Health Care as Economic Cancer

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Health care is clearly entering into a new era: Infinite health needs have run into finite resources. The miracles of medicine have outstripped our ability to pay, and some thoughtful and equitable thinking has to be done to ensure that America gets the most health care for its limited dollars.

It is a very serious mistake to deny that a major change is in the wings. No sector of the economy, no matter how important, can continue to grow at two-and-a-half times the rate of inflation. We are heading rapidly toward an America that has rusting plants, closed factories, staggering trade deficits. Health care cannot continue to operate under the illusion that it can continue with business as usual.

Once we accept the fact that there are limits to what the nation can afford (and, increasingly, people are recognizing this truth), then we will begin a process of asking how to get the most health benefits for the most Americans for our money. We should have asked this question years ago. It is outrageous that this country spends five to eight times what other countries spend, and yet has no better health outcome. America is going to demand more accountability for the more than one billion dollars a day it now spends on health care. Many countries give a high level of health care to all their citizens for a fraction of what we spend, and yet keep them healthier. We are no longer rich enough to give a blank check to an inefficient health care industry.

Once we start to apply even minimum management standards to the health care industry, we will see some substantial changes. If we ask how to get the most health benefits for the greatest number of Americans for our tax dollars, many of today's practices will not meet the test. If we zero-budget all that we now do in health care, we shall inevitably close unnecessary hospitals, close excess ICU units, and look much more closely at utilization factors and outcomes. We shall have to develop a concept of cost-effective medicine. Virtually every health care provider will agree that much of what we do today in medicine has "marginal utility." When a society faces fiscal reality and seeks to optimize its dollars, it not only starts on the road to financial sanity, but it also brings dramatic change to existing medical practices. Dialysis and transplantation will undoubtedly undergo major change. The "opportunity costs" in other areas of medicine are clearly greater than much of what is being done today. The bottom line is that we can save more lives and bring better health care to more Americans for many of the dollars we are spending today.

Economist Lester Thurow suggests that, to impress upon health providers what they are doing when they order marginal services, we should require them to imagine an American worker sentenced to a period of slavery long enough to pay the medical bill for that procedure. Dr. Thomas Starzl recently gave a liver transplant to

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New Options

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It would be unjust to describe a public servant of Richard Lamm's distinction and courage in any but the most flattering terms. Mr. Lamm has contended for a number of years that health care costs must be contained. He has pointed out that too much of the high-intensity care provided for aged or hopelessly ill patients is not only costly, but may also be inhumane when all that is achieved is prolongation of painful dying. These messages are so important that they deserve the kind of thoughtful examination that depends upon accuracy more than rhetoric.

Two cases can illustrate the point. The first came to my attention and to Governor Lamm's in October, 1984. A 13-year-old girl was admitted to the Colorado General Hospital in Denver with acute hepatic failure from previously undiagnosed Wilson's disease. She required ventilatory support because of unconsciousness, hemodialysis because of the hepatorenal syndrome, and repeated closed cardiac massage. Her physicians realized that liver transplantation was the only treatment that would be more than symbolic and that would allow real recovery. Governor Lamm was reported, perhaps incorrectly, to have disallowed public assistance for this purpose on grounds that this would be a costly exercise in futility.[1] Support mechanisms in Denver, Houston, and Pittsburgh were quickly developed, whereby the child was transferred to the Children's Hospital of Pittsburgh. Liver transplantation was carried out on October 17, 1984. The girl returned home to Colorado on December 1, 1984. The cost of her care was $87,322, of which $54,000 was paid eventually by Colorado State Medical Assistance. Today, she leads a normal life on the farm where she was reared.

The second example concerns the 76-year-old lady mentioned by Mr. Lamm in his editorial. The extent to which the ethical and societal issues in this case were examined by a broad consortium of interested parties has been exceptionally well-documented.[2] The fact that advanced age alone does not preclude liver transplant candidacy or significantly degrade postoperative survival also has been reported.[3] The 76-year-old patient whose treatment was decried is coming up to the one-year follow-up mark in excellent condition at home. The enslavement of 100 families, working for one year to pay a $240,000 medical bill, was not required. Surgical fees were written off. The hospital cost of $68,000 has not been paid and may never be. The willingness of the Presbyterian University Hospital and its University of Pittsburgh faculty to take responsibility for this case without assurance of payment was an expression of a moral position like that of the Colorado physicians in Case One.

It has been said that society and its institutions are judged by the way they treat those who cannot defend themselves, as exemplified by its very young and very old. It would have been members

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Thomas Starzl will be honored for his achievements in transplantation at the International Organ Transplant Forum in September.

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a 76-year-old woman. It cost $240,000. Dr. Starzl should understand that, with the average U.S. family making $24,000 a year, he has sentenced 100 U.S. families to work all year so that he could transplant a 76-year-old woman.

Such actions are cheating our children of resources that they desperately need to build a better life and to revitalize the United States economically. If all of us, or even a significant percentage of us, take $240,000 in high-tech medicine as we are on our way out the door, we are stealing resources that our children and our grandchildren desperately need. Health care is important, but it cannot be the only value of our society. It cannot continue on its growth curve without bankrupting America.

Health providers are not used to thinking this way. Many of you will cry foul and think this heresy. But alas—it is true. A nation that runs $200 billion deficits and borrows 20¢ from its children out of every dollar it spends must one day demand more accountability from its politicians, from its industries, and from its health providers. That day is near at hand, and we should welcome it—for our children's sakes.

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of these extreme age groups who would have been deprived of effective care by their exclusion from transplantation in late 1984 and more recently. In the process, Mr. Lamm, a decent and compassionate man, had no objection to the expensive care provided to the child and to the old lady who had become invalided and hospital-bound by their diseases. The objection was to the only treatment that was capable of liberating them from hospital life, restoring them to society, and putting an end to a continuous accrual of expenses down a therapeutic cul-de-sac.

It is conceivable, but highly unlikely, that society someday will decide that no patient with liver disease, or diseases of certain other organ systems, such as the heart or kidney, will be treated. If so, Mr. Lamm's arguments will have great force, and physicians (those who are left) will want to determine the cheapest way to exercise what will have become a priestly, not therapeutic, function. Until then, the proper first decision by those serving society will be *whether* treatment should be carried out. If the answer is yes, the appropriate second question will be, what is the best way. Then, what will be purchased per health care dollar will be real, not symbolic.

Developments in transplantation and artificial organ technology have changed forever the philosophy by which organ-defined specialties such as nephrology, hepatology, and cardiology are practiced. Until recently, what could be offered victims of vital-organ failure was a rearguard approach designed with diet, medicines, or surgical procedures to extract the last moment of life-supporting function from the failing organ. Now, and for the first time in human history, the breathtaking possibility has emerged of starting over when all else fails, with an organ graft or with a manufactured organ.

Much of the groundwork for this revolution was laid at the University of Colorado during Mr. Lamm's enlightened gubernatorial administration and during that of his predecessor, Governor John Love. The failure of Mr. Lamm to take advantage of what has happened under his own sponsorship is like giving birth to a beautiful child and then trying to starve it so that it will not threaten the food supply.

REFERENCES

☐ 1. Burling S. *The Rocky Mountain News*, Wednesday, October 17, 1984, p. 16.

☐ 2. Koenig R. *The Wall Street Journal*, Tuesday, October 14, 1986, pp. 1, 32.

☐ 3. Starzl TE, Todo S, Gordon R, et al. Liver transplantation in older patients. (Letter to the Editor). *N Engl J Med* 316:484-485, 1987. DGT