Hospital Costs: Can They Be Cut?

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WHEN THE ORGANIZERS OF THIS CONFERENCE[1] asked us to consider the feasibility and consequences of a 25 percent cut in health spending, they were talking about major surgery. They were asking us to consider major surgery for a relatively new and very poorly understood disease—let's call it "malignant hypertrophy of health budgets." Now, if we were meeting to consider any *other* relatively new disease, we would at least start the discussion with a review of the etiology and the nature of the illness. We would consider cures, including major surgery, only afterward. So before doing what I was asked to do, namely, to consider radical surgical intervention, I would ask you to spend a few minutes with me in considering the nature and causes of the illness.

First, a few definitions. I would define the disease we are referring to not simply as excessive increase in the cost of health services, but more specifically as the increasing *percentage* of the gross national product (GNP) that the health industry is consuming. And I would

[1] At the 1979 Northeast Canadian/American Health Conference, the theme was "Painful Choices for Tomorrow: Health Care on Diminished Budgets." Experts in the field were asked what would happen to their component of health care if they were to suffer a 25 percent cut in their budget and how they might survive it. Dr. Maurice McGregor is one of eighteen speakers who responded to this challenge.

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define "*health* industry" as the sum of the activities of the doctors and nurses and health workers and hospital staff who spend almost all their time caring for, palliating, and very occasionally curing the sick. It should be called the sickness industry, for that is what it is.

Now we do not know whether this industry is efficient or not. I am sure you will all agree that its presence or its absence has very little to do with the health or productivity of the population. There is therefore no reasonable way in which we can estimate the benefit of this system. Without a way to estimate the benefit, we have nothing with which to compare the cost. Yet to estimate efficiency, we need some sort of cost-benefit ratio. When worthy politicians, administrators, and pundits tell us that they have a gut feeling that hospital budgets are fat or lean, one should remember that the gut is poorly designed for thought. We have no idea whether the health industry is effective, efficient, or grossly inefficient.

However, there is no doubt at all, and this is the reason for our conference, that this sector of our economy is consuming more of the individual citizen's earnings than ever before. So my first question is, *Why* is this necessarily a bad thing? Why should we consider it a disease and not rather a benign hypertrophy, a boom in a consumer industry, a matter to celebrate in our capitalist system? Surely there have been many other major fluctuations in how we spend our dollars. Booms have been experienced in many sectors—the soft drinks industry, transportation, domestic electronics such as radio and television. Why was there no national outcry as the proportion of the GNP spent on these items doubled and redoubled?

A partial answer lies in the fact that in both our countries the health industry is largely funded by the public purse so that increasing demands, when they occur, mean increasing demands on the national budget. But this cannot be the whole reason. I remember no such public reaction over the prodigious increase in spending on public education when this was at its peak. I suspect that the reason that the boom in the health industry is considered negatively, something that must be bad and has to be stopped, is the fact that the price is rising without the public's *perceiving* that it is getting more for its dollars. When there is a boom in the motel industry, we see new motels all around us. Even in the education boom we saw new schools and new state universities soaring upward. But in the 1950s our hospitals were all there, giving excellent service, as determined by

the technological standards of the day, when the health industry consumed only half its present percentage of the GNP.

Our increased costs have largely been within existing hospitals and institutions and have not, in the public's perception, involved any improvement in service at all. It appears, then, that the nation pays more and more without *seeming* to get any visible benefits or improvements. And this is the basis, not very compelling, for the widespread belief that health costs are too high. So from question one I conclude that I don't really know how much of the GNP *should* be spent in the health sector. I don't know if we are looking at a normal physiological hypertrophy of the health budget in response to need, or at a malignant uncontrolled growth, a cancer. What is certain is that the public, the media, and our governments consider the latter to be the case. And this is what matters, since they control the budget. In any event, we must all agree that the growth is large, whether benign or malignant, and its causes should be considered further. It is extraordinary that the causes of this growth have not prompted more discussion. Perhaps we think we already know the answer.

Those who lean to the left see the high health costs as resulting from excessive profits of the pharmaceutical and electronic industries and the demands of a grasping, self-gratifying medical profession. Those whose predilections are to the right see the soaring costs as the natural outcome of an open-ended system in which economic restraint has been removed from the consumer. Creeping socialism! In the hospitals, our medical staffs tend to believe that the whole problem is due to top-heavy and inefficient bureaucracy, while our bureaucrats, particularly our governmental ones, believe much of the problem lies in senseless duplication and competition between institutions, and vast quantities of overtreatment. There is some truth in each of these explanations.

Ann Somers (1979) recently listed what she believed were the "obvious" principal inflationary factors in the system. These included the aging of the population (the elderly need caring for more than the young), and new environmental threats such as pollutants and increasing behavioral threats such as new hedonistic lifestyles. I suspect that these latter two factors really cannot be very important in economic terms since it is only those hazards that kill slowly, more slowly than can be normally expected in the elderly, that will increase

the overall costs incurred by the health care system. We must also question the oft-repeated assertion that preventive medicine, diet, clean environment, etc., etc., will reduce health budgets. These are fine ideals in themselves, but if they succeed they will increase the age of the population still further. People will continue to suffer illness and eventually they will fall ill and die. Do not look for a saving in health costs by this mechanism.

There are three principal causes for the increases in health care costs that are common to Canada and the United States and two lesser causes that are peculiar to one or the other of the two countries.

The first, and most important, is the increasing public expectation for its health care systems. If the public were ready to undergo confinements, sickness, and death in the home or in poorhouse-type institutions, a 25 percent reduction in budgets would pose no problem. The public of both our countries, however, has decided that free access to doctors and hospitals and the best available treatment under conditions of comfort and dignity are a citizen's right, not just a privilege of the middle and upper classes. They have taken political action to sustain this belief—more thoroughly in Canada than in the United States. But in both countries this principle has been clearly accepted.

The second cause, which we also share, is the technological revolution in medicine, its extraordinary success and its great cost. I refer specifically to what Lewis Thomas (1971) calls "half-way technology"—those measures that we adopt to mitigate the ravages of diseases we do not yet understand and thus cannot control. Artificial kidneys, pacemakers, coronary by-pass surgery, cancer therapy, and the diagnostic procedures and tools that they require, the ultrasound, the catheterization laboratory, and the computerized axial tomography (CAT) scanners; these are the principal, often overlooked, causes of the explosion in health costs. Their benefits are at the best palliative: they are life-prolonging but none of them is capable of prevention or cure. They are to be distinguished from the technical advance that follows the *complete* understanding of a disease, which is often relatively inexpensive, easy to apply, and eliminates the disease in question. Vaccination for tuberculosis or poliomyelitis are examples.

The cost problems attendant on half-way technology may be exemplified by medical progress in the treatment of heart-block. A few years ago, little could be done for a patient with symptoms of im-

pending heart-block, except to warn him that he might suddenly be dead. That was inexpensive. Today, a pacemaker can be implanted and five years later, when the batteries fail, another one can be put in. He may get subacute bacterial endocarditis and need intensive antibiotic therapy, etc. Prolonging the period of invalidism is expensive. The more successful we are, the more health care costs will go up.

The third cause, then, for increasing costs, which is common to the United States and Canada, is the very success of this expensive half-way technology. If we abstained from installing cardiac pacemakers, heart valves, and coronary bypasses, banned the artificial kidney, agreed that cancer therapy was largely palliative, expensive, and a luxury the country could not afford, we would save enormous sums of money, not only on the expense of these activities, but by not prolonging the period of invalidism, which of itself is expensive to the health system. Death is relatively cheap and is a constant under all health systems.

The fourth cause for cost increase in the health system operates much more in the United States than in Canada. It is due to the retention of a capitalist system of control after, and in spite of, the adoption of a socialist sentiment in relation to health services. I refer to the prevailing sentiment that recognizes that good health care is a *right.* A right for veterans, for the elderly and the poor, and, I presume, a right for the rich too, although it is understood that they can purchase it for themselves. This has resulted in a system in which the stimulative aspects of the free enterprise capitalist system operate to the full. I refer to the incentive to *compete,* with all the most expensive gadgets that we possess. Those *regulatory* factors that should inhibit expansion beyond the ability of the customer to pay have been removed from the system. The health system paid for by the public purse in the United States, probably the largest socialized free health system in the West, has not been allowed to develop the bureaucratic machinery by which a socialist society controls its expenditures.

On the Canadian side of the border, we have a different inflationary factor, but it too is based on an inappropriate mixture of capitalist and socialist components in our system. Unlike the United States, Canada has excellent machinery for containing health expenditure, a centralized fiscal control system that in effect allows our minister of finance to say yes or no to health expenditures. It is our particular

misfortune, however, that we have retained the industrial strike weapon in our state-run health industry. This rough but effective tool was the product of a free-enterprise competitive system of a century ago. With many suppliers, a strike in one did not hurt the general public. Some restraint was essential lest the strikers force wages so high that they put their own employer out of business. To apply the same technique to settle disputes between employees and monopolistic employers, the state in particular, is, however, absurd. The state does not go broke, so the principal reason for restraint is missing. Using the strike weapon, the worker, be he technician or physician, has no limit on his demands on the system except the amount beyond which he is prepared to be ruthless in extracting what he wants from the system. He may become more ruthless in the future.

So I must tell you that news of an impending 25 percent cutback in health spending would of itself precipitate major strike action across Canada. There would be a trial of strength between the health unions and the government that few politicians would contemplate. The power of those who work in the health industry to perpetuate their activity, irrespective of need, is very considerable. It has already been exercised. This constitutes a major impediment to health economies in Canada.

So where does this review of the system leave us? It tells us, first, that under existing conditions in our two countries, a cutback of 25 percent in the health industry is impossible. For different reasons, neither country has the power to carry it out.

Could we, you may ask, close 25 percent of our hospitals? This would undoubtedly be a most efficient step to take. But the patients treated in those hospitals would still have to be treated. They could probably be treated in the 75 percent of hospitals that remain open, at some cost saving. But the increased turnover, increased night and week-end operations in the remaining hospitals, would have to be paid for, as well as the unemployment and welfare payments for displaced hospital workers. Canada has the means and the ability to do this, or at least some portions of it, without serious deterioration of health care standards. But even if we have the means, we don't have the will. Or, to put it differently, the reactions of our unions, on the one hand, and the communities that we deprived of their neighborhood hospitals, on the other, would make such a step po-

litically impossible. So long as politicians have to get elected, we could not carry through anything so unpopular.

What else can we do? In Canada we can certainly slow down the introduction of expensive new technology. We can even eliminate some of the useless technology, although I believe this to be a small component at this time. Our governments certainly have the power to demand far more profound evaluative studies for items such as CAT scanners than they have in the past, before they allow their introduction. It would be quite within their power not to fund the purchase of capital equipment, or operations such as a coronary by-pass, until their indications, benefits, and costs had been precisely evaluated in institutions chosen for this purpose.

Having said this, I must admit that I do not think even a rigorous application of such policies would produce major savings, though the rate of expansion could be retarded while the data were being gathered. It is my suspicion that when all the evidence is weighed, we will find it essential to fund by-pass surgery for almost everyone with significant coronary disease; to authorize dialysis, as you have in the United States, for almost all patients with renal failure; and to authorize the purchase of CAT scanners in all but the small medical clinics. Thus we may retard the advance of half-way technology in this manner and occasionally protect ourselves from unjustifiable technological innovation. But we certainly will not arrest its advance in general. Because to do so would require a deliberate decision to withhold what we know to be the best medical treatment from some of our citizens, and I don't believe this is politically possible today in either of our countries.

Well, you must be thinking, this is a very negative fellow. A typical member of the medical staff. We tell him to cut 25 percent from his operating budget and he takes all this time to say it cannot be done. It's impossible.

I must confess this is true. Given our present administrative structures and our present political and social background, I do not see how it *can* be done. But there *are* many small savings that could be made and there *are* strategies that will at least start us moving toward the desired objective, which I take to be the elimination of "unjustifiable" expenditures.

The biggest gain is clearly to be made in the expansion of the

health maintenance organization (HMO) type of structure. This is very much more feasible in the United States than in Canada where extensive legislation and universal syndical-like organization of the medical profession have virtually fossilized the present structure. It is fixed by interlocking legislation and industrial agreement such that HMOs are no longer an option for us in Canada. It would take a revolution to change this. But this has not yet happened in the United States and, if I were your secretary of health, I would be looking for executive means to stimulate this form of development.

Then there are gains to be made, as I have said, by holding back new technology and demanding better evaluations of new procedures before allowing their widespread introduction. And this type of approach is much easier to apply in Canada where the administrative-fiscal structures are already in place. And there are some gains, not giant ones in Canada, at least, to be found in the elimination of unnecessary duplication. This deserves to be investigated further. But don't expect too much of it. Most medical procedures cost the same whether they are carried out in a few large hospitals or in many small ones.

The clue as to where to put effort is to be found close to the big expensive capital equipment. Where you find expensive equipment is being underused, you will find dividends in centralization. But to look for gains in centralization elsewhere is largely wasted effort. This is particularly so in open-heart surgery, which carries very little capital equipment with it. Any hospital can do it that can do serious surgery. The administrators will not save money by concentrating such surgery in fewer centers. Most important, there *are* savings, many, many small ones, to be made in every hospital. You won't find them easily or implement them easily without the close collaboration of your medical staff. To find these savings requires, therefore, the combined skills of the administrator and the medical staff, working with the same objective. And when they have been identified, it takes their combined application to realize the actual savings.

Joseph Terenzio, president of the United Hospital Fund in New York, has pointed out with great clarity the unique structure of the North American hospital. The medical staff (who initiate the costs) play a major administrative role without being on the payroll of the institution and frequently feel little responsibility for the overall management of the institution outside their own particular sector.

You can't expect them to exercise restraint, until you take them in and share with them the administrative responsibility. The gap that usually exists between administration and medical staff is not closed by the appointment of one or two doctors to the board of governors. It requires the creation of joint structures made up of governors (trustees), administrators, and medical staff wherever decisions bearing on cost and service coexist.

The creation and successful functioning of such structures has been a principal factor in the identification and realization of extensive fiscal cutbacks in my own hospital over the last three years. And this has been done without serious loss of service, reduction of research, impairment of teaching function, or impairment of morale. Creation of such structures requires a real cession of some power by the administrator to the medical staff. In my hospital, a joint committee of governors, executive officers, the medical and nursing directors, and the chairman of the medical staff is presided over by a senior physician. It is charged with making the expenditures match the budget. It is to this body that the case for new apparatus, or research, or the library budget, etc., is made. Its ability to enlist the support of medical staff in the program of fiscal restraint has been remarkable. The perpetual problem of doctors and administration assuming opposing roles is avoided.

Obviously, I have not done what I was told to do, namely, cut my budget by 25 percent. I have made, superficially, several points:

1. We do not have any reasonable index of productivity to tell us just how much we should spend on so-called health services.
2. Six causes are listed for the increase in growth of the health budget. These include: the increasing age of the population; increasing public expectations; the high cost of half-way technology; the high success in half-way technology, which keeps individuals functioning so that they grow older and remain invalids longer; the absence of bureaucratic control mechanisms in the United States; and the syndical power of health workers in Canada.
3. Neither country has the ability to make a budget cut of 25 percent. While we remain democracies, I do not think that this reduction will be possible.
4. On the other hand, small gains are to be made in several areas and the strategies by which they may be achieved are described.

References

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Note: The conference, now the nonprofit Northeast Canadian/American Health Council, facilitates idea-sharing and cooperative ventures in evaluating health care problems among the five eastern provinces of Canada and the six New England states. Information on the conference or the health council may be obtained from Robert S. Tonks, Ph.D., Dean, Faculty of Health Professions, Sir Charles Tupper Medical Building, Dalhousie University, Halifax, Nova Scotia, B3H 4H7, Canada; or James E.C. Walker, M.D., Chairman, Department of Community Medicine and Health Care, University of Connecticut, Farmington, CT 06032.

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