The Nation

Curbing the High Cost Of Health

By MICHAEL M. WEINSTEIN

A MODEST proposal: give every American an M.R.I. as part of a yearly checkup. The scans will surely catch disease at an early stage for a few, and they won't harm anyone. True, they may cost a few thousand dollars per person, but in America cost is not allowed to affect medical decisions. Indeed, the subject of cost is taboo, even in the face of the threat that health-care premiums will rise beyond the reach of millions of poor and low-income families.

Recently, Blue Cross of California announced that it would begin paying bonuses to doctors whose patients give them high marks. It is, of course, good news when managed-care plans try to improve the quality of health care. But what if getting "high marks" simply means lavishing inappropriate care on patients? And how can it not mean that when the nation lacks a mechanism for talking about cost, let alone rejecting coverage of expensive treatments that offer meager benefits?

There are plenty of real-life examples of what happens when cost cannot be considered. Drugs are prescribed costing hundreds of dollars a year, but reduce the chance that a middle-aged woman will suffer a hip fracture by only 1 in 7,000. New types of X-rays cost 15 times the traditional type, but reduce the risk of a nonfatal reaction by only about 1 in 2,000. Physicians routinely prescribe antibiotics for infections that are presumably viral and, therefore, unresponsive to the treatment, just to make the patient feel something is being done. Some doctors use anti-cancer drugs several times more expensive than alternatives without clear evidence that they work better.

These examples, and innumerable others, expose "the core fiction of American health care," says Professor Alain Enthoven of Stanford University: "that insurance should cover every useful medical procedure no matter how small the benefit or prohibitive the cost."

Reality will eventually force the issue. Propelled by the increasing use of new drugs, imaging technologies and other wildly expensive innovations, insurance premiums are rising fast. In parts of California, often a harbinger for the rest of the country, premiums are rising by between 13 percent and 24 percent this year for a package of unchanged benefits. In fact, health plans are trimming benefits to keep premium increases under 10 percent. If costs continue to spiral upward, more employers will drop coverage entirely, adding to the ranks of the 40 million uninsured.

Yet one could sift through hours of the Congressional debate over patients' rights without finding mention of the need to say no. Cost containment, it seems, has become the new "third rail" of American politics — replacing Social Security reform.

Politicians happily turned over the task of holding down costs to the managed-care industry in the 80's and 90's. But the HMO's often proved clumsy at public relations, not to mention patient requests for treatment, and they were reviled. During the patients' rights debate, House and Senate chambers were flooded with tales of health plans denying access to life-saving treatments for the sake of earning a few extra dollars.

Such stories, horrific as they are, are rare in real life. Despite data showing that plans covering millions of patients trigger only a few hundred complaints a year, a public backlash has forced many managed care plans to retreat, agreeing to pay for almost everything doctors prescribe. And while...
Indeed, the legislation that has passed the Senate and is being fought over in the House, despite its promising patient protections, could make the problem of cost control worse. It guarantees that patients who are denied coverage can refer the dispute to an outside panel of medical experts.

Professor Uwe E. Reinhardt of Princeton, once an outspoken critic of managed care, dubs the legislation “patients’ rights to unnecessary care.” Academic studies, he says, show that “perhaps 25 percent of all healthcare treatments are a waste of time.” By other estimates, up to a third of prescribed treatments lack a scientific basis.

Mr. Reinhardt worries that if managed care is further hobbled, the country will move to a two-tier system. Employers will shift to a system that gives workers a fixed, modest amount of money with which to buy coverage. High-paid workers will buy Cadillac-style coverage. Everyone will be able to afford much less.

Practicing physicians, in fact, see waste all around. Dr. Gerald Leventhal, a New York City internist, says that doctors “prescribe too many pills, too many procedures, too much cross-fertilization of specialists.” And he admits to being part of the problem, “because some patients reject my advice and demand more.”

Oscar Sotos for The New York Times

rather than less. Too few employers offer workers a choice of managed-care plans, which would generate price competition. And lobbying by trial lawyers, the drug industry, insurers, physicians, hospitals and consumer groups work against fundamental change.

Is there a way out of the endless spiral of rising costs, rising premiums and rising numbers of uninsured? The state of Oregon controls the cost of Medicaid, the program for poor families, by ranking hundreds of medical procedures from most to least important, then eliminating coverage for lower-ranked procedures. The idea is to cover more poor families with the money saved by cutting out nonessential treatments. The state estimates that between 1994 and 2000, it extended coverage to about 1 million new people.

BUT there is another answer, although one that seems unlikely anytime soon. Professors Reinhardt and Enthoven call for a politically independent commission, modeled on the Federal Reserve, which would review medical technologies and decide which costs outweigh the benefits.

The idea, they say, fits nicely with patients’ rights legislation. The commission would issue findings that would serve as guidelines for external panels that would