

The New York Times

November 25, 2007 Sunday
Late Edition - Final

The High Cost of Health Care

SECTION: Section 4; Column 0; Week in Review Desk; EDITORIAL; Pg. 9

LENGTH: 1925 words

The relentless, decades-long rise in the cost of health care has left many Americans struggling to pay their medical bills. Workers complain that they cannot afford high premiums for health insurance. Patients forgo recommended care rather than pay the out-of-pocket costs. Employers are cutting back or eliminating health benefits, forcing millions more people into the ranks of the uninsured. And state and federal governments strain to meet the expanding costs of public programs like Medicaid and Medicare.

Health care costs are far higher in the United States than in any other advanced nation, whether measured in total dollars spent, as a percentage of the economy, or on a per capita basis. And health costs here have been rising significantly faster than the overall economy or personal incomes for more than 40 years, a trend that cannot continue forever.

It is the worst long-term fiscal crisis facing the nation, and it demands a solution, but finding one will not be easy or palatable.

The Causes

Varied and Deep-Rooted. Contrary to popular beliefs, this is not a problem driven mainly by the aging of the baby boom generation, or the high cost of prescription drugs, or medical malpractice litigation that spawns defensive medicine. Those issues often dominate political discourse, but they have played relatively minor roles in driving up medical spending in this country and abroad. The major causes are much more deep-seated and far harder to root out.

Almost all economists would agree that the main driver of high medical spending here is our wealth. We are richer than other countries and so willing to spend more. But authoritative analyses have found that we spend well above what mere wealth would predict.

This is mostly because we pay hospitals and doctors more than most other countries do. We rely more on costly specialists, who overuse advanced technologies, like CT scans and M.R.I. machines, and who resort to costly surgical or medical procedures a lot more than doctors in other countries do. Perverse insurance incentives entice doctors and patients to use expensive medical services more than is warranted. And our fragmented array of insurers and providers eats up a lot of money in administrative costs, marketing expenses and profits that do not afflict government-run systems abroad.

Does It Matter? If citizens of an extremely wealthy nation like the United States want to spend more on health care and less on a third car, a new computer or a vacation home, what's wrong with that? By some measures, Americans are getting good value. Studies by reputable economists have concluded that spending on such advanced treatments as cardiac drugs, devices and surgery; neonatal care for low-birth-weight infants; and mental health drugs have more than paid for themselves by extending lives and improving their quality.

But if health care spending continues on its same trajectory, the United States will reach the point -- probably several decades from now -- where every penny of the annual increase in gross domestic product would have to go for health care. There would be less and less money for other things, like education, environmental protection, scientific research and national security, that may be equally or more important to the well-being of society.

Governmental budgets will face the crisis even sooner. States are already complaining that they have to crimp other vital activities, like education, to meet soaring Medicaid costs. And federal spending on Medicare and Medicaid is surging upward

at rates that will cause the deficit to soar. That means politicians will have to raise taxes, severely cut a wide range of other governmental programs, or chop back the health programs themselves.

The question is: What can be done to lower both the high level of health care spending and its high rate of increase from year to year?

The Solutions

Geography. Pioneering studies by researchers at Dartmouth have shown enormous disparities in expenditures on health care from one region to another with no discernible difference in health outcomes. Doctors in high-cost areas use hospitals, costly technology and platoons of consulting physicians a lot more often than doctors in low-cost areas, yet their patients, on average, fare no better. There are hints that they may even do worse because they pick up infections in the hospital and because having a horde of doctors can mean no one is in charge.

If the entire nation could bring its costs down to match the lower-spending regions, the country could cut perhaps 20 to 30 percent off its health care bill, a tremendous saving. That would require changing the long-ingrained practices of the medical profession. Public and private insurers might need to refuse coverage for high-cost care that adds little value.

Stick to What Works. The sad truth is that less than half of all medical care in the United States is supported by good evidence that it works, according to estimates cited by the Congressional Budget Office. If doctors had better information on which treatments work best for which patients, and whether the benefits were commensurate with the costs, needless treatment could be junked, the savings could be substantial, and patient care would surely improve. It could take a decade, or several, to conduct comparative-effectiveness studies, modify relevant laws, and change doctors' behavior.

Managed Care. For a brief period in the 1990s it looked as if health maintenance organizations competing for patients and carefully managing their care might bring down costs and improve quality at the same time. The H.M.O.'s did help restrain costs for a few years. The problem was, doctors and patients hated the system, management became much looser, and the upsurge in costs resumed. Managed care techniques are creeping back into some health plans, especially for services apt to be overused, but too heavy a hand would most likely produce another backlash.

Information Technologies. The American health care system lags well behind other sectors of the economy -- and behind foreign medical systems -- in adopting computers, electronic health records and information-sharing technologies that can greatly boost productivity. There is little doubt that widespread computerization could greatly reduce the paperwork burden on doctors and hospitals, head off medication errors, and reduce the costly repetition of diagnostic tests as patients move from one doctor to another. Without an infusion of capital, the transition from paper records is not apt to happen very quickly.

Prevention. Everyone seems to be hoping that preventive medicine -- like weight control, exercise, better nutrition, smoking cessation, regular checkups, aggressive screening and judicious use of drugs to reduce risks -- will not only improve health but also lower costs in the long run. Preventive medicine actually costs money -- somebody has to spend time counseling patients and screening them for disease -- and it is not clear how soon, or even whether, substantial savings will show up. Still, the effort has to be made. The Milken Institute recently estimated that the most common chronic diseases cost the economy more than \$1 trillion annually, mostly from lost worker productivity, which could balloon to nearly \$6 trillion by the middle of the century.

Disease Management. Virtually all policy experts want more careful coordination of the care of chronically ill patients, who account for the largest portion of the nation's health care expenditures. Although that should improve the quality of the care they get, coordination may not cut costs as substantially as people expect. In some initial trials it has cut costs, in others not.

Drug Prices. Compared with the residents of other countries, Americans pay much more for brand-name prescription drugs, less for generic and over-the-counter drugs, and roughly the same prices for biologics. This page believes it would be beneficial to allow Medicare to negotiate with manufacturers for lower prescription drug prices and to allow cheaper drugs to be imported from abroad. The prospect for big savings is dubious.

Who Picks Up the Tab?

Pay Providers Less. With doctors dreadfully unhappy under the heavy hand of insurers, it would seem shortsighted to make them even unhappier by cutting their compensation to levels paid in other countries. But many experts believe it should be possible to tap into the vast flow of money sluicing through hospitals, nursing homes and other health care facilities to find

savings.

Emphasize Primary Care. In a health system as uncoordinated as ours, many experts believe we could get better health results, possibly for less cost, if we changed reimbursement formulas and medical education programs to reward and produce more primary care doctors and fewer specialists inclined to proliferate high-cost services. It would be a long-term project.

Skin in the Game. The solution favored by many conservatives is to force consumers to shell out more money when they seek medical care so that they will think harder about whether it is really necessary. The "consumer-directed health care" movement calls for providing people with enough information about doctors and treatments so that they can make wise decisions.

There would most likely be some savings. A classic experiment by Rand researchers from 1974 to 1982 found that people who had to pay almost all of their own medical bills spent 30 percent less on health care than those whose insurance covered all their costs, with little or no difference in health outcomes. The one exception was low-income people in poor health, who went without care they needed. Any cost-sharing scheme would have to protect those unable to bear the burden.

And consumer-driven plans have limitations. Most health care spending is racked up by a small percentage of individuals whose bills are so high they are no longer subject to cost sharing; they will hardly be deterred from expensive care they desperately need. Moreover, few consumers have the competence or knowledge to second-guess a doctor's recommendations.

Single Payer. Deep in their hearts, many liberals yearn for a single-payer system, sometimes called Medicare-for-all, that would have the federal government pay for all care and dictate prices. Such a system would let the government offset the price-setting strength of the medical and pharmaceutical industries, eliminate much of the waste due to a multiplicity of private insurance plans, and greatly cut administrative costs.

But a single-payer system is no panacea for the cost problem -- witness Medicare's own cost troubles -- and the approach has limited political support. Private insurers could presumably eliminate some of the waste through uniform billing and payment procedures.

By now it should be clear that there is no silver bullet to restrain soaring health care costs. A wide range of contributing factors needs to be tackled simultaneously, with no guarantee they will have a substantial impact any time soon. In many cases we do not have enough solid information to know how to cut costs without impairing quality. So we need to get cracking on a range of solutions. The cascade of knowledge flowing from the human genome project, new nanotechnologies and the advent of treatments tailor-made for individual patients may well accelerate, not mitigate, the rise in medical spending. If we want the benefits, we will need to make them affordable.

URL: <http://www.nytimes.com>

LOAD-DATE: November 25, 2007

LANGUAGE: ENGLISH

DOCUMENT-TYPE: Editorial

PUBLICATION-TYPE: Newspaper

Copyright 2007 The New York Times Company