course, our behavior, our eating and diet, and other aspects, probably have a larger effect on health outcomes than the health care system does, and we're doing far too little to apply the insights of how people actually make decisions to improve health outcomes.

One of my favorite examples, by the way, this is just on the side and I'll come back to this bucket, favorite examples involves our eating behavior, which, you know, in perfectly rational space involves the enjoyment we get out of the food, or how hungry we are, the caloric needs. I think a lot of people who do research in the field have a much different perspective, that basically how much we eat depends on how the food is presented to us and kind of other framing things.

I had recently read this book, Mindless Eating, and I note the author of that book is now a consultant to USDA; my favorite example from the book involved putting people in a room like this, putting a movie up on the screen, and serving them stale popcorn, or I believe the technical term is aged popcorn, where you age it for two or three days. So this is totally disgusting popcorn, nothing that anyone would ever want to eat. And it turns out, if you put people in front of a movie theater and you give them free buckets of stale popcorn, the people given larger buckets of stale popcorn will eat more of it than the people given smaller buckets of stale popcorn, even though no one would ever want to eat this stuff in the first place. And my favorite part of the story was then, of course, the popcorn was free. One of the guys walks out after the movie is done, goes up to the concession stand and says, hey, this popcorn was stale, can I get my money back.

In any case, that's obviously a kind of superficial and glib example. But the point is, if you put the fruit at the beginning of the cafeteria line instead of at the end, fruit consumption goes way up. There are all sorts of behavioral things that we are not doing that effect exercise and diet that could help people do what they say they want to do, which is lead healthier lives, but that are not happening.

On the doctor's side, and here's where I want to wrap in medical malpractice, a lot of this variation seems to be driven by social

norms among medical professionals, that in some areas of the country, this is what we do, you come back and you visit me four times a month after your surgery instead of twice a month because that's the way it works around here. I suspect that medical -- either the perception or reality of the existence of medical malpractice helps to strengthen those social norms, that is to say, I'm more likely to do what the guy down the hall is doing if I'm worried about being sued. And the variation and the strength of the medical malpractice system may not have that big an effect on its impact on the social norm. That is, a slightly stricter medical malpractice system in state A versus state B might not map directly onto the strength of that social norm, in which case you simultaneously could have the perception of medical malpractice reinforcing social norms and causing this significant regional variation, which is a form of inefficiency in the health system, and not be able to detect any significant impact on the variation from medical malpractice stringency across states or areas on health care costs or other variables.

So that's the way most studies have tried to look at it. They look at variations in medical malpractice stringency across, you know, this area versus area. It may not be that small changes in the stringency of the medical malpractice system are the primary channel through which it effects behavior, it may just be the existence of it reinforces social norms. And by

the way, if we had more comparative effect on this research and however organize the Institute of Medicine or whatever, the Dartmouth Group, whomever, saying in this kind of -- given these kinds of conditions, here's the recommended best practice guidelines, that may actually provide a safe harbor against medical malpractice liability.

It may be more likely a doctor will follow that rather than following what the person down the hall is doing as a sort of protection against liability, in which case, the accumulation and adoption of more information and best practice guidelines may have a larger effect on behavior than one would think. But in any case, obviously, behavior both on the patient side and the consumer side matters a lot.

I'm going to close with two other thoughts; first, just to make sure everyone in the room knew, CBO is very significantly expanding its already excellent resources on health care. We have already moved -- we're an institution of 235 FTE's, we've already moved from 30 working on health care to, including the people who are coming on board, more than 45, which is actually a very significant move in about a year. We're putting out more reports and we're going to continue doing so. By the end of this year or early next year, we will have a report that we're calling Critical Topics in Health Reform, in which a CBO view on the literature and the possible budgetary and quality and coverage and other impacts of all the things that people in

rooms like this tend to talk about, care coordination, disease management, health, IT, what have you, will also be published, and that's actually a massive internal effort that's consuming a lot of our staff time and my time, but that I hope will inform the policy debate, so there's a lot going on there.

And then the final thought I want to leave with you before taking questions is that I think an aspect of our demographics that has gone relatively unremarked upon and that is quite striking once you start to look into it, involves a different dimension of inequality than income inequality.

There's been increasing recognition that income inequality has risen significantly in the United States. There's been very little recognition that life expectancy inequality has risen very substantially in the United States and in Continental Europe and in Japan and other areas. I think a lot of people know that life expectancy is going up. A few people or many people know that higher educated, higher income people tend to live longer than less educated, lower income people. I think few people know that that gap has been rising very rapidly over the past couple decades. And what I do to try to calibrate this for you is to take a recent study and show you, for example, at age 65, the increase in average life expectancy, which is the light blue bar, and increase in that gap between high socioeconomic status and low socioeconomic status that are people.

And what you can see is that the increase in the gap is almost

as large as the increase in average life expectancy over the -- between 1980 and 2000. And I have reason to suspect, no one knows, but there are reasons to suspect this may continue in the future.

And I don't think that we have fully appreciated all of the consequences, both in terms of the federal budget, where this differential life expectancy means that Medicare and Social Security are becoming less progressive on a lifetime basis, because high income beneficiaries are increasingly living longer than everyone else; nor have we fully appreciated the potential social consequences that could follow from even more dramatic differences in life expectancy opening up in the future. And so it's just something that I think people need to start paying more attention to given how dramatic the magnitudes are. With that, thank you very much, and I would be pleased to take questions. Are we doing the microphone? We're doing the microphone, all right.

MR. BLOCHE: In your talk, you showed 25 and 50 and 75 year windows, and then you talked about four things that could effect costs in the long term. One of my concerns about the conversation about health reform right now is that your budget window is actually five years and ten years, and whether there isn't some rational exuberance about the effect of cost saving measures, even those four that you mentioned, in that five and ten year window.

And so, first of all, do you think that's true, that those four things that you mentioned actually might not result in the large savings in five to ten years that is going to pay for the coverage, because that seems to be what some folks are saying? And that's really the primary question.

MR. ORSZAG: I think there are lots of things that could help bend the curve over the long term that don't generate significant cost savings over five or ten years, and, in fact, if anything, cost money over five or ten years. I would note I'm often blamed for the five and ten year window, that was not my choice, that's the Congress' choice, and, in fact, many members of Congress blame me for their choice, but that's my job. And I want to say a little bit more about the scoring process, because part of my job involves explaining it and also trying to explain why it is that things that people think will save money over those windows don't.

There has been a perception, which I think is unwarranted, that CBO is kind of biased against showing any savings whatsoever ever. And I want to say, where the evidence is clear that there is a channel and evidence in favor of cost savings from a policy intervention, we score that, and we will score that.

So let me just be very clear, I am not biased against savings, and I think actually one of the reasons we're putting more resources into the health area is to expand the list of options that policy makers have before

them that would actually save money, not only in Medicare and Medicaid, but in the overall health system.

But often the evidence for savings for things that people believe in are not really there. Disease management might be a good example, where if the buzz in the air is often for exceptionally large savings, and the story line is that beneficiaries with chronic diseases account for a very large share of cost, which is right, and I have, you know, we have the data for that, and that disease management programs can cost effectively reduce those costs, that's where you get into a little bit of trouble.

Of course, it then gets a little bit more nuance, can disease management programs for people with congestive heart failure, if screened appropriately and done in this particular way, can those reduce cost, and it gets a little bit, you know, you can perhaps open up some targeted opportunities where there's evidence for a reduction of cost, but in many cases, the evidence backing up the buzz is not there, that's the first thing.

The second thing, even where there is evidence backing it up, often the savings occur, you know, in year 15 or year 20, far outside the budget window, and that's just the way it is. We're trying to do more in terms of providing information, that if something costs money up front, but holds the potential to reduce cost over time, that it's reflected.

And then finally, there are often cases where something is a

good idea or has significant social benefit, but the cost implications go in other directions. So whether something is justifiable or something is beneficial is not the same thing as whether it has the following impact on cost. And the example that was raised earlier about Gregg inflating himself in order to die earlier provides an example of that, or I'll give you another example.

We recently scored some tobacco legislation which would have many effects, one of which was to save some money because especially a reduction in teen smoking among pregnant teens can help to reduce low weight births, and that can help to reduce Medicaid costs, but on the other hand, it also increases the number of successful live deliveries, and that can, even if it's a good thing, can increase cost.

And then you have other effects on whether people later in life are smoking and dying earlier or later. So often the sort of welfare implications or the social implications are not exactly aligned with cost, and people often confuse that and they get mad at me because something that they like costs money, and that may often be the case.

SPEAKER: It's always troubled me that we project Medicare and Social Security at 75 years; do we project defense out 75 years? And if we would have tried in 1932 to project health care costs today, how accurate would we have been? And is this really a useful way to talk about the politics

and what we should be doing now? I guess a parallel question to that is, the health care sector, unlike most other sectors of the economy, the vast majority of the money stays in the United States and goes to pay for -- I mean it's the --

MR. ORSZAG: It wasn't about your question.

SPEAKER: It's one of the fastest growth in terms of job producing in the Unites States in the health care sector, and so do we think both about the positive and the negative effects of increased spending, however much it's going to be over the next 15, 25, 75 years?

MR. ORSZAG: All right. So let me break that down into a couple of pieces. First, we project defense and other spending, that's the other, but it's a simplistic projection mechanism, which I would say even a lot of these things, the projection methodologies by necessity -- we exclude debt services because that follows mechanically from everything else, and we have numbers embodied in the actual document that shows you those numbers.

Paul Volcker once said, pick a number or a date, but never both, and unfortunately, I don't have the luxury of doing that, so the budget process is based on five and ten year budget projections, and so we have to provide some clarity about, or pick a point estimate. In many cases, we try to provide a lot of information about the uncertainty surrounding those

projections, and there clearly is a lot of uncertainty even over a ten year window.

What I would say is, I wouldn't pick -- I don't take, you know, these projections so seriously that I would stake my life on the projection being right, plus or minus X in, you know, 2040, both because of the underlying uncertainty, and also because these assume unchanged federal policy, and that's not going to happen. In reality, policy is going to change, one way or the other, it's going to change. And so the basis upon which these projections are made will not turn out to be reality, and we acknowledge that.

All of that hasn't been said. The question becomes, does it help to illustrate the kind of basic magnitude of the problems that we face, and that's where I might differ with you a little bit.

Whether this is, you know, ultimately 20 percent of GDP for Medicare and Medicaid, or 15, or 12, I don't think matters as much as we are on a rapidly rising path, and that, in the absence of policy changes, that I'm fairly confident about. And in terms of signaling -- it's why I'm a little bit nervous, I don't really like walking around, and some people, other people use dramatic numbers that involve, you know, I won't even go into the details, but, you know, $50 trillion in fiscal gaps and what have you, I don't think that the political economy addressing this problem involves a failure to

make the numbers seem as big as they might be.

I don't think that that's the key impediment to action here. And so if the concern is that there's sort of a false precision, my interpretation of what we're trying to do is just provide a kind of -- some best guess that we can, indicator, that we've got a problem coming, and I firmly believe that.

On the political economy of it, and then I'll get to the rest of your question in a second, on the political economy of it, this is another area where I think we've, frankly, gotten the political economy of the nation's long term fiscal problem wrong. We framed it wrong and we've misunderstood it because we're framing it and describing it in terms of the dark blue area.

The key political economy problem that we face I think is two-fold. The first is that -- well, three-fold actually. The first is that the political system, which is not the political system's fault, it's our fault, but the political system does not deal well with gradual long term problems. And I think that it's caused by the -- what has been referred to as the M&M problem.

Each individual M&M is like two or three calories or whatever it is, and so you eat one of them and you say, oh, it's only an extra three calories, who cares, and then you eat another one, and so on and so on, and pretty soon you've eaten 400 calories worth of M&M's because each individual decision is rational from its own perspective.

The same thing here, I cannot tell you that failing to address

this problem this year versus next year is going to cause the whole system to collapse. In all likelihood and very high probability, it won't. But you repeat that same calculus year after year after year and you slide through a inertia into not addressing something that ultimately does become a problem.

I also think that trying to create a false sense of crisis, which arguably has been an approach adopted in other policy arenas in the past, doesn't seem to work. So that's a key impediment, and I don't have a solution to that, and I think that happens not just on the nation's long term fiscal problem and on health care, climate change, anything that's a gradual long term problem has this key political economy difficulty embedded in it, so that's the first problem.

The second problem is that, unlike in social security, where the options are kind of fully laid out, and in some sense, it's simpler because it's a simple cash transfer program basically, so it's not too hard to figure out the options, here, as I think -- I hope to give some sense of -- the options are a lot more complicated, and we don't have them all fully delineated yet.

And then the final problem, which is kind of related, is that in health care, income for, or sorry, cost for beneficiary, which is the way we're framing this, is income for providers.

And in some sense, that final thing may be the ultimate political economy challenge, because, you know, people talk about comparative

effectiveness research, some people in the budget world have gotten concerned that somehow I am making it seem like it's this kind of magic bullet that's painless, and therefore, it makes them nervous, like there can't be anything painless. Make no mistake about it, I mean actually doing comparative effectiveness research, reaching conclusions based on that research, and then tying financial incentives to that, that is not a painless approach. And anyone who's lived in the health system will know that. And, in fact, I think a key question becomes, how do you design a set of institutions or entities that are undertaking this kind of thing to withstand the political pressure, which will be severe, once it's actually making any judgments or conclusions about anything that's consequential.

So a lot of the kind of political economy of the nation's long term fiscal problem I think has not been -- it's sort of orthogonal, it's not addressing effectively the key issue, and just ramping people up about the size of the problem we face I don't think is going to be as auspicious.

As, for example, correctly pointing out that you're giving up, you know, whatever the number is, five, six, whatever it is, $5,000 in take home pay for your employer sponsored insurance, and we could probably be providing that a lot more efficiently, or do you realize that you're paying $50,000 a year per beneficiary at UCA Medical versus $26,000, and we actually don't know what we're getting in exchange for it. Those are today,

those are not things out in the future, that's today. I guess your final thing was about jobs and economic growth involved in the healthy system, and I guess I'm just going to defer that and come back to it if -- because I saw lots of hands that were up, if that's okay.

MR. EPSTEIN: Yeah, thank you, Richard Epstein again. This is a very simple question. You've persuaded me that the political gridlock is really quite difficult, but I haven't heard you address is, and I don't know if it's within your peculiar jurisdiction, if you had to name one or two key --

MR. ORSZAG: Well put.

MR. EPSTEIN: What?

MR. ORSZAG: Well put.

MR. EPSTEIN: Well, you know, it seems as though that's the dominant constraint on this. But I mean I'm going to ask the Lennon question, which is what is to be done, and in view, looking at the excess cost growth as being the key feature, how would you try to address that? Because I was trying to listen, but I didn't hear any particular suggestions. I have some of my own, but -- aren't very popular in Washington, so I'm wonder exactly what your proposals would be.

MR. ORSZAG: Well, I'm not allowed to have proposals, so let me give you kind of things that might be useful to do.

MR. EPSTEIN: I asked -- I had the right intuition, unfortunately

I had the wrong answer.

MR. ORSZAG: You did have the right intuition. But here's what I think, I think that we are not yet, as I said before, in a position to actually, if you closed the doors for policy makers and asked them to like come up with some plan that would credibly, significantly reduce costs over a significant period of time, there's some things, there's some tools in that tool kit.

But mostly what would be productive to be doing in the meanwhile, while there are larger debates swirling about the direction of our health system, is to be building the infrastructure that would better inform those choices, and we can be doing a lot of that now.

So that involves a significantly expanded comparative effectiveness research effort, that involves building out the HIT backbone, mostly so that it can feed information to that thing, it involves significantly improving the demo projects that occur in Medicare, because a lot of those projects are not designed optimally, mostly, frankly, because of statutory restrictions that CMS faces in terms of actually teaching us anything, it involves using a lot more registries on measuring what works and what doesn't, it means more aggressively moving to the kind of coverage with evidence development that is occurring in very narrow perspectives. So I think there's a lot of kind of experimentation that could be done ahead of the

hard choices that will have to be made, in part because I'm not fully confident, I think this is the purpose of that critical topics in health reform volume that I mentioned that will be out later this year.

To kind of try to say, okay, what do we actually know about different things, and what could you be more confident about doing now, in many cases, on many of the key topics, I do think building the infrastructure out is a key step so that in two, five, six, however many years it will take, we're in a much better position to make those decisions.

I know it's not a fully satisfying answer, but it -- I understand that, but that partially reflects, frankly, how little of this we have done. And so, yes, we had to have started this all yesterday, but you're caught in the situation we didn't, so what do you do now? Okay. One more, last question. Or actually, you know what, let's do two collective together and then I'll answer them both at the same time, there and there.

SPEAKER: Hi; all morning people have been talking about cost. I was wondering if you're also looking at price. Price in medicine is not always the same as cost. It would be, if the markets were all efficient, but, in fact, the markets are very peculiar for doctor services, for imaging, for procedures, for equipment, so that's my question.

MR. ORSZAG: Okay.

SPEAKER: We've been talking about cost all day, and we

have the title of the conference, Medical Cost Catastrophe and so forth; how would you answer economists who have published in good economics journals, who have said, look, we're spending X amount of money on cardiovascular disease, but look at the Y, the result of that cardiovascular sums of money on better health, better outcomes, greater longevity, better quality of care who receive that cardiovascular disease; how do you answer those questions about those who point to the benefits of the health care system?

MR. ORSZAG: Okay.

SPEAKER: And I think the articles have mostly been concerned with cardiovascular disease, so I'm talking about David Cutler.

MR. ORSZAG: Yeah, I know who you're talking about. So first, we have examined price variation and the effect of prices on both overall health care spending and what have you. I would -- and I will refer you to a variety of reports that we've put out.

I would say that while -- two things, one is obviously measuring prices in health care, especially on equality -- is really hard to do, and secondly, that the imperfect information that we do have suggests that most of the cost variation and most of the cost growth is due to intensity of services and not the price thereof, even though, in terms of levels, there might be an impact.

With regard to Professor Cutler, I will reveal, because I don't think he would mind, that one of the people who was nearer the 50 percent range of that response on my panel of health advisors, upon which Mr. Cutler serves, is Mr. Cutler himself, which is to say, I think it is simultaneously the case that, on average, health care spending is to help to improve health outcomes, but that lots of health care -- so think of innovation A, I'm not even going to -- because every time I mention the specific technology, I always get the company or the vice -- so it's a widget that improves health. The widget gets invented, it improves health, on average, and then it spreads across the country into lots of low value or even negative value settings in which the cost increase is not associated with an improvement in health.

If you had that kind of phenomena, you would simultaneously say, health care spending, on average, produces significant health benefits, and there's a lot of health care spending, all that low value, negative value diffusion, that could be eliminated without harming health outcomes.

And the trick becomes, how do you change incentives so that we continue to have innovation that improves health outcomes on average while getting a lot more efficiency out of it, and I think as long as we have incentives for more care, we're going to have lots of innovation that then diffuses in a way that is not high value, and we're going to be spending a lot of money that need not be spend, and we're going to wind up with the five

percent of GDP opportunity that I'm going to attribute to Mr. Skinner in the back of the room. And with that, I want to thank you, and I appreciate my time with you.

MR. BLOCHE: We're now going to proceed to our two afternoon panels. There will be a 15 minute break between the panel that's coming up and the final panel of the afternoon. And our moderator for this panel will be yet another Brookings wunderkind, the second boy wonder of the -- the second consecutive boy wonder, the current Director of the Hamilton Project, Jason Furman, who also holds a PhD in economics from Harvard University, and is also a visiting scholar at NYU's Wagner School of Public Service.

He's done research in a wide range of domestic economic policy areas, including health economics and social security. But I also discovered, here's a secret about Jason Furman, that if you are -- if, instead of following the old fashioned kind of March madness involving college basketball players, you follow the new form, delegate counting, that Jason is the math whiz behind the Slate magazine delegate counting tool. And so he's a man of many capabilities. And I'm going to leave it to Jason to introduce the other panelists for this second panel.

MR. FURMAN: Thank you, Gregg, for that incredibly kind introduction, and there's an even more elaborate delegate counter I have

upstairs, but it doesn't tell me who's going to win. I'll just briefly introduce everyone, and then they'll all start presenting, and you're going to hear an enormous range and diversity of perspective about what's wrong with our health system and what to do about it, grounded to some degree in different disciplines of some of the folks we have up here, as well as different places they're coming from in their analysis.

And we'll start with Bradley Herring, who's an Assistant Professor at Johns Hopkins Bloomberg School of Public Health, and went there from the Council of Economic Advisors, where he worked last year on the president's Health Tax Proposal.

Then we'll have Jonathan Skinner, who's the author of a lot of the work that you've seen Peter Orszag just present, and he's the John Sloan Dickey third century Chair of Economics and Professor on the Department of Family and Community Medicine at Dartmouth University.

Then Dana Goldman, who's the Chair and Director of Health Economics, Finance, an organization at RAND. And finally you'll hear the presentation by Richard Epstein, who's a James Parker Hall distinguished service Professor of Law at the University of Chicago. But then I believe your division of labor is that all the difficult questions are going to be answered by David Hyman, who is a Professor of Law and Director of the Epstein Program in Health, Law, and Policy at the University of Illinois, and

author of the most colorfully titled book I've ever read, *Medicare Meets Mephistopheles*.

MR. HERRING: Bear with me for a second. Okay. So first off, thanks a lot for having me, I'm really pleased to be here. Jerry Anderson is the co-author on this paper, as is Calypso Chokado. Jerry sends his regards from Costa Rica, so although I'm sure he'd love to be here, I'm sure he's also having a pretty good time.

Calypso is with us at Hopkins for about a year or so, but her primary job is with NICE over in the UK, and so this is some work we've done that tries to do the following; and in essence, I think we get to the heart of your question about prices.

But what I'll first do is give some international comparisons, and then from there, transition to thinking about quantity versus prices, examine some initiatives to control quality, initiatives to control prices, focusing on differences between competition and regulation, and finally just throw out a couple of policy options if you were so inclined to try and really address high prices. So first off, international comparisons, looking at spending in the U.S. relative to other OECD countries, we spend about twice as much as the median OECD country. If you account for income differences, it's probably more like 50 percent. And then moreover, the rates in growth in spending in the U.S. are a little higher, especially more recently,

than these other countries.

If you use the same OECD data to look at differences between quantities of services and prices of service, I think you come to the conclusion that it's largely differences in prices.

So, for instance, on the hospital side, the number of beds, the number of days are similar between the U.S. and other countries, the number of physicians per capita are similar, drug utilization is a little higher in the U.S., but it's comparable, whereas if, instead, you look at prices in the U.S., significantly higher for hospitals, physicians, and drugs.

And so here's a slide we got from the folks at CMS, Office of the Actuary, that essentially tries to decompose increases in spending over time between price and utilization. And so the first thing I'll say is, this is brought with all sorts of assumptions and uncertainty, and then there's also a really important technical question, how do you really address changes in service intensity. You can tell stories about how there's a change in the price, you can tell a story about how it's changes in quantity. But taking this data as given, the same result that you get from making these international comparisons that it's largely price that's driving these differences, if you look at changes over time within the U.S., it seems to be prices, the purple portion, as opposed to utilization, the yellow portion, okay.

So in our paper, we first kind of start off by talking about some

of these initiatives to control quantity, and for the most part, somewhat more successful than those on prices. The starting point is to think about this underlying geographic variation and thinking about supplier induced demand.

One thing that we tried to do with this work is really focus on how insurance mechanisms, whether it's private or public, influence these quantities and prices. And so, in large part, while we don't generally have a really good idea of what drives these geographic variations, I won't try and convince you that it's geographic variation and insurance coverage that's drawing that, because I don't believe that, but I certainly believe that insurance is a strong catalyst for creating whatever it is that's causing these geographic variations. I feel pretty confident that insurance has something to do with it, like I said, it's a catalyst. So if you look at past incentives, to control quantity, cost sharing, you know, RAND health insurance experiments, consumer directed health care seems to have, you know, success in limiting utilization. There's certainly a limit to the extent that you can do that, because as people pass their deductible, they're in a range where they're no longer cost sensitive.

Managed care seemed to have a pretty good effect on reducing utilization through utilization review, gate keeper models, but we all hated that. And then shifts to out-patient settings, I think most notably in mental health, seem to have done good jobs to control quantity.

And then finally, if you look at trends in volume over time within the U.S., number of visits, for instance, physician visits over time, has been pretty steady. But, in contrast, the number of prescriptions has increased I think from around like seven or so in 1996 to about ten per year more recently.

So this kind of leads us, well, perhaps the main emphasis really here should be on trying to control prices. The first thing to note is that in a perfect world, these prices would be real transparent. One difficulty here is that being sensitive to prices really is going to occur more in a non-urgent setting than in an emergent setting. Another thing to think about is, well, it's kind of easy for me to think about prices when I shop for cars, but it's a lot more difficult when I'm thinking about, you know, medical services.

So generally, when I get a hospital bill, I see, you know, an itemized list of the ten to 15 things that were included, and, you know, it maybe not be that helpful to me to know all this stuff up front.

So, again, so this section on prices really, we try and think about, on one end of the spectrum, competition, private markets handling prices, and on the other side, regulation.

So whereas the high deductible consumer directed health care movement certainly had -- or attempts to have an effect on reducing quantities of service, I think there's also this hope that as prices become

more transparent, and people are facing the full cost of their care, that providers will have stronger incentives to reduce prices as we become more conscience of --

Selective contracting, such as HMO's, tended to reduce utilization, they can also try and reduce prices by selective contracting. So, you know, give us a discount off your price and you'll be part of our network. Finally, you know, as Tom Rice tells us, you know, there's certainly something different about health care that -- it's not truly a competitive market, economics can certainly tell us a lot about what's going on.

But anti-trust is important. Hospital competition, there's extensive literature, but the jury is still kind of out on whether competition raises cost, lowers cost. More recently, there's issues of competition, there are problems, but potential competitive forces in the pharmaceutical industry with these so called reverse payments, to generics, to delay their entry, you know, that's kind of on the competition side.

On the regulation side, you've got perspective payments, the transition from cost based reimbursement to DRG's, to essentially try and reduce prices. And then on the RBRBS side, you had incentives, or techniques to try and I think improve the equity across specialists and primary care physicians. So this final point here is to think about, well, if you go by what MPAC has shown, which is that private prices are about 25 to 60

percent higher than public prices, what can potentially be driving that differential. And so one potential is that there's really a lack of competition in the private setting. So if a provider is willing to accept X amount of money to see a Medicare patient, presumably that provider would be willing to see that patient in a private setting for the same amount of money, but they're currently getting more.

So if you've heard me talk on other issues, I'll generally rail against the tax subsidy as both being inefficient and inequitable, and you may be saying, well, gosh, is he trying to make a square peg into a round hole here on this issue of provider prices, but I do kind of think there's something at play here, which is, if private prices are say 30 percent higher than public prices, the tax subsidy as currently constructed, this open ended subsidy, if I'm at a marginal tax rate of 33 percent, I'm not really facing that higher price of providers of 30 percent in my premiums, I'm really just facing 20 percent due to the tax subsidy.

And then finally, a potential cause for -- an explanation for this differential could be monoxony power. If you're not familiar with this term, just think about on the seller side, you've got monopoly power, well, monoxony would be all this power on the purchaser side. So an argument could be made that this differential between private and public is really that the public ones are too low because of this, you know, heavy handed source of

regulation, but as someone who last year sat in a bunch of briefings from CMS on how they're coming up with the complicated methodology of the DRG's and RBRBS, I mean it sure seems to me that there's a real, you know, honest effort here to make sure that the reimbursement reflect cost and not some, you know, evil motive here.

So then the final -- my final -- some specific proposals, like so if you come to this conclusion that if you are going to try and reduce health care costs, and what we hypothesize in this paper is that it's largely due to prices, if you were really to try and tackle this issue by lowering prices, we can think of a number of options, one might be to try and have a federal registry of bundled prices, so this bundling would help address this issue of transparency of, you know, multiple items within a charge.

But the notion of a federal registry can help us all in shopping among different plans. But the denominator here, you know, some metric of quality is going to be really, really important. So in Germany, there is wide scale negotiation between the sickness funds and the physicians there, and Jerry explains it as, you know, on one side of the table, you've got the sickness funds, on the other side of the table, you've got the physicians, and they just negotiate what the prices are going to be.

It might be hard to apply here because we've got both private and public insurers on one side of the table. And then there's, of course, the

issue of collusion among those private ones.

Another option might be to start considering Medicare. The price ceiling, or go even one step further, which would be to say that we're going to have an all payer rate setting, which is something that's currently going on in my new state of Maryland. I know we've got a full panel so let me turn it on over to the next.

SPEAKER: -- as Mr. Skinner.

MR. SKINNER: No, I thought it was -- competent -- like -- legitimate academic, which I like more. This is a paper with -- co-written with Julie Binam, who's a physician and -- not gerontologist -- geriatrician, thank you, she is the person you want to have looking after your mother, as well as the person you'd want to be doing a data analysis, as well. But this is all very much based on the Dartmouth Group. This is a typical day at work here for us. You may recognize some friends, we even have -- we've managed to get Lauren Baker to come along, he's over there on the right there, too, and Jack Windberg, of course, who's up in the corner. But I can't emphasize how much this is a collaborative effort, particularly arising from Jack's visionary work.

Well, I want to start with -- you may have seen this, I was actually quite struck by this. It's not, no. But I was amazed to see this, controlling health care costs will take fundamental change, nothing short of

the complete reform of the culture of our health system and the way we pay for it will suffice.

Now, of course, the kinds of things that I may be saying may be -- absolutely have nothing to do with his proposals, but I think it's notable that this is one person who seems to be saying something about, gee, we really have to change the way we pay for health care, which I tend to agree.

And, sorry, I have to put this up, this is actually from the CBO report, because I -- let me recommend it to you, it's excellent reading. I didn't write it, I did review it at one point, but I did not write it, it was really very well done. But to kind of give you an idea of the opportunity cost, the amount of magnitude of money involved, if you take a lifetime present value of spending for a 65 year old in Los Angeles and you compare that to Minneapolis, you end up with a used Ferrari, not a new one, it's about $125,000. My Italian friends tell me that no self-respecting Italian would ever drive a yellow Ferrari, it has to be red.

But nonetheless, that's the kinds of magnitudes we're talking about. And so the question is, you know, would somebody in Los Angeles rather have a new Ferrari in their driveway and Minneapolis style health care than the kind of health care they get now, well, probably.

So the point is that the orders of magnitude here, even per person, are staggering large in terms of -- well, some of them do anyway.

And so what I'm going to talk about is, I'm going to sort of take two approaches here, one is to talk about how important I think it is to monitor and to measure expenditures, not prices as much, but expenditures, which is really quantity at the population level. You can argue about whether patient X should have a stent or not. But when you look at these broad aggregates, it's a lot harder to make arguments about how some people are so much sicker than others that they should be getting a lot of health care. But I'm also going to talk about growth rate, because the sort of traditional Dartmouth view is, let's look at these, you know, let's look at the map here, that's a point in time.

I want to think about differences in growth rates and whether there are areas that have obtained lower growth rates than others, because that's really the key to solving the problem, it's not so much levels, it's not, you know, we could fix all these levels here and so everybody is spending the same as Minneapolis, but if everybody is growing, continues to grow at six percent, we'd still end up with problems at some point in the future.

And so this is about measuring quantities, and this is something that's not really I think done very much. But these are -- so people probably know about stents. This is not for heart attack patients.

Most stents, which are these little -- basically things to hold open arteries in your heart, are not used for heart attack patients, they're

used for sort of people who come in, they take an exercise stress test, you know, maybe you get a few abnormalities, and you may end up with a stent, surprise surprise, if they find a blockage. And there's some regional variation, you can see these are rates of five per 1,000, Pueblo, Albany, Richmond, Houston sort of rates of three to four to one. And then there's Lafayette, Louisiana, which this is an FBI press release, a cardiologist indicted by a federal grand jury for allegedly performing unnecessary procedures. I don't think that explains most of the variation in health care.

But this is something that should be monitored. I think they started looking at it because of the Dartmouth atlas, oddly enough, is the only one who seems to be publishing this data, and so this is sort of what's caused some attention.

But the more interesting case is actually Olerio, Ohio. My uncle lives in Oberland, which is in this Olerio area. And I went to visit him, and I said how are you doing, he said pretty well, he said I had a couple stents put in, I was like okay.

And so this is a rate of 45 -- so this is like ten times the rate of Pueblo. And, you know, this is not a really sick area, this is kind of, you know, farm land Ohio. And again, the point is, nobody is monitoring this. Elliot Fisher, this started coming up on the atlas data base, and we were like, what's wrong with the data. Finally we fed it to the New York Times. There's

actually one of the cardiologists up there, a picture on the front page of the New York Times, and it turns out we started getting all this email about, oh, my gosh, there's all of this stuff going on and nobody is talking about it, because there's no kind of outlet, there's no measurement, there's no monitoring.

So I think that's a really important thing to do, is just keep track of where all of this money is spending, because Medicare is set up to pay for anything that won't actively kill you, and there's no sense of, you know, the way that the structure is set up, and some of it will, but there's just no -- never anybody is asking a question of, well, wait a minute, is this stuff actually useful to you.

I show you this because this is also kind of a good starting point for asking, what kind of incentive structure would have stopped this from happening, would have demand driven, what health savings accounts, what's a kind of a system that would have stopped this, because any system that you want to put in should be effective at stopping this.

I'm not so sure about health savings accounts, because if your doctor comes in and says, I don't know, you know, we've got to get some stents in there, you can do research, but do you really want to second guess your doctor? Physicians have very strong opinions and they are often as different as economist opinions, shocking to say. The one thing that I think is

useful to keep in mind is that there's actually not a lot of correlation between surgical rates, which tend to be very idiosyncratic, in overall spending.

So the overall spending doesn't occur on the surgical table, it occurs in sort of care of chronic illness, how often you're hospitalized, how often you use the ICU and so forth. So, again, so this is angioplasties or stents per thousand on the vertical access, medical expenditures per capita on the horizontal access. And you can see some of the really high spending areas, like Miami, actually very low on surgical procedures. Hips and knees, you can't get them in Miami, sorry.

But let me tell you again about growth. And this is new data, and I'm pretty sure this is right, but I sort of can't believe it, but these are two pretty comparable places, they're in the same state, Texas, they're both kind of a border town, El Paso and McAllen, Texas, very similar in kind of demographic SCS. And in 1992, they were almost identical, within dollars of overall spending. You can see short stay hospitals, physicians, lab testing, home health care, all pretty similar. In fact, notice Mcallen was the low El Paso on home health care spending. Well, they have very different growth rates. Mcallen has grown tremendously.

As you can see, it's now almost twice as much of spending per capita, it's among the highest in the country in terms of per capita spending, about $13,000 per capita. These are not prices, explain this difference, by

the way. The average is given by this -- this is the U.S. average here, so El Paso is just a little bit under the U.S. average.

Where's all this money going? Again, another test. What could -- what kind of health care incentive structure could you set up that might have prevented what's going on in Mcallen, assuming, of course, that, you know, you'd want to prevent this kind of thing.

Well, let's look at where the money is going. A lot of it is going for home health care. Even -- this is per capita, this isn't per person who's getting home health care. Even with the -- on the overall reimbursement per capita for home health care, it looks like almost -- I mean a lot of people here are getting home health care in Mcallen. In fact, I looked on Google earth and I just like Googled the number of home health care agencies near Mcallen, about the same number as in El Paso, but El Paso is two times as large, so go figure, about 16 -- 1,700 home health care facilities in the nearest city of about 100,000.

So what is it that's explaining this rapid growth, and how can -- what can we do to make sure that our health care system, at least we hope, grows more at the rate of El Paso than Mcallen?

Let me show you -- now, you may ask, well, but maybe Mcallen is doing a better job on quality, and so maybe yes, maybe no; this is based on some work that Julie Binam is doing. And, first of all, mortality

rates for the over age 80 group is exactly the same, it's a little bit lower in Mcallen, Texas than in El Paso, my guess is it's probably a little bit thicker, hip and knee replacement slightly higher in Mcallen, but not very much difference, a lot more heart surgery in Mcallen, there's a Mcallen heart hospital there, which is equity owned by at least 56 of its doctors there.

This is an interesting number, treated by ten or more different physicians, so this -- in some cases you want to have a lot of physicians on the job, but in other cases, you end up with a lack of communication because, you know, how can they all talk to one another. This is not always considered a good thing. A lot more in Mcallen. And in the last six months, 80 plus, so these are old, very frail patients with a feeding tube, I can tell you, it's not something anybody wants unless it's absolutely going to save your life.

The rate is eight percent in health in El Paso and 15 percent in Mcallen. The quality indicators are about the same, the other kinds of quality indicators that you see. So, again, I think it's possible that you're getting something for your money in Mcallen, but it would be nice to see what that was.

And I don't see it, nor when I go down and talk to physicians, I talked to some physicians in Houston, they had no idea that any of this was going on. So, again, it's very hard to monitor -- to do anything about things

when you don't know what's going on.

Miami and Salem, Oregon are two very different growth path stories. Salem has been remarkable actually in maintaining a low path. Miami, the percentage growth rate is actually not that different from the average. It's because we started so high in 1992, so a percent of $8,000 is not that much growth. But here's the calculation I like; if you look at the dollar growth in spending in Miami since 1992, the growth is more than the level of spending in Salem, Oregon in 2005. The change over time since '92 in Miami is more than the level, than the total amount we're spending in Salem. So clearly, you want to be on this kind of sustainable path as opposed to a path like that.

If you do the numbers, 2017 predicted health care expenditures are about 4.3 trillion. If you applied Mcallen growth rates and started it back in 1991, we'd be at 11 trillion, well on our way to 100 percent of GDP. And if we applied Salem, Oregon growth rates, we'd be at 2.8 trillion, which is actually I think perfectly sustainable. I mean it's two trillion now, the economy is going to be quite a bit bigger in 2017, we would hope.

So I think going to communities and seeing what they did differently is an important part of figuring out what works and what doesn't. We would like to have a lot of different little experiments in our country. We already have them going on, it's just we're not really looking and seeing

what's going on.

I think where I end up is that you ultimately to, if you want to change the system, you have to think about changing how you pay at the provider level, monitoring quality, monitoring expenditures at the provider level. And the key thing you have to avoid is this; now, the date, those of you who are familiar with Puffy know that he was pretty popular in 1999, so this is sort of the end of the HMO experiment. It's the perception that you're cutting costs in order to deprive patients of the kind of care they need.

That is where HMO's stumbled, and that's where any cost containment policy has to be very careful about that you don't fall on this one, because it'll undo any policies in a hurry.

There is an effort by Elliot Fisher and Julie Binam and others to start thinking about creating, if not de jure groups, de facto groups, and the way they do this, they've actually done this, they've created these de facto groups in the U.S., they go around and use the Medicare claims data to find where are patients going to, whose doctor, which doctor did they go to see, so here's the -- patient, they go see this doctor here, this doctor is loyal to the hospital, too, it turns out doctors are incredibly loyal to specific hospitals, even if the patient never goes to the hospital, you know where they'd be likely to be admitted because they go to see this doctor. So there's these very strong loyalty patterns. So you can basically create these panels of

people who are loyal to this hospital, and in theory, if you can sort of make this happen, get people to sign up, or actually I should say, they don't even have to sign up to a group, but you can hold this group responsible for excess cost.

So if Mcallen heart hospital and a patient are accounting for huge growth rates, let's do something about it. Maybe we can monitor it, maybe we can pay for performance for those groups.

Even within these regions, so here's the El Paso hospital, the Mcallen hospital, and this is just one measure based on patients who die, because we consider -- they tend to be very sick, they tend to show up in the hospital. We can see differences within the region in terms of which hospitals seem to be doing a better job.

Obviously, you'd have to risk adjust, that's a critical factor here, to really figure out how to measure quality and how to measure illness. So the essential features of this accountable care organization idea that you have competition, but it's on the basis of within the groups, that is, you may be able to -- some groups that are highly efficient may be able to actually pay patients to join them in order to bring along the revenue that they would bring. You don't compete on price procedure, I think that's where sort of HMO's fell down. They must be large enough to provide coordinated care and statistical precision in any measurement so you don't get just the small

numbers problem.

And I think they require a really deep understanding of quality measurement, that is, are we providing good care, good quality care, and making sure that we're risk adjusting properly so that they don't have an incentive to get rid of the sickest patient.

So essentially, just to kind of wrap up, I think monitoring is really important, I think thinking about growth rates is critical to understanding how to get out of the problem of cost growth, well, obviously, you know, the coming cost growth, and what I've tried to do is illustrate a sort of basic structure of these organizations which compete on the basis of cost, which compete on the basis of quality, and which somehow avoid this HMO peril of being accused of saving money by withholding valuable care. Thank you.

MR. FURMAN: So Dana.

MR. GOLDMAN: So in some ways, what I'm going to talk about is the prequel to what John was talking about, and so it's kind of like the Star Wars movies, if any of you saw those. And so this is the graph that's been causing all the hand wringing, it's the reason why we're here, it's health care as a percent of GDP, and we've talked a lot about it.

If I had put up here how much we're spending on micro processors, it might actually look exactly the same, and so the question is, why do we care that we're spending a lot more on health care.

And as has been emphasized, on average, health care spending is worth it. So, for instance, if you look at early in the life cycle and look at changes in infant mortality in the United States over say the last 50 years, we've done a really good job, and we've talked somewhat about the improvements in cardiovascular disease, as well.

And so, on average, we're doing okay. But the question is, what does it look like going forward, and why are we spending so much, and where should we spend the next dollar, which is very different than saying where should we, on average, where have we gone. So this is the slide that people have been talking about, as well, and it's an important slide because it explains a lot of our cost growth. And wealthier countries spend more, and that makes sense as you -- if you're earning more money and you're living longer, you want to -- economists are very clear that you want to enjoy the fruits of your labor in some sense, and so it's optimal that you'll spend more, and that's why we see all these countries with a very surprisingly linear relationship between GDP per capita and per capita health care spending.

As was noted earlier, Luxemburg is off the curve, but they have very strange banking laws, and so no one is sure what's going on there, and then here's the United States as an outlier. So, clearly, it's not the income growth that's been explaining what's going on.

Now, a lot of this has to do with demographic trends, we spend

more per capita as we get older, and we know that we're facing this increase in the elderly population, so that's going to explain some of this.

And then the final point that's come up, and I think is important, Brad mentioned it, is that when you give people -- when you lower the price of things, they consume more, and that's what we've done over time. If you look at the rate of out of pocket spending as a percentage of all personal health care spending, it's actually gone down historically, and a lot of this had to do with the introduction of Medicare and Medicaid in the mid '60's. So while it's true that the levels have been going up, and that's what you see in the blue bars, and people -- that's a source of a lot of consternation for people, well, I'm spending more out of pocket, well, you can take some solace in that your insurer is paying even more than you are. Of course, we all pay for that anyway in premiums.

So looking over the last 50 years, and let me make sure I keep on track, what explains spending, and Joe Newhouse has done a decomposition, and these are always fuzzy calculations, but on average, about 15 to 20 percent of the cost growth can be due to this change in the demographic profile.

And then, as I said, you know, there's just a natural tendency that income is going to increase spending, and it's about 20 percent. Now, when we look at income, it's difficult, because cross national estimates of the

sort I gave you are very different, give different numbers than if you look within a cohort of people and say why are the rich spending more. But, on average, I'd say it's about 15 to 20 percent. There's this insurance effect, we're just giving people more. Now, then there are prices, and you know, you've heard a lot about prices, and it's very difficult to measure the price. So when we say what's the price of a day in the hospital, well, in the 1960's, there was just a bed and a bed pan, and now there's a bed and a bed pan, but then there's a bunch of other stuff that's hooked up to those things.

And so really, I'm going to argue that what's really left in this bucket is technology. And so if we want to try to think about the increase in total medical spending, all kinds of the things other than technology are things that are good, and they're welfare enhancing. You know, the fact that we're richer and spending more is a good thing, not a bad thing. And insurance generally, we all agree, is a good thing.

So you've seen all this. So the key is understanding medical technology. This is a picture of a left ventricular system device. It's kind of like an artificial heart, except if you look closely, you still have the heart, it's just that we've connected the prosthetic left ventricle, the system controller, and a bunch of other things. And what's amazing about this is, there was recently a -- oh, I don't have the slide. There was a recent study in the New England Journal of Medicine showing a significant improvement in health for

people who have had heart failure when you use this device. Now, the unfortunate part of that is that everyone in the study was dead within two and a half years, and this device, regardless of whether they went to optimal medical management or assigned to the L vat, as it's called, and this device costs about $500,000 right now.

And, in fact, when this came before the Medicare Coverage Committee, there was unassailable evidence that it improves health, okay. This was a very well done study. And the bioethicists who's on the Coverage Committee abstained from voting because he couldn't bring himself to approve it even though, as John said, Medicare's general charge is to approve anything that's shown to be efficacious.

So we engaged in a process at RAND where we looked at the likely consequences of new technologies, and this, essentially, amounted to trying to do a systematic screen of what was going to happen and how it would effect health care spending.

We looked at devices, drugs, treatments, clinical practices, we screened 21,400 articles, I did them all myself, I want you to know that. And then we got together these panels of private and academic experts in biomedicine, and we fed this information to them in various areas, and they identified kind of 34 key emerging technologies. And the idea was to say, okay, if we focus on these key technologies, what would their implications

be.

So in order to do that, we had to build a model, and I'm not going to go through the nuts and bolts of it. But this shows, if we just assume we'd continue to practice the status quo of medicine as it existed in kind of the '90's, here is what the forecast of real health care spending would be for the elderly. This was sponsored by CMS, so we focused on the elderly.

But, of course, the interesting thing is to think about what these technologies would do. So here's another example that you may have heard of, the implantable cardiovascular defibrillator. And when they work right, they're quite effective, and if they haven't been recalled.

And so what happens is, if you go into a life threatening arrhythmia, then it shocks the heart, it's like those paddles, they have them at the airport and such, and it restores natural rhythm. And if you look at people who have these arrhythmias like Dick Chaney, these devices have been shown to be quite efficacious. But you can make the case, why shouldn't everyone have one, okay. You never know when you're going to have an arrhythmia, and if it's truly safe and efficacious. And what our panel told us is that we'd see a dramatic increase.

Now, this panel met in 2000, and, in fact, this has come to fruition, Medicare is covering them, and Medicare has certain clinical

restrictions on who'll they'll cover, but as far as I can tell, no one reports medical record data to CMS, so I don't know how they even monitor that.

And so we forecast what the effects would be, and this is the prediction of how many of these things would be going on over the next 30 years among the elderly population.

And I went home after we did the study, and actually I said to my son, you're going to be an interventional cardiologist, and he said to me, no, I'm going to be a plumber, and I said even better.

So -- but you can do some simple math. There's 550,000 of these things, and they cost about 35,000, and so the total cost is about 19 billion for this one device alone. But, of course, one of the problems is, it's not just the cost of this device. People are going to live longer, or shorter if it doesn't function. And it's going to -- they're going to die of something, and it may be more expensive or less expensive. And so we built this micro simulation that kind of goes through and deals with all that stuff.

And what you look at in the steady state, with just this expansion in ICD's, it would add 30 billion to health care spending, okay. And so this one intervention, in fact, would increase medical spending in 2030, we were forecasting, by about 3.7 percent.

Now, it's just one thing, and you know, what always happens in health care is, it's just one thing. And the other part of this that's kind of

difficult is, if you look at the cost per additional life year, it's about $100,000, and I'll come back to that in a minute.

Here's another example that our panel told us about. It turns out that there's not much we can do in medicine, there are very few things that work, with the exception of maybe some antibiotics and stuff like that that really have huge effects. But one of the most amazing biomedical findings is that if you reduce caloric intake of animals by 30 percent, it increases their life expectancy by about 25 percent, and so long as they're premenopausal, by the way, you can still see benefits if you do it late in life, so keep that in mind. But -- and they've shown this in all sorts of animal models, you know, mice. They're even doing it in primates now.

So our panel told us there might be a pill that could emerge that does this. And actually, the interesting thing is, every biomedical institution for profit is looking at this kind of stuff. So you may have heard about resveratrol, that's the substance in red wine, and they feed that to mice, and they can actually mimic the effects of caloric restriction.

So it turns out the amount they gave the mice, by the way, is equivalent to about 800 glasses of red wine a day. So I don't recommend it, at least not if you want to get any research done.

But it's interesting to speculate, you know, this is an active area, we're making scientific progress, and so we modeled out what the

effects would be. So all the hand wringing is about Medicare especially, and here are the forecasts for the -- you can see here, there's that inflection in 2011 as the baby boomers enter Medicare.

Here's what would happen if such a compound emerged for humans. So if you think there's a problem now, wait until someone actually comes up with an anti-aging compound. And, in fact, if you look at the prevalence of heart disease, right now it's forecast to be about 43 percent in 2030; if something like this emerged, more than half the population would have heart disease.

And here's what we would forecast for health care spending among the elderly. These are in real -- some dollars that I don't know, but it doesn't matter. You know, this compound by itself could increase health care spending by 70 percent.

Now, of course, there's going to be a policy response to this, but should Medicare be covering this, for instance, should it give -- cover resveratrol supplements, do we want to only give access to resveratrol to the wealthy? It raises a number of questions.

And you can do a healthier scenario in which you think of these pills as being perfect pills that are basically for stalling disease. But even in that case, it's going to increase medical spending by 14 percent. And what's really -- and we populated this table with a bunch of stuff, and maybe the pointer -- so here you can see the left ventricular system devices,

those will increase spending by 2.3 percent. You know, what's remarkable about this thing is that nothing is going to save money, but even more difficult is a lot of them are worth it. So it's not the case that we shouldn't be spending money on these things, it's actually that, you know, if you think of $100,000 as the magical cut off, as many economists do, it's actually the case that some of these are quite valuable, and so it really raises questions that would suggest that we're not spending enough.

So are there any exceptions to this? Prevention -- so this is the evolution of man in the United States. Europe is about here, Asia is about here, but they're getting there.

So prevention actually is the one important exception. It can forestall disease, but the -- this is why people hate economists, by the way. Patients accumulate more cost, they die of something that may or may not be more expensive.

And so Leslie went through some of these numbers, so I'm not going to belabor the point. Actually, I think I'm doing pretty well on time. But, you know, just to say that -- so here's our baseline forecast of the number of people over age 51, here's what would happen if we could eliminate obesity, you get a slight bump in population, but not much, because she's right actually, the evidence suggests that obesity is protective in older ages, and so it doesn't have a big effect on life expectancy. Here's what diabetes

prevention would do and here's what -- smoking actually has the biggest impact.

But the thing I want to emphasize is actually what the quality of those years are like, so this part I want to go through. So under the status quo, a 51 year old is expected to have remaining life years of about 30, and of those, about 6.5 will be spent in a state of disability, and 23.5 in a non-disabled state.

Suppose we could roll back obesity to the levels we saw in 1980. Well, on a population basis, so this is not for a person who's obese, this is averaged across the entire population, you would add only about a half year of life. But what you've added is a full year of non-disabled life, so a very active life, and you've actually reduced the amount of time they'll spend in disability, and so the value of that is quite great.

If you look at the other scenarios, you tend to see similar gains. If you could get rid of smoking, you'd essentially add two years of life without any change in the amount of time people are spending in disability. And what does that do to health care spending? Well, you know, it has modest effects, and in some cases, like smoking, they're living longer, they're spending more, but, you know, if we could come up with cheap interventions, they're incredibly valuable, that's kind of the point.

So the value of healthy aging swamps the fiscal

consequences, and it's very cost effective. Obesity reduction actually could save us some money. And so the policy lesson, which is what people always want to hear when I'm in Washington, is to save money, reduce obesity, if you want to save lives, reduce smoking.

So let me summarize overall. Health care costs are rising rapidly, part of it is demographics. I'm going to argue a lot of it is technology. So looking forward, rising costs mean higher premiums, and so we may be pricing people out of the market.

Insurance becomes so expensive that we see fewer people being insured, and you create kind of an insider/outsider model of health care, which is why we have so much -- why there's such bifurcation I think in the debate, which is some people saying we have the best system and some people saying we have the worst system. I actually get my care at UCLA, and I'll take the Ferrari, red or yellow, it doesn't matter. But the key is rationing technology, and rationing is a bad word. Prices usually ration markets. They don't in health care for various reasons.

People have been talking about health savings accounts, John mentioned it and was quite skeptical. I'm skeptical, as well, for a different reason, though, which is, you know, the technologies we're talking about here cost $35,000; if your deductible is 1,000 versus $200, at the margin, it's not going to effect when you're making life saving decisions. And so all the

costs are accumulating in the area where insurance kicks in anyway. So I'm not as optimistic that we can just get out of a problem with MSA's or HSA's or whatever the flavor is.

The real issue is coverage. And all the things you've heard today are, you know, comparative effectiveness, and how do we make these coverage decisions. And there's a debate, do you release information and then let private plans make coverage decisions? One thing you might think of in the private market is having plans print, this is what our cut off is, you know, if we get to 100,000 a year or less, we'll cover it, otherwise, we won't. And I have a plan that goes to 300,000, and if we all had the right information, it would be very easy to understand which plan is going to be more generous than the other. So there are ways to do it in a private model, and, of course, there are ways to do it in a public model; if Medicare would just listen to Sean Tunis, we'd all be fine. And so I think, you know, but I do think that issue of how we get the technology is the key. Thanks.

MR. FURMAN: Thank you. And if this is Star Wars, I think Richard is coming to blow up the duck star.

MR. EPSTEIN: This is on behalf of David and myself, and I was trying to think of how utterly miscast we are on this particular panel. And the way in which I would summarize the difference in approaches is that everything we've heard today is an extensive amount of day with very little by

way of solutions, and we take the opposite approach, we're very emphatic about solutions, but, of course, we have no data.

And so there is a kind of a real difference with respect to the way in which people look at these problems. And my view about it is that, and I think David shares this, it's a large part of what you have to think about when you're looking at health care and how the system is organized. Is it the thing seems to have promoted this much discontent on all three relevant access, that is, on the access of -- access on quality, on cost. Clearly, you have to have something which is fundamentally wrong philosophically, because you can't make these kinds of cumulative errors just by accident.

And I think in many ways the problems that we see here is that what we do is, we have a series of rising expectations, and that they tend to lead to exactly the wrong set of social kinds of responses. And so when I think, for example, back to Senator Daschle's success this morning, he starts to talk about some of these problems, and his first suggestion is, well, we have to have universal health care which will solve all of these particular differences.

And for somebody like David and myself, what we think about it as a problem, well, no, you have to really ask the following question, how much of the cost is going to come in trying to extend the coverage from X percent to 100 percent. And if, in fact, everything was just simply linear, the

multiplication would be the only solution to the problem, but the world never works in linearities. One of the standard rules that you have in virtually every kind of industry is that something like 80 percent of your problems are caused by 20 percent of your people, and a very tiny percent of your people are going to cause huge amounts of the sorts of problems and questions. So when you have this very strong egalitarian ideal, what happens is, you tend to project low on the cost side, whereas, in fact, the change in the mix in the kinds of pools that you're going to put forward are going to create much more pressure on the system than you would have ever thought to be possible.

And so, in effect, what I think is that every time you act, you sort of move with respect to these kinds of universal aspirations. What's going to happen is, you're going to face the fundamental trade-off, which is there will be greater fiscal pressure, this will create distortions on other sectors, and will result in probably a lower level of care for those individuals who are most productive within the system.

And if I were trying, for example, to explain one of the many failures of the original Clinton Health Care Program, once it became very clear that you were going to try and boost the level of care to everybody up to the level of those received by Medicare recipients, the leading objectives to this particular system became Medicare recipients, because they saw the

program of universal station as a program of redistribution, and this is, of course, one of the reasons why it turns out to be so utterly difficult for us to get one of these programs through, because it's never a question of being able to add new people into a system and not changing the position of everybody else who's already there, it's a question of one set of change is inducing a whole variety of changes.

Since many of these are difficult to estimate and to determine, what you then come up with is a political uncertainty, which will generally work in favor of the status quo as against any of these kinds of powerful reforms.

And the question is, well, why does one start to talk about these things. And, in fact, David and I kind of pushed the little notion that there's much too much of a sense that the kinds of goods that are provided through health care are sort of governed by different metrics than those which are supplied for other kinds of things.

And so, for example, often it's said that health care is a kind of a mired good, which means it ought to be supplied by mechanism independent of a market. Well, the first point I think to make is, there is a sense of mired good, which is, of course, important and cannot be price related if you're trying to give examinations for price and for -- if you allow people to buy A's in school, you don't get any information from the grades, so

certainly you'll have to use non-price mechanisms.

But you're not trying to do that when you're providing health care. And the problem that we always seem to have is that the moment we decide that we're not going to use prices, to use that dirty word, ration, we then have to switch to some other kind of mechanisms to do the allocation, and nobody has ever yet come up with a system of allocation that will work when demand can go all the way down to the -- access, because there is no way in which the costs are going to be internalized.

I asked Dana before, just in some of the questions, I said, my impression has always been that one of the great problems with respect to Medicare is that the margin, the price of virtually any treatment for anybody inside the system turns out to be zero, at which point the prediction that there's going to be excessive consumption of health goods, does not depend upon any of the particulars in question. So what is the way in which most people want to solve this? And I think, again, and I think David agrees, is, there's a kind of a perpetual situation that we're going to dispose stuff by trying to collect more information which would allow us to make more kinds of informed policy choices. But we're always collecting the information today, and we're always making the policy choices tomorrow, so that what happens is, we never get ourselves into a point of equilibrium, we're actually making some kinds of hard choices today about what it is that ought to go on and

how these particular changes ought to be made.

And so our proposals to deal with this stuff is, in effect, trying to pick off an inside that had been mentioned by multiple people today, which is that the problems associated with the increase in cost associated with health care and with the possible reduction and access which is consequenced upon that, is not the result of the single particular phenomenon to the exclusion of all others.

The sort of mathematical version I'd like to give about this, and it applies with respect to particular sectors like medical malpractice, or with respect to the overall health sector, is simply a simple numerical kind of model. You take something like medical malpractice, and you ask any serious lawyer, can you explain the change in document which led to the increase of premiums by 16 fold between say 1900 and 1980, or 1960 rather and 1980, and the answer is, you cannot. What happens is, judges and policy makers often make each change in isolation on the assumption that every other portion of the system is perfect, and what happens is, you expand liability here by 1.25 percent, you do this five times, you do it multiplicatively, and all of a sudden you've got yourself a very large number, but you don't have a single cost, because the model that's working here is essentially one which is cumulative, multiplicative, and repetitive.

And it turns out by implication, you don't have a simple way to

undo the particular causes in question because there are so many points that you have to attack that it becomes very difficult to figure out which ones are appropriate.

Now, in dealing with this problem of how it is that you attack the cost side, we think that basically you have to divide it kind of in two ways. It's very difficult that the programs that we're talking about, to make a direct frontal assault on Medicare and Medicaid, these are institutions which live unto themselves, but instead of trying to worry about the entitlement side of the thing for a moment, although certainly if it was up to me, I would worry about it in a very big way, what one wants to do is to look at the cost side and to ask yourself the following simple kinds of questions, what systems of deregulation could we propose right now which would reduce the degree of costs associated with the system, which should unbalance, allow any form of the system to run better, whether it be a competitive market, which, of course, has to respond to universal system costs, notwithstanding the fact that the firms are in opposition to one another, or some kind of a more centralized system.

And we could kind of come up with a number of these proposals which we think make sense, all which would be subject to an enormous amount of opposition, but will state them anyhow.

And so one of them which I've certainly worked on for many,

many years is to say that the reason why I think the medical malpractice system is so far out of whack, goes back to a decision in 1963 called Punk against UCLA, your hospital seems to be coming up in everything, in which efforts to contract out of liability through some kind of a voluntary mechanism was struck down as being preposterous by an incredulous California Supreme Court, which was sure that the only thing to explain why prices and exclusions from liability were appropriate, it was the factor of exploitation of particular patients by various kinds of individuals. The reason why this turns out to be so important is, we do not know what the exact cost of the medical malpractice situation is when you take into account direct and indirect costs.

It would be silly to say that it's driving the entire operation of the system for many of the reasons that Bill said before. But even if you listen closely to what he said, the variations and responsible estimates are rather hard.

What happens is, though, the moment you keep the contractual solutions out of these things, your policy is going to be set by a bunch of uninformed judges and ignorant juries being persuaded by very passionate lawyers one way or the other, and there is, if you've gotten this thing wrong, absolutely no mechanism of self-correction. The only thing that you could do now is go to legislation, which in many cases will introduce difference kinds of distortions for different sorts of reasons.

So one of us thinks -- if you think as I think and as David thinks, that the system of decentralized information through voluntary exchange is a better way to figure out what you want to do, what you'd want to do is to relax these kinds of restraints and to move very strongly to a much more voluntary system, and hopefully this will lead to an erosion of some of the cost pressures or reduction of the cost pressures that operate on the system.

A second feature I think which is enormously important is one which is everybody's favorite in Washington, which is to create mandates of health care with respect to private plan.

In order to figure out why it is that private coverage is slipping, you cannot explain it as a reduction in wealth on the one hand or a reduction in demand for health care on the other. If you're going to try and figure out why it is that the system breaks down, the best explanation is that it's being subject to a large number of implicit taxes which comes from all sorts of direction.

A mandate to my mind is a tax. To put it to you in a very simple form, if we decided that mental health care was extremely important and put it into a health plan, generally speaking, putting it into that particular plan on a voluntary basis gives you some degree of confidence that the benefits that are supplied by that are going to be greater than the costs

which are going to be imposed. But if it turns out there's a learned committee of senators out there who decide that mental health coverage is going to required, now you think of it as a form of lobbying, which is imposed by various kinds of interest groups. And so even though some people might do this voluntarily, it doesn't follow that every employer should do it under a coerced basis.

The moment you put this in there, you now have a tax. What does a tax do? It does one of two things. Either it keeps the plan in place, but reduces the consumer and produces surplus that it generates by creating essentially unwarranted expenses, or in some cases, and these cases will always arise, what happens is, it will tip the balance such that the coverages will be essentially dropped by the parties who have to provide it.

And so one of the things that one always has to ask when you're worrying about coverage is, you could supply coverage to people, but the question is, what's the breadth of the coverage, it's something which, when determined by legislation will over state the demands that are appropriate, and once you tend to do that, you will see that the voluntary market will start to erode. If you could find a way to reverse that particular phenomenon, it would certainly make an enormous difference in the operation of the system. The third element I think which is extremely important in trying to do with this whole problem is just the question of

licensing and the ability to have interstate competition.

One of the things that's so striking if anybody looks at medicine is, you come from New York and you want to practice in California, or you want to go to Arizona and to follow your customers down there, you have to take licensing tests which indicate that everything you've done for the last 40 years is now open for scrutiny.

My favorite illustration of this involves Regina Casper, a very distinguished researcher having to do with a lot of problems with respect to bulimia and anorexia and so forth, and the question is, how do we dare let you practice, we can't recover the results of your undergraduate education in Germany in 1956 from a hospital building that is already burned down.

So you could slow people up, drive them out, you could also do it with respect to competition, with respect to insurance. And so what you have to remember I think in this particular case is, if we allow the state -- of markets, what happens is, we create lots of little monopolies instead of one relatively more competitive national sort of market, and this is going to have all sorts of adverse effects on the pricing of various kinds of health care in the voluntary arrangement. So, once again, the kind of strategies that one has to have under these circumstances are deregulatory, not regulatory.

I think perhaps the most important of all the changes that one could try to do in these circumstances is to separate the provision of medical

care from the provision of physicians, that is, do not think of this as something that doctors provide, but think of it as something that firms provide.

One of the things that doctors love to say is that they're not engaged in the provision of mere commodity, they're always engaged in the provision of special and wonderful kinds of resources. The phrase that, "my good is special and therefore immune from market forces", is perhaps the single most costly phrase in the history of western civilization.

No matter where you look, you will always find somebody who says, well, you know, food is really special, so instead of giving more at competitive prices, what we do is, we have an elaborate set of acreage restrictions on the one hand and then subsidies on the other, which has created a market which is so grotesque that nobody could quite undo. Want to figure out the way in which the housing market can go in disarray? Housing now becomes the special community. Health care is exactly the same thing. And the quicker we start to recognize that even though it's vitally important to people like food and clothing and shelter, the thought that somehow or another a different metric is going to work to get it to you in the best way is always going to be a mistake.

So our modest proposal is that what you want to do is to make sure that ordinary businesses get higher physicians, figure out the way in

which they're going to supply health care, so that if somebody wants to have a clinic at the back end of a Wal-Mart or a Walgreen or a CVS, that ought to be the way in which this thing ought to go.

The thing that one has to watch all the time in dealing with this situation is the view which, when translated to other markets, means if you want to drive a car, you have to drive a Mercedes Benz, used to say a Cadillac, but that's no longer the appropriate standard.

And under these circumstances, therefore, again, the idea is if, in fact, you could allow free and complete and open entry into all medical markets under all circumstances by a whole variety of firms, what this will do is completely change the cost in price structure. Now, this is very different from the kinds of proposals that we've heard about here today, and let me explain I think some of the differences.

When you listen to anybody come from the CBO, you're always going to hear exactly the same thing we've heard today. Here is all the data, we have no policy recommendations that we can make about it, we want to collect more.

The problem is, all markets have to work within perfect information, and they might as well start working right now instead of waiting for another three or four years with respect to the collection.

And once you put them into place, they'll start to collect the

data which will allow you to get the greater efficiencies that take place. And if, in fact, they really work well and they're -- as we never quite know when we look at the various kinds of Windberg data, as to whether or not these local variations are driven by cost or whether they're driven by a local monopoly, the one way you'll find that out is through new entry. If it's a cost phenomena that we can't understand, entry won't change the situation, because the new entrant will have to bear the old cost. If it turns out to be a little form of local monopoly, the whole thing will start to blow up very quickly. So it turns out, what the competition does under these circumstances is exploits the information that we have and allows you to draw some kinds of differentiation.

And it's important that we remember that, because remember, Medicare is a uniform and a national system, and if you find utilization rates that are that different, you've got to be able to find some local causes to explain them, you cannot push this on the national.

And the last thing in effect, and here I want to disagree with what Professor Herring said, sort of violently, I suppose, is that you start seeing, for example, differences in rates between Medicare and non-Medicare kinds of patients, and the proposal is that the docs could work off the Medicare kinds of rates in their non-Medicare areas, so you now have a suggestion for universal kind of health price insurance caps of one kind or

another.

Let me tell you what I think is wrong with that. The older literature used to say that whenever there was a price discrimination between difference kinds of providers, this was regarded as evidence of some kind of monopoly power within the industry, because otherwise, you couldn't get yourself the price discrimination, competition would bring you back to the same level. That's clearly incorrect. I mean if one looks at the airline industry or looks at the hotel industry, you can see an industry which has lots of competitors going from point to point, it basically earns competitive rates of return, and you start looking at the people flying these planes and living in these hotels, and they're paying 72 different rates at any given one time.

The reason why this happens is that the Medicare game and the non-Medicare game all work off the system in which there are joint costs that have to be allocated across different providers. And the reason you see the price discrimination takes place is that the government is a demand that will not cover anything other than your variable cost and maybe a tiny fraction of your fixed cost.

You're going to have to, in order to remain in the business, to shift those fixed costs onto somebody else. And the whole reason why market discrimination can rise in cases of competition of one form or another

is that these joint costs are, you know, something that you've got to swallow. And it turns out that there's no way for their allocation. Market after market shows this kind of phenomena. If you're trying to figure out why drug prices turn out to have lots of discrimination between different providers, it's because no one will pay for the cost of the first pill, and the moment you have to push it downstream, the basic theorem is, there's no unique allocation of joint cost.

So just to sort of put this whole thing together, one of the things that you really have to be extremely careful about is going in exactly the wrong way, finding out that there are all sorts of things that are complicated like by the current market, and instead of arguing for more deregulation, perhaps in Medicare's case, there's more levels of co-payment, you find yourself arguing in exactly the opposite way.

You see something which is a healthy market response to some really very complicated pressures, and what you try to do is to engage in a system of regulation, which stamps out the anomaly and makes the system even less efficient than it was before.

So as far as we're concerned, I think David and I, we would want to start with the following situation; a way in which you want to attack these things first, and the only unambiguous way to cut cost is to engage in a program of deregulation wherever and however that turns out to be efficient.

There are other cases like HIPPA, where you could do exactly the same kinds of things, and so what you want to do is to go through the statute books and figure out where you could begin with a system of either amelioration or appeal; when you do that, then you could reassess. And it turns out that if you got the course problem correct, you're going to have easier on the access and the quality problem, as well.

And when I look at the way in which it turns out that all the modern health care programs that are coming out politically, they're going in exactly the opposite direction, more price controls, more committees, more reviews, more centralized planning.

The Daschle Commission is essentially, as far as I'm concerned, a recipe for long term disaster. You're trying to have an industry run by a committee, which has got the speed of a dinosaur when the technical changes take place at a very much more rapid rate. So deregulation first is I think the appropriate record, even at the Brookings Institute, and even for the O'Neill Center. Thank you.

MR. FURMAN: So now that the last presenter and first discussant have both finished, if we could bring everyone back to the podium. And I'll start by saying a few things that I think -- that I took away from this, and I think Gregg and Leslie have done a great job with all of this and in putting together this panel. And then we'll open it up and we'll go until

about 2:35.

But as I see it, there's a few questions; one is what the diagnosis of the problem is, and in the most basic terms, it's spending is price times quantity, and do we think the problem is price, and that was one of the presentations that we heard, and do we think the problem is quantity, which as I -- for the most part, where the other three presentations were.

And then within the quantity, what is the problem, and whether it's a problem. And I think Jonathan's work has a lot of variation in the quantity, with not a lot of explanation about why that is, except that there's nothing there to stop it, especially in a world of ignorance and in a world where Medicare pay for anything.

Dana has a little bit more of a story in terms of technology and the ways in which almost every technology we've seen that we thought might save money ended up costing money and now gives us usefully that information so we know it in advance should anyone be thinking about inventing a pill to extend all of our lives. We know now, don't stop working on it because it'll make our social security problem worse. And then finally, the last paper we had had another diagnosis of quantity that was much more embedded in -- not in accidents of decisions and accidents of what technologies we have are not, but tried to find the root cause and the set of incentives that our institutions give, our regulatory institutions, our

malpractice, and then in the context of the paper, but I don't remember you mentioning it in the talk, as well as the tax treatment of health insurance, which we talked about in this room a week ago.

So I guess if I had to try to address all of this, some of the questions I'd come away with is, trying to get -- move further to figuring out what really is causing it, and then going on to the second question of, is the cause the same thing as the solution.

So you could have 50 percent of the reason that health costs have gone up be technology. That doesn't necessarily lead to the corollary that you want less technology going forward. You could have benefit mandates and health insurance, make health insurance more expensive, but it doesn't necessarily tell you that the right answer to that is that you don't want benefit insurance -- benefit mandates and health insurance. Or it could be that our prices, indeed, are higher than prices in Europe, but you want to ask what the consequences or unintended consequences, and Rich addressed some of this, of bringing those prices down are and what it would do to the prices we saw elsewhere in our system, what it would do to medical innovation, and what it would do to the people we tracked into the profession of health care.

But that's just some of the thoughts I come away with from this. But I think we should go to your questions and the degree you want to

address any of that and answering questions, you can bring it around, as well. Yeah.

SPEAKER: (off mike) two presentations have such dramatically different allocation of the decomposition of cost or inflation to price. And, of course, the big driver of that is where you put technology. Is technology a quantity component or is technology a price component?

So I guess I'd like -- I'm curious to hear more reflection on that. But one way to get at it is to say, to what extent do we have good price comparisons between the U.S. and Europe for actual, you know, homogenous medical goods or services. And I know we had this for prescription drugs, but beyond that, for just sort of a standard visit to a primary care physician or a day in the hospital, do we have any good measures with price comparison either, you know, over time or between now and -- between here and Europe?

MR. SKINNER: Let me just say one thing about price, which is, it's not even the right price, it's price per unit of service anyway, and what we really should be thinking about is price per unit of -- and that's a very different metric, so -- and you get into the wrong math when you do that.

Before the introduction of anti-depressants, the price of treatment for depression was infinite, okay. You can go, and when we developed anti-depressants, we brought that down to a level of spending, a

price that was finite, if you will, and it turns out costs went up for treating depression, and so everyone said, oh, that's bad, the price has gone up, but, in fact, the price has gone down, and when you start doing the math, or the policy recommendations, you get into the wrong metric.

So thinking about Europe actually, it may be that things look much better because their health outcomes are better. Now, it's obviously a very difficult comparison to make international judgments based on what's going on overseas, but I just want to say that we're not even talking about the right price yet.

MR. FURMAN: Do you want to address that?

MR. GOLDMAN: Yeah, let me just add one thing. I think that there's an important distinction to be made between cross sectional variation and cost, so what's going on like say within the U.S., and I think the Dartmouth work is really important and a better understanding that, for a set Medicare price, you've got a lot of variation in quantity, and so, you know, the fact that our paper says, you know, it's really prices here that's important, I mean it doesn't discount that.

But if you look at cross sectional variation between the U.S. and other countries, you know, physicians earn a whole lot less in other countries, the cost per service, per, you know, per a particular treatment in the hospital is a whole lot less in these other countries, so that really led to

our discussion or our emphasis on price.

But I think when you think about increases in costs over time, there it's really -- it really is the technology. And again, like, you know, I kind of referred to earlier, it does get to this tricky issue of, you know, how do you think about increases in technology over time, is that price or quantity. I mean, you know, think about a stent, if we move from a regular stent to a drug coded stent, it's still a stent, and so maybe the price goes up. Or alternatively, you can think about it, well, there's the stent and then there's the drug coding it, and so the stent is the same, but we've gone an increase in quantity from no drug coding to now a drug coding, and, you know --

SPEAKER: But I think that also has implications for the policies you recommend. So if the reason the price is going up is that you're adding a drug to the stent, then paying less for drug coded stents is probably not the best way to bring costs down.

SPEAKER: Yeah; so a couple --

SPEAKER: Whereas, getting the drug coded stent doesn't do any better, then it's about having a lower quantity.

SPEAKER: So I mean I think the ideal thing to have is that the patients face the true marginal costs of these added technologies.

SPEAKER: Medicare is a zero marginal cost system. So how are you going to -- unless you fundamentally change the utilization, that

becomes the facts. And also, we know independent of that marginal cost, pricing doesn't work for bridges, it's not going to work for health care.

SPEAKER: Well, it could happen in private insurance.

SPEAKER: No, it can't. You can't get marginal cost pricing in effect means -- it's not a possibility. For every system of pricing you introduce, there's always going to be a second best accommodation. It's true with a patent, it's true with a bridge, it's going to be true with an expensive drug. And markets are better are figuring out who bears the cost when you can't use marginal cost pricing and regulation for the most part, because it's going to be sensitive to these variations and be responsive in the shift, so -- and that's why you have to find a way to defossilize Medicare, I think.

SPEAKER: And let me just -- just real quick, just one final point. So my last slide was four different policy options. I mean we're not really endorsing one, we're just laying out the different options and the pros and cons of the different options. I think at the end of the day, Jerry and I might disagree about the relative merits of one versus the other, but on the other hand, we can agree about what the pros and cons are.

SPEAKER: Thanks; from the front lines of medical care, one thing none of you have talked about is relative price, the difference between what you pay a doctor for a consultation and what you pay a doctor for a procedure. One gets something like -- cataract surgery takes 11 and a half

minutes and it's one of the best procedures ever invented, no question about that.

But a doctor who does a cataract surgery gets something like eight times what a person gets for an office visit. And maybe you say, well, the office visit, you know, was just for a cold, but if the office visit is to take care of a chronic patient with four or five chronic conditions, maybe that's worth a lot more, or at least if you paid more for it, you would get more of it.

A doctor coming out of residency has a choice, you can become a general internist and see 30 patients a day, or you can become an interventional cardiologist and you can do three catheriterizations in the morning and you're done, and what's that going to do to the supply of physicians. You're going to have more proceduralists because it's an easier life and you make a lot more money. More proceduralists means more procedures. And Winberg has shown that the more doctors who -- the more proceduralists you have, the more procedures you get without any improvement in health outcomes. So that's a place where, if you change the relative prices using the RBRBU system, it's not for efficiency, sorry, it's not for equity, it's for efficiency. You might get a system that looks a little more like Europe.

MR. FURMAN: I don't know if you want to -- yeah, Jonathan.

MR. SKINNER: Actually, no, thank you for quoting Jack's

work. What I find fascinating actually about the health care system is that, in one case you have something like Medicare, which is totally non-market, they have administered prices. The prices are determined by a committee which is basically in charge of the AMA.

And the way that cardiac procedures are priced, a hospital almost has to have some kind of cardiac center in order to survive, because that's the only way -- there's an expression, it's no profit, no mission basically, no margin, no mission, thank you, I was blanking on that, in that they have to compete on the cardiology surgery centers in order to survive.

And so that's definitely a fault of Medicare. And, you know, again and again you hear about proposals to like get the primary care spending back up, but the fascinating part of this is that this is -- on the other side, the physician market is almost totally deregular, in fact, it is deregulated, there's no regulation at all. Once, you know, you get through medical school, you can go anywhere you want, you can -- within reason, you can charge any price, you can decide to get out of Medicare, you can do whatever you want.

And so I think the best way to explain why you get kind of Mcallen versus El Paso or Salem is how sensitive the physicians are to market forces. And so in some cases, you can go into these centers where they are totally optimized, you know, you just can't believe how much money

they're turning over, and because that's the way they structure themselves, so they are competing like crazy on that dimension, whereas other physicians, they're like, no, I'm in it, you know, I see some patients, I get my salary, it's not much, but that's the way it is.

And it's interesting that I think there are these differences in variation. There's some very interesting work from AARP about how, you know, if you look at these health care differences, they're correlated with lots of measures of social capital, places where there's little social capital you tend to find a lot of rapid growth in health care spending, along with sub prime markets and all these other things, as well. So this may have something to do with explaining why some regions are different from others.

SPEAKER: (off mike)

MR. SKINNER: No, I totally agree. I'm just saying the fascinating thing is how some places respond to those profitable opportunities and other ones don't seem to.

MR. FURMAN: Yeah, if you want to go quickly. There are a lot of questions.

SPEAKER: Just very quickly; we got RBRBS because we were trying to rejigger the allocation of payments between procedure and evaluation and management or cognitive specialties, and, you know, they actually fairly significantly changed it, and now some 20 years later, we're

basically back where we are, mostly because of growth and imaging, you know, it's sucked up all of the money.

So there have been losses per unit for proceduralists stuff, but overall, we're basically at the same point, that's part one. Part two is, there are real problems with the market mimicking strategy, like RBRBS, where, you know, when you're under compensating, they show up and complain, when you're over compensating, you never hear a peep, and so you sort of systematically see things being levered up and nothing is almost ever levered down. And, you know, we have, I think it's fair to say, single specialty hospitals and the things that we do because we overpay for those things, and so that creates an incentive for unbundling.

The last very quick point I want to make, and maybe it's a political economy point, is, you know, I look at John's excellent work showing this regional variation and huge differences in pay out, and I can tell you the reaction of people in the states, as well as in Congress, that look at that, is not we have to bring those people at the top down, it's how do we get the Medicare train to unload more money in our state, okay.

So that I think is a tremendously complicating factor, to try and address that regional variation problem by taking money out of the system.

SPEAKER: So if you'd only stop publishing that atlas, we could get this problem under control. Gregg.

MR. BLOCHE: First, a quick thought about the RBRVS. To me, in part, a story about how a good idea got progressively corrupted by interest group pleading over the decades.

SPEAKER: I'm shocked to hear about that.

SPEAKER: Not in this town; but there's a paradox that struck me, and I'm even more -- after hearing this panel, and that is, on the one hand, there's the work that Dana has referenced, and earlier David Cutler's work on the same thing was referenced, showing that certain treatments give us enormous value, and that if we say take $50,000 or $100,000 for a quality as our standard, we should do all these wonderful things.

And then on the other hand, there's this equally wonderful Dartmouth data that shows these astounding variations unaccompanied by differences in outcomes. And to these things -- these bodies of work pushing very different directions, and I find myself worrying that perhaps it's a little -- that the David Cutler work and other work in this direction is a little bit like looking under the street lamp for the keys because that's where the street lamp goes.

On the one hand, we've got a set of procedures that we can study that do certain things, treatment for depression, or treatment for cardiovascular disease. On the other hand, we have this huge amount of spending that goes on in intensive care units, in kind of desperate

circumstances where docs don't know what to do, and in the absence of empirical evidence bearing on efficacy, we have more variation. Are we looking in the wrong place when we do those studies of particular procedures? What accounts for the contradiction?

SPEAKER: I have to catch a plane, so let me use that as a pre-empt. No, quickly, the difference is average versus marginal care, and the problem is that all these technologies, like take statents, for someone -- the clinical trials show that if you've had a heart attack, they're enormously effective.

Should we all be on staten, should it be in the water? That's where we're going towards. And so it really has to do with -- it's not about rationing the technology, whether it gets into health care. These implantable defibrillators, what you're seeing is the average effect is on that quite good, but then when you look across regions, the marginal population that's getting them in, what's that town in Ohio, Olearia, is a population that won't benefit very much.

SPEAKER: (off mike)

SPEAKER: They don't reflect hydrenganaity within the population.

SPEAKER: Ninety percent of cancer drugs are given off label. I mean so, you know, we don't know necessarily what the effects are.

SPEAKER: One very simple kind of observation, the culprit here is administered prices. Let me give you another example. You could do the identical table that they did with drugs if you ran through OSHA, and you figure out ten kinds of things that you can ban right in the work place, and some of them will give you a return of, you know, one live safe of $50,000, and one will give you for $4,800,000 or whatever it is, and therefore, the process -- the whole thing in this case is clearly that kind of process leads to these immense sorts of distortions, and unless you can undo administered prices, you will never be able to get out of that variation. On this point, there's absolutely nothing which is distinctive about health care.

SPEAKER: I mean this is actually a paper that I've been working on for a while, and that is that, first of all, the heart attack, the decline in sort of the real price, that was only for ten years, after 1995, it's basically stopped. Health care costs for treatment of heart attacks have been going up at, you know, on the order of a quarter of a million dollars per life year since then. And I would guess it's the same for depression. It's sort of a punctuated equilibrium in the sense that something happens quick. There's a decline in mortality, and then it kind of flattens out again. But health care costs continue to rise. And the two are almost unrelated, in part, because the scholars who have looked at the causes for why mortality has fallen from

cardiac care, from cardiovascular disease. There was a recent New England Journal study showed, first of all, half of the decline was behavioral, having nothing to do with health care. So Richard Simmons have saved more lives, I hate to say it, then Michael DeBakey. And the second part is, the real sort of stars of cardiovascular health care treatment have been aspirin, beta blockers, anti-hypertensives, off patent drugs that are remarkable effective.

The contribution of surgery, of interventional cardiology, is seven percent of the total gained between 1980 and 2000, very little of it. So, again, it's the marginal versus average.

You know, it's not the big, fancy machines, it's the aspirin. And I think that's where -- that's why there's so little correlation between changes and outcomes, health outcomes and changes in cost, it's because the really important things that have to be done are not always -- they're either these low cost things or else it's the way that the hospital is organized. You know, do the nurses, you know, do the hand off of the cardiac patient to the CCU properly, and those are things you can never measure.

SPEAKER: (off mike)

SPEAKER: You make more money putting in the stent, that's true.

MR. FURMAN: Well, I think this has been a lively discussion.

And my guess is, there's a lot of questions out there and that they will be equally applicable to the panelists on the next panel as they were on this one. So if you can just save them, we'll continue it. Thank you.

MS. MELTZER: Go ahead and take a 15 minute break, meeting back, sorry, ten minute break, meeting back here at ten of 3:00.

(Recess)

MS. MELTZER: Welcome back to the last panel of the day. We commend you for sticking around this long and we're so happy to have you here for this final panel on bending the curve. Let me take this moment to introduce you to our final moderator, Pat Healy, who is the Senior Research Assistant here at the Brookings Institute. He works with Henry Aaron and Mark McClellan and has actually written what we think is a quite influential paper for the book that Gregg and I are editing, Beyond Learned Helplessness, America's Health Care Cost Conundrum. He's written that paper with Henry Aaron on, Is Health Care Cost Stupid. Patrick also maintains a position with the U.S. Department of Justice, and has an MSB in health economics from the London School of Economics and Political Science.

Most of his work to date and also the main area of his interest right now are on health care delivery. And with that, I introduce you to Pat Healy.

MR. HEALY: Thank you for that kind introduction. I'm here as

a replacement for Henry Aaron. I hope I'm not above my pay grade, but I'll do my best for everyone. I'm pleased to moderate this final important panel on cost containment strategies and the issues surrounding them.

Henry affectionately likes to call these final panels the meat and potatoes, that's my obligatory joke for everyone. But before I introduce the speakers, I just want to briefly say that while we all know the discussions of cost containment are nothing new, there does -- and as Tim Jost reaffirmed this morning, there does seem to be a sense of urgency surrounding them. And just as a simple case in point, of the past 18 presentations delivered by the Director of the Congressional Budget Office, including today's, all but three have focused directly on the problem, the long term problems of rising health care spending, which I think is remarkable. And in these presentations, as you might have observed today, the director emphasizes that reducing the growth of health care spending is the central long term challenge in setting federal fiscal policy.

Henry and I active support this view, and have written a couple papers on it, most recently in the book underlying this conference. In the chapter for the book, we simply show -- we use the CBO numbers to show that rising health care spending is responsible for all of any long term fiscal problems that may arise in the future.

And what this finding serves to do is point the debate away

from a general -- from a discussion of a general fiscal crisis or an entitlement crisis and towards a discussion of the most promising measures for reducing the growth of health care spending, which I think is the right discussion to have, and I'm pleased to moderate the panel and have these panelists discuss that today.

I've decided to have Sean Tunis speak first. I'm going to introduce everyone at once, but Sean is the Founder and Director of the Center for Medical Technology and Policy in San Francisco. He's also the former Chief Medical Officer at CMS. Following Sean, we'll have Mark Hall, he is the Fred and Elizabeth Turnage Professor of Law and Public Health at the Wake Forest University School of Law and School of Medicine. Third we have Gregg Bloche, one of the core organizers, of course, today. Gregg is a Professor of Law at Georgetown University Law Center; he's also an Adjunct Professor at Johns Hopkins University Bloomberg School of Public Health and a Non-Resident Fellow here at Brookings.

Finally, last, but not least, Jeanne Lambrew is an Associate Professor at the Linden Johnson School of Public Affairs at University of Texas and also a Senior Fellow at the Center for American Progress.

MR. TUNIS: Well, thanks very much. You know, usually I get asked to give presentations over about 20 minutes long, and for people who have heard me before, it's about ten minutes of fluff and then ten minutes of

what I think is substance, so since I only have ten minutes today, I'm just going to do -- just do the fluff. And also, it's late in the day, so I think that's probably a better choice than the alternative. So I think -- I'm pretty sure my assignment for the book and for today was to talk about some of the challenges for Medicare of introducing considerations of cost and value in policy decision making. And what I spent a lot of time on was this question in regards to coverage policy. So hopefully this will be a little window into some of the broader issues of value and cost considerations in health care decision making, particularly clinical policy and coverage policy, and hopefully that'll have some generalized ability to broader challenges in this whole issue of getting policies to promote better value for money.

But, you know, I thought -- I have a little story that I think is kind of a metaphor for the stubborn refusal to deal with limited resources. And this story involves some elk hunters in Oregon, so I thought I'd take most of my ten minutes and tell you this story.

I don't know if any of you know Mark Gibson, but he was actually the Chief of Staff to Governor Kitzhaber during the implementation of the Oregon Health Care Plan, so as a particularly unique perspective on the whole issue of rationing and cost effectiveness analysis. And so he likes to tell the story of the three elk hunters who flew in a small plane to remote eastern Oregon, and when they were dropped off, the pilot said, you know,

it's a small plane, so just remember, I know there's three of you, but we only, you know, can carry one elk, so make sure, you know, you only get one elk because that's all we can possibly bring back. And so the hunters said, fine, and when the pilot dropped them off, two days later he came back, and sure enough, they had shot three elk, and a big argument ensued, and finally, you know, the pilot said, you know, no way, but the hunters said, look, you know, last year you told us just one and we, you know, we shot two, and we paid you twice as much, and you know, you flew us back, so how about this year we pay you three times as much.

So the pilot said, well, all right, and they strapped the elk to the plane, they take off, and they failed to clear the trees on the other side of the lake and they crashed. But fortunately everybody survived, and one of the hunters finds the pilot and he says, what happened, and the pilot said, well, we crashed, and the hunter said, well, where are we, and he said, about 50 yards from where we crashed last year.

So the stubborn refusal to acknowledge limited resources. And I would say that we, you know, have the same kind of policy dilemmas in health care that we continue to make decisions and promote policy ideas, you know, that don't have a prayer of clearing the trees on the other side of the lake. And with that, I think I'm done. No, so let me just tell you a little bit of the tangled story of Medicare and how Medicare makes its decisions

about what it will and won't pay for.

So in 1965, in the Medicare law, there's a little piece of the statute, a very powerful piece of the statute that says, no payment may be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury.

So basically, in order for Medicare to pay for anything, it has to be determined to be reasonable and necessary. So it would be reasonable to think about, you know, how that term is defined.

So in order to try to seek some enlightenment or to understand what the term meant, Jackie Fox, who is a former Greenwall fellow, in fact, came to Medicare to work with us and went on this quest to help us understand what reasonable and necessary meant in the Medicare law.

And she actually tracked down three living human beings who had actually helped to write the Medicare statute in 1965. And the story that she learned was that there was no language on reasonable and necessary until the last 48 hours of the writing of Title 18 of the Social Security Act. And at that point in time, they were originally just going to have the part A hospital benefit, but then they decided to add physician coverage, the part B benefit, and there were these great concerns about, you know, what that might do to spending.

And so what one of these people said was, you know, we had

no idea what to put in there, so I grabbed my personal Aetna policy off of my desk, and that policy said Aetna will only pay for things that are reasonably necessary, that was the language, reasonably necessary.

And he said, well, you know, I thought it would be more like effective to have two requirements than one, so I made it, you know, reasonable and necessary. And so Jackie has written this up in the Buffalo Law Review, in a very nice article, where she describes all of her email exchanges with these folks.

Actually, the great thing about this, this explanation of where did reasonable and necessary come from, and by the way, there's no other language that explains what it means, so whatever this guy, you know, Robert Hoyer, who still lives down at Ocean City, told Jackie, as much institutional knowledge as there is, it actually solved the puzzle for me, because all those years when I was in charge of -- basically my job at the CMS was to interpret reasonable and necessary, so I would stay up at night pondering this, you know, puzzle, because it did actually control, you know, what 40 million, you know, plus a million Americans were entitled to, so I thought it was useful to think about it.

And it always puzzled me, like why was it reasonable and necessary and not necessary and reasonable, because that would be more the logical order, like first something is necessary, and then, well, it's

necessary, is it reasonable. Well, now I know why the order was what it was, it was just a mistranslation of somebody's personal policy.

So in terms of defining what reasonable and necessary means, you know, ordinarily, statutory language, you probably all know, is defined in the process of rule making, right, so there's a process by which you actually go through.

Like, for example, the FDA determines what's safe and effective, right, so there's 10,000 pages of regulatory language that defines what does safe and effective mean. For reasonable and necessary, there's exactly zero pages of regulatory language that define what it means. So there was no language at all; then in 1977, there was -- Medicare sent out a letter to their contractors and said basically what it means is, things are safe, effective, appropriate, and not experimental.

And then, in response to a lawsuit in 1989, CMS, Medicare put out a notice of proposed rule making, so they started a rule making process, and in addition to safe and effective, they proposed that technology should also be cost effective, you know, good value for money.

And so, you know, this was a bold move, and what ensured was 11 years of, you know, commentary and failure to agree on the wisdom of having cost effectiveness as a criteria for what Medicare pays for.

So obviously this suggests at least some discomfort with the

notion of what's cost effective, and presumably it's because what cost effective would imply is that something could actually be effective, but not paid for by Medicare because it was considered to be too expensive, in other words, the R word, right, so that's what cost effective translates to. That's why this notice of proposed rule making was never finalized, and it was formally withdrawn in May of 2000, and they replaced it with something which always amused me personally, what's called a notice of intent of a notice of proposed rule making, which is regulatory bravado of the first order. It's like we're really so sure you're not going to like what we're going to propose here that we're just going to put out something that says we're thinking of proposing to put this out there for comment, so why don't you comment on that.

And I think in another, you know, kind of clever, bureaucratic move, they removed the language cost effective, and instead, added the -- put in the criteria of added value, hoping that no one would notice that, in fact, that also related to cost versus benefits. And there was no more success with that, and so that was also withdrawn within a year.

And so from 2001 basically to the present, what Medicare's working definition of or what it pays for, what's medically necessary, is really a -- there's no formal language, it's merely a matter of case law, essentially, it's adequate evidence of improved net health outcomes.

So adequate evidence of improved net health outcomes, that's the Medicare language. Nothing in there about cost, right, nothing in there about value. So I don't know who's heard of the editor of the Baltimore Sun, I think in the late 19th century, H.L. Mencken, who said, whenever they tell you it's not about the money, it's about the money. So CMS coverage got it and said Medicare does not consider cost in making coverage decision, so I think H.L. Mencken's law probably applies. When it comes to Medicare coverage decisions, I can tell you from having worked there for many years, that it's definitely not about the money.

So what does Medicare mean by -- that costs are not considered, that we don't -- in fact, there's explicit language and Medicare guidance, and the CMS senior officials will always say we don't consider costs, what does it mean?

Well, it means unit cost, aggregate cost, and cost effectiveness are not explicitly considered. You will never find any mention of economics or cost impact in a Medicare coverage decision.

However, and this is basically a direct quote from a former CMS official, "more expensive items are reviewed more carefully", right, it's nothing to do with economics, it's just that we look at the scientific evidence, that's actually a quote of mine so I thought I'd put it in there.

But the, you know, current CMS folks will say exactly the same

thing. It's, you know, we take a more careful look at things that are more costly. And so in terms of selecting technologies, selecting which technologies to review for national coverage decisions is partly a function of cost because they're not all reviewed, in fact, a very small universe are reviewed. And then within what actually is -- even when Medicare decides to cover something that's extremely expensive, it's much more likely that you're going to have restrictions applied to that.

So, for example, remember when Dana mentioned the left ventricular assist device, $500,000, you know, it even starts to feel a little expensive from a Medicare point of view, well, the policy around Elvad says that they can only be implanted by credentialed heart transplant centers who have done 15 or more of these procedures in the last three years. Well, that's a completely arbitrary, you know, limitation, and it's entirely intended to limit the number of centers that could implant Elvads, because there's a perception that they're not particularly cost effective.

So that's how Medicare implicitly takes cost considerations into account and coverage decisions, but, in fact, can, you know, legitimately say, reasonably legitimately say, in fact, we're not looking at cost effectiveness. I mean another good example that he also -- Dana also mentioned implantable defibrillators for which the cost effectiveness may be around $100,000, you know, give or take. And in the case of implantable

defibrillators, originally the Medicare coverage was only limited to a subset of patients who were enrolled in the eligible population based on kind of a retrospective subgroup analysis that showed that patients with a particular EKG abnormality seemed to obtain a particular benefit.

Again, why would you bother to cover only a subset of patients when the clinical trial was actually positive for the entire population of patients, you'd do it because you were worried about spending $19 billion a year on one technology. So anyway, there's a whole other set of examples of those.

So let me just talk briefly and I'll finish up. Gregg, am I going way too long now? Okay. Two more slides. And by the way, I'm done with the fluff now, there's actually two slides of substance. So whoever has been doing their blackberry, you might want to pay attention because this is, you know; Stu, I saw you, by the way.

So anyway, there are a number of legitimate barriers to Medicare or I think any payer using explicit cost effectiveness considerations in making policy decisions. You know, one is the issue of, I'm going to call it procedural fairness, but the issues of, you know, how transparent is the process, are there appeals, are there true freedom of conflict of interest. I mean part of the reason that people don't trust Medicare to make decisions based on cost effectiveness is, they don't trust Medicare to make coverage

decisions, you know, even just based on scientific evidence. The process still lacks a whole lot of transparency, it lacks a whole lot of ability, you know, to appeal it, so, you know, people don't trust their process to begin with.

I think a huge issue is, there's often uncertainty on key questions of clinical effectiveness, so it's very difficult to do a cost effectiveness analysis where the underlying information about comparative effectiveness is of poor quality, which is, you know, frequently the case.

The whole issue of, you know, third party decision making, who should be in charge of ultimately making clinical decisions, is it, you know, federal health boards, is it, you know, the coverage in an analysis group at CMS, is it the medical director of a payer, or ultimately, you know, should that be the province of clinicians and patients, and I think there continues to be a lot of tension around that issue. Another huge issue which actually, I think it was from Bill Sage's slides that really focused on this, which is, you know, most people think that where the money is being wasted in health care is on waste, greed, and unconscionable profits of drug companies, so why would anybody feel like, well, it's legitimate for me to be deprived of this service because it's really expensive and not much value, that really isn't where people should be looking to make savings.

And then the last thing, which actually I think is quite important is, there's a strong view that paying things based on cost effectiveness, in

other words, the price reflecting the value, does not sufficiently reward innovation, that there should be a built in part of the price of things, which is not usually considered in cost effectiveness, which is a stimulus for further investment in future innovation.

So actually, I think buried in the whole resistance to cost effectiveness are concerns about what impact that will have on innovation.

Potential solutions, well, you know, I actually think that, you know, that what CMS is doing in terms of implicit considerations of cost and coverage decisions, given the enormous discomfort with explicit consideration of costs, you know, it might be the best we can do in the short term. So I would actually propose one possibility is that Medicare should make a lot more national coverage decisions and go wild with their implicit considerations of cost.

You know, again, if part of the notion is to try to get better value for money, these things like restricting Elvads to heart transplant centers, you know, might be about the best you can do, given that there's no way that Medicare is going to be able to say we're not going to pay for Elvads because it's just not a good use of money.

I think there's lots of steps you could take to improve procedural fairness, investing in comparative effectiveness research to improve the precision of understanding of the effectiveness part of cost

effectiveness.

And then one last thing I'll say is that, you know, instead of using cost effectiveness as it's sometimes used, for example, at Nice in the UK for a yes/no decision about what is and isn't paid for, there's probably much more potential in this country for using cost effectiveness in value based insurance designs such that you have a variable amount of cost sharing to patients based on the cost effectiveness of a service. So perhaps something that is extremely expensive for a limited benefit, it's available, but it's available at a 50 percent co-pay; for something that's inexpensive and high value, there would be no co-pay or a limited co-pay, and that way you're not actually saying, this is not available to anyone, it's saying the amount of the patient cost share is reflective of the value of the service.

So anyway, hopefully that gives you a little bit of, you know, insight into the ongoing challenge, which I think is not historical, it's both historical and it's still current, of, you know, trying a program like Medicare to consider costs, and I think, you know, the same sorts of issues will play out as we continue to try to incorporate value in individual clinical policy decisions. Thanks very much.

MR. HALL: Okay. So like Sean, my fluff to substance ratio is pretty high since it's Friday afternoon and raining outside. So I'm going to entertain you with a couple stories, as well, despite being under a strict time

guideline.

This is work I've done with Carl Schneider, but all these little funny things are my own. So one thing that struck me in titling this was, originally it was advertised as the Health Care Cost Conundrum, and now I see that it's called the Health Care Cost Catastrophe. I guess Gregg and Leslie realized that a conundrum doesn't draw an audience in D.C. these days, you have to have a catastrophe. But most people refer to it as a crisis.

And so at one point I got curious about how long we've had a health care crisis, so I did a little bibliographic research, and I found that the first book written about the crisis was in 1960, not coincidentally at the same time that insurance became widespread.

And, you know, even as late as -- a decade later, it was still thought that there was a crisis looking ahead. And one indication of how long standing the crisis is is that Ted Kennedy was a young senator when he first read about the crisis.

Even by 1974, the crisis was so well studied that there was a bibliography of books and articles about the crisis. Dimensions of the crisis had expanded to the extent, by 1978, we now have a general theory of the crisis. And lo and behold, here come HMO's as a solution to the crisis, and so we're hoping that perhaps the crisis is going to be over by the mid '80's.

But, of course, it's not, and so Kennedy, in the middle phase of his career, wrote another book about the crisis, so the crisis spans all parts of Kennedy's career, which really tells you it's lineage. Yet again, another reference handbook, it's now become so established that it has a place on the reference shelf, not just a bibliographic and a theory.

And Congress finally steps in here about 1992 and issues its thoughts. Somebody named Maynard Myer Hoffer has a simple way to solve the crisis, which is good to know. And, again, we have another bibliography 20 years later.

And finally, someone in 2007 thinks that the crisis, the story of the crisis hasn't yet been told, and so titles his book accordingly. And we hear this morning, of course, that Senator Daschle and Jeanne Lambrew and others have yet another book on crisis, so critical --

All right. So the point here is that everything we've been doing so far hasn't -- we had this oxymoron of a chronic crisis. You usually think of crisis as an episodic emergent, you know, acute situation that must resolve because it can't possibly go on that way, but, of course, we've been talking in that language now for going on 50 years. And so it must be that whatever we've been doing is not working and we have to think of something new to do. So before, you know, the approach was managed care and what manage -- how I characterize managed care is an attempt to control costs

through second party and third party mechanisms. This party mechanisms is insurance and government telling the doctor and patient what to do; second party mechanisms is incentivizing the doctor to do the right thing. And those didn't work. And they were harshly rebelled against, both politically and in the popular imagination, as we've seen and heard. And so we have now the dawn of a new era.

We have a consumer driven health care as the idea, and you see the tiny little consumer there on the beach alone facing the new dawn, and the idea, of course, is the one that we're familiar with.

Just three weeks ago in the New York Times, Michael Levitz said, we have a better option to provide beneficiaries with reliable information about cost and quality, and given that information, we know that consumers will make decisions that drive down cost and quality up.

So the gist, as you all are aware, is, it's pretty much the way in which I went about buying my brand new DVD DVR recorder just two weeks ago, and this is a picture of it. I spent, pretty much, I don't know, eight, ten, 12 hours researching this thing, because with all the changes in the television formats and the DVD recording formats and, you know, TiVo and what have you, there's a lot to sort out, and a lot of sources of information to evaluate these products, and a lot of uncertainty about what was going to happen, and so I was unsure where to plunk down my $500, and the best

models weren't available, and the cheap models didn't have good performance.

Anyway, so I wrestled and agonized and finally ended up buying something that, after three weeks, I'm pretty happy with, okay.

So the question is, you know, is health care purchasing capable of following that model, and of course, I'm presenting this in a way in which I'm pretty skeptical about that, that these sort of hopes for consumerism I think are greatly overstated, they have a somewhat romantic disregard for what we know about human nature in the face of illness and facing the complexity and uncertainty and fear and rest that -- medical decision making, and therefore, certainly will not work anything like the idealists suggest, but much more captured like this, a person, you know, covering their eyes, surrounded by question marks. And so what will actually work when the consumer faces the reality of consumer driven health care. So my talk is supposed to be a systematic critique of this, and of course, I'll speed through it. But let me just sort of preface the ending, which is that despite all the skepticism I have about the idealized form of consumer directed health care, I do think there's some merit in the idea in the sense that it helps give the consumer, the patient, a stake in the cost of health care in a way that I think will realign the agency relationships among doctor, patient, and insurer, so that now, let's see, traditionally, no one had an

incentive to contain cost other than the insurer.

Managed care tried to align the physician's interest with the insurer, but this, of course, created a conflict of interest for the patient. But to the extent you give the patient a stake in the cost, now the patient has an interest aligned with the insurer, and then, therefore, potentially the doctor with the patient, and therefore, it has more receptivity to the idea of managed care, if you will, at least that's my sort of idealistic wishful thinking.

But that's much different and I think it's more accurately captured in the phrase, consumer driven, that is, the patient has a stake in the outcome, rather than consumer directed, which is the term you more often hear. So think about that distinction as capturing sort of what I think is the sort of pros and cons of the concept. But thinking of it in terms of consumer direction, that is, picking health care treatments and providers like I picked my DVD recorder, you start with the simple question of price.

I mean forget about quality and all the different -- of measuring it and relaying that information reliably, the simplest thing is simply price, okay, and we all know the difficulties, and we had the discussion earlier, what is price, but here's a price list. And so if you go to a hospital and say what are your prices, they won't tell you because it's a secret.

All right. So California says, well, okay, you have to post your prices on the web, so here's their charge master for the -- alphabetically the

first hospital, and these are the prices for ordinary labor and delivery charges, which is an aspect of medical care that has some degree of consumer elements because you can anticipate the need for the service and, therefore, research it ahead of time.

But the point is, there's 50 some odd items of service that are entailed in the labor and delivery part of the hospital charge master. So before you know, you know, which hospital you might want to go to, you've got to know which of these 50 some odd items of service you might need. And, of course, you don't know how long your -- how protracted the labor is, what kind of complications, what sorts of tests and what not, you need expert advice on that.

And so there's quite a bit of information costs in seeking this out.

Now, this doesn't mean that the problem isn't capable of better, you know, approaches than currently exist, and certainly, as we give consumers more stake in the price, we can expect a greater transparency in price, a somewhat more bundling of price services.

But this is a part of the market that has already been subjected to some degree of consumer direction in the sense that a good number of people pay out of pocket for this and what not, and still the prices aren't bundled and not particularly easy to find out.

And others have looked at, for instance, cosmetic surgery or

laser eye procedures and what have you, and indeed, there's a fair amount of price information out there, but you have to go to a lot of effort to get it. And so one of the points is that you can't find out whether you qualify for the low price, the medium price, or the high price until you go in and get an initial evaluation, and by the time you've done that, you've already pretty much picked who your provider is anyway, and most people pick those providers not by doing any kind of research ahead of time, but simply by word of mouth or referral and that sort of thing.

So when presented with this kind of information, you simply don't know what to do with it. It's just not presented in a way in which people can wrap their minds around it.

Well, what about the web, so everybody says, you know, the web can solve everything, and what about quantity, if we can't necessarily shop based on price, can we think more carefully about whether you actually need the thing in the first place, and therefore, restrain utilization.

Well, suppose you went to look up a particular miracle drug on the web to get more information about whether you really needed it or what the risks are, here's what Web MD has about one particular miracle drug, it causes stomach problems, more stomach problems, more stomach problems, more stomach problems, and more stomach problems and now skin problems, itching, hives, rash, wheezing, breathing, allergic -- giant

hives, not just hives, that's pretty bad, large skin, blotchy skin, my wife wouldn't like this one bit, and et cetera, et cetera. Well, of course, what is this, yes, okay. So what do you know, you know? You get all this information, you have no way to process it, and so the point is -- the answer is aspirin for anybody who's listening out in the hallway, that, you know, patients aren't able to process this, they don't want to.

And our lunch time speaker, Peter, referred to behavioral economics as the growing field of study, and the point is that, we have to understand the psychology of patients and their ability and willingness, not just their ability, but their willingness to become informed consumers.

And as educators, we all know that unmotivated students are pretty poor students, and if you don't want to learn this stuff, you're not going to do a very good job of mastering all this detail.

And people are very fearful, anxious at this time and these points of consumption, and so they tend to adopt sort of either -- well, passive approaches, they either put it off and don't go to the doctor or when they go to the doctor, they simply do what the doctor says rather than be more activated. And that's essentially what the 1970's RAND Health Insurance experiment found out when they put people under a high deductible, the people -- 30 percent was saved, but mainly by not going to the doctor in the first instance; once people went to the doctor, they spent the

same amount regardless of their deductible, because they followed a passive approach that referred heavily to their physician.

What other examples do we have of consumer driven healthcare? We have prescription drugs. And thereto, there's been somewhat more success that patient cost sharing has greatly facilitated a shift a generic substitution and therapeutic class substitution and that sort of thing, although that's been complimented to a great extent by managed care assistance in the form of formularies and what have you.

So, but thereto, there's been a lot of study that shows that the decisions aren't necessarily made wisely. So, the doctor may prescribe the right drug, but the patient doesn't take it and suffers as a result, and as a result of that, ends up spending more on hospitalization and longer term medical costs. That's what that study shows in The New England Journal. Here's Rice and Masouka with a lit review finding essentially the same thing.

So, the bottom line is consumers unassisted aren't going to make good decisions but of course, they'll have the assistance of their physicians. So, in the last couple minutes I need to think about what is the doctor patient relationship going to be like under consumer driven healthcare.

That's really the important question because can you essentially turn to your physician as a purchasing agent, someone to guide you through this complexity and help you make wise purchasing decisions?

Well, one problem with this is this is sort of inconsistent with the culture of medicine, and not just because of this collective guild interest of maximizing profits, but a sense of professional ethics and appropriateness that long predates the insurance era. Of course, medicine has been consumer driven for all of history except for the last 50 years.

And so we go back to Hypocrites, who says do not start by discussing fees because you'll suggest to the patient that either you're going to leave them if they can't pay or that you're not going to prescribe what they need. And such a thing, such a worry would be harmful to the troubled patient, particularly if the disease is acute.

So, the ethic in medicine throughout history has been treat first and bill later. We'll do what you need, and we'll worry about the money afterwards. And in some form or shape or fashion, that's always been the ethic and continues to be so. And so, one can question whether that ethic is capable of changing overnight despite, you know, a millennia of experience under it.

So, that's in terms of the physician raising costs as the consideration on account of the patient's interest, but what about the patient? Can we expect the patient to start a tug of war with the physician? Well, hardly not. And physicians of course are well armed to resist patients who they think are make improvident decisions.

And so, Carl and I have done a number of interviews, qualitative interviews with physicians about how they deal with cost concerns and how they deal with patients who they think are not make good decisions or at what point they're willing to go along with patient refusals of treatment versus when do they start insisting otherwise.

And we collected a number of examples that I've quickly summarized here that suggest that physicians have at their disposal a lot of sort of moral psychological sort of persuasive, I would somewhat say coercive ability to pressure patients into doing what the physician thinks is right.

So, the point is if you don't have physician buy in to this general approach, it's never going to work. And how are you going to get physician buy in? Well, I do think we need to revisit professional ethics and medical law, in part to ask is it a safe environment in which physicians can act as purchasing agents. Is it an ethical environment? And that's part of the project that I'm engaged in.

But the upshot is that if consumer driven healthcare works, it won't work because the patient is driving the decisions. It will work because physicians' interests are aligned with the patients' and ultimately with the insurer.

So, if we're trying to slay the cost dragon, roaring with fire and what have you, the point is it's not a single sort of heroic knight riding up on a white horse that slays the dragon in the form of either the government or the consumer or the private market. But it's all these forces marshaled around that will have to come to bear.

And this sort of set of common interests that realigns agency relationships in favor of cost containment might well merge from consumer driven healthcare, but it's not going to be in the fashion that Secretary Levit outlined at the beginning of the talk. So, thank you.

(Applause)

MR. BLOCHE: I have a PowerPoint but I'm not going to inflict it on you. I'm not even going to hook it up. Instead, I'll use it as my cheat notes.

I titled this paper, "The Emergent Logic of Healthcare Cost Control" and then with a subtitle of "Moving Beyond Learned Helplessness." And I'm inclined to drop the subtitle because I don't want to be all gloom and bleakness.

But the learned helplessness, I think is understandable. We've had, as Tim Jost pointed out this morning, 40 years -- well, as he pointed out, really goes back 70 years of failed efforts to contain medical spending.

The 1970s brought us regulatory constraints on the supply side, health planning, and certificate of need regulation. The 1980s brought us a try at antitrust law and competition among doctors and hospitals.

And the 1990s brought us the idea of managed competition under a global budget, an idea that collapsed with the failure of the Clinton plan. The 1990s also brought us managed care and the integration of healthcare financing and delivery, more or less -- it turned out less rather than more and competition between healthcare payers.

And what all these things had in common is that none of them worked, at least in a sustained way, to contain costs. Now, some might say that well, there were all these things we tried incompletely. If we tried with great rigor and thoroughness, any one of them, whether the pure market forms or the pure regulatory forms, could have worked.

But the failure of our system to be able to try them with rigor is part of the failure of cost containment. And there are other failures at the federal level, and they've been touched on earlier today.

Sean talked about Medicare's unsuccessful efforts since 1989 to incorporate cost sensitivity into national coverage decision making, even though the word reasonable in lots of other parts of the law, both common law and the court's interpretation of regulatory statute, the word reasonable is quite regularly assumed, treated as a term that incorporates cost benefit balancing.

The old Office of Technology Assessment, remember that? Some with gray hair will remember it. it performed cost benefit studies with some clinical measures. And it was put out of business by congress in 1995, one of Team Newt's first pieces of work.

And the old AHCPR, the Agency for Healthcare Policy and Research, established back in 1989 and the back surgeons, who got mad at the practice protocol saying back surgery wasn't a great idea and who arched their backs and the unhappy providers, not just back surgeons, but others, who allied with device companies to persuade congress to strip this agency of its power to develop clinical practice guidelines.

AHCPR was reconstituted in gelded form as AHRQ, the Agency for Healthcare Research and Quality. It's now a research agency, a small board research agency with no ability to issue practice protocols.

What are the lessons learned from this? Well, we've heard lots of talk about the R word. And other than the Supreme Court uttering it

multiple times in a 2000 case, Peakman versus Herdrick, Justice Souter saying HMOs ration care, by the way, they ration care. And did you know, America, HMOs ration care? Americans didn't want to listen. Other than some rare quirky moments like that, we haven't been willing to talk about the R word.

The overt withholding of beneficial care to save money is a nonstarter for Americans at the present time. Regulatory measure that force cost benefit tradeoffs in healthcare will be angrily rejected by Americans. That's an important lesson.

And health plans or providers that make cost benefit tradeoffs overtly will arouse consumer ire. And covert rationing of healthcare by either government or private actors will eventually be exposed and then widely condemned. That's part of the lesson of the managed care backlash.

And there's lessons to be learned here about interest group power. Providers and drug and device makers and others will fiercely resist public and private efforts to limit spending at their expense. And they have a one two punch they can deliver. They can ground their resistance.

And I guess the first punch is based on a mixed metaphor here, but lack of scientific support for and lack of evidence against most

medical treatments. And this empowers interest groups, these interest groups to claim that failure to provide these treatments constitutes denial of potentially beneficial care.

Combine that with the reality of Americans' resistance to rationing, and it gives this claim, the you might be denying possibly beneficial care. We don't have the science. We don't have the science to show it does work. That means we don't have the science to show it doesn't work, so it's rationing to withhold this treatment. And once you bring up this idea of withholding potentially beneficial care, the claim of the interest groups has a deep resonance in politics, the marketplace, and the courts.

And another important lesson learned, in our system, stakeholders who want to resist the squelching of a costly treatment get many, many bites at the apple. Our fragmented governance mechanisms offer stakeholders many chances to foil public and private efforts to control medical spending.

And earlier speakers have touched on different aspects of this. The federal and state agencies that make the call, congress and state legislatures and federal and state courts, the bottom line is that when stakeholders can deliver the one two punch in defense of a tested treatment, they're more likely than not to prevail.

So, what's -- what can we do about all of this? That's the question that few folks have asked and even fewer folks have answered. And I don't claim to have any -- certainly, I don't claim to have a scientifically rigorous answer.

There is today, at least here in Washington, on Capitol Hill a pretty broad -- and elsewhere, a pretty broad consensus on what's needed. First of all, there seems to be broad consensus on the need -- and bipartisan consensus on the need for a robust publicly supported program of comparative effectiveness research.

Some are willing to go further and to say it needs to include comparative cost effectiveness studies to build an evidence base for clinical practice and provider payment. And we're moving towards a consensus, but we're not quite there yet.

We're moving towards agreement on practice and payment, the idea of practice and payment protocols that say no to tests and treatments that are of minimal or no value, in other words, the Dartmouth 30 percent. The problem, of course, is that we know there is the Dartmouth 30 percent out there. We just don't know which treatments and tests fall into the Dartmouth 30 percent because we don't have the data for the most part.

And eventually, there's the sense over the long haul,

although no one is politically moving in this direction yet -- no one dares. Eventually, there will be a need for practice and payment protocols that incorporate cost benefit tradeoffs if we're to break out of the dismal logic of the congressional budget offices long term cost projections.

And what's to be said in this regard about campaign 2008? Well, I wander onto risky ground here, seismically unstable ground because, as I mentioned at the beginning of this conference, there are some donkeys and elephants in this room and I am amongst the beasts in this regard.

But what passes for discussion of healthcare costs in this election season falls far short of what's necessary. Electronic medical records and consumer directed healthcare, drug re-importation, and aggressive antitrust enforcement, those are some things that have been mentioned by all of the remaining candidates. They won't -- in the -- to use the term in a Commonwealth Fund study published a couple months ago and we used the term as well for this panel, they won't bend the curve.

But the candidates are in a bind. They can't propose much more without inviting harsh responses from stakeholders and from voters. They're haunted by the back surgeons, and yes, they're haunted by Harry and Louise.

There's -- I want to submit an alternative way of thinking about this set of problems. And I think of it in terms of emergent systems theory, but I'll be kind of simple in talking about it. First of all, let's stop blaming the politicians, including the three remaining presidential candidates. Their reticence reflects the reality that there are obstacles that we're not willing or able to surmount.

So, let's then stop thinking about cost control as something to be achieved -- and here I think I'm kind of segueing from what Mark said at the end of his comments, but stop thinking of cost control as something to be achieved by discrete one shot reform. We are not -- we -- Americans, we are not culturally ready for what ultimately what needs to be done to bend that curve.

So, let's instead try to anticipate pathways. Let's be more modest, much more modest about this. Let's try to anticipate pathways that might emerge and design policies that might perhaps nudge us along some of those pathways.

There are some emergent opportunities, I think. For one thing, it's interesting that some of the health plans that have emerged this election season involve competition between private and public plans. And that kind of competition could lead to evolution toward a larger public plan that's able to then push down the uniquely high prices Americans

pay.

Back to the lesson of the last panel, the it's the price is stupid message that Ubi Reinhart and Jerry Anderson delivered in health affairs a couple of years ago and have driven home since. So, Americans might choose that. Does that eventually morph towards single payer? It's conceivable, but people will choose in market format -- in a market form, whether they're going to go -- we're going to go to single payer or whether we stick with private plans.

And even if we have private plans that aggregate buying power through mechanisms like insurance exchanges or in combination with large employers, that can perhaps build up a purchaser of bargaining power.

And let's also hope -- let's accelerate the creation of institutional mechanisms. This is something that's already happening in the private sector. There's kind of civil society mechanisms emerging, one of them being pushed by Mark McClawen here at Brookings with some support from Johns Hopkins.

Let's move ahead with the creation of institutional mechanisms for achieving broad agreement on performance benchmarks, benchmarks that consumers and health plans can then use in decentralized fashion to reward value through the market.

If you want to go consumer directed, okay, consumers can apply these benchmarks, but so can health plans with things like value based insurance of design. And let's move towards payment systems that do reward value.

And although price and quantity are, you know, as it was pointed out in the last panel, separate in many ways, the dynamic -- there's a dynamic relationship between the two -- if the we stop paying doctors a huge premium for sticking sharp needles attached to electronic beeping machines, you know, into our bodies, then down the line, investment decisions are going to be influenced.

And if we start putting the premium on value, then the science that's most likely to lead to breakthrough -- to breakthroughs in medicine is more likely to receive investment dollars.

And beyond that, comparative effectiveness and comparative cost effectiveness findings can serve the function of -- can serve as groundwork for future cost benefit tradeoffs, tradeoffs that we are not ready now as a society to make. Let's build up that data. Some might say well, the bill is pending in congress now, and the references to comparative effectiveness research in the three presidential candidates' reform plans, that's not nearly enough because none of them are talking about the R word.

Well, perhaps, except once we have that data building up and we have Americans seeing that a whole bunch of other things that are commonly done clinically are in fact, you know, ineffective or are marginally effective, that kind of primes the environment for accepting some of this balancing and certainly the physical pressures that Peter Orszag pointed out at lunch, will prime the environment in the decades ahead as well.

Now, on the comparative effectiveness up front there are some real challenges and limitations and I worry about that in the kind of Washington rush towards comparative effectiveness research as the new Panacea, we're not paying sufficient heed to those challenges and limitations. One thing we are paying heed to finally is that such research is a classic public good, underprovided by the market, so public support is essential.

It's also essential to shield comparative effectiveness research design from special interest capture. And yet, on the other hand, research agendas do need to be responsive to public concerns. This creates some awkward balancing of imperfect institutional design strategies or this requires awkward balancing of imperfect institutional design strategies.

Another challenge is that there's a kind of fractal geometry of

comparative effectiveness research and guideline promulgation. It's necessary to put patients into clinical categories for the purpose of comparing treatments. But patients and responses to treatments will often be clinically diverse within these categories.

No matter how small you make the categories, there's still going to be different presentations of patients just because clinical medicine is so astonishingly complicated because our physiology is so astonishingly complicated and variable.

And the pharmaceutical industry has certainly -- they're really smart. They have really smart lobbyists, and they've seized upon this. They're now pushing the idea of so called personalized medicine well before the science is ready to do it, they're pushing that in part as a way of pushing back against the movement towards comparative effectiveness research.

And another challenge for this research is that a whole lot of the most expensive treatment, intensive care unit treatment in the last months of life, et cetera, is provided in individualized contexts, not readily amenable to categorization for the purpose of comparative effectiveness research design.

You can identify say a large population of folks with stage 1a breast cancer and you can test two or three different treatments, you can

do a clinical study, or you can go back and look retrospectively at the claims data and come up with some pretty good conclusions. But the individuality of each, you know, six figure case in medical intensive care unit is another story entirely.

Yet another concern arises from the tension between the use of qualities, which are practical and I think necessary tool for this research versus ADA or Americans with Disabilities Act type of values. There are objections to discounting the value of life based on disability, objections enshrined in this statute and reflecting moral intuitions that many of us have, intuitions that are at odds with the concept of the quality.

I want to finish up by offering up what I think of as kind of a downsized, downscale, deflated version of what Senator Daschle began with when he talked about a national health board. And that is something that I'll call just for convenience a council on clinical standards for the limited purpose of overseeing and planning comparative effectiveness research and application of this research.

And this could be pursued as either a Medicare only experiment or it could be a collaborative effort between the private and public sectors meant to apply to private insurers. And this council as I'd like to set it out would have three main tasks, number one, to develop a

long term agenda for clinical outcomes research. And this would include administering a peer reviewed grant making process for the conduct of this research. We -- I'm disinclined to see it all done by the government.

Number two, to develop cost benefit tradeoff principles or frameworks to guide the crafting of payment protocols. You don't even have to put in the numbers, but develop the analytic framework so that perhaps Medicare or private insurers can put in different numbers to come up with different formulations.

And then number three, develop evidence based payment protocols for all forms -- eventually all forms of healthcare or many at least, perhaps to have them -- they could be binding for Medicare, and conduct periodic review of these protocols.

Institutional design for the management of interest group conflict would be crucial to make this work. The goal would be to channel discontent into this system, rather than to outside actors like congress with the power to scuttle efforts to set limits as the back surgeons have demonstrated in gelding AHCPR.

And so, key here is to provide ample opportunity for the affected interests to state their concerns and their supporting arguments during the process that leads to the protocols this entity might generate. And during the process, it leads to an agenda being formed for

comparative effectiveness research.

And one can enhance the political durability of creature via strategic use of budgeting mechanisms and administrative law concepts to insulate decision making processes from undue congressional and White House interference.

This is, I think, part of what Senator Daschle was trying to get at with the Federal Reserve analogy. Yes, this thing would be asked to do, as Richard has pointed out, a whole lot more.

Even the downsized version that I'm talking about would be asked to do a whole lot more than the fed. But the analogy here is one of providing some insulation from the destructive interest group and political pressures. And as part of this insulation would involve making this entity independent, apart from say, health and human services.

Council members could have staggered terms, appointed in bipartisan fashion from a roster of fancy people in medicine and health policy. And it's working agenda would include developing a strategic plan for clinical outcomes research, which would evolve with the science base in changing perceptions of need and also the development of cost benefit tradeoff principles and perhaps, the biggest challenge would be to develop payment of protocols.

And it could do that through not having a centralized council

do everything, but it could have NIH style or Institute of Medicine style study committees developing protocols, committees of research clinicians who are expert in different areas. And the paper will set out a kind of appellate process to give interest groups voice in this process.

But interest groups would not be able to control it. and I wanted to just finish up by offering up some potential benefits of doing this. We'd, number one, accelerate outcomes research greatly. There would be transparency in cost benefit decision making and there would be candor about the need to set limits. And without transparency in the cost benefit decision making, it's not going to be possible to do it because there will be kind of that whiff of scandal.

We'd be able also to offer a template for private sector cost control, reduction in clinical practice variation, the map with the different shades of blue would look less colorful, and even standards of care for medical malpractice litigation, reduce the sense of Russian roulette that makes doctors loathe and fear the medical malpractice system. And loathe and fear my students, the lawyers, who they worry will go out and sue them.

Thanks a lot. I'll stop. I know I've gone over.

(Applause)

MS. LAMBREW: All right. Thank you very much. I have

the, I think, distinct dis-privilege of being the last speaker of the day after having such a great day and should caddy out this with I did work with Senator Daschle in talking about his policy, but the policy I'm about to present, he did not endorse, as you'll see in a second.

I have no slides, I have no stories, and I am clearly sick, so I'm going to keep this short. But my paper that I'm working on is called "Constructive Deconstruction: Breaking Down Barriers to improved Health Policy Governance."

The thesis -- actually, I'm going to try to whisper if that's better -- is that better? I don't want to -- it hurts you more than it hurts me.

My thesis is that the policy process has led to unnecessary complication in the system, which has both contributed to costs, inability to implement policies to contain costs. So, in order to solve the crisis because I have to use that word, Mark --

MR. HALL: Catastrophe.

MS. LAMBREW: Catastrophe -- catastrophe, crisis, or critical nature of the situation. We really do have to fix the process. But to start with, we all know how the complex the healthcare system is. As a teacher, I try to teach it and it's very difficult.

We have different types of insurance, self funded plans, fully insured plans, public programs. We have different eligibility rules. If

you're a person with breast cancer, you might be able to get eligibility for Medicaid, but if you have lung cancer, you can't.

We have different benefit designs in public programs with differences that are not easily explained. We have different quality standards. I mean, that's one of the areas where I find it most inconceivable. Why should there be different quality standards applied to our different public programs?

Complexity by itself is not necessarily a bad thing. We know that having kind of a multiple kind of pair and multiply delivery system promotes innovation and entrepreneurial opportunities. It also enables local leadership so we've seen some real, you know, improvements in the VA system or some of the state Medicaid programs.

And it also allows patients a degree of choice, so that if you don't like what you're getting, there's this idea of voting with your feet, so you can leave and kind of force those changes, a little bit of what I think Mark was talking about with his consumer driven idea.

But we also have negative consequences of this complexity. It clearly leads to duplication and waste, the duplicative tests that get taken when you change insurance, all the kind of paperwork that's associated with it. we have the geographic variation and sporadic quality across the nation.

We have gaps and discontinuous access to coverage. We have challenges in promoting prevention and making the types of critical investments in our healthcare system because we had no way to kind of make those investments across programs.

And more importantly, what I'd like to talk about is it makes it very difficult to make changes because we don't have either an executive branch with sort of a centralized authority or kind of a congressional process that can make that happen.

Why is this the case? Primarily, it's historical. We've had this accretion of public programs over time. The employer system developed in World War II. The public programs kind of wrapped around it. we've had this kind of odd split between the states and the federal government in terms of who is responsible for what.

We have some regulatory authorities delegated to states, some kept with the federal government. Medicaid, which but for the drug benefit would be a bigger program than Medicare is 50 different programs.

So, we have the historical kind of accretion of differences, as well as the reason that it's easier to add programs than to change them. We know that s-ship was, in a way, an add on, because it was hard to go into Medicaid and change it because some of the Medicaid advocates

were concerned about that.

Excuse me. What that has meant is that we basically have a very difficult time at the federal level trying to figure out how you implement policies coherently. When I worked at the White House, we had a policy group on health policy and you wouldn't believe the number of people we had to have because DOD, VA, HHS, Department of Labor, Treasury all had some finger in healthcare. And you're trying to bring them together, figure out what their authorities were, and make a difference was very difficult.

And as a result, we also maybe -- I'm not sure if it was a cause or an effect, we had multiple committees of jurisdiction. So, when you try to figure out how to do health reform and you don't know, you kind of touch all sorts of different committees of jurisdiction, partly because of the accretion of programs, but partly because of the diffusion of power over healthcare.

Now, my solution is independent of your particular bend. If you're a free market person or a single payer person, I'm putting that aside for a second because I think the reality is that we all agree that there's a rationality in the system today and that we need a new governance system to achieve the disparate goals, irrespective of your political bend.

Now, you could argue that you can enact this within the current framework. Senator Daschle talked about reconciliation as one of the tools to get from here to there. We also know that once we have created legislation, there are ways to run it under existing processes. But I'd argue that it's hard both to pass it, sustain it, and keep it going if you don't have a new governance structure to make it work.

So, I propose four things to do. The first -- and these are a little bit controversial. The first is to consolidate the congressional committees that have jurisdiction over health. If you think about, with the multiple committees, it means that we have a diffusion of responsibilities for the different public programs and regulatory authorities.

If we have them consolidated, we can make the kind of tradeoffs that we really need to make in healthcare so that we're not looking to fund something in ways and means from something in energy in commerce. So, if we had that kind of one committee with kind of the jurisdiction on the house and the senate, we could make the kind of systemic tradeoffs that we would otherwise do.

It would have to be a big committee. It would have to be closely balanced in terms of partisanship. You might not put FDA or some of the public health groups -- or public health programs in there. But at the end of the day, if we're going to try to figure out how we make systemic

changes to the system, I'd argue we need to have sole committees of jurisdiction over health.

The second is similar. I think we need to figure out how we consolidate our federal bureaucracies. It's hard to argue why we have to have a separate and distinct bureaucracy for veterans and Indian Health Service and some of our different public programs. The idea of trying to bring them together in a more simplified system with some single lines of accountability is something I think that should be considered.

When Senator Daschle talks about his federal health board, that primarily is a standard setting organization. It would kind of figure out what should be covered, some of the things we're talking about with value this morning, how do we align some of our systems, but it really wouldn't be executing per se. it would be the federal bureaucracy that needs to do that.

If we had simplified systems, plus a standard setting agency, I think we could go a long way for implementing what we know will work in cost containment.

Third, I think that our budget rules really do work against us in trying to figure out how we get to a more rational health system. If we cut a public program but it increases private spending, we get to call that a saver, even though it's not a saver. It's shifting costs from one sector to

the other and vice versa.

If we make a public investment, for example, in health information technology, we don't get to count the savings in the private sector when we're doing the Paygo rules that determine whether or not we can, you know, get the requisite votes to pass legislation.

I think there is ways to kind of -- we've seen this in the past when in 1995, the new congress implemented a new requirement that CDO put a small business impact analysis at the back of every score. We have rural impact analyses that are required. Why not a private health spending impact analysis that might actually be linked up with some budget rules or special budget status?

Similarly, I think that we all know healthcare is harder to project and predict than anything else. Why do we have to have point estimates? Why can't we, for something that's bigger than a certain threshold, use some sort of range or build in some duplicative processes so it's not just that one number that Dr. Orszag comes up with?

And I know that he's very, very smart and comes up with good numbers, but why not think through a process that is more flexible and realistic when we try to think through the cost implications of our legislation?

I will put on the table an idea that a friend of mine, Tim

Westmoreland, has had, which is why we didn't go beyond that. And I think Dana Goldman said this a little bit in the previous presentation. He said we should be looking at price per unit of health. We do this in regulatory analysis consistently.

We always look at the quality and the impact on quality of life. Why not in our legislative process at least have the information, at most, consider it when we're trying to make our rationing decisions, which is what we do at the federal government?

In addition to budget rules for congress, I would also give HHS some investment authority. If we really do have some consolidation, we really do have some accountability, why not let HHS do what Kaiser Permanente or any other insurer does is think through what are the long run investments we need to make and give them some sort of fund, percent of their funding that they can be making investments with oversight from CBO or Medpac or somebody to really make a difference in our long run trends?

Comparative effectiveness, I would argue would have been going on long ago if we were able to kind of have an executive branch authority that could say hey, we need this and we need to invest in it and you're able to kind of get around that. I think even without the independence of the Federal Reserve board, it could happen.

So lastly, after I put on these simple easy proposals, how do you make this happen? My fourth idea is that you create what I call a trigger for action. What I would say is that congress has a choice. Congress could come up with ideas, reform the system. We all know there's plans out there, and I encourage them to do it. But, you give them a deadline.

If congress can't enact comprehensive reform, reform that does whatever your triggers are, whatever your criteria are, then the system goes into place. This is a backstop, not a first stop. And I don't know why we couldn't basically say if congress can't enact something in 2009 or 2010, we give them a deadline.

This is how we did the controversial HIPAA regulations or changing privacy regulations because we had a hard time figuring out what to do, so we gave the executive branch authority to do it if congress didn't act. I don't know why we couldn't do it in this process.

I also, coming from the state of Texas, have learned all about sunset processes. All the department -- the Texas Department of Insurance will sunset next year if the legislature doesn't reauthorize it. I think that's a healthy thing.

They review their mission, they look at their structure. They think if there's anyway to update it from the last 12 years after it was

reauthorized. Why not apply some new standards to what will potentially be a consolidated authority for health?

Now, I'll end by saying, you know, I think if we actually had such a system in place, I think a lot of what we would have -- we have today as problems wouldn't be problems. I think there's a lot of -- we know a lot of the policies that could contain costs. We just don't know how to get from here to there.

Comparative effectiveness is one classic case. I mean, I don't know why we spent so much time and energy trying to get this enacted. SCHIP is a case you can argue that it was something that was bipartisan, easy to do, but it's hard to do with our congressional structure.

I think we need to have this. I think we can see through 30 or 40 years of cost containment problems that without it, we have problems. But I will say, obviously, it is difficult.

I was thinking about calling my friends on the Hill to tell them I was doing this speech because clearly, nobody wants to relinquish power. And when I told one of them, she said that's fine, so long as you give the authority to me. Doing this is not easy. I understand that. and it clearly creates the valid fear of concentrating too much power.

That said, I can argue that if we don't figure out how to consolidate these authorities -- and I do think it's a consolidation of the

authorities, not necessarily an expansion of them. It's not creating new programs. It's not trying to figure out how we'd use something bigger or better. It's trying to consolidate those authorities.

I think we can have both more accountability, which we don't have today, and more rationality in how we think about our health policy. This would enable policymakers to execute consensus policies so whenever there's a consensus, we can move forward on them. And it also could, even if it doesn't result in comprehensive reform, allow us to begin to make those time sensitive regular changes that can make a difference.

So, I'll end by saying that, you know, there are lots of ideas out there on how we can contain costs. But I think until we figure out how we make changes in the public policy setting to enable that, all those ideas will be kind of -- the subject of a conference next year and the next year again and 30 years from now when we talk about our catastrophe. Thanks.

(Applause)

MR. HEALY: Thank you for those speeches. It's late. I think I'll go directly to audience questions to keep everyone roused. If you have any, please, we'll start now.

SPEAKER: We don't have questions?

SPEAKER: Oh, wait. Here's one.

SPEAKER: Sean, in your --

SPEAKER: We were the most boring panel. All the others had lots of comments and questions.

SPEAKER: Not at all. Sean, in your presentation, you talked about cost effectiveness, but how do we keep cost effectiveness from being used by budgeters on the Hill as simply choosing the least costly alternative to services and drugs?

MR. TUNIS: Right. I mean, I think -- so, we should add that to the list of fears, right, which is sort of the misuse, if you will, of cost effectiveness in policymaking. So, I guess, you know, what I tried to say, you know, in that small sliver of stuff about substance was, you know, that the -- there has been such a reflexive fear of even having a conversation about cost effectiveness.

You know, you can't really talk to a senior person at AHRQ, at Agency for Healthcare Research and Quality, about, you know, economic evaluations and our cost effectiveness. It's like it's explicitly, you know, a dangerous part of their portfolio. And I think if you can't have a conversation about it, you can't get anywhere.

So, we can always speculate that in fact there are going to be nefarious uses that deny people care that's really appropriate for them. But, you know, I think, you know, the work -- I think the body of work that

the National Institute of Clinical Excellence over the last 7 or 8 years shows that there are responsible ways to use cost effectiveness to get you to reasonable outcomes, not perfect and not everybody agrees, but you know, kind of along the path to something that's more rational than, you know, what we have currently.

So, you know, if -- I mean, lots of people have been saying this as just sort of a thoughtful dialogue about how it could be used responsibly in clinical policy making, you know, just seems to make sense.

SPEAKER: It's a two fold question, but they both go to the same thing. You hear countless variations of proposals. Sort of historically I'd like to know one thing. Is there any one particular proposal that we could point to which sort of gives a kind of success and aspirations that people have, which I think would be extremely important if we could identify it?

And then secondly, what's the half rate -- half life of any reform that we propose? I mean, several people have mentioned DRGs as a successful or moderately successful reform and everybody seems to think that they kind of ran out of steam, five, six, seven, eight years after they were put into place by endless sorts of accretions.

And so, the question from institutional design is, which one

of these events do we learn from and how do we make sure that it doesn't depreciate. This is a panel question to anybody and if you can answer it, I will give you a Nobel Prize personally.

SPEAKER: I was going to try to answer it until that last test. Well, my take on this is that we shouldn't set as the goal that we're going to come up with some permanent solution. And that goes back to the -- my drawing on the whole emergent systems thing.

This is an incredibly complicated system. It is going to change in inevitably unpredictable ways, that there will be perturbations that we cant anticipate that will -- you do the kind of butterfly flapping its wings in China thing with this system.

And DRGs should be viewed as a remarkable accomplishment, even if an inevitable process of accretion of complicated adjustments gradually led them -- led the scheme to grow old.

I'm reminded of a point that Justice Briar made before he became a judge in his book, Regulation and its Reform, about simplifying gestures when it comes to rate regulation that you can always -- that there's this kind of cycle.

And I don't remember if he said it in exactly this way, but this is kind of how I remember it. there's this cycle. You have a -- you make a simplifying move in which you cut out a bunch of adjustments and have a

broad sweeping rate, and then inevitably, lots of interest groups will be able to point to the little differences that they have from each other.

And there will be little changes introduced over time. And eventually, you'll have all of the complexities of cost of service ratemaking. So, you have this inevitable kind of almost gravitational force operating on a concept like DRGs to return it to the original cost plus payment system, not quite to the original cost plus system from which it came but from something closer to that.

And then you need to do something new. This is inevitably a process of -- this is a process of constant care and feeding, constant tending. It's not a system that's going to sustain itself.

SPEAKER: Everyone has talked about the importance of a system -- a cost -- a system to determine cost effectiveness that's separated from politics. and I think in the end since you're getting allocation decision, there's -- there is a political element.

And if you ignore the political element, you end up like Oregon, which had a -- which determined by scientific principles what was most cost effective and the list came out and the state went wild.

And they had -- I don't remember what they had at the end, but it was some kind of referendum or something so that the scientific cost effectiveness list was reordered by politics. it's an allocation or a rationing

decision and people are entitled to have something to say about it.

SPEAKER: I don't -- I certainly agree with that and I think, you know, Dr. Wikler's comments about, you know, one of the primary flaws in the Oregon experiment, if you will, was you know, kind of the, you know, letting the numbers speak for themselves as if, you know, fairness and other procedural mechanisms were not also necessary.

And I apologize if I'm getting that wrong, but it seems to me that the Oregon experiment did not prove that you cannot build a benefit package around -- you know, that is informed by calculations of cost effectiveness. I just don't think it was -- you know, I don't think there were sufficient processes of fairness and other mechanisms, you know, what kind of transparency, et cetera.

I think it was a failed experiment. I don't think it disproves the point -- I don't think it proves that you can't get it done.

SPEAKER: And I would just add that we have seen some states effectively use a lot of this information for their Medicaid drug programs, their state employee drug programs.

I'd also argue that, you know, look at the kind of irrational rationing that we do in the Medicare drug benefit with its donut hole and kind of all that kind of stuff. You know, we do make research allocation decisions. I'd argue that if we had this type of information aggressively at

our disposal, it would be more preferential to policymakers than the donut hole, for example.

MR. GUTTERMAN: I'm Stew Gutterman with the Commonwealth Fund. I'd like to distinguish between the perspective that any policy we come up with is somehow going to degrade as opposed to that maybe the world changes and we can't view it as final necessarily.

And DRG is probably a good example of that. I don't view DRGs as -- you know, that policy as having degraded as much as -- that it -- and it in fact helped move the world forward because it showed that we could pay on a bundled basis. And now, the, you know, people are looking at it and saying you know, the hospital stay is not the ultimate bundle of services and that an episode would be more appropriate.

But I think, you know, we need to view and you know, just because of the amount of skepticism that's bound to be generated by any policy proposals, I think we need to view these things as things we need to do now to address the problems we know now.

Our -- part of the reason that we've had the same problems over such a long period of time is because we haven't done that much to address them. I'm fully confident that our system can come up with new problems that we'll have to address with new policies if we find a way to address these. But the thing is, you know, by God, we have to address

these.

SPEAKER: I think that's a fair point. And maybe RV, RVS is a better example of something that degraded and degraded rapidly. I guess my point is that this task is inevitably a whole lot less like engineering and a whole lot more like say sailing, constantly having to make adjustments and having occasionally large scary unpredictable things happen.

MR. HEALY: If there's no further objections, I think I'd -- will elect to wrap it up there.

SPEAKER: I'm going to just make a few --

MR. HEALY: Okay.

SPEAKER: I promise 30 seconds of closing comments. Just to -- I just above all want to thank those of you who have remained and shown endurance. You are true wonks and thanks for bearing with all this.

We can't claim to have offered up a neatly packaged solution to this gory scary mess. But I hope what we've done is at least, you know, put some ideas out and invited folks to see some of the complexities involved and to realize that ideology of any stripe isn't going to solve these problems and to see that our public discussion in the press and the public space and political campaigns on the Hill and all such places isn't nearly

what it needs to be to take these issues seriously to engage the American people in the choices that need to be made.

I wish I could wrap this up more neatly than that, but it's not possible. And I think the yawning kind of open claws of Peter Orszag's curves maybe are the appropriate wrap up. If we keep nothing in mind except the open jaws of his curve and that map -- that geographical map of the different blues, which to me was looking too much like these maps of the vote after primary day, but if we keep those open jaws in mind, then we diminish our chance of getting ensnared by them.

Thank you very much for coming. Thanks a lot.

(Applause)

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