Can we control health care costs?

Cite this article as:

C W Weinberger

Health Affairs 1, no.1 (1981):53-61
doi: 10.1377/hlthaff.1.1.53
The online version of this article, along with updated information and services, is available at:

http://content.healthaffairs.org/content/1/1/53.citation

For Reprints, Links & Permissions: http://content.healthaffairs.org/1340_reprints.php

Email Alertings: http://content.healthaffairs.org/subscriptions/etoc.dtl

Not for commercial use or unauthorized distribution
Prologue:
The process of government decision making has become so complicated, so vested by interests representing narrow viewpoints rather than broader national goals, that one of the chief products of American government has become stalemate. From his many years of experience as a distinguished state and federal government leader, Weinberger writes about the importance of the policy process, concluding that the executive and legislative branches are independent, as envisioned, even when they are controlled by the same political party. In the health field, Weinberger views the cost-reimbursement formula upon which Medicare is based as a fault that must be corrected. This payment form has led to an attitude that the government, not the patient or provider, is at risk so they don’t worry about costs. Weinberger, former Secretary of Health, Education and Welfare is now Secretary of Defense, Washington, D.C. The speech from which this article is excerpted was given in April, 1980 when he was General Counsel to Bechtel Power, Inc.
I had planned to address one aspect of American health policy choices and that was “How We Control Health Care Costs.” That title suggests, however, a degree of optimism which I do not, on further reflection, really feel and so I have pushed that aside to talk about “Can We Control Health Care Costs?” There is not much good news in the whole area of trying to control costs. There does seem to be some slight grounds for hope. Besides, it is a Californian’s constitutional obligation to be optimistic, and I don’t wish to be in any way unconstitutional.

If there are some things we can do to reduce inflation in health care costs, that would certainly be one of the major choices in health policy. It is very important, though, before going into any detail, to discuss briefly certain facts that underlie all of our discussions about American health policy choices, including health care costs.

One of the primary considerations that we must bear in mind is just how you establish any kind of policy in the United States today. It should be evident, for example, from our struggle to adopt positions on energy for the last ten years, that at the very least, it is difficult for the federal government to adopt any policy on any major controversial topic. Part of the problem is structural, being built into our system, and part of it is traceable to some facts in our recent history. We should be aware particularly of the structural problems, because they apply when we talk about how we can change some aspects of our health care policy.

Probably everyone knows that one of the fundamental principles of our government is the separation of powers that, of course, grew out of the desire in Revolutionary times to prevent tyranny, or the imposition and use of too much governmental power. Our founding fathers felt there was considerable safety is dispersing this federal power. This dispersement was to be accompanied by a system of checks and balances which would help achieve that elusive goal of securing freedom and order. To make things more complicated and more difficult for any possible tyrants, we would also disperse power among our states and to our local governments. That was an even greater dispersal because we gave certain defined and named powers to the federal government. Then we said everything else belonged to the states. So looking at the federal government initially, we have the legislative branch, which was supposed to set the broad policy for the executive branch. The executive branch, headed by the president, was supposed to carry out the policy set by the Congress. The veto and overriding powers and all of the rest were supposed to check and balance legislative powers. Then political parties, that were not even mentioned in the Constitution, came along. They were supposed to provide the necessary systematic coordination of effort between the two branches. This coordination is secured in the parliamentary countries by the fact that the principal executive officers
are, in fact, members of the legislative branch. Here, the political party structure, an extralegal innovation, grew up in the first twenty to thirty years of our existence as a country. This mechanism arose to meet the need for greater coordination, which clearly was not going to be possible without some such innovation.

This is not to be a constitutional discourse. You know all of these things. But the simple fact is that the relationships between our executive and legislative branches have deteriorated so greatly that the easiest thing for the American federal government to produce in almost any field is stalemate. For those persons who worry about tyranny and worry about too much power, that is comforting. But even people who worry about such things agree that occasionally the government does have to do something, and form some policies. That is where we have had a considerable difficulty, particularly in the last ten years. This is one of the really vital problems we must recall as we consider health policy.

It is fair to say that there are many ideas that individually might have great appeal, and even consensus, but are not capable of being enacted. Congress is most responsive not to a single voice, but to a very large number of comparatively small, very vocal, very effective, special or single-interest groups; and these groups frequently have a negative program—“Don’t change anything, don’t eliminate any existing programs.” When I was running the Office of Management and Budget, we formally recommended the elimination of 105 separate programs that we felt could be safely dropped, with no harm to anyone except perhaps a very few of the people who were managing them. The Congress eliminated only one, and that by inadvertance. They gave the Arctic Health Research Center back to the University of Alaska. The next year, the senior senator from Alaska found out about it, and it went back to the federal government again and so even that was gone. All 105 appropriate targets for discontinuance remained undisturbed and are still there. Those are examples of things we can do without.

Many interest groups are extremely strong. For example, just in the energy field, there are many strong lobbies against eliminating the various government controls on prices and production of more energy. So, for at least eight years, it became virtually impossible to adopt any kind of policy of encouraging more production through deregulation because of the fears of various small groups from different parts of the country that this would lead to price increases. It was recognized that a price increase might be a very good conservation measure, but it was politically unacceptable and so nothing happened.

The president, elected by the country as a whole, also may have a very specific group of policies, including some that might have been a crucial part in his campaign. Frequently, though, he is totally unable to
have anything significant enacted. The Congress, even though it might consist of a large majority of members of his own party, becomes a separate agency. There is a Republican congressional party and a Democratic congressional party and a Republican executive party and a Democratic executive party. And even though they are members of the same party, they do not support many of these proposals, even if made by their own party members in the executive, because the Congress responds to these special interest groups much more readily than it does to the national interest.

As to health policies, we have debated some form of health insurance for over twenty years. Various presidents and presidential candidates have had quite specific and detailed plans. Congressional committees have proposed and considered plans on their own. Some legislation has passed. There has been major federal governmental assistance in health since 1789 when the first Public Health Service hospitals were created for merchant seamen who had no home, and no place to go for medical treatment. Of course, we have also had the Veterans’ Administration, an enormous health system managed and administered by the federal government. But the first time the federal government began the general delivery of health care—aside from those other specific instances—was Medicare in 1965, a program designed to reimburse costs of care of those over age sixty-five.

There are several constructive lessons to be derived from the experience of enacting Medicare. There was the usual strong opposition to it that had defeated similar bills in earlier years. But passage of Medicare was ultimately secured in 1965 when the supporters of the program promised the health care providers that all of their claims, practically speaking, would be honored with no tiresome questions asked regarding the necessity, or the quality of the services being provided. This was sufficient to eliminate enough opposition among the providers so that the measure could be passed. It is also important to bear in mind that this fault in the design still requires correction. We spent a lot of time when I was at HEW (now Health and Human Services) trying to correct that fault. It is built into our whole system and is one of the prime causes of inflation in health care costs. Medicare led to an enormous new demand for health care services. At the same time, it guaranteed payment by the government for all services, without constraint, to a large section of the population without regard to need for that particular medical or health service or its quality, or how it was delivered, or finally, the cost. The government did keep its part of the bargain, so to speak, by not challenging claims for several years; and we were pretty well launched into a major inflation-producing program. Not only did
Medicare guarantee payment for anything that was provided, in the amount charged, without very careful examination; but it was also heavily oriented to hospitalization which is our most expensive form of health care. It induced an attitude that “the government is paying for it all . . . we don’t really know if you need hospitalization, but since it’s all taken care of why don’t you go into the hospital for a few days?” That, in turn, led to an overuse of this very expensive aspect of health care.

There are other items that have also brought about a very large increase in health care costs. One of the few cost-increasing stimuli for which we cannot blame government is the effect of American technology. As the volume of health care grew, with huge built-in demand factors, there was also a great increase in the intensity of the care and the new technologies that were developed. Many of these are necessary. Careful studies have demonstrated that the CAT scanner—once bought and installed at large initial expense—can deliver certain services very much less expensively than might be delivered otherwise. This raises the question of what we did before there was a CAT scanner, and also the question of whether every hospital in every section of every city needs one. Of course, most hospitals feel that they should be the best equipped general hospital in any city, even if there are five, six, or seven of them. That has added substantially to the overall cost.

There has been another problem, and that is the explosion of malpractice suits. This is largely a domestic phenomenon in the United States. I am not aware that it has taken place in other countries in the size and scale that it has here. This led, again quite understandably, to a tremendous amount of defensive medicine being practiced—“You do not need the X-rays, but we had better take them, because if we don’t have a good file we may be sued and we won’t have a good defense.” When I was HEW Secretary, I called for estimates as to what this defensiveness was costing. While the figures lack precision, they came back somewhere between $2 and $8 billion a year. There is indeed a lack of precision here that troubles one. We must content ourselves by saying simply that a very large amount of money was devoted to such defensive practices, and that comparatively little of it could be demonstrated to be absolutely essential.

Then there is the fact that there is relatively little competition in health care, in the sort of salutary form that we believe exists in the free market system. It is not very practical for the patient to shop around and try to choose the least expensive, the most efficient, or the best hospital. Patients go to hospitals that are assigned by the doctors and the doctors use hospitals where they are admitted to practice. This may be good or it may be bad. But it does mean that the opportunities to allow market factors, which we might otherwise like to apply in this particular situation,
are not really present.

There is another factor, also caused by government, and that is the heavy burden of regulation pervading the entire area of health care. This necessitates many nonproductive activities at a very large cost, which has to be borne by someone—either the taxpayer or the patient or both. And there are numerous other factors in the picture. We all know there is not just health care inflation in the country, but inflation in general which the health industry must cope with as well. A good bit of this general inflation is also governmentally caused. So, we have a very large number of causes of inflation.

Things can be done to treat some of those causes. For example, with malpractice suits, we could—as I suggested when I was at the Department of Health, Education and Welfare—make a number of changes in our local tort laws that govern the bringing and disposition of these suits. We could, for example, have a much shorter statute of limitations. We should also not permit the so-called contingency fee under which an attorney takes one of these cases and does not charge the patient. Indeed, the plaintiff becomes quite a nominal plaintiff, and the battle is one between the attorney and the defendant’s hospital or doctor, I suggested that we eliminate contingency fees in these cases. My colleagues in the bar did not feel that this was in any way a constructive suggestion, and the negative mail I received was voluminous. But the fact remains that we do incur considerable additional cost because of this.

One of the things with which we must try to deal is the fact that many of these inflationary causes are initiated or caused by government. As previously noted, it is a difficult matter to change government policy in this country. But when you have a bad set of statutes or a bad program, it is desirable to be able to change it. However, it is equally as hard to change even when there is a perception that a law or rule is no longer needed, as it is to adopt anything new.

I have in mind, for example, our so-called Hill-Burton Act. The Hill-Burton Act provided for government subsidies for hospital construction, a very necessary piece of legislation immediately after World War II when we did not have enough hospital facilities, and when local finance was heavily engaged in other rebuilding. But like the sorcerer’s apprentice, it keeps going on and it is totally unstoppable. We are still spending somewhere in the neighborhood of $750 million a year to subsidize the construction of hospitals even though we now have 80,000 to 90,000 surplus hospital beds.

I am the trustee of a private hospital in San Francisco. We receive occupancy reports each month. If the hospital is more than 65 percent occupied, the report is presented by the staff with a great deal of pride. Yet the government continues to subsidize hospital construction. It is an
easy calculation to show that it is a great deal more costly to run a hospital with empty beds than with full beds, particularly when you are paying off large construction loans at high interest—even where the government has subsidized those loans.

Welfare reform, another field in which I have long been interested, provides demonstrable evidence that we have a kind of nonsystem in welfare that encourages people to go on welfare; discourages people from getting off the rolls; condemns people to a very narrow kind of existence; and intrudes into their private lives with all kinds of very difficult and highly insulting types of questionnaires. Nonetheless, apparently it cannot be changed, even though we have full knowledge of the difficulty with the system; its costly nature; its lack of delivery of welfare to people who actually do need it, the people who are most in need. That is, again, an issue that has been brooded about, debated about, written about, for a good fifteen years and change seems simply not to be possible in this field. The same thing is true with a number of the health plans.

I suspect that there are some plans for health insurance that would be supported by the majority of the American people. A number of state governments have quite detailed and costly plans for health care delivery. One of the inducements for a national system has been that it would relieve those states that are chronically supposed to be hard pressed in raising revenue. The difficulties of obtaining any kind of decision underlie and explain why it is that a number of people are now talking about some form of direct legislation. We do not have provisions for direct legislation in the federal government. We do have it as an option in many states. Some of you may have heard of Proposition 13. Proposition 13 was the California reduction of $8 billion a year of real estate taxes, and it came about as a result of pent-up frustration over attempts during a five or six year period, to obtain a significant reduction or reform in the property tax in California while very large surpluses were building up in the state treasury. The proposal could never be passed in the legislature. But direct legislation is possible in California and a number of other states. Necessary signatures were secured in a very short time and there was a large vote in favor of the proposition. The next year another proposal was passed which attempted to limit state spending in the future.

These are big blunderbuss laws. They are not very carefully drafted. They create substantial difficulties in administration. They are prepared by committees or anonymous groups, who then go out and secure the necessary signatures on petitions. But their passage by these very large majorities demonstrates a reaction to the frustration that has no outlet
in the federal government. We still have a system in which people who urgently want something, frequently do not have an effective governmental outlet for that desire. I doubt that there is enough frustrated demand for national health insurance at the present time that would prompt voters to take things into their own hands, even if there were a mechanism for them to do so.

A number of states, something like thirty-three of the necessary thirty-six states, have now adopted a request for a constitutional convention, or a kind of constitutional amendment that would limit federal spending. That is one of the things that may prompt a structural change in the next few years, because there may be many other things that people feel they want very much. At the moment, one of these is far less government, less costly government, less intrusive government. The people feel that this is not obtainable through existing indirect legislative processes. It may well be that there will be a groundswell of demand for a constitutional convention, or a constitutional amendment, or other kind of change that would enable a particular piece of legislation that people want very much to be enacted. That may well happen in the future.

Let me now close on a more optimistic note. It is not chauvinistic, I hope, to remind ourselves of the gains that we have made in improving the health of our citizens over the past few years. But in terms of government spending, we should note that there has not yet been a very demonstrable relationship between increased public spending on health and improved health care. But we do have some very good statistics and a rather good record of substantial improvement in the last several decades. Also, we have something to be quite proud of in our expansion of successful research conducted in this country. Much of it has been under private sector auspices, but also very important work has been conducted under government aegis through the National Institutes of Health.

I want to quote a few words from Dr. Lewis Thomas, one of America's finest essayists. He states: “It is extraordinary that we have just now become convinced of our bad health. Our constant jeopardy is disease and death at the very time when the facts should be telling us the opposite. In a more rational world you would think we would be staging bicentennial celebrations for our general good shape. In the year 1974, out of a population of about 220 million, only 1.9 million died, or just under 1 percent, which is not at all a discouraging record once you accept the fact of mortality itself.” Dr. Thomas' figures from 1974 have been improving since then. “The life expectancy for the whole population rose for seventy-two years, the longest stretch ever achieved in this country. Despite the persisting roster of still underserved major diseases, that is, cancer, heart, stroke, arthritis and the rest, most of us have a clear,
unimpeded run of a longer and healthier lifetime than could have been foreseen by any earlier generation.”

Dr. Thomas closes on the most optimistic possible note: “Most things get better by themselves; in fact, most things are better by morning.” And with that I agree completely.