The scientific revolution in medicine poses two problems for medical policy that previous generations almost never had to face. First, patients and their families, on the one hand, and practitioners, on the other, must decide when therapies capable of extending biological life are beneficial. Second, policymakers at all levels, including elected officials, hospital administrators, and physicians, must decide whether all beneficial care should be available to patients. If the answer is “yes,” they must decide how to pay for it; if the answer is “no,” they must decide how to enforce that decision in a politically acceptable and sustainable way.

These questions should not be confused with one another. The first is simply one of identifying when extension of life is beneficial; the second is a question of whether therapies acknowledged to be beneficial are worth the cost. In Chase Peterson’s article in this issue of Health Affairs, these two questions seemed to me not to be clearly distinguished. I believe that it is important that they should be.

The first question is not one on which I or anyone else has much to say that should influence anyone else. Whether the miseries of chemotherapy, burn treatments, dialysis, or dependence on others are compensated for by extended life is a question each person must decide for himself or herself. For the reasons that Thomas Schelling so humanely expressed in his marvellous essays on self-control, I do not take very seriously those who would preach to others on this question.

As a boy I saw a movie about Admiral Byrd’s Antarctic expedition and was impressed that as a boy he had gone outdoors in shirtsleeves to toughen himself against the cold. I resolved to go to bed at night with one blanket too few. That decision to go to bed minus one blanket was made by a warm boy. Another boy awoke cold in the night, too cold to retrieve the blanket, cursing the boy who had removed the blanket and resolving to restore it tomorrow. But the next bedtime it was the warm boy again, dreaming of Antarctica, who got to make the decision. And he always did it again.

How should we conceptualize this rational consumer whom all of us know and who some of us are, who in self-disgust grinds his cigarettes down the disposal swearing that this time he means never again to risk orphaning his children with lung cancer and is on the street three hours later looking for a store that’s still open to buy cigarettes; who eats a high-calorie lunch knowing that he will regret it, does regret it, cannot understand how he lost control, resolves to compensate with a low-calorie dinner, eats a high-calorie dinner know-
ing he will regret it, and does regret it; who sits glued to the T.V. knowing that again tomorrow he'll wake early in a cold sweat unprepared for that morning meeting on which so much of his career depends; who spoils the trip to Disneyland by losing his temper when his children do what he knew they were going to do when he resolved not to lose his temper when they did it?1

While policymakers have nothing to contribute, other than the best possible information, to the personal decision about what therapies are beneficial, they have an important responsibility to decide within a democratic framework what incentives should operate when patients and physicians make that decision. Within whatever set of incentives and constraints exists, patients and physicians will decide what services to generate. How to fashion those incentives and where to set those constraints is what the cost-containment debate is all about.

**The Right Question**

Peterson asks whether we can realize sufficient savings in our present system to pay for high-technology medicine. I don't think that that is the right question. I think the right question is: "For how long can we pay for medical advances from improved efficiencies without having to sacrifice some beneficial care for people who have the means to pay for it?" The phraseology of that question is not ideally suited to rouse a mass rally, but I think that it states the various aspects of the problem precisely. That wording implies clearly that the current system of providing medical care contains pure waste—surplus facilities, services that do no one any good, methods of delivering care that are needlessly expensive, and so on. We can save a lot of money by getting rid of pure waste. Exactly how much is a matter of some uncertainty. Based on the health insurance experiments, Manning and colleagues report 23-28 percent fewer hospital days per enrollee in HMOs than under free care.2 However, W.P. Welch reports only a 13 percent difference.3 That is very big money. But unless technological change and an aging population, the same forces that have been pushing up real medical costs 5 to 6 percent per year for at least two decades, were altered; eliminating waste, important though it would be, would give us a respite from rising outlays of only a few years. Then we would have to decide whether we should deny some beneficial care to some people who have the means. As Reinhardt has pointed out, we don’t have to do that.3 We can pay for the cost of medical care which continues to rise just as fast as it has in the past and still have enough left over to consume increasing amounts of other things. I have no idea whether, when we are through squeezing out all the waste we can, we should ration care or not. The problems of rationing will be divisive and agonizing; the costs of avoiding those problems will be great. I do not know how we will decide that question. I am sure that we will have to face it.
Can Technology Reduce Costs?

It is dangerous to count on technological breakthroughs to save us money, except occasionally and in small amounts. The reason is the simple one, often observed, that health care is engaged in an ultimately losing struggle with mortality. Medical defenses can delay, but not prevent, the outcome they try to avert. To reduce costs, technological advances must do two things: first, they must replace something we did before with something less costly; second, they must not increase our capabilities enough to generate costs, directly or indirectly, that exceed the savings. That means that the research must not increase materially the number of people who can be treated. It also means that it must not allow people to become subject later on to diseases that cost more to treat than the amounts that have been saved.

I submit that research satisfying these two conditions is not very exciting and that even if consciousness of cost is raised a good deal more than it has been so far, not much research is going to yield benefits of this kind. Certainly, very few of the technological advances for which the middle of the twentieth century will long be remembered have met this description, and very few now on the horizon seem likely to do so. As Peterson has pointed out, even the most remarkable of advances, antibiotics, have contributed to rising costs by sparing patients death from infectious diseases so that much later they can decline more slowly and at far greater cost from other illnesses. The fact that even the costless elimination of cancer would in short order raise costs is now fairly widely understood.

The news that health costs rose slightly less rapidly than income over the last year has led some to speculate that we have turned the corner on health costs, that we have broken the decades long trend of rising proportions of gross national product going to health care. I suggest that this self-congratulation is premature. The upward trend has been interrupted before. We can eliminate waste once, and most of the savings we are achieving now stem from the fact that patients and physicians are resolving close questions differently from the way they resolved them in the past. Nothing has occurred to suggest that the demographics of an aging population have become more favorable; and, I submit, nothing has occurred to suggest that the nature of technological advance has changed.

When we are done with the very important work of improving efficiency and have saved the large sums that can be saved in this way, the number of persons over age eighty-five will be going up just as fast, the cost of heart and other organ transplants will still run to six-figures, Nobel prizes will still be awarded more often for lifesaving breakthroughs
than for cost-reducing improvements, and death will still be more certain than anything else, even taxes.

NOTES


3. W.P. Welch, “Health Care Utilization in HMOs. Results from Two National Samples,” *Journal of Health Economics* 4 (December 1985): 293-308. This difference is not statistically significant.