



# The NEW ENGLAND JOURNAL of MEDICINE

## Perspective Roundtable: The Cost of Health Care.

### Introduction

**DR. ATUL GAWANDE:** Welcome to a Perspective Roundtable from the *New England Journal of Medicine*. I'm Atul Gawande, a staff surgeon at Brigham and Women's Hospital and an associate professor of surgery at Harvard Medical School and of health policy and management at the Harvard School of Public Health.

One of the key goals of the current health care reform effort in our country is to achieve universal health coverage. But everyone agrees that it will be impossible to afford health care for all, even afford it for those who have it now, if we don't find a way to contain our very high and rapidly rising health care costs. Today, we want to discuss the economic dimension of health care reform. How can we reduce overall health care spending, or at least its growth, before it bankrupts the country?

With me here to discuss the economics of health care reform are Elliott Fisher, a professor of community and family medicine at Dartmouth Medical School and director of the Center for Health Policy Research at the Dartmouth Institute for Health Policy and Clinical Practice. We have Jonathan Gruber, a professor of economics at MIT, and Meredith Rosenthal, an associate professor of health economics and policy at the Harvard School of Public Health.

### Why We Need Cost Control

So let me start with you, Professor Gruber. Is it actually that important that we reduce how much we spend on health care?

**DR. JONATHAN GRUBER:** In the long run, cost control is what it's all about, because ultimately the federal government will be bankrupted by the costs of medical care. Here's one simple example. Just to pay off what Medicare is going to owe under projected law with no changes, we'd have to raise the existing payroll tax rate which is 2, a little over 2%, to about 14%. And that's just — and that's under very conservative projections, actually. So if we want to keep our fiscal system in order, we need to control the cost of health care.

**DR. GAWANDE:** Well, but if this is what it takes to save people's lives, if it's taking more of our economy, and this is what people want to spend their dollars on . . . We're spending more and more dollars on little tiny electronic gadgets. Why not on health care?

**DR. GRUBER:** If you want to take that perspective, then we need to move to a system where voters and consumers understand that set of priorities. That means, for example, not including a bunch of subsidies towards health care that are sort of hidden in our tax system and in our spending system, but making clear to consumers what they're spending. If, in that situation, America decides that they vote 50% of GDP to health care, great. What's more important than your health? But we're in a situation today where Americans don't understand what they're devoting to it and don't understand that they're not really getting the value for their dollars.

**DR. GAWANDE:** Professor Rosenthal, do you agree that inflation of health care costs is this fundamental as Professor Gruber lays it out to be? And if so what are the kinds of options or strategies we have, if you do agree?

**DR. MEREDITH ROSENTHAL:** I think surely this is true. And I think aside from the public burden of increased Medicare and other government spending on health care, I think we have to recognize that the high and growing cost of health care also means that we can afford to cover fewer people and to subsidize less the health care for the low-income folks. Even if we do get universal coverage, there are going to be serious equity implications for high cost growth.

So I think looking at reforming the health care payment system would be number one on my list for ways to start approaching cost control. But I think more broadly, we need to have a more open societal dialogue, I think going back to what Jon said, about what our priorities are. And we have never in this country been comfortable talking about rationing explicitly. And I think there's a need for that dialogue informed by evidence.

### **The Payment System**

**DR. GAWANDE:** So I'm interested that the first place you went to is the payment system, how I get paid as a surgeon. And that implies that our payment system, when we think about the runaway health care inflation problem, that the payment system is the root cause of it.

**DR. ROSENTHAL:** Well, of course it's complicated. The payment system interacts with things like norms and other aspects of the institutional nature of health care. But we have very good reason to believe that because we pay for units of service, for visits, for surgeries, for days in the hospital, that we get more of these things. And there's good evidence from experiments and natural experiments that show very significant changes in patterns of health care when payments change.

**DR. ELLIOTT FISHER:** I think it's a subconscious influence on the way many of us practice. And a lot of it is driven by the environment within which we practice. Hospitals are paid the same way, and hospitals need to balance their books, and often are recruiting more physicians who have — provide services that have higher margins that are more profitable, so that the hospitals can balance their books.

But I think the way it influences our practice is in very subtle ways. Medical care system currently, fee for service does not pay for us to have long conversations with our patients. When we're feeling constrained, as many of us are in the

current system (price for an office visit isn't very much), it's much harder for us to have that long conversation with a patient with heart failure to see if we can safely manage them at home.

The default position in many communities becomes, "Gosh, I'm too busy. I better send them to the emergency room." The emergency room physician recognizes full well that they don't have time to manage the patient with heart failure in the emergency room, so admits them to the hospital. To the extent that those resources are available for us and we're not paid to do the things that we really would like to do or know we should do, we see huge differences in the likelihood of really unnecessary hospitalizations in different communities.

**DR. GAWANDE:** So if payment systems are one of the core things to address, how do you address it? What are the proposals that are actually out there being offered? And Jon, I think you're being asked to actually make cost estimates based on some of these proposals and what they're going to do.

**DR. GRUBER:** Okay, the right answer is, managed care 2.0 done smart. And by "done smart," what we mean is the following: a) smarter on the input side, which is, don't just pay a flat fee, pay in a risk-adjusted way based on what's wrong with the patients. And the second change is on the output side; don't just reimburse them flat out, but reimburse them based on the quality and the value of what they deliver. And put it together in what we call an accountable care organization, we know what to do.

The problem is, we're pretty far from legislative language. And there's not that, quite frankly, can be in a bill by October 15th or by November 15th or probably even in the next couple of years. My feeling is, as we look to this round of reform, the science of coverage has gotten so far past the science of cost control that that's why I feel like the President, on one level, did a bit of disservice holding up cost control as such a key feature of this round of reform. Because quite frankly, we can't do yet what Elliott wants us to do. We know theoretically what to do.

What we need to do in this round is set the predicates, set the landscape so that that can happen. That means, I think importantly, setting up institutions to study comparative effectiveness so we can get that information in place, and importantly in my view, making consumers more cost-conscious so that they're more receptive.

Until we're willing to tell doctors and the patients they can't have everything they want, we can't control costs.

**DR. FISHER:** Boy, I think there's so much unnecessary care in the current system that right now we can give patients everything they need and would want if well informed. I'm absolutely convinced. I don't think patients want unnecessary hospital stays. I think they'd much rather stay home than go to the hospital when they have heart failure. And we as physicians would much rather be able to take care of them in ways that are safer for them. I think the payment system and a number of other things, our sort of cultural norms in many places, drive us to do unnecessary things.

**DR. GAWANDE:** There is no solution like, "Put everybody on salary. That'll solve the problem." We — first of all, we're not sure that works. But second of all, we don't know how to do it in a safe way. So what is a possible next step?

**DR. ROSENTHAL:** It's not just that we don't know what the end goal should absolutely look like. Even if we knew the global payment system, risk adjusted with quality incentives, at the end of the day that we'd like to see, we have a delivery system that can't operate under that payment system. We have a very fragmented delivery system. And obviously conversations about accountable care organizations is part of trying to knit that together. But there needs to be a transitional payment model that would be paired with a transition in the delivery system.

And I think most of the proposals along those lines involve bundled payment of one form or another. Bundling payment for readmissions with the primary admission is the smallest piece of that. But there are payment models like Prometheus payment that are looking to put together all the components of care for a clinically defined episode, and try to get various clusters of providers maybe acting as medical groups, maybe working together collaboratively to accept risk for those episodes. So I think that's the path towards a more global payment model.

**DR. GAWANDE:** Experimenting with these kinds of approaches makes perfect sense. Imposing it across the country as the way we're now going to pay everybody as of January 1, 2010, would cause havoc, because we're still figuring out if it even works for a single disease. And so, first of all, what are the provisions in health reform that can — that can push us down the path of trying these experiments?

**DR. FISHER:** I think the House legislation that we've seen so far and the drafts of the Senate legislation from the Senate Finance Committee that we saw earlier all include pretty aggressive pursuit of pilots on all of these dimensions, whether it's medical home payments for primary care, essentially bundling payments to support-- strengthen primary care or accountable care organizations, or bundled payments and readmission payments.

### **A Public Insurance Option**

**DR. GAWANDE:** But then there's all these other possible approaches that people are suggesting. So one that is very much on the table is the idea of a public option for insurance coverage.

**DR. GRUBER:** The important aspect of a public option is: will they regulate rates that are paid to providers within the public option, as is in the House legislation, for example? And that's, among sort of the thinking people in this fight, what the battle is about. The less important part is who owns the plan. Is it GovCare or Aetna? Well, the truth is, if they're paying competitive private rates, it doesn't really matter that much.

**DR. GAWANDE:** So does paying providers less change the cost of the system?

**DR. ROSENTHAL:** If the public option could come to the table with a reformed payment system, a radically different payment system, and perhaps not contract with every provider, allow certain accountable care organizations and others to come forward, it could perhaps innovate in a way that's just not possible based on the way health plans compete in our system now.

**DR. FISHER:** Although we don't necessarily need a public option to do it. We have, for the Medicare population — a large population that is very interested in some of these pilot — you know, in some of these new ways of paying.

**DR. GRUBER:** The problem is, politically, we've tried Medicare pilots and they get killed. But if this legislation could bring the hammer down, say, you know, "We are going to have these pilots even if local politicians don't want them. We are going to have these pilots," then that would be a very significant step forward. We have a goal we'd like to achieve, which is to bring our health care costs under control in a sensible way. That's a goal that we don't know how to achieve yet.

**DR. GAWANDE:** What about the argument, though, that we do know how, single payer? If we had a single-payer system, this would control our costs.

**DR. ROSENTHAL:** I mean, I think if you — if you just look at Medicare today and all you did was expand it to the rest of the citizenry, then we'd still be facing the same problems that we're facing now. So I think, again, you need a — you need a shift in social decision making around health care. And I think there's been some conversation about creating an entity that would be somewhat politically insulated that could make and really implement decisions about reform — an entity with the legitimacy to guide the country towards making more reasonable tradeoffs in terms of— in terms of how much and— and what we want to spend our health care dollars on.

**DR. FISHER:** There are more optimistic visions of what a single payer might do, become an aggressive, you know, supporter of reorganized and improved care. That's a different vision of what a single payer might be like, one that I could be attracted by.

### **Consumer-Based Approaches**

**DR. GAWANDE:** The other point of view is that we should really be heading in the direction of creating medical savings accounts where people have high-deductible health care coverage, and they have some skin in the game as— as the economists like to say.

**DR. ROSENTHAL:** Well, first and foremost, we have lots of evidence that when people pay out of pocket, they don't make terrific decisions about what to— what to seek and what not to seek. And second of all, because of the nature of insurance, we need to protect people against catastrophic risks, against high costs. This cost sharing would be limited to the end of the distribution of health care spending that matters least. So what is driving high and growing health care spending in the U.S. is in the tail of the distribution, very high-cost interventions and very sick people. And cost sharing is totally inappropriate there.

**DR. GRUBER:** There's no one who thinks seriously about this that thinks that a consumer-based approach can control costs in a fundamental way. I mean, ultimately, the supply side is where it has to happen. Physicians make the decisions.

Hospitals make the decisions. Consumers can't shop from the back of an ambulance of where to get treatment for their heart attack.

That said, I think it's very important to recognize, to learn from the lesson of the managed care backlash. I think the fundamental lesson there is people didn't see the savings. We had 3 years where health care costs grew by-- employer-sponsored premiums grew by 2% or less a year, which is amazing, below inflation for 3 years in the late '90s. But people don't know that. And unless you give people a financial stake in what's happening, there's going to be a backlash against accountable care organizations, just like there was against managed care.

### **Comparative-Effectiveness Research**

**DR. GAWANDE:** There are a number of provisions that would-- that would come into-- as a part of health reform and make a difference in care. And you mentioned one early on, comparative effectiveness. Exactly how does someone doing research in Washington on whether one statin or another statin works, and having a result 5 years from now, how does that translate into savings? Or am I misunderstanding what comparative effectiveness really is?

**DR. ROSENTHAL:** I do think in general, we have a grave lack of head-to-head evidence on the effectiveness of clinical interventions. And without that information, commercial payers in particular, but also Medicare really lacks the ability to try to impose rules that might improve the value of health care spending.

**DR. FISHER:** As a clinician, it would be wonderful for us to understand better what the real risks and benefits of these treatments are so that we can help our patients make wiser choices. And that's the fundamental issue. You know, lung reduction surgery for chronic obstructive pulmonary disease, if it doesn't work, gosh, we really shouldn't be doing it.

So the other thing that's missing from the comparative effectiveness discussion is that we really need to be understanding the effectiveness of different delivery systems and different approaches to delivery. Because that's where the real opportunities for both improving care and reducing spending are.

**DR. GRUBER:** This is actually almost certainly a no-brainer. It's just impossible to argue that more information here wouldn't be good. And I think the notion that, gee, somehow making the information available will turn the government into Big Brother is just crazy within the context of our political system. Right now we are so far away from Big Brother, we are so hands-off, we do so little to really talk about what's effective, that we can only move in the right direction at this point.

**DR. GAWANDE:** I'm suspicious we won't have enough information in the next 5 or 10 years to actually make a significant dent in the system. We will always have to be making decisions in the gray zone, even with comparative effectiveness. I mean, can we claim billions and billions of dollars from the research that will come out of this?

**DR. FISHER:** I think it depends on-- I agree with you. Judgment is essential. This information, especially Treatment A versus Treatment B, is not going to dramatically deflect the growth of health care spending.

**DR. GAWANDE:** Especially when it shows us that the 10-times-more-expensive Treatment A was better.

**DR. FISHER:** — was better, that would probably, could increase costs.

**DR. GRUBER:** Maybe you do learn that the 10-times-more-expensive Treatment A is better. Great. Then do Treatment A, as long as the public understands its costs, and we understand its effectiveness. Then super, then let's do that. The problem is, neither's true today. Both those need to be addressed. And it's never going to take out the huge share of decisions that are gray zone. But look — even a tiny, tiny effect on the growth rate is billions and billions of dollars over time.

**DR. FISHER:** We see huge differences in growth rates across communities. So, you know, you have San Francisco, San Diego, central Pennsylvania, many other communities around the country, Tallahassee, Richmond, Virginia, where cost growth has been at least a percentage point below the national average. And no one in those communities is aware of rationing. None of the physicians in those communities would say, "We aren't providing the beneficial treatments." So the kinds of deflections that we need to achieve trillions of dollars of savings are relatively modest. And they're mostly going to come, I think, from reorganizing care delivery, not from eliminating beneficial and wanted care.

### **The Need for Reform**

**DR. GAWANDE:** What do we need to see coming out this year and what might happen if we don't?

**DR. GRUBER:** I really think what we need to see coming out of this year is coverage. I think that even if this bill fails, I think cost control's a longer-run battle of which this is just a very small part. The critical part is about covering the uninsured Americans. It's our moral obligation to do so.

**DR. ROSENTHAL:** I think passing coverage may be critical in part because it's an opportunity to be giving with one hand and asking with the other. And so giving to the pharmaceutical industry, giving to the insurance industry, and asking for reform, for changes in the way these private entities, which have such an important role in our health care system, do business. And I think without having that authority, it's going to be hard for the federal government to-- to begin us down the road of cost control. So I think it's a political balancing act, but I think that coverage creates an opportunity.

**DR. FISHER:** Well, I think it would be a tragedy to miss this opportunity to expand coverage, in part because it helps fix so many of the problems that Jon and Meredith have identified with the health insurance system. I think the cost issues, I agree, are a longer-term issue. But gosh, it'd be too bad to miss this opportunity to get our children covered.

**DR. GAWANDE:** Well, thank you for that important sum-up, bringing back how the coverage fits together with the costs. This is an important moment for the country, a vital debate. And costs have been in the center of it, in part because it is the question of whether we can afford that coverage for everybody. So thank you. And thank you all from the *New England Journal of Medicine*.