Health Care Cost Management: Has the Private Sector Lost its Chance?

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Thank you Steve very much, good morning. I very much appreciate the opportunity to be here, as Steve mentioned I do not come to New England very often. I did get some amusement from Stephen's admonition to be sure not to duck controversial issues, and to be provocative - those of you who are familiar with my work realize that's like advising Refrigerator Perry to stop picking at his food or Danny Ainge to get physical.

I am going to jar a few of the people who were expecting to hear a ringing defense of Reagan-era health policy. I couldn't find one to defend. The Reagan administration had a *fiscal* policy swathed in a rhetoric of self-sacrifice and competition. You won't hear a lot either about the impact of competition on our health care system over the last 7 to 8 years, because we haven't had much of that either. There's been almost no meaningful de-regulation of our nation's health care system during that period of time. And even in the wild and wooly west, in California. where conventional forms of hospital payment and physician payment have virtually disappeared, cost conscious, quality providers of health care services have yet to be rewarded with additional volume or patronage by people switching from less efficient or less high quality providers of care.

What I am going to try to do instead is address what I gather our central issue of our session - the appropriate role of government in the American health care system. We are, as we've been told, *ad nauseum* a wealthy nation. We will spend this year in excess of $540 billion on health care services. And yet we live in the midst of this plenty with the paradoxes (and sad paradoxes they are) of a large population with no health insurance at all, and a very large body of illness, chronic Illness, for which no insurance exists except the pauper's insurance provided by Medicaid. As a conservative, I find the existence of these problems in the midst of all this plenty a moral indictment of our society. And I am not naive enough to believe that market forces will solve either of these problems any time soon.

Let us begin our investigation of this issue by discussing the proposition that most Americans believe they have the right to health care. I challenge those of you who believe such a right actually exists to go find it. It is easy to find it in Canada. You just look in the preamble of the Canada Health Act. Universal access to health care is a condition of citizenship of the Canadian nation. You will not find such a forthright legal statement in our country. You may argue that malpractice insurance has provided us a right to perfect results after the fact. That's the closest I can come to a legally guaranteed right to health care. The belief that we have a right to health care is grounded in a lie - a complicated lie - told to us by an earlier generation of politicians who, for better or worse, are no longer here. The reality is that less than 40% of those living in poverty in the United States are eligible for medical assistance under the nation's Medicaid program. And despite catastrophic health insurance, most elderly are still naked as jaybirds relative to the cost of chronic illness such as Alzheimer's Disease. While it has become fashionable to blame greedy employers or heartless insurers for these problems, the roots lie in the inherent defects of the government programs that were put in place in the 1960s to try and address the health care needs of these two very important populations. Those flawed mechanisms have combined with a progressively declining commitment to protecting the poor, and the growth of the very large underclass to create vast gaps in our nation's health insurance system.

A right or entitlement to health care implies a government guarantee, both of the resources and control over how the resources are used to see that that entitlement is delivered. We are often reminded by our Canadian colleagues that our nation is the only major nation on earth without a national health insurance system. It is equally significant. that only in the United States that government provides a minority of the funding for health care services for its population. In fact, the government provides only about 42% of the total health care resources in our country. compared to about 75% in Canada, and 900%+ in Scandinavian countries.

The latest panacea for the problem of the uninsured, is a program, such as you've enacted in Massachusetts, mandated health insurance benefits. It is a politically elegant solution in an era of scarce resources. It distracts public attention from the declining commitment of governments and politicians to protecting the poor by blaming the problem on employers. It also extends benefits to the uninsured without the politicians having to incur the political costs of raising taxes. But I believe there is a serious problem with this approach. It is a problem of exercising of authority without responsibility. We tend to spend other people's money, both as individuals and as a society considerably less carefully, than we spend our own money.

If enacted nationally, mandated benefits would constitute roughly a $40 billion tax to fall selectively on the small employers in our country. who have produced nearly all of the new job growth we have experienced in the past 20 years. And unfortunately for those businesses, it isn't a tax that would stay at the $40 billion level for more than a few months. I have personal experience with the market for small employer health insurance, because I am the proprietor of a small start-up company. Our firm faces the direct trade-off between the ability to grow the firm and the necessity of providing benefits, including health insurance to the employees that we already have. The mandate of health benefits to the small employer means sequestering a significant chunk of the working capital that creates new jobs. Employers like myself will steer clear of states and regions of the country which decide how to allocate those dollars for us. The jobs that we create will go elsewhere.

My other experience. which is a somewhat more distant one, is part owner of a company that sells medical benefits to small firms through multiple employer trusts. That experience has taught me that the small-employer group insurance market is in chaos. It is an underwriting nightmare for large and small insurers alike. Cost of insurance benefits to small firms is presently rising by 40 to 60% a year. Which means the cost of mandated benefits will double in a 2 to 3 year period of time. No politician in his right mind would enact a tax that doubled in less than 3 years. They would be blown away by the resulting electoral reaction. But the ability to mandate the expenditure and hide the cost in the general inflation rate (e.g., paying $2.50 for a hamburger at McDonald's), makes it possible for politicians to escape paying the stiff political cost of devoting tax resources to meeting the needs of the poor and uninsured themselves. The nice part of the bill you've enacted in Massachusetts Is that you've given yourselves 3 years to evaluate what you have done and repeal it, and substitute for it an appropriate method of public financing of those services.

Realistically, if government is to guarantee an entitlement to health care services. It is going to have to come up with more than the 42% that it currently devotes to the nation's total health care bill. It is going to be very difficult for any government to do this without substantially reallocating dollars from other sections of our total economy or raising taxes in some fashion or other. In other words, the ability to grow authority by growing the responsibility for financing care is likely

to be very limited. Another constraint on the ability of government to guarantee an entitlement to health care services relates to our managerial record in dealing with the health care system. How good a job have we done through government mechanisms in managing our nation's health care system? One of the problems I think we are going to have managing/exerting central control over our nation's health care system relates to the scale of the enterprise. As you can see, the U.S. health economy is the size of a large Industrial nation. In fact, in 1985, there were only 5 nations on earth that generated more total wealth than we spend as a society on health care in our country. in talking with Jonathan before our program, we discovered that the American health economy is $ 100 billion American dollars bigger than the entire Canadian economy. So you have the initial problem of the massive scale of this enterprise and the political and other baggage that that scale carries with it.

Now the traditional reasons for explaining why government hasn't done an effective job in constraining our health care system is because of the political power of providers of care and vendors.

But I think there is a deeper problem that bears on our ability to manage this mammoth economic activity. And that is for a variety of reasons that disturb me as a citizen, Americans seem to do an abysmal job of managing things we declare to be public goods. we have created in our country a whole new class of oxymorons: public education. public housing, public transportation. The word public is. when attached to a service, becoming an epithet. We tend to provide ourselves those free goods in a fashion that none of us would really buy if we had a choice. We starve our public institutions for capital. And gradually erode their Infrastructure. We preside over a gradual decline in real dollar operating support. We pay its managers inadequate sums, and thus fail to recruit top quality managerial talent. We impose political constraints on the managers we do recruit that make it virtually impossible to administer these systems, let alone manage them effectively.

Looking specifically at our managerial record in public health care system, with the shining exceptions of our National Institutes of Health and the extraordinary maintenance efforts in our biomedical research, It is not an inspirational record. We have for example the Veterans Administration, a truly surplus health care system, that functions as a vast patronage sink for our local Congressmen and a large public employment program being maintained at a time when we have 350,000 empty hospital beds in our private sector. We have our nation's public hospitals that have struggled valiantly to serve the large uninsured population with very little political or financial support from government or the general public. We have our nation's Medicaid program, which has not only progressively over a period of the last 20 years abandoned the people it was designed to serve, but in many states has been riddled with fraud and abuse. Medicaid has been responsible for creating a nursing home system where none of us really feel comfortable about placing our elderly parents or relatives. In fact, Medicaid payment for nursing homes in many states, is so inadequate that in order to stay in business, you have to get your raw food costs down to a dollar a day per patient.

The record in health insurance is little better. We have had an extensive experiment with mandated benefits in our country: the nation's workers compensation program. What is the record there? A program that is also riddled with corruption, waste, kickbacks, occupational health mills, and a staggering cost to our nation's employers without a measurable payback in the productivity of our workforce.

On the regulatory side, we've had a whole raft of alphabet agencies, HSA. CON. PSROs, etc. which all seem to have in common, cost without apparent measurable benefit. We have had rate review programs for hospitals, systems of budgeting for hospital resources. How effective you feel rate review has been is as much dependent on religious values as it is on the numbers, but at least the data we have suggests a marginal record. After doing marginally better than the free market states in the late 70s and early part of the 80s, the rate review states actually had a substantially higher percentage increase in per capita hospital expenditures than allegedly free market states such as California from 1983 to 1986. It is not obvious that this mechanism is really an effective cost containment tool.

The most significant cost containment achievement - the downward trend line for Medicare hospital payments under the DRG Prospective Payment System - even that success has been tarnished by the insistence of the federal budget managers in holding hospital reimbursements so far under the rate of inflation that they have precipitated a cash crisis and driven many otherwise well-managed hospitals to the brink of Insolvency. On the public health side, we've had the swine flu vaccine fiasco, and more recently and tragically the near paralysis in responding to our nation's most serious public health crisis in a generation in AIDS.

There is little comfort in this record of accomplishment to suggest that a wider role of public management of the health care system is going to produce the results we are looking for as consumers and citizens and taxpayers. Now you're probably saying, what is the answer, what is the appropriate role of government. Rather than tell a new wave of lies to a new generation of voters that weren't around for the last wave, we ought to keep the promises that we made to the poor and elderly back in the 1960s and reform our nation's public health care financing programs to reflect new demographic and epidemiologic realties Those programs Medicare and Medicaid are antiques and need to be revised not only to fill the gaps in cover-age that exist today, but also to cover the substantial unmet future health care needs. our nation's Medicaid program should be removed from the welfare department, decoupled from categorical assistance to the needs, renamed to strip it of the welfare cast, and refocused on the non-elderly poor. The responsibility for financing chronic care services to the elderly should be a federal responsibility under the nation's Medicare program. States should not be given the option - as states like Texas and Tennessee have - of defining poverty in their state as an income of $2,500 a year for a family of 4. That is also a lie. Standards should be established so that people living at 80% or below poverty line of their communities should have access to publicly financed health insurance programs, regardless of which states they live in. For people above that threshold, with some degree of resources. they are their employers encouraged to buy into the program in proportion to their resources.

The Medicare program must be refocused on the problem of chronic Illness. It is going to be essential for our nations Medicare program to eliminate many of the insidious forms of subsidy that we have tolerated in that program to date. While Medicare has masqueraded as a health insurance plan, it is in fact a deeply regressive income transfer program that transfers wealth (as is to some extent inevitable in any welfare state) from the working to the non-working population. But it also transfers wealth from people who arc renting their own homes and will never be able to buy one themselves, to people who own their own homes free and clear. That uninsured worker at MacDonald's is subsidizing through his Social Security deductions medical benefits being provided to retired doctors and lawyers. To put it somewhat rhetorically, should Sam Walton or Armand Hammer have rights to health care financed at the public's expense? I don't think so.

Part of our problem is that we as a society find it much easier to finance entitlement programs, which some of us call welfare to the well-off than we do to provide the limited amount of resources we have as a society to the people who are truly needy. We're borrowing ourselves into oblivion as a society to give money to people who could get along without it. If we do have limited resources, it seems to me that those resources should be focused on those most in need, and that people should contribute to health insurance payments in proportion to their incomes. There is going to be a need for incremental funding -there is no way you're going to move the Medicare program into the financing of long term care without more money. Where that money comes from is a function, obviously of one's political preferences. I would cut the agricultural subsidies to plantation owners and agribusiness firms. We pay for these subsidies twice - when we pay taxes and when we buy food. But I guess everyone has their own sacred cow of somebody else's they'd like to butcher. But 42% of the total health care spending from public resources, even if it were rearranged and purchased more efficiently isn't going to be enough to meet those chronic care needs.

Because of the inevitable shortage of public capital, public programs are going to have to do everything they can to try and lever-age not only private health insurance markets, but private capital formation to provide a body of resources to supplement what governments can afford to spend in caring for our elderly population. We need a vital private sector in long term care Insurance precisely because public dollars are going to be limited. We are going to need strategies from the government which encourage people my age to begin setting aside resources, so that when the Medicare program can't pay for our health care needs, there'll be a body of private capital available that we were encouraged to set aside to do so. Our federal government particularly can do a very effective job of encouraging experimentation and Innovation in new forms of health care financing and delivery that can address some of the pressing problems that we have identified. A perfect example of that would be the Social Health Maintenance Organization project which represents government at its best. The S.H.M.O. experiment is an elegant mechanism from bridging between acute and chronic care financing that uses some of the savings from reducing unnecessary acute hospital use to finance many of the social and human services that chronically ill people need, but funding of which was excluded from the original Medicare program.

We are a wealthy society, but I do not believe we are wealthy enough to treat health care as though it were free. Given the management record we talked about a moment ago, our nation's health care system is too important to treat it as a public good. If we really can't think of healthcare as an entitlement how should we view it? I believe we should view health services as precious resources that we must all have an economic stake in conserving. I use the word conserving deliberately to contrast it with the bitter medicine/rationing language that some of your fellow New Englanders are using. Conservation implies something we do voluntarily to protect something of value. Rationing, at least to me, implies something that a government imposes on a lot of people who don't understand the value of the commodity they are using. One of the reasons I think that rationing is bitter medicine is that it is the wrong medicine for dealing with our nation's healthcare problems.

What's really been happening out there in the last 6 or 7 years, in my judgment as a field observer, is not competition so much as a rearrangement of the economic responsibility for the cost of health care services. After all what do DRGs and Capitation and negotiated contracts do to hospitals and physicians? It put them at risk to a degree that they had never been before, and

provided incentives for them to control and to conserve the use of their resources - both institutional and physician resources - in caring for patients. What did cost sharing do for patients who were asked to pay a larger portion of their health care bill or larger portion of their health care premium? By encouraging them to spend a little more of their own money on health care services, it encouraged patients to start asking "What is the real value received to me?”

The fallacy of global budgeting as a policy approach is that you can meaningfully affect the doctor patient relationship (where all the costs are generated) by filtering that message of conservation through ten or fifteen layers of bureaucracy and hospital management. By the time it reaches the doctors and patients, it's sort of a hushed whisper in the hall. You're not really telling them to change their behavior in any meaningful way. You're just creating a tatty, shopworn atmosphere that you hope in some indirect way will result in a conservation of resources. I think we're more mature as a society than that. I think a lot of Americans want to know the value of a medical encounter that they receive. in terms of its impact in improving the quality of their lives. One of the by-products of this so-called competitive era is a concerted effort to measure the value of a medical encounter - and to ask is health care really worth the price that we are paying as a society? Physicians and patients are the people who generate healthcare costs in our society and. until both are more directly accountable for the cost and quality of services provided to them, and have to worry a little, not a lot. about the social costs that their interaction generates, we're not going to have meaningful cost containment. No person should be asked to bear all of the economic risk of health care, as indeed the uninsured and those exposed to the cost of chronic illness are today. But by the same token, nobody should be free of that economic risk either. I believe as well, that physicians and hospitals interacting with patients should not be doing so under no-risk arrangements. Hospitals and physicians need as well to share a portion of the economic risk and cost associated with the use of their services.

For better or worse, our nation's health care system Is a reflection of our society and provides us a remarkable, sometimes sobering picture of ourselves. It displays, for example, our optimism and faith in the perfectibility of man. But at the same time, it shows us a shallow and futile quest for eternal youth and immortality. Our health care system reflects a reverence for science that has also has as its noxious by-product an exaggerated faith in the efficacy of technology in improving the quality of our lives. Our nation's health care system displays a flair for drama and heroic measures. We have fleets of helicopters and trauma systems, patrolling the skies and streets for people in extremis. But at the same time, it shows a startling obtuseness to illnesses that only gradually overtake us, and inexorably cripple and kill us. We have in our health care system an outpouring of private capital. not only investor capital. but philanthropic dollars. A significant number of hospitals in the major cities in our country were not built by our government, but by private philanthropy. At the same time we have a depressingly high tolerance for inequity and an ability to ignore those In the most serious need. As a society we are extraordinarily lucky. We have the resource base - unlike other countries to fix these problems and to craft a spectacular health care system for the 1990s and beyond. And I don't believe it is an absence of central government direction of our health economy that stands in our way, so much as a lack of vision and a shortage of political courage. Thank you very much.