a report from Mo Udall
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The Cost of Health: A Udall R_x

"It's time we faced the illness in our national health care system. Once we have done that, we can get on with the cure."

Our country has the best doctors, the best technicians and nurses and some of the finest medical equipment and hospitals in the world. Tucson abounds with good hospitals and skillful specialists, many of them with national and even international reputations.

And yet, our health care system isn't functioning very well. It costs too much, has too many layers, and in some cases, the federal government seems to be working to keep costs up.

Harried Middle Class

And in away, several kinds of health care now exist in this country: if you're very wealthy, you get one kind -- the very "best of the best." And if you're poor, you get fairly good care.

Meanwhile, that big harried chunk of our population we call the Middle Class is paying too much, gets too much of some kind of medical attention and too little of another, and the situation just keeps on getting worse.

If that isn't enough, consider that our health care system is perhaps the single most important contributor to inflation: between 1950 and 1965, our national rate of inflation was running between 1 and 1.7 per cent. And in those same years, the national hospital bill was going up at a rate of *9 per cent per year*.

So while we were looking for cures for what ailed our national health, it seems to me that we were ignoring the real illness: a financially leaky health care system, one that has been operating under the rule that the more hospitals spend, the more money they in turn collect -- but more on this later.

In short, our health care system lacks incentives to hold down the cost of doing business. Instead, it's just the other way around -- the incentives work to keep costs high.

We have the best, most successful economic system in the world, and one of its great strong points is that it is consistent with human nature.

Americans have learned that we get the best results when we structure our institutions and our systems in harmony, and when they use our basic human instincts to the best advantage.

Our economic system doesn't run against human nature, it builds on it. That's as it should be.

The free market economic system, the system of market prices, all rewards those who are productive, rewards thrift and rewards efficiency.

The system also penalizes those who waste, or those who are inefficient.

Well, I'm afraid that in the field of health care we're running against the grain. Instead of working for low prices and efficiency, just the opposite has happened.

I want to note at this point that I'm not suggesting that any of this came about as a result of some grand and evil conspiracy. Somewhere along the way, the system just got out of whack.

What happened? What went wrong?

I'm not sure I have all the answers, but I do have some thoughts I'd like to share.

The Population Shift

One important factor, I'm convinced, is the dramatic shift in the age of our population -- we just aren't as young as we used to be.

Let's imagine, for a moment, a village in southern Arizona. This imaginary community has a population of 1,000. It is a population that has remained about the same ever since 1950, and will remain so through the year 2000.

But something has happened in this little town, and it gives us a scaled-down view of what has happened throughout the country.

In 1950, there were 310 people in this village who were 18 and younger, 609 who were between 18 and 64, and 81 who were 65 or older.

But in the 1960s, fewer babies were born. And by 1970, while the 18 and under category had increased slightly to 341, the 18 to 64 category had dipped to 561 -- and the over 65 group had increased to 98.

Age Marches On

By the year 2000, this little town will really feel the population pinch. Only 166 residents will be 18 or younger, 613 will be in the middle range, but 122 will now be in the group that is 64 or older.

Meanwhile, the average age in this village is slowly inching up from 30.2 years in 1950, to an expected 35.5 by the year 2000.

The only age group showing consistent and steady gains in numbers is the one composed of older citizens.

It isn't difficult to see how this has affected everybody's taxes. We have Medicaid and Medicare, we're facing a growing population of older citizens and a shrinking population of young people.

So, as the population of little towns like this one grows older, the part of our federal budget set aside to help seniors grows larger, from $40 billion in 1969, to a projected $153 billion next year.

The problem here is our population *shift* --a lower birthrate and an expanding older population with longer life expectancy. The elderly are not the problem. It's only that so many of us are moving into that category, while at the same time the birthrate is dropping.

The very special and real needs of the elderly American concerns each of us, for if there is one certainty in life, it is that each of us will eventually be older.

But the shift in our population is only part of the cause for the increase in health care costs.

Let's take a look at some other causes, and how our health care system arrived at the point where it is today.

For starters, the health care industry may be one of the few businesses -- if not the only one -- where the buyer really doesn't make the decision to buy.

Decisions to buy are made by the *seller* -- the type of treatment, whether or not you need X-rays, what type of surgery, what type of medicine, and so on.

In theory, the patient does control these decisions, but the very human tendency, probably a correct one, is not to question our treatment. That means we seldom question the cost of it, either. We Americans have a tradition of equating quality with high cost, and if our health is on the line, we want the very best.

Out of Sight, Out of Mind

But most of the time, most of our medical bills are not paid by us at all, but by "third parties" -- insurance companies, group plans, employers, the government.

That means a big part of the bill is not only "out of sight" but "out of mind," too. What we don't pay, we don't worry about.

How many times have we heard a friend say, "Hey, remember when my son was in the hospital? It only cost us $150 and the bill was $1,150." There is good reason for his jubilation -- and bad.

True, the man only paid $150 out of his pocket, but the other $1,000 came from *somebody else's* pocket. As someone once said, "There ain't no such thing as a free lunch."

Let's suppose the entire cost of the man's insurance is borne by his employer, who happens to manufacture, for example, refrigerators.

If the cost of hospitalization of that man's son is higher than it was a year ago, the insurance company that takes care of that group plan is likely to raise the cost of premiums.

Now, the refrigerator manufacturer is faced with higher insurance costs. What can he do? The easiest solution is to raise the price of refrigerators.

And if the hospitalization and premiums go up again, the price of refrigerators will rise again.

And if the patient happens to be on Medicare, you might even get hit a second way, with higher taxes.

An Apple a Day?

If an apple a day won't keep the doctor away, chances are that more than one visit won't do it, either.

The truth is, our health care system just doesn't reward the doctor who gets the job done with one visit or one treatment or one trip to a laboratory.

The more tests that are run, the more times the patient is seen, the longer he or she is hospitalized, the more profitable -- and costly -- it becomes.

Why?

Well, the biggest insurance companies, who long ago set the standards in their business, decided they would pay "all reasonable costs" that result from seeing a doctor, or from hospitalization, or whatever.

It can turn into a cruel cycle. Insurance companies can always pay because they can always raise premiums, and because they can always raise premiums, our health care system can always charge more and more.

Faced with this kind of picture, it's little wonder then that charges keep escalating. What's the incentive to hold costs down? There is almost none.

That, clearly, is a big part of the problem.

A Drug By Any Other Name

Likewise, there is no incentive to prescribe, or even produce, medicine at the lowest possible cost. Our system rewards brand-name drugs, the most expensive kind.

On a small scale, you've seen this at work in your local supermarket: a brand-name bottle of aspirin sits on a shelf next to the "house brand" aspirin. Chances are, both bottles of aspirin came from the same factory. Regulations govern its manufacture, and you know there is virtually no difference between the two.

But the brand-name aspirin will cost a lot more.

We might even go a step further and find some slight differences between a brand name and a Brand X drug, but even if there were differences, even if the quality of one were higher than the other, you probably aren't paying for that.

What you're usually paying for is advertising.

The "difference," then, is more likely to be in selling the heavily-advertised "Udall's Wonder Elixir" at $5 a bottle, and selling the same thing as just "Wonder Elixir" with the same ingredients for only $2 a bottle.

Advertising campaigns on television, radio and in the print media cost millions. Somewhere, somehow, we all pay for it.

So, you can have a pill imprinted with a brand name that might cost $1.20, and the same, identical pill, made in the same factory, costing maybe 20 cents.

Everybody makes more money if you use the pill stamped with the brand name, not because doctors or pharmaceutical houses have planned it that way but because that's just the way our health care system has pushed it along.

The 'Bed Boom'

If the system has encouraged the use of higher-priced medicine, it would seem to have likewise promoted the creation of too many hospital rooms, filled with too many hospital beds.

Think about it for a moment in terms of building another room on your home, and then buying two extra beds for that room -- when you didn't need either the room or the beds.

We would have a hard time justifying that kind of expense. We don't want more beds or rooms than we need. It just doesn't make good sense.

But for years, the United States has had more hospital rooms and more hospital beds than it needs or can use. And hospital costs, which account for 40 per cent of the national health bill, have gone up nearly 7 times from what they were back in 1960.

In 1976, extra and unused beds cost Americans an extra $4 billion.

Why?

There can be a number of reasons.

One might be pressure in a community to keep a hospital open, even though it may be old and inefficient.

Such an effort, when successful, may extend beyond just keeping the hospital open -- there may even be a push to add another wing.

On top of that, massive and highly sophisticated and expensive pieces of equipment are bought and installed, but used only a small percentage of the time.

The huge new wing, while standing as a source of some civic pride, may also stand virtually empty a good deal of the time. Patients who are admitted to the hospital are kept for a longer period of time than necessary -- getting, in fact, too much care that is also frequently too elaborate and always too costly.

Well, when beds and space and equipment are unused (or underused) someone has to pick up the cost of all of that.

To some extent, hospitals are like hotels. Empty beds and empty rooms generate no money, but the beds and rooms have to be paid for somehow.

Like the hotel where you may only want a place to sleep and where you don't use the gift shop, the lounge or the swimming pool, you still wind up paying, in some way, for all those services that are available.

Inflation, Separate and Unequal

Inflation also has played a role in putting health care costs where they are, but not in the way you may think.

Our health care system has its own rate of inflation. While the national rate of inflation in this country hovered at 1.7 per cent per year or less between 1950 and 1965, the inflation rate for health care services steamed along at a mind-boggling *9 per cent per year*.

That rate of increase was compounded when the Congress enacted Medicare and Medicaid, because it pumped billions of dollars into an already leaky system, one riddled with all the wrong incentives.

How leaky?

Well, in just the first five years of both programs, health care costs rose by a more astonishing 15 per cent per year, wildly beyond the national inflation rate.

We jumped into a sinking boat and tried to bail it out with a sieve.

Help From Hospitals

All the news about health care isn't gloomy. Following introduction of the Administration's hospital cost containment legislation, Arizona hospital administrators have taken the lead in trying to attack the rising costs situation with a voluntary cost containment program. Already, the program has chalked up some successes, and this kind of effort is both encouraging and commendable.

The Voluntary Cost Containment program represents a big step in the right direction, and I think our health care system can use all the help it can get.

Other Approaches

Let me offer, for a beginning, some other approaches. They may not represent a complete cure, but I think together, they might help put health care in this country back on the right track:

* First, I think we should consider the Health Maintenance Organization, a plan that takes far better advantage of human nature, because it works for us, and not against us.

Health Maintenance Organizations, something which has caught the eye of HEW Secretary Joseph Califano these days, are what is called "comprehensive, prepaid" plans.

The employee or employer pays a flat yearly fee, regardless of whether a patient sees his doctor about a sinus infection, brain surgery, or not at all. One fee "prepays" for all the care that year.

But doctors are paid at the *beginning* of the HMO plan, not at the end, and since there is only one payment, they have a stake in holding down costly procedures.

This sort of arrangement doesn't inspire the incentive to spend but instead inspires the good business practice that is caused by paying attention to a budget, by watching what you spend because it may eat into your profits.

This means that HMOs have an incentive to use hospitalization, the biggest health care cost, *as little as possible*.

As a result, many of the largest HMOs care for members with 60 per cent *less* hospitalization than the national average (excluding the chronically ill.) HMO members and their families don't go to the hospital as much and don't stay there as long.

General Mills executive vice president Paul L. Parker, for example, recently told a Washington meeting of 600 leaders of the country's biggest businesses and labor unions that an HMO has helped his company cut health care costs drastically.

General Mills workers who belonged to their company's HMO *had less than half the number of hospital days per year than workers with conventional insurance,* according to Parker.

Secretary Califano told the same meeting: "I am convinced that when it comes to developing HMOs, anything government can do, you can do better."

When good and tough-minded businessmen are seeing HMOs as a solid, efficient and cost-conscious way to care for their workers, I take that as a pretty good recommendation.

The General Mills-HMO experience also tells us, I think, that there is another health care system that not only accomplishes the same end but at considerably less cost.

* Secondly, I think the United States needs some form of national health insurance to replace the patchwork of programs that now exist.

I cosponsored such a proposal last year. Formally known as H.R. 21, the legislation was introduced by Rep. James C. Corman of California.

This bill would create a system of health insurance to make care available to all Americans. At the same time, it would distribute the cost of health care in relation to income and would offer major coverage against the big costs.

But a major part of the proposal aims to improve the efficiency of services -- *and to strengthen the financial controls to keep costs down.*

* Third, we in Congress must take a closer look at agencies of the federal government to insure that Washington is part of the answer and not part of the problem. if our policies are actually encouraging higher costs, then those policies must be changed.

Tighter Controls

We can't keep throwing good money after bad. It's not only important that we see that our citizens are well cared for when they are ill, it's also important that they be cared for as efficiently as possible.

If a man runs to shelter in a rainstorm, he doesn't want to stand under a leaky roof. So if our government programs need tighter controls, then let's get them.

A Final Look

In summing up, I think our health care system in this country can be cured by encouraging a system with more incentives to keep costs down, a system that goes with the grain and employs sound business practices. It's a fact that we, as a nation, are growing older. Soon, our population will be growing older faster. Barring any sudden jump in the birthrate, this fact is inescapable, and we have to face it. The population shift will be with us for some time. If we are to care for the health of our people, then let us do it as sensibly and as carefully and as well as we can. It's time we faced the illness in our national health care system. Once we have done that, we can get on with the cure.

The 2nd Congressional District of Arizona includes portions of Maricopa and Pinal Counties and all of Cochise, Pima and Santa Cruz Counties.

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