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**Daniel Callahan: Taming the Beloved Beast**

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## INTRODUCTION



### TAMING THE BELOVED BEAST

#### HOW MEDICAL TECHNOLOGY COSTS ARE DESTROYING OUR HEALTH CARE SYSTEM

Once again the United States is in the midst of a periodic health care “crisis,” one that has emerged about every 15 years since World War II. Once again talk of reform is in the air. Once again public opinion polls show, as they have done for decades, that a strong majority of Americans want universal health care—and also how divided they are about how to get there. Once again the complexity of reform, competing interest groups, and the long-standing resistance to an expanded role for government stand in the way.

Is it different this time? Will reform elude us? Will hopes be dashed? I will not try to prophesy how and when the current struggle will end. I want, instead, to examine a critical variable in any discussion of health care reform, one that is known and visible to health care experts and increasingly by the public but, curiously, politically minimized and evaded as well: the growing cost of medical technology.

In a rare instance of consensus, health care economists attribute about 50% of the annual increase of health care costs to new technologies or to the intensified use of old ones.<sup>1</sup> That annual increase has fluctuated between 7% and 12% a year for many years now, and there is every expectation that it will persist at around 6–7% for the indefinite future. Medicare’s cost increases are projected to be 7.4% a year between 2006 and 2017. The health portion of the GDP was 16.3% in 2007 and, at the present rate of increase, will consume 19.5% by 2017.<sup>2</sup> The so-called “magic” of compound interest, much cited as an argument for saving money has, as its nasty twin, rapidly compounded costs. The projections

are that the Medicare program will go bankrupt in 10 years or so, and the overall cost of health care will rise from \$2.2 trillion in 2007 to over \$4 trillion in the next decade or so, an astonishing jump.

That trend is a major contributor to the steady growth of the uninsured, now at 46 million and increasing at the rate of 1 million a year (although 2007 saw a small drop). Costs are no less a contributor to the gradual decline of employer-provided health care (now down to 60%), a reduction in benefits, and an increase in cost-sharing. American health care is increasingly unaffordable for business, for government programs, and for individuals. Despite a popular Medicare program, its beneficiaries, those over 65, will spend an average of \$5000 a year of their own money on health care, and some as much as \$10,000. Half of all personal bankruptcies in the United States are occasioned by health care debts.

If close to 50% of the cost problem can be traced to medical technology, then one might expect that its costs would occupy a central place in the national debate, and, more specifically, that the various reform proposals now in circulation would give special consideration to the control of technology. The only bright spots have been the inclusion of a \$1.1 billion budget item in President Obama's stimulus package for technology assessment (TA), and a smaller amount for information technology (IT). It was immediately attacked by conservatives as a government threat to the doctor-patient relationship. Michael O. Leavitt, the Secretary of the Department of Health and Human Services in the George W. Bush administration, was one of the few people in government to complain vigorously about that neglect. The present growth of health care spending, he said in a September 2008 speech, "could potentially drag our country into a financial crisis that would make our major subprime mortgage crisis look like a warm summer rain."<sup>3</sup> The extensive academic and policy literature that I heavily draw upon in this book tend to treat the cost problem as serious but in far more muted language than that of Secretary Leavitt. His words strike the right note and tone.

One aim of this book is to assess this reticence, but, in brief, the most likely reason is the superelevated stature given to steady medical progress and technological innovation in American culture, medicine, and industry. Progress and innovation seem self-evidently valuable, not to be questioned. The frightening thought that the innovation that has saved so many lives and reduced so much suffering could itself be playing a leading role in our health care discomfort is hard to accept, difficult to talk about openly, and politically controversial. It connotes rationing

of medical treatment, limits, and a direct threat to the cherished value of relentless progress against illness and death.

We can readily agree that medical progress and technological innovation have been an enormous human benefit and that many of the readers of this book and I, not to mention millions of others, might not even be alive but for them. They have helped to lower death rates from lethal diseases, extended average life expectancies, relieved us of many forms of physical and mental suffering, and have given us a confidence about living into old age, and a good old age at that, in ways impossible for past generations even to have imagined. Yet if the cost of all those benefits begins to exceed what we can now afford, how do we decide when enough is enough, and just what might count as “enough”? What might be of immense value to us as individuals may not be compatible with an equitable health care system, aiming for a common good, not just the private good.

Is there any wonder, then, that politicians and reformers shy away from the subject? They have trouble enough devising viable system-wide reform proposals without throwing cold water on their own case by dealing directly with costs and technology. They hardly confront the subject at all or, if so, in some soft, nonthreatening way. The most popular line is to pledge a vague reduction of waste and inefficiency, a 30-year-old refrain that is lofty in its rhetoric and devoid of much success. But such a proposal does not get anyone’s back up.

Even though technology is the main driver of cost increases, perhaps the reticence to recognize this that I note reflects a belief that technology expenses are important symptoms of the cost problem but not one of its primary underlying pathologies. Often cited are high administrative costs, fee-for-service medicine, a profit-driven private sector, the economic incentives for physicians to use (and misuse) technology, and a medical-industrial complex that finds technology an unparalleled cash cow. Those causes are indeed important, and I discuss them in detail as the book progresses. But I give technology a place of primacy for two reasons. First, I see it as both a cause and an effect, not one or the other. It is a cause because, for most Americans and most doctors, it is the most visible and attractive feature of contemporary medicine and health care. Drugs, surgery, and medical devices of one kind or another are what save our lives and relieve our suffering. And they have a more important role, real and symbolic, in American health care than in most other health care systems. Technology pulls us along, raising our health aspi-

rations as well as our costs. Ezekiel J. Emanuel and Victor R. Fuchs, in a valuable survey article, speak of overutilization of health care procedures, but much of that I call the use, and over-use, of technology. Those are the expensive items but they well bring out how there are other instances of overutilization as well.<sup>4</sup>

Second, technology costs reflect the way our health care system is financed and organized as well as the way our physicians are trained to practice medicine. Even if the many incentives for both the excessive use and misuse of technology as well as its use in cases providing only minimal benefit were all eliminated, the *cost* of technology would still remain a problem because of its very success. Ironically, those very technologies that do work to improve our health and quality of life are increasingly becoming the expensive long-term problem, and that will be the ultimate dilemma for any future health care system.

This book is based on a number of convictions. If costs are not controlled, the health care system will not collapse; it will fall into a gradual decline, with increased inequities, ever more uninsured, and a deterioration of quality. The emergence of a three-tiered system can already be observed. At one level are those with adequate and ample health care coverage, either through private employer-provided coverage or through Medicare, and who are comfortably able to afford co-payments and deductibles. At another level are those who have coverage but are either underinsured or for whom the co-payments and deductibles are economically stressful. Those who must buy their own insurance, or whose employer-provided care does not cover family members, or who face unbearably high costs because of gaps in coverage (many Medicare recipients), fall into this group. It is the second group (estimated at about 25 million) that is fast growing and increasingly touching middle-income people who were previously covered at the first level.<sup>5</sup> At still another tier are those who do not have, or cannot afford, private insurance but must depend on Medicaid, with coverage that is often inadequate. An important way to control costs is to control the use of technology, and the key to doing this is to control physician fees, reimbursements, and acceptable procedures, and to limit industry's excessive influence on the use and marketing of medical technologies.

I can sum up what I want to say in some simple propositions. First, ways must be found to return to more basic levels of medical care for ever more patients (e.g., to emphasize prevention and primary care) and

to make it more difficult to receive medical care at the higher levels (e.g., advanced expensive cancer treatments or heart repairs). Second, the priorities for technologically oriented health care should begin with children, remain high with adults during their midlife, and then decline with the elderly. Third, if the medical care received during those first two stages of life is good, the elderly will have a high probability of a good old age even if advanced technologies are less available to them. Fourth, health care cannot be reformed, or costs controlled, without changing some deeply held underlying values, particularly those of unlimited medical progress and technological innovation.

The title of my book, *Taming the Beloved Beast*, is meant to catch the basic dilemma I will be exploring. How do we cope with the much beloved technology of medicine, that brings us uncounted benefits, when that same technology—like a beloved dog who chews up the furniture, scares strangers and small children with his excessively friendly behavior, and is not house broken—begins to create new problems as fast as it can solve old ones. We cannot kill off technological innovation any more than we can comfortably send our dear pet to the vet to be put to sleep. But neither do we have any electrifying ideas about controlling the costs of technology, particularly when, as with our sweet but unruly pet, all of the experts on training dogs (and managing technology) have torn out their hair trying to induce better behavior.

Even if through some miracle we do achieve a universal health care system, we will have an almost impossible time holding on to it without controlling costs in a rigorous way. Steadily growing technology costs, compounded by the retirement of the baby boomers and increased demand on the system, would make it unsustainable. That latter possibility can be seen in European health care systems, struggling to hold on to their universal care in the face of the same kind of cost pressures we face (although doing much better at this than we currently are).

The worst reality of all now is that there are no reliable or seriously envisioned practical and politically acceptable means of managing costs anywhere near the extent necessary. There are, to be sure, many good ideas for controlling escalating costs, but most are theoretical and only speculative. They do not pass the test of “practical and politically acceptable.” Most are just band-aid solutions that I consider minimalist and incremental. As the Kaiser Family Foundation, a highly reputable source

of health policy analysis, bluntly put it recently (in a little noticed 2005 study), “none of the usual policy options raised in health policy or political circles is likely to significantly close the gap between the growth of health spending and [national] income.”<sup>6</sup> No one, in short, really knows in a pragmatic sense what to do with a problem that is both real and threatening. The public has heard about and experienced the cost problem, but they have heard little about the pessimism, almost despair, that has marked some of the most important studies of it.<sup>7</sup>

With health care reform in general, there are many novel ideas in the air, often accompanied by a strategy to implement them. But specifically for the management of technology, most general proposals do not encompass an implementation strategy. Why is that? That is the question I wish to deal with in this volume: trying to understand why the control of technology intimidates politicians and health care administrators alike; why technology has unusually deep roots in American culture and commerce; and why the tried and effective means of controlling technology in Europe have such difficulty gaining acceptance here. Then I want to offer some concrete strategies for managing technology, propose some benchmarks for success in doing so, and try to show that nothing less than a cultural revolution in our thinking about progress, technology, death and aging will suffice to do the job.

I will use the Medicare program as my point of departure for a variety of reasons. With the advent of retirement looming for the baby boom generation, the weight of an aging society on health care will soon be felt with its full force; and that pressure will be set within a health care system already in deep trouble. As a government-financed program, Medicare can rightly be described as universal health care for the elderly. It thus offers a test case of managing that kind of system in the United States, one that will be useful if a universal government-regulated system ever emerges.

But I stress that Medicare is *only* my point of departure, and I will move in and out of Medicare cost considerations and those of a more general kind. Even without universal care, the present Medicare program is heavily influenced by American health care practices and policies. Medicare cannot be reformed in a cost-saving way without simultaneously changing that background dynamic. Medicare’s important and ever-growing role in American health care means that the health care system cannot be reformed without drastically changing Medicare. The

dilemma is a dynamic two-way street. The retirement of the baby boomers will be the great demographic event of the first half of the twenty-first century, just as the birth of that generation was the great demographic event of the last half of the twentieth century.

The analysis will proceed on two levels. One of these will be an examination of the available data and information on the impact of technology on health care costs, the nature of that impact, and the proposed and actual means of attempting to cope with them. I will argue that many of the most discussed ways of managing technology costs are minimalist and utterly insufficient to do much good. I will also argue that, like it or not, we will have to look toward European health care systems for effective means of dealing with costs—or fashion a compromise situation meant to bring together European and American values in some politically acceptable way. Not an easy exercise.

The other level is that of culture and politics. I do not believe we can effectively cope with the practical managerial, organizational, and policy issues without attempting to change many underlying cultural, social, and ethical premises. We have a culture addicted to the idea of unlimited progress and to the technological innovation that is its natural child. In its present form, this is an unsustainable value. There must be limits. American health care is radically American: individualistic, scientifically ambitious, market intoxicated, suspicious of government, and profit-driven. I put changing those values within health care in the class of a cultural revolution dedicated to finding and implementing a new set of foundational values.

The medical model that needs change encompasses a combination of Manichean and utopian values: that suffering of any kind, but mainly biological suffering, is an inherent evil; that death is intrinsically wrong and should be the main enemy of medicine; that the antiageism movement of recent decades is *de facto* acting as if old age were a biological anachronism, to be transcended even if not quite eliminated; and that endless medical progress should be pursued. There is, many seem to believe, no such thing as enough good health. Those are understandable values, the Enlightenment played out in medicine. They have become, however, the wrong ones to undergird health care systems and the practice of a medicine that aims for equitable access, a good balance between health and other social needs, and that are affordable, sustainable in the long run, and accessible to all.

Although there seems at first no direct connection discernible between them, it is remarkable that global warming is now, finally, being taken seriously in the United States; and that there is, simultaneously, a fresh push for serious health reform. In both cases, some deeply seated values must be changed, amounting in the end to fundamental alterations in our way of life. The drive for progress and constantly growing prosperity in the industrial order is behind the emergence of global warming; and an analogous drive has created the cost crisis in health care. In both cases, technology occupies a central place. In each instance, a basic question is whether we should be prepared to sacrifice some of the present and future benefits of science and technology, which have created the parallel dangers, or look to them for new initiatives to rescue us from the unwanted complications they have created.

The problems of Medicare ought to force us to think about the war against death, aging as a part of life, the place the elderly should have in our common life, obligations between young and old for their mutual flourishing, and what kind of resources—medical, social, and financial—should be devoted to health care in general and as well as to elder welfare. In particular, the American health care system as a whole raises an even wider range of basic questions. What is most important in health care? Staving off death and lengthening our life expectancy? Curing all the lethal and dread diseases? Helping us to cope with pain, suffering, and disability even if they do not kill us? Is quality of life more important than length of life? How do we balance the claims of different age groups? Those are the ultimate questions in thinking about health care but ones rarely confronted in the political debate about reform. Questions of that kind make politicians nervous, and thus they remain outside the scope of conventional economic and policy analysis. I will try to show these questions cannot be avoided.

Chapters 1–5 provide an analysis of the cost problem for Medicare and the underlying health care system. Their principal aim is to show that the cost problem is serious and urgent and that efforts to address it are marked by ambivalence and hesitation, in great part out of fear that technological innovation could be stifled. How can we control, much less cut back on, a medical technology that has had so many historical benefits and can bring so many more in the future? We can achieve this only if we are willing to take tough steps and admit that medical technology's economic harms can often exceed its benefits. The public will not

strongly object to cutting physician fees or hospital reimbursements (although they may indirectly feel the consequences), but any thought of controlling or reducing the use of technology will seem to be much more direct and personal. I also consider the arguments for competition as a basic means for controlling costs as well as examine the relationship of American medicine and the medical industry.

Chapters 6, 7, and 8 present a set of revised values on which to base health care reform. These values will encompass a rejection of the reigning model of limitless medical progress and technological innovation, the use of the different stages of life, from childhood through old age, as a foundation for health policy, and setting health care priorities on the basis of the statistically most likely needs that people will have over their lifetime. I will offer a strong, perhaps utopian, plan and a less extreme parallel set of reforms, hoping that my more lofty proposals might someday prevail but, more realistically, propose a possibly more palatable menu of options, but one that would push us farther along. I will make clear my own bias toward the more radical possibilities but try to be plausible with the compromise possibilities.

The improvement of health, the relief of suffering, and the forestalling of death are as open-ended as the exploration of outer space. In each case, the possibilities are endless: no matter how far we go, there is always further we could travel. If we all lived an average of 150 years, the offices of the doctors would still be full, patients would still be looking to have their diseases cured, their pain and suffering relieved. Learning how to manage medical technology, which constantly extends the frontiers of medicine but requires economic limits, will be a vital first step toward a sustainable health care system.