

A Lecture by Humphrey Taylor: The Big Health Care Debates that Lie Ahead

In February, Humphrey Taylor, Chairman of *The Harris Poll*®, gave the annual Charles E. Leighton lecture at the Leonard Davis Institute of the University of Pennsylvania. His theme was “The Big Debates that Lie Ahead,” or more specifically, 11 health care debates that he believes will be important over the next decade.

The 11 big debates that Taylor reviewed and discussed were:

1. Measuring the cost-effectiveness of different tests and treatments
2. Pay for performance
3. What are the appropriate roles of market forces and government?
4. Cutting administrative costs
5. Finding the right balance between health care as an entitlement and as an economic good
6. The appropriate role of the employer
7. The “R” word: rationing
8. What are the real benefits of individually purchased versus group insurance?
9. A basic minimum benefits package
10. How much tiering is desirable
11. The long-term effects of consumerism in health plan choice

Additionally, Taylor addressed how much should be spent on health care, and *why* we need to learn much more from international comparisons.

This is the text of his lecture:

A somewhat silly word, much beloved by our contemporary leaders, is the word “humbled.” They tell us how “humbled” they are to be elected or to be doing important things. I will admit I was not in the least “humbled” to be asked to give this year’s Leighton lecture; I was flabbergasted. I was also immensely flattered, proud and pleased. I am truly honored – but not “humbled!” – at least not yet. That will depend on your reactions. After all, this is Friday, the 13th.

One of the many reasons I am grateful for your invitation is that I am using this as an opportunity to be somewhat self-indulgent. The overwhelming majority of my talks are really research presentations, where I am presenting or summarizing survey data. I take seriously the advice I give to my colleagues that our job as pollsters is to be professional voyeurs, not advocates, and that unlike other voyeurs we should not be aroused by what we are observing and measuring. Today, I will not follow that advice. I will step back from all the data we generate and give you some of my opinions, often unencumbered by facts or data.

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HEALTH CARE RESEARCH

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Before I do so I should, however, declare my many conflicts of interest. Harris Interactive is happy to get paid for our work by all the larger drug companies including Merck, which generously funds the Leighton lectures, and many health insurers, hospital systems, medical device companies, schools of medicine and public health, the N.I.H. and other government agencies and some health care foundations. So there is no reason why you should trust me or believe anything I say.

There are other reasons why you probably should not have honored me with this invitation. I have never been an academic. While I have been doing survey research on health care issues for more than 30 years, I am not a health care expert, and my knowledge of health care, while quite wide, is only an inch or two deep. On many health care issues I only know enough to be at best provocative, at worst dangerous. Nevertheless, I know enough to have enormous respect for the real health care experts who are smarter, more knowledgeable and more careful than I am – and especially when, like Mark Pauly, they are brilliant, original, provocative and witty – not that there is anyone like Mark.

Unlike many of those previously honored to give the Leighton lecture, I never met Dr. Charles Leighton but from what I have heard and read he was obviously a wonderful man. I note that David Kessler (who knew Dr. Leighton well) when he was here 10 years ago used phrases such as “enormous respect” ... “a new level of professionalism” when talking of him. He said that “Dr. Leighton cared about improving people’s lives and his way of doing this was to make sure that new therapies moved from the bench to the bedside as thoughtfully, as meticulously, and as expeditiously as possible.” I’m sorry I never met him.

Anyone coming to this great university would be insensitive if he or she were not awed by its history. I recently enjoyed Isaacson’s fine biography of Benjamin Franklin. I learned of Franklin’s “Proposals Relating to Education of Youth in Pennsylvania,” written in 1749, that the Academy which he helped to found was the first nonsectarian college in the colonies (unlike the four religiously affiliated colleges which preceded it). And that its goal was to cultivate “an inclination joined with ability to serve mankind, one’s country” (at that time, of course, England!) and “friends and family.” And that Franklin was the first president of the Academy, and that he remained a trustee for the rest of his life. That Academy, of course, became the University of Pennsylvania.

Before going further I should acknowledge a debt to my friend Kim Slocum of AstraZeneca. I showed him an early draft of this lecture and he gave me several ideas and constructive suggestions, which, I believe, greatly improved it. But that is not to say that he shares my opinions or is responsible for anything I say.

I have never found quite the right word phrase to describe what I do. Sometimes I call myself a pollster but on occasions that has triggered requests to re-stuff people’s old sofas. Having been in the so-called polling business (so-called because only a tiny proportion of our research work is really public opinion polling) – based for 13 years in Britain and 27 years in the United States, I am struck by the different attitudes in these two countries to public opinion.

In this country, there is much more reverence for public opinion – a widespread belief that the public is wise and a sense that if only politicians did what their voters wanted, everything would be just fine. In Britain, there is more acceptance of Burke’s famous comment that “your representative owes you not his industry only, but his judgment; and he betrays you, instead of serving you, if he sacrifices it to your opinion.” This old question of how much elected officials should be followers of public opinion and how much they should be leaders seeking

to change public opinion is as old as the ancient Greece of Pericles and Cleon. Many pollsters, I think, assume more than I do that the public is always right. But most great political leaders were more leaders than followers of opinion.

Churchill was in the wilderness for many years because his views were very unpopular, and I love his comment that when a politician keeps his ear too close to the ground, it is difficult to look up to him in that undignified position. But, of course, that does not mean political leaders can ignore public opinion. James Madison wrote that “public opinion sets bounds to every government, and is the real sovereign of a free one.” And Abraham Lincoln wrote, “A universal feeling, whether well- or ill-founded, can not be safely disregarded.”

Sometimes in the hurly-burly of politics, it is hard to see the forest for the trees. Political debate and election campaigns often focus on what look like big issues but are really only second- or third-tier issues. When it comes to health care policy, most of the time we focus on incremental changes to the system rather than on the system as a whole. We are often more aware of the ripples on the surface of the health care system than the tides which are slowly changing it. The recent debate about a Medicare drug benefit and Medicare reform looked like a huge deal to many people, but as Tom Scully said (*Health Affairs*, Nov/Dec 2003), these reforms “are not revolutionary at all; they are incredibly modest.” (Five hundred billion dollars doesn’t sound incredibly modest, of course.)

Politicians, the public and the media (not to mention employers and health plans) usually focus on the short term. Politicians need to produce results that will help them to win re-election. This is sometimes a pity. If you look around the world, the major differences between different health care systems are not about the details which we debate, important as those often are, but about the fundamental values and assumptions that underlie different national health care systems.

Many of my friends believe that, as we are not likely to get major health care reforms any time soon, we can at least move the system in the “right” direction (right may, of course, be right or left depending on their political ideology) with incremental reforms. They may be correct, but incremental reforms may actually make it harder to improve the system at a later date.

Every new incremental reform grows its own constituency of beneficiaries whether they are consumers, providers, employers or insurers. In this context, the French saying “plus ça change, plus c’est la même chose” misses the mark. A more apt saying might be “the more things change, the harder it is to change back.” Incremental changes may lock us into policies that make “good” reforms more difficult or impossible.

So, if we want to have the best possible health care system at some point in the next 20 or 30 years, we should devote far more time to discussing some of the fundamental issues, not just the policy changes which may be politically practicable in the short term. This paper lists 11 fundamentally important issues that should receive far more attention from policy makers and the media than they have done up to now – and I think most of them will.

1. Measuring the cost-effectiveness of different tests and treatments

Whenever anyone has proposed a U.S. government agency to study the cost-effectiveness of treatments, tests and care, the health care industry has mostly opposed it. It was afraid that some of its products and services might be shown not to be very cost-effective. The approval of new therapies, and the use of new tests and surgical procedures, has been based only on information about their efficacy and safety, not about their value or cost-effectiveness. This makes no sense given that, in the real world, we only have finite resources.

A rapidly growing number of other countries have set up, or plan to set up, agencies to study and report on cost-effectiveness (including head-to-head trials of competing drugs). Should we do this? Should a government agency do it? Or if, being America, we don't trust government to do this, should we find ways to get the private sector to do it? And if it is the private sector, who (apart from those with a vested interest in the results) would pay for this?

I have been trying to make this point for some time, so I was delighted to see a new paper by Dr. Steve Schoenbaum and others (*Health Affairs*, Nov/Dec 2003) arguing the need for an American agency, somewhat like the U.K.'s National Institute for Clinical Excellence (NICE). Is it possible that the Agency for Healthcare Research and Quality (AHRQ) could morph into something like that?

There are, of course, many potential problems in measuring cost-effectiveness. How do we define effectiveness? Much of the management of chronic conditions like high cholesterol, high blood pressure or diabetes has immediate costs but little or no immediate benefits. Their effectiveness comes from delaying or avoiding the consequences of diseases that would only occur much later. If "cost-effectiveness" is defined in narrow economic terms, how does one define and quantify these huge and important benefits? How do you quantify the benefits not just of longer lives, or perhaps longer working lives, but also the benefits of a better quality of life?

Furthermore, any agency producing influential data and analysis of cost-effectiveness will find that some interventions are much more cost-effective than others. And all of those "others" are likely to be opponents of the agency and fierce critics of its findings. But those are not reasons for doing nothing.

2. Pay for performance

Tom Scully has said it as well as anyone (*Health Affairs*, Nov/Dec 2003): "Everyone with an M.D. or D.O. degree gets the same rate, whether they are the best or worst doc in town. Every hospital gets the same payment for a hip replacement, regardless of quality. We have zero ability to monitor utilization or understand or differentiate payment based on quality." He was referring to Medicare, but he could equally well have been referring to Medicaid and private sector insurance.

Scully used this argument to support competition between private sector plans as more likely to behave rationally (and more efficiently) than single-payer Medicare. But so far, private sector insurance and managed care plans have not been much better. They also tend to pay the same amount to doctors and hospitals regardless of quality. Of course, this is one area where the Leapfrog Group is trying to change things. Let's hope they succeed.

It is not just that we lack incentives to improve the quality of care. We actually have many perverse incentives (described by Don Berwick and others as "toxic incentives") which reward bad care and penalize those who provide better care. Doctors and hospitals who do "re-work," repairing their own mistakes, often get paid more than those who got it right the first time. Providers who use drug-eluting stents complain that this powerful new technology reduces their income from the cardiac surgery they no longer need to perform.

Shelia Leatherman and Don Berwick in *Health Affairs* in March last year described how "current payment mechanisms allow, even reward, defective care because they are unable to reward future benefit."

They described how "in a fragmented health system, in which the patient moves among different providers, employers, and payers, major challenges arise in aligning the financial incentives for improving the quality of care. The challenges are even greater when, as in health care,

important decision-makers cannot distinguish among levels of quality, when payment is unresponsive to defect levels, when the harvest in improved patient outcomes and reduce cost occurs mainly in the long term, when administrative pricing separates value from payment levels, and when cultural and managerial constraints limit the pace and penetration of improvement ... Many defects in care have no consequence to the organizations that could reduce them.”

This is one of the many problems that are made much worse by our “thousand-points-of-payment” system.

In Britain’s National Health Service, doctors are rated and receive “stars” – based, I understand, on peer reviews. The more stars (from one to three) that doctors receive, the more they get paid. It is a simple form of pay for performance that is at least better than nothing, and nothing is what most plans have.

Arnie Epstein in *The New England Journal of Medicine* (Jan. 22, 2004) gave some exciting examples of new developments of pay-for-performance. Among these are the Bridges to Excellence programs at General Electric, Partners Healthcare, Tufts Health Plans, the Lahey Clinic, and other Massachusetts employers who will pay bonuses to physicians based on certain measures on the quality of care they provide. He described the Integrated Healthcare Association (IHA), a collaboration of six California health plans with over eight million lives which will pay up to \$100 million for quality on a yet-to-be- defined formula. And, beyond the modest starring system I just mentioned, the United Kingdom “has recently adopted a payment for performance initiative of unprecedented size and scope. Nearly a third of G.P.’s income will depend on practitioners’ performance as defined by 130 quality indicators.”

So I was delighted, of course, to see the open letter, “Paying for Performance; Medicare Should Lead” signed by 15 illustrious health leaders and policy researchers in the November/December 2003 *Health Affairs*. Let’s hope they have more influence than health care policy wonks usually do.

Here again there are big potential problems. We must avoid the temptation to define performance as “cost-minimization.” We see a growing trend for managed care plans to use tiering not just for drugs but also for hospitals and physicians. This might sound promising, but in most cases these tiers are based on costs not on quality, and are designed to get patients to choose less expensive providers, regardless of whether they are better or worse.

Based on my limited understanding, I tend to share the view that comprehensive pay-for-performance programs will only be possible when we have integrated IT systems, including comprehensive electronic medical records.

3. What are the appropriate roles of market forces and government?

Over the last few years, this topic has received more attention than some of the other “big issues” on my list today. It is a polarizing issue dividing most Republican members of Congress from most Democratic ones. But their different opinions seem to be driven more by ideology than by information. Three years ago, we surveyed Republican members of the House and Senate and found that most of them believed Medicare + Choice had actually saved the government money when the best research had concluded that it had not done so. People tend to believe what they want to believe: “Don’t confuse me with facts.”

On this issue – the role of market forces – we often wear ideological blinkers that distort our vision. Many conservatives assume that “the market” always performs better than government (except perhaps with regard to the military, highways or law enforcement). Many liberals see

markets as often helping corporations more than the public. Other developed countries have wrestled with this question and they all have both public-sector and private-sector health care but the balance varies.

I suggest that we need to throw away our ideological blinkers and look at what works well (and less well) in the United States and other countries. Most of our policymakers are notoriously ignorant of other countries' systems. They tend to assume that they are inferior (in spite of much evidence to the contrary) and that if it's not invented here, it's not worth considering. They should think again.

4. Cutting administrative costs

Experts disagree on how to define "administration" and on how to measure its cost but, regardless of the definition or the measures used, nobody disputes that the American health care system has far higher administrative costs than any other developed country. By some measures, U.S. administrative costs are twice as high as they are in Canada and three times higher than in Britain. By some measures, up to one quarter of health care spending goes to administration. And, of course, money spent on administration is money not spent on providing medical care.

Much of the huge cost of administration is a direct result of our "thousand-points-of-payment" reimbursement system and its incredible complexity. Many organizations have become rich teaching hospitals and doctors how to code and bill. Hospitals hire armies of coding clerks. Their billing and accounts receivable departments often have more employees than many of their clinical departments. There are acute shortages not just of nurses but also of coding clerks.

Many American doctors who regard themselves as full-time clinicians spend up to 40 percent of their time on administration, much of it on billing and collection. And they have to hire, and provide office space for, the people who help them do this. Our cross-national surveys of doctors suggest that not just the costs but also the hassle factor from all of this is much higher here than in countries with universal coverage.

Our health insurance companies hire hundreds of thousands of people who not are needed in other countries. And American employers, unlike their foreign competitors, incur the costs of human resources and corporate benefits staff to manage their health insurance programs. My impression is that we don't even include employers' administrative costs in what we call "health care spending."

Is this how we want to spend our "health care" dollars? What would we be willing to change in order to reduce administrative costs? There are potential savings of hundreds of billions of dollars. Yet the issue is rarely discussed.

There are many difficult issues here also. I, and many others, believe that we need to invest many billions in the building of integrated IT systems to improve quality and to reduce errors and the wasteful duplication of care. We hope that in the long run these IT systems will also reduce administrative costs, but in the short- and medium-term they will add huge sums to what we now spend on administration.

Another big problem here is the lack of uniform standards. Other countries can impose uniform standards; in this country, there is a real danger of additional costs and a lack of true integration because of a lack of uniform standards.

5. Finding the right balance between health care as an entitlement and as an economic good

In every developed country, whatever the health care system, health care is partly an entitlement and partly a private economic good, and this will surely continue for the foreseeable future. But outside this country, there is almost a consensus that it must be, in large measure, an entitlement or public good.

Have we in the United States got the balance right? And if not, which way should we tip? What services should be “rights” and for whom? What services should only be available to people who can afford and choose to pay for them, directly or through private-sector insurance?

This, perhaps more than any other item in my list, is an ideological issue, a fundamental ideological divide. A growing number of influential Republicans talk privately, if not publicly, of the need to “break the culture of entitlement.” That will be really tough to do. If one includes the cost of the tax exemptions for employer-provided care, the government now pays for most of the cost of American health care. Our polls show that most Americans see health care more as an entitlement than as an economic good, that they are very uncomfortable with the profit motive in the financing and delivery of care, and that it would be extraordinarily difficult to change these opinions.

6. The appropriate role of the employer

In many countries, employers pay part of the cost of health care through taxes, and, almost everywhere, governments mandate either uniform health care taxes for all employers, or uniform benefits, or both. Employers cannot opt out, and there is a level playing field for all employees. Of course, that’s not true in this country where voluntary employer-provided health insurance took off as an unintended consequence of wage controls in World War II.

But is the current role of employers good public policy? Should employers get out of the health insurance business? Most people don’t think so. Nor do most employers. Do we care that, because of employer-provided health insurance, we have, by a huge margin, the highest administrative costs (and therefore the lowest percentage of spending on the delivery of care)? Does the cost of insurance put American companies at a disadvantage when they compete with Japanese or European companies? Is the American “thousand-points-of-payment” system a laboratory for testing new and better models or a wasteful, inefficient, costly and essentially unfair anachronism?

A major criticism of our employer-provided system is that employers’ time horizons are much too short. Given the mobility of American workers, most employers derive little economic benefit from providing much vital care. They may get little or no return on any investment in paying for good care, good disease management, for people with asymptomatic conditions like high cholesterol, high blood pressure or the early stage of diabetes. The real economic beneficiaries of this care (apart from the patients) may be other, later employers, or Medicare and Medicaid.

On the other hand employers, especially larger ones, currently play a vital role in creating risk pools, in reducing administrative costs (compared to individual insurance) and in creating leverage to negotiate with health plans and providers. Insured individuals could not do what the Leapfrog Group or Bridges to Excellence are attempting to do.

7. The “R” word: Rationing

A recent series of articles in *The Wall Street Journal* show that in the United States we “ration” care, as does every country, even though we pretend we don’t. The gap between what we feel we can afford, and what health care we’d like, is big and growing. In other countries, governments ration (though governments and politicians avoid calling it that); they constrain the supply of medical services and set limits on what they will pay for. However, in every country, with some exceptions in Canada, people are free to spend their own money on additional health insurance and/or medical services.

In this country, we ration care by coverage and reimbursement (whether by Medicare, Medicaid or private insurance) and we limit resources, so that doctors and hospitals sometimes have to ration care, as reported in *The Wall Street Journal*.

I believe that the need to ration care will increase as the gap grows between what we could do for everyone if resources were infinite, and what actually we will pay for. In my opinion, our political leaders – and those in many other countries – are currently involved in a deceit that is damaging to them and harmful to the development of good policy.

A few years ago, I was at a meeting organized by The Commonwealth Fund attended by five health care ministers from the U.S., U.K., Australia, Canada and New Zealand. I challenged them with two questions. “Do you believe that your system does not ration care by one mechanism or another?” *Silence*. And then, “Are you willing to stand up in front of your voters and tell them that your system rations care and must do so?” *Silence*. Rationing is not something politicians want to talk about.

If you look at most political leaders’ speeches on health care reforms, there is often an implicit message that “if my policies are adopted, we will fix the system.” It is a classic case of politicians promising much more than they can deliver. As a result, the public tends to believe it should get everything it wants.

In one recent Harris Interactive survey, only 29 percent of all adults agreed that “there are so many expensive treatments, surgical procedures, transplants, and medical devices that it is impossible for any health insurance plan to pay for all of them.” Most people (57 percent) believed that “health insurance should pay for any treatment which will save lives, even if it costs a million dollars to save one life.”

I tease my British friends with one observation they don’t much like – that the National Health Service has been successful not only in controlling costs (which it has) but also in lowering expectations. The British have more of a sense that resources are finite than people in many other western democracies. They are more likely to think that it’s okay to wait some time (though not too long) for elective surgery. And the only speech I have ever found by a minister of health explaining that care is rationed and must be was by a British Minister of Health, Enoch Powell, some 40 years ago.

Politicians and governments everywhere need to admit that we must ration care. What is needed is a vigorous debate about how we should ration care, what criteria should be used and who should be the key decision makers.

8. What are the real benefits of individually purchased versus group insurance?

This is another issue where attitudes tend to be distilled through ideological filters; conservatives tend to like the individual insurance market, liberals tend to dislike it. Here again we need to throw away our ideological blinkers and look at the evidence from this and other countries.

What are the real differences in administrative costs and how could they be reduced? How much can we rely on consumers to make reasonable choices (and do we care if they don't)? How much (or how little) regulation is desirable to make the market work well, protect the public from itself, and to contain waste, inefficiency and fraud? And how can we ensure effective insurance pools where the healthy pay for the sick?

9. A basic minimum benefits package

Even if we are unwilling to pay for a reasonable level of universal coverage, as in other developed countries, can we agree in principle on some minimum package of benefits that we think everyone should have? If we could reach a consensus on this, we could then debate how to move in that direction, whether in one leap, or by incremental steps. My assumption here is that this would be a "bare bones" package much less rich than Medicare, most employer-provided plans, or the health plans of other countries. But, given that most people believe that the federal government should ensure that everyone has access to a reasonable level of coverage (as they do), this would be a reasonable response to public opinion.

10. How much tiering is desirable?

Contrary to some of the political rhetoric, health insurance has always been tiered, with more or less generous benefits in both the public and the private sectors. The last few years have seen an explosion of a different kind of tiering by health plans which is likely to grow rapidly, multi-tiered formularies. Now we are seeing the tiering of hospitals and physicians' services, with different levels of copays.

Most other developed countries are proud of their universal coverage and think of tiering as inequitable and unacceptable, but they too have always had their own forms of tiering. They almost all have substantial private health insurers and providers of medical services for those who want and can pay for more, faster and better services than their government-funded (or government-mandated) programs. This, of course, is another form of tiering.

The evidence of tiered formularies is that tiering produces both intended and unintended consequences. They help to contain costs but they also lead to massive noncompliance, which is presumably bad for people with diabetes, hypertension, high cholesterol, or asthma who are noncompliant because of cost. How far do we really want to expand tiering if it means that large numbers of sick people are noncompliant?

Over the last three years, our research has documented huge increases in noncompliance as a direct result of increased cost sharing, particularly higher copays. As copays have increased, many more people have skipped doctors' visits, failed to fill prescriptions, or used maintenance drugs less often than prescribed.

What is particularly disturbing, if not particularly surprising, is that this noncompliance is strongly correlated with the seriousness of the disease. Very sick people need more care than less sick people, so they are the people who get to pay much more out of pocket for care. Furthermore, sickness is correlated with lower incomes. So this new trend – which is likely to continue for the next several years – means that people who need care the most are increasingly noncompliant. The much-vaunted "empowerment" we hear about all too often means we empower the sick not to get the care they need.

11. The long-term effects of consumerism in health plan choice

Consumerism sounds good. Most people like to have choices and giving them choices is the American way. Adam Smith taught us that efficient markets lead to better products and services at lower prices. Surely giving people a choice of health plans (like giving people a choice of home insurance) must be a good thing?

But health insurance is not like fire insurance. We know that if we have a serious medical problem or a chronic condition we will need expensive care. Fire insurance works because many people whose houses do not burn down are willing to pay for those that do. Health insurance only works if the healthy majority pays for the minority who need expensive care.

Consumer-driven health plans are now the flavor of the moment in our continuing search for some way to contain costs with consumers being told to “choose the plan that’s best for you.” That sounds great until you realize that the plan, which is “right” for the healthy majority, is “wrong” for the unhealthy minority, and vice versa. If people make rational choices (and there is evidence that they do), they will choose different plans. In a free market, this would trigger a death spiral of adverse selection, leaving the sick – the people who actually need care – without coverage, unless the government steps in to provide or mandate it.

This death spiral can be avoided by government regulation or if employers make sure their plans use the premiums of the healthy to pay for the sick, and resist the temptation to “save money” by allowing their healthy employees to join cheaper health plans designed for healthy people. But are employers that wise? Do advocates of consumer choice understand the dangers and how to avoid them? Do employers understand the dangers of going down this seductive road? If not, we need to educate them.

Recently WellPoint conducted an interesting test. They offered one group of plan members a choice between a high premium, low copay plan and a low premium, high co-pay plan. Many plan members made rational choices. Sicker people, likely to need more care, tended to choose the high-premium, low-copay option. Healthy people tended to choose the low-premium, high-copay option. When I asked about adverse selection, the WellPoint executive explained that that was not a problem as they could set the rates so that the healthy majority would continue to subsidize the sicker minority. But he went on to agree that if employers offered a less expensive plan with even lower premiums from another insurer, the death spiral of adverse selection would begin. In other words, consumer choice is fine only if the same insurer provides all the choices – not exactly what Adam Smith had in mind.

In our research, most people clearly perceive having choices as a real benefit. But a recently published study (of food products, not health plans or providers) found that having too many choices could sometimes have negative consequences, including difficulty in making decisions and dissatisfaction with the product bought because of a feeling that one has made the wrong choice.

Perhaps my biggest concern about consumer choice of health plans is that it undermines the social contract and social solidarity on which, I believe, health insurance must be based. I read that 30 percent of all health care costs are consumed by one percent of the population and that more than 50 percent are consumed by five percent. These very sick people are also much less affluent than the majority. George Halvorson of the Kaiser Health Plans has spoken eloquently on this problem. The only way that we can provide the care needed by those relatively few people who need a lot of acute care, or by the much larger number who need two or three maintenance drugs for diabetes or heart disease for the rest of their (hopefully long) lives, is for the healthy majority to pay for it.

My anxiety is increased by our polls that suggest that this social contract or social solidarity is under attack. In every other western country there is, I believe, a broad national consensus that in health insurance the healthy help pay for the sick and the rich help pay for the poor.

In this country, that social solidarity is beginning to unravel. In the United States, those who believe that “people who are unemployed and poor should be able to get the same amount and quality of medical services as people who have good jobs and are paying substantial taxes” have fallen from 84 percent thirteen years ago (1991) to 75 percent last year (still, of course, a big majority).

Those who believe that “the government should do whatever is necessary, whatever it costs in taxes, to see that everyone gets the medical care they need” have fallen from 76 percent to 69 percent since 1991. And those who believe that “the higher someone’s income is, the more he or she should expect to pay in taxes to cover the cost of people who are less well off and are heavy users of medical services” have fallen fifteen points from 66 percent to only 51 percent.

How much should we spend on health care?

I have one other observation that is not exactly a topic for debate but which should, I think, color it. It relates to the old question “how much should we spend on health care?”

“Health care costs are out of control.” “The rate of growth of health care spending is unsustainable.” We have heard or read claims like those hundreds of times over the last 30 years – not just in the United States but also in many other countries.

Nevertheless, I believe they are dead wrong. Increased health care spending is sustainable because people want more and better medical care, and economic growth will allow us to pay for it, even if the rest of the economy grows at a lower rate. Furthermore, the evidence of the last decade strongly suggests that health care spending in the United States, and in most other developed countries, will grow much faster than their economies and that this growth may even accelerate.

The evidence is compelling. In most countries, health care spending has grown much faster than gross domestic product (GDP). Between 1990 and 2000, health care spending per capita in the United States, in inflation-adjusted dollars, grew by an average of 3.2 percent per year, 39 percent faster than GDP’s average annual growth of 2.3 percent.

During that decade, health care spending increased faster than GDP growth in 23 out of 30 of the world’s richest countries, all of which belong to the Organization for Economic Co-operation and Development (OECD). In all 30 OECD countries, during the 1990s the median increase in real (adjusted for inflation) health care spending was 3.1 percent, 63 percent greater than the 1.9 percent mean increase in GDP.

Of course, that trend goes back much farther than the last decade. Health care spending has grown faster than GDP in most countries for at least 50 years.

A regression analysis finds that, statistically, the size of GDP per capita in 1990 explained more than half – 56 percent – of the variation in the growth rates of health care spending in the OECD countries (if Luxembourg – a tiny, rich country that spends very little on health care and is a striking exception to this rule – is excluded from the analysis.)

Statistics – like pollsters – are always better at describing what has happened than at explaining why it happened, but the following common sense ideas help explain why health care spending tends to grow faster than GDP and why it grows faster in richer than in poorer ones:

Health care is what economists call a “superior good.” A recent Harris Interactive survey found that Americans choose health care as the best way to spend additional money as the economy grows, ahead of education and far ahead of defense, cars, food, clothing, shelter, entertainment, or anything else.

Medical advances allow society to provide more care to more people. That means more and better tests, new and better drugs, new and better surgical procedures. As a result, many people are alive who would have died; and medicine has improved the quality of life for many people with chronic diseases and serious injuries. That is expensive, and it will cost more in the future, but people in developed societies believe that’s a good way to spend money.

Public expectations are rising. Even if there were no new technologies, it is probable that, as consumers become better educated and better informed, they will demand and use more medical products and services. It is clear that the public’s expectations for the care they should receive have increased very substantially – to the point, some argue, of being unreasonable. That’s human nature.

The population is aging. Although the precise impact of an aging population on health care costs is debatable and is often exaggerated – because a healthier population presumably needs less care – there is a general consensus that aging adds significantly to costs.

What are the chances that those trends will continue for the next decade, with health care spending increasing much faster than the economy and increasing fastest in the richest countries? As the British economist Alec Caincross once wrote: “A trend, to use the language of Gertrude Stein, is a trend, is a trend. The question is: Will it bend? Will it alter its course, through some unforeseen force, and come to a premature end?”

The key phrase here is “some unforeseen force.” All of the known forces that explain the high rate of growth in the 1980s and 1990s seem likely to continue during the next decade, unless we abolish death, disease, pain and suffering.

There will be many exciting new medical technologies, the population will get older, consumer expectations will increase, and health care will continue to be a superior good. As always, we will argue about who should pay for all the health care we want: the government (taxpayers), the employer, or the consumer? But pay for it, somehow, we will.

So I’d be willing to bet a lot of money that over the next 10 (and 20) years, health care spending will continue to grow much faster than the economy in the United States, and in most other countries, as it has over for the last 50 years. That’s what happens in democracies.

We Need to Learn Much More from International Comparisons

The bigger and more successful a country, the less open it seems to learning from the best practices in other countries. Unfortunately, the United States is particularly prone to the disease of “not invented here,” and Americans often forget that anything worthwhile happens anywhere else.

A couple of weeks ago, I spoke at a conference in Washington billed as **The World Health Care Congress**, whose speakers included the great and the good – from Tommy Thompson and Milton Friedman, to Bill Frist and Hilary Clinton. In all, there wasn’t one speaker, or, as far as I could tell, even one of the 800 plus attendees, who was from outside this country. Yet I seemed to be the only person who asked, “Where’s the World here?”

When I spoke I couldn’t resist reminding them of part of John Cleese’s remarks when asked on American TV about the difference between Britain and America. “There are three differences,”

he said. “We speak English. When we hold a world sporting event, like your World Series, we invite teams from other countries.” And the third difference, alas, is not printable in this august setting. He was talking at the peak of the Monica Lewinsky scandal.

One splendid exception to this tendency is The Commonwealth Fund’s international health care symposiums which have started to generate an increasingly relevant and useful flow of data comparing health care systems, inputs, outputs, and outcomes – particularly in the major English-speaking countries and the major OECD countries.

There are many valuable lessons to be learned from other countries. Some of the best medical practices, from palliative, geriatric and home care to prevention, maternal and child health, are found abroad. And many other countries get a much bigger bang for their much more modest buck. When you look at what they do it is no surprise that some of their vital statistics – for infant mortality, as an example – are much better than ours. But it is very hard to get American leaders and policymakers to learn from the success stories in other countries.

Reforms Are Difficult

Reforming the health care system is really tough. Cost containment means containing someone’s income. A lot of powerful interests have a lot to lose. There are, however, times when I think all of us are impatient with the difficulties implementing reforms in this country.

In the 27 years I have lived in this country, I have often marveled at how the United States and Britain can be so very similar in so many ways, with a shared sense of the common law, history, literature, political philosophy and many common values, and yet so very different in others. One of the biggest differences is in how easy it is in Britain, and how difficult it is in the United States, to pass radical new legislation. I’m not sure what Benjamin Franklin and the other Founding Fathers would make of contemporary American government but I think they would be pleased to see that many of the checks and balances they designed are still in place. In Britain, of course, the government almost always controls the House of Commons, and although the Law Lords and now the European Courts can sometimes overturn British legislation, there is no real equivalent of the Supreme Court. The party whips are so much stronger in Britain that most governments can pass almost whatever they want – sometimes for better and sometimes for worse. After World War II, British governments nationalized the steel industry, denationalized it, nationalized it again and denationalized it again. It is a miracle there was anything left at the end of this process.

Many years ago I heard a quotation, allegedly by Winston Churchill, which I used in testimony to a congressional committee (and has now been used so often by others that it has lost its surprise) – that “Americans can always be relied upon to do the right thing – after they have exhausted all the other possibilities”. A few years I searched several Churchill biographies to find when he said this and I could not find it. So it may be apocryphal! However, it does convey a sense, though perhaps an optimistic one, of how difficult it is under the American system of government to make major changes.

An alternative view was expressed by the comedian George Carlin when he said “there is no problem, however difficult, which if we roll up our sleeves, we cannot completely ignore.” The possibility of radically reforming the American health care system and addressing the many problems of waste, inefficiency, inequity, access and variable quality is not good. I would like to share Churchill’s optimism, but there are many times when I’m sorry to say Carlin’s pessimism seems more plausible.

I wish I could have come here today with one idea so powerful that I could have dazzled you with it and gone on to win the Nobel Prize or its equivalent for Health Care Policy analysis. I hope that you can forgive me for making do with a bit of a laundry list of my personal hobbyhorses.

Hairy Audacious Goals

I forget who first coined the phrase “hairy audacious goals,” but I think we need them for reforming America’s health care system. I don’t see many of them around. But I look forward to hearing about the hairy audacious goals that will come from the Leonard Davis Institute, and the University of Pennsylvania, in the future.

This may be the time by which I should feel “humbled” as you realize what a mistake you have made in inviting me. One of the best things in my working career is that I get to work with an amazingly varied group of clients and colleagues. As Lou Harris once told me: “We are lucky. We get paid to get educated by our clients.” Whether we get educated enough may be questionable. I once spent a very frustrating day at the Robert Wood Johnson Foundation arguing with a bunch of academics and policy wonks about a draft questionnaire on health insurance. In the evening, my wonderful friend Donald Stokes, who was then the Dean of Princeton’s Woodrow Wilson School, told me, “You have to understand that you make a living out of making complicated things as simple as possible. Many academics make theirs making simple things as complicated as possible.”

I’m not sure if that is fair but I am very, very grateful for your invitation and your hospitality.

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What’s Ahead in Health Care News?

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