FROM BIRTH TO DEATH AND BENCH TO CLINIC

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CHAPTER 17

Health Care Costs and Medical Technology

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health care costs and medical technology

by Daniel Callahan

Framing the Issue

Almost everyone knows that this country has a scandalously large number of people who lack health insurance, now up to 46 million and growing. That number is vivid and evocative. But it has overshadowed another, more serious issue—that of the steady escalation of health care costs. Largely due to the use of medical technology, those costs are now increasing at an annual rate of 7% a year. The Medicare program as a consequence is projected to go bankrupt in nine years, and overall health care cost to go from its present $2.1 trillion annually to $4 trillion in 10 years.

Those rising costs are an important reason why the number of uninsured keeps going up. Business finds it harder and harder to pay for employee health benefits, and only 61% of employers even provide them now (from a high a decade ago of close to 70%); and the employers who do provide benefits are cutting them and forcing employees to pay more themselves in the form of copayments and deductibles. The 15% who are uninsured are surely faced with both health and financial threats. But the cost problem now threatens everyone else as well, including those using the Medicare and Medicaid programs.

Yet even if most people are now aware of the dangers of cost escalation (and many know it from personal experience), the problem has not gripped the imagination of the public, the presidential candidates, or the media with the force of the uninsured (even though recent public opinion polls indicate it is catching up). There are a number of proposed and detailed schemes for universal care, but nothing comparable for cost control, which is implicitly unpopular. That's because cost control will mean that just about everyone will be forced to give up something and accept a different, more austere kind of health care.

Consider what serious cost control will require: moving from a 7% annual cost growth down to 3%, which is an inflation of health care costs that is no greater than that of the per annum rise in general inflation. That amounts to a cost reduction of $1.5 trillion over the next decade, so that health care costs settle in at $2.5 trillion in a decade. This would represent an enormous and unprecedented drop in annual costs for a health care system that has never since World War II seen anything more than a short, temporary decline from time to time.

There are at bottom only three system-wide ways in the pres-

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HIGHLIGHTS

- Health care costs are increasing at an annual rate of 7% a year, which if sustained will bankrupt Medicare in nine years and increase the nation's overall annual health care tab to $4 trillion in 10 years.
- These rising costs are an important reason why the number of uninsured has soared, but the cost problem affects everyone.
- Unlike the problem of the uninsured, the cost problem has not captured the public imagination.
- New or increased use of medical technology contributes 40–50% to annual cost increases, and controlling this technology is the most important factor in reducing them.
- Universal care is the only tried and effective way to control costs but will involve a large cultural shift because cutting the use of technology will seem wrong—even immoral—to many.
- Our dialogue on health reform needs to move beyond organizational and management schemes to an examination of our fundamental values about life, death, and how we allocate our resources.

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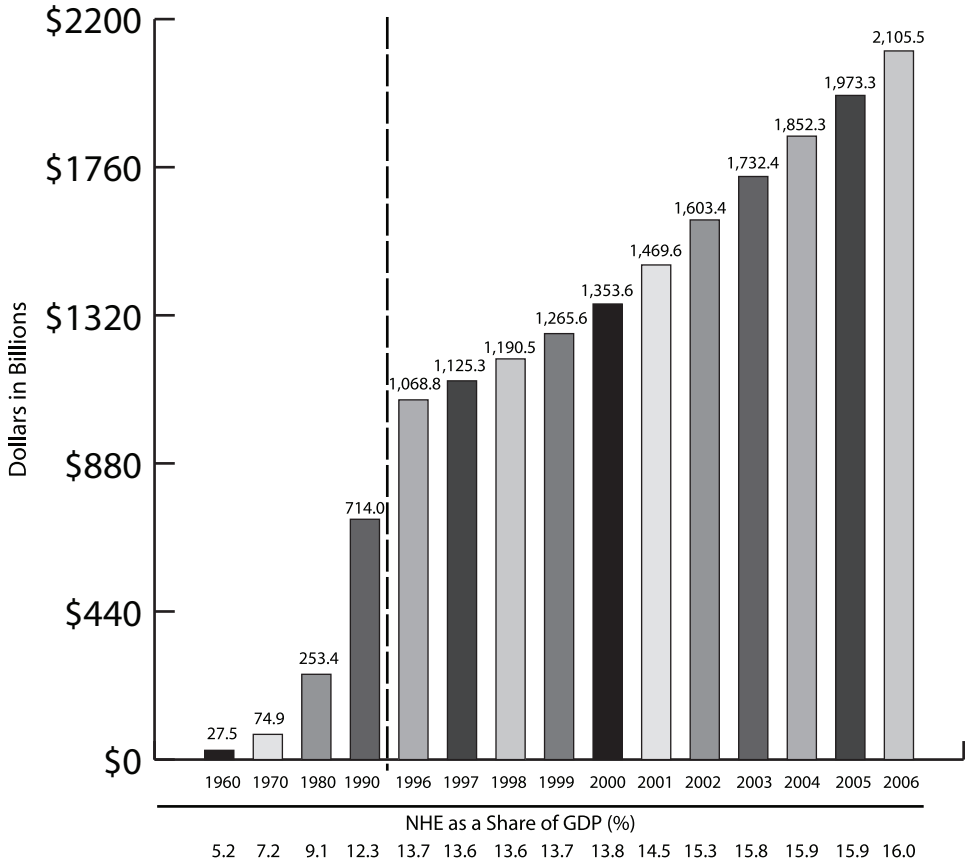
National Health Expenditures and Their Share of Gross Domestic Product, 1960-2006



Source: The Kaiser Family Foundation, Kaiser Fast Facts. Data Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

ent system to deal with the high cost of health care, each of which would be unpopular. One of them is to sharply raise taxes to pay for government programs such as Medicare, and for private insurance to do the same with the price of premiums. Another is to drastically cut benefits, giving people less care. Still another is to force individuals to pay more out-of-pocket for their care.

Medical Technology: The Main Cost Driver

The feature of cost escalation that should catch our eye most is the role that medical technology plays. Health care economists estimate that 40–50% of annual cost increases can be traced to new technologies or the intensified use of old ones. That makes the control of technology the most important factor in bringing costs down. Ethics comes in at this point because medical technology is highly valued as a beloved feature of American medicine. Patients expect it, doctors are primarily trained to use it, the medical industries make billions of dollars selling it, and the media loves to write about it. The economic and social incentives to develop and diffuse it are powerful, and the disincentives so far weak and almost helpless. Cutting the use of technology will seem wrong—even immoral—to many.

Even among the economists and others who concede technology's central role in the cost problem, there is considerable ambivalence about how to deal with it. Technological innovation is as fundamental a feature of American medicine as it is of our industrial sector. After all, that innovation has given us vaccines, antibiotics, advanced heart disease care, splendid surgical advances, and fine cancer treatments. And many diseases and crippling medical conditions remain that call for yet more innovation. The opposition to imposing controls on costs is politically more intransigent than the opposition to providing universal coverage. In the case of technology, this opposition is deeply rooted in American culture, which has an obsession with health unmatched by any other society. Comparative public opinion surveys in Europe and the United States indicate a much greater belief in the benefits of technology in this country. An astonishing 40% of Americans believe that medical technology can always save their lives; many fewer Europeans share this fantasy. The old joke that Americans believe death is just one more disease to be cured is no longer a joke. No wonder Brookings Institution economist Henry Aaron—who has prominently called attention to all the problems of technology—has nonetheless written that any effort to curb the introduction of new technologies "beyond what is required for safety and efficacy would be sheer madness."

Indeed, Congress—with support of physician groups and the medical industry—killed two federal agencies designed to assess medical technology from a scientific and economic perspective. Ever since the advent of Medicare in 1965 Congress has not allowed that program to take costs into account when determining which technologies and treatments it will cover.

Changing Values and Seeking Solutions

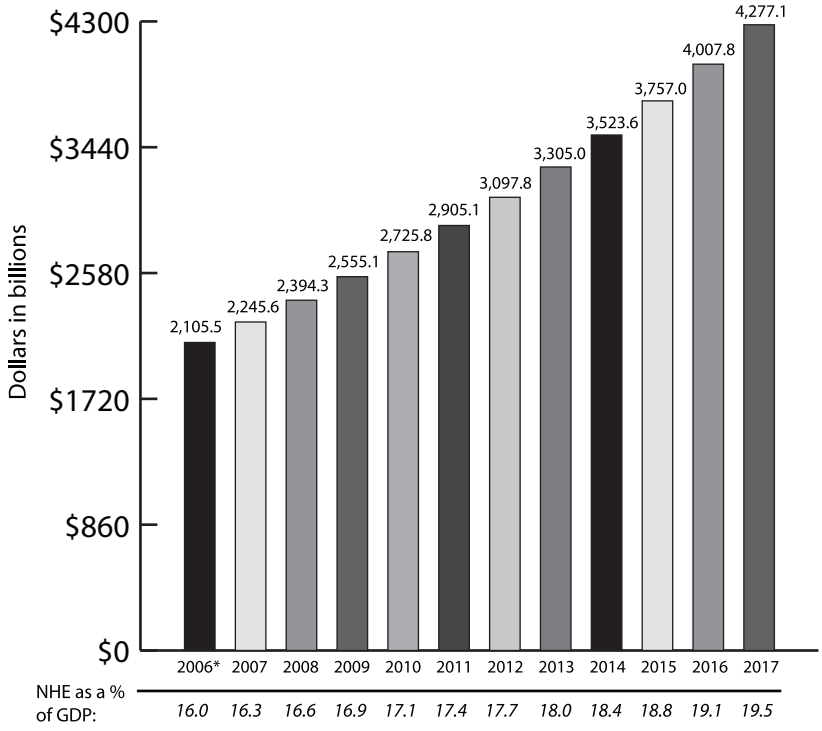
What then can be done about costs? There are a number of ideas available to meet the challenge, few of them rooted in any experience or evidence. The long-time favorite has been that of eliminating waste and inefficiency, which I liken to keeping the dust out of a drafty house located in the middle of a desert. Medical information technology is a more recent candidate, along with increased efforts to advance disease prevention efforts, consumer-directed health care, and disease management programs.

These are all attractive ideas, but they share a common and crippling handicap. In our messy and fragmented mix of public and private health care there is no effective leverage to put in place good but painful ideas. Government might manage to implement some of them, but only after a long and difficult fight. The private sector has never shown much capacity to do so and, with its market philosophy, it would surely resist government's efforts to impose cost control mechanisms.

Universal care is the only tried and effective way to control costs. The European health care systems do so effectively by means of a strong government hand. They use—among other tools—price controls, negotiated physician fees, hospital budgets with limits on expenditures, and stringent policies on the adoption and diffusion of new technologies. The net result is that they keep annual cost increase within the 3–4% range, have better health outcomes than we do, and achieve all of this at significantly less cost. With the exception of the United Kingdom and Italy, there is little rationing and there are no waiting lists for care.

These methods work well but are culturally and politically unacceptable here. For me, that is the fundamental dilemma in trying to think through the problem. Controlling health care costs requires a change in culture, not just in the management of health care. Since many of the effective means of controlling costs will be painful for us because of our bemusement with technology, resistance to change will be formidable. Effective control will force patients to give up treatments they may need, doctors to sacrifice to a considerable extent their ancient tradition of treating patients the way they see fit, and industry to reduce its drive for profit. Hardly anyone will want to do such things. Liberals will oppose it because, though they favor universal health care, they are also children of the Enlightenment, wedded to endless scientific progress and technological innovation. Economic conservatives will oppose it as an interference with market freedom and consumer choice. Social conservatives will see the necessary rationing as a form of social euthanasia, killing off the burdensome in the name of cold-hearted economics.

Projections of National Health Expenditures and Their Share of Gross Domestic Product, 2006-2017



* 2006 are actual data from the 2006 National Health Expenditure Accounts; 2007-2017 are projected data from the 2006 National Health Expenditure Accounts

Source: The Kaiser Family Foundation, Kaiser Fast Facts. Data Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

RESOURCES

Web sites

- www.allhealth.org -- Alliance for Health Reform
- www.iom.edu – The Institute of Medicine of the National Academies. Includes reports and issue briefs on public health policy matters, including rising health care costs and the problem of the uninsured.
- www.cms.hhs.gov – The Centers for Medicare and Medicaid Services. Includes research, statistics, data, educational materials, FAQs, and a newsroom.

Recent news

- Robert Pear, "Fed Chief Addresses Health Care and Its Costs," *New York Times*, June 17, 2008.
- Christopher R. Anderson, "Righting Healthcare Reform," *Boston Globe*, March 31, 2008.
- "Medicare's Financial Woes" (editorial), *New York Times*, March 28, 2008.
- "Technology's Temptation" (editorial), *Boston Globe*, February 19, 2008.
- James Roosevelt, Jr., and Charles D. Baker, "How to Control Healthcare Costs," *Boston Globe*, December 1, 2007.

Further reading

- Sean Keehan et al., "Health Spending Projections through 2017: The Baby-Boom Generation Is Coming To Medicare," Web exclusive, *Health Affairs*, February 26, 2008. Available at http://content.healthaffairs.org.
- U.S. Congressional Budget Office, *Technological Change and the Growth in Health Care Spending*, 2008. Report available at www.cbo.gov.
- Henry J. Aaron, "Should Public Policy Seek to Control the Growth of Health Care Spending?" Web exclusive, *Health Affairs*, January 8, 2003. Available at http://content.healthaffairs.org.

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However, in principle, cost control is a problem that can be solved. Our health care system indeed contains waste and inefficiency, enormous and absurd variation in costs from one geographical region to the next, a great deal of useless or only marginally useful treatment, great possibilities in disease prevention programs, far too few primary care physicians and geriatricians, and far too many specialists. The fact that the European countries can control costs and limit technologies without harming health is a patent rebuke to our way of doing things.

Can we get there from here? There is a huge economic gap to be closed and no less of a cultural gap as well. We have become accustomed to live (and die) with an expensive and disorganized system, one that serves many ends other than health—a system designed for ever-increasing affluence. It builds upon a model of health and of medical progress that is open-ended and infinite in its aspirations. Suffering, aging, and death are enemies to be conquered, at whatever the cost to other social needs.

We need a good dialogue on health care reform, but one that moves beyond organizational and management schemes. They are important but no less so than some deeper matters:

- Should death be seen as the greatest evil that medicine should seek to combat, or would a good quality of life within a finite life span be a better goal?
- Do the elderly need better access to intensive care units and more high-tech medicine to extend their lives, or better long-term and home care and improved economic and social support?
- Does it make any sense that the healthier we get in this country, the *more* we spend on health care, not less?
- Should we be spending three times more of our gross domestic product on health care than on education, when 40 years ago these amounts were about the same?

For me, those are rhetorical questions. But for everyone, questions of this kind are the place to begin any serious discussion about the control of costs and technology—and that discussion merits attention every bit as much as that of the uninsured. It will be harder but even more necessary.