MANAGED CARE FOCUS

By Walter Alexander

On the Slippery Slopes: Money and Medicine

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HARTFORD, Conn.—The thrombolytic wars have been fought and, some say, won. But like so many other wars, they won't simply go away. Some of the lingering issues in these thrombolytic wars, according to ethicist David J. Rothman, Ph.D., Bernard S. Schoenberg professor of social medicine at Columbia University College of Physicians and Surgeons, are particularly intriguing because they go to the heart of American health-care reform debate. Examining them may help in the crucial and complex struggle to discover the rightful place of economics in medicine.

At a Hartford Hospital-sponsored presentation, "Ethical Considerations in Balancing Risks, Benefits, and Costs of Thrombolytic Therapy," the thrombolytic debate is stretched between the poles of two "slippery slope" arguments, Dr. Rothman explained. The first of them, he said, is the traditional ethical argument, which maintains: "As soon as the doctor in the examining room allows the accountant to have any role in making clinical decisions or pays any attention to HMO cost directives, then medicine has lost its calling and is fast on the road to becoming a profession that has lost its ethical base."

While in Dr. Rothman's mind there is no room for summarily dismissing that argument, he also acknowledged there is little doubt that the luxury of not talking about costs of therapy belongs to an era that has already passed.

The second slippery slope argument is a response to the consequences of excluding costs from medical decision-making, as follows: "To the degree that we pay no attention to money in health care, to that degree we make certain that those presently inside the system (the insured) will continue to get good medical care, and those outside will remain in the cold." Furthermore, escalating medical costs will almost certainly guarantee that well after the year 2000, the United States will remain, along with South Africa, the exception to the rule that modern industrialized nations have a system of national health insurance.

The prospect of 40 million Americans getting nothing while the rest have good medical care, Dr. Rothman suggested, violates ethical principles of fairness, which themselves are linked to the concept that we owe something to each other—that there is

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common good. The relationship of
that concept to thrombolytic therapy,
the comments, is unambiguous once
the particulars are examined.

At the same Hartford Hospital pre-
sentation, Paul M. Ridker, M.D.,
M.P.H., Brigham and Women’s Hos-
pital, reported that in clinical trials
both TPA and streptokinase had re-
luced mortality by about 27 percent.
The argument as to which one is bet-
er is over decimals,” he pointed out.

The GUSTO trial finding of a 1 per-
cent mortality advantage for TPA over
streptokinase is diminished somewhat
by a markedly higher stroke rate for
TPA, and for various reasons, remains
contented. The glaring economic fac-
tor, however, is TPA’s cost of more
than $2,200 per dose against around
$300 for streptokinase.

“If you can’t let cost play a role
here, you will never let cost play a role
anywhere,” Dr. Rothman maintained.
Claims by TPA supporters to the effect
that using TPA costs $35,000 to
$40,000 per year of life saved, a figure
comparable to some other accepted
therapies, he noted, obscure the impor-
tant fact that at current usage, choosing
TPA adds $5 million to $600 million
per year to the health-care budget.

“Such statements make it seem as if no
one is paying, but the absolute dollars
are very important, because they oil
the second slippery slope, ensuring
that those stuck on the outside remain
here without health insurance.”

Bioethicists, Dr. Rothman con-
tinued, have generated some 10 to 12
major treatises on how to ration health
care fairly. On analysis, however, they
demonstrate that most rationing uti-
litely turns out to be rationing for
someone else.

The Oregon plan, for example, ra-
tioned Medicaid. “Rationing is always for
him, not for me, which raises basic
issues of fairness,” he observed. That
state of affairs suggests unhappy sce-
narios in which the well-to-do take ex-
ensive drugs and the less fortunate
take cheaper ones. Worse than adverse
health effects would be the adverse so-
cial costs, he said.

Although Dr. Rothman did not
speculate on social costs, a prominent
cardiologist, Oxford University’s pro-
essor Peter Sleight, M.D., went on the
record recently about the connection
between socioeconomic factors and
public health. After a European Soci-
ey of Cardiology press conference of-
fered new evidence on the pernicious
effects of smoking on cardiovascular
mortality, Dr. Sleight discussed what
he termed “solid statistics,” demon-
strating an increase in mortality among
younger middle-class men in the
United Kingdom. “If the spread of in-
come in a country is low, so that
distress earns, say, one-quarter or
one-fifth of what a high court judge
earns, then mortality from coronary
heart disease is low. But if there is a
huge increase in the separation be-
tween the richer and the poorer, as has
happened in the U.K. in the past 15
years—what I would call the Thatcher
legacy—then mortality starts to in-
crease among the deprived people.”
Poor and unemployed people, Dr.
Sleight told the audience, spend more
of what they have on tobacco and less
on fresh fruit and other healthier foods,
with an adverse effect on longevity.

The relationship between socioeco-
omic status and health, cardiovascular
health in particular, has been well estab-
lished. A 1993 American Heart Associa-
tion review of 40 years of research into
the subject by George A. Kaplan, Ph.D.,
and Julian E. Keil, Dr. P.H., reported in
Circulation, found a direct, striking rela-
tionship between lower socioeconomic
status (SES) and increased risk of ath-
rosclerosis, heart and blood vessel dis-
case, and premature death.

Among the components of lower SES affecting all-cause mortality, Drs.
Kaplan and Keil identified: likelihood
of being unemployed for considerable
periods, the inability to own a home
and an automobile, and poor capacity
for advancement. The researchers also
found a number of studies showing
that risk for atherosclerotic heart dis-
case later in life was increased by poor
living conditions (including poor nut-
rition) in childhood and adolescence.

Finally, what lies behind Dr.
Rothman’s discussion of fairness may
be fear over the constantly widening
chasm between those who have very
much and those struggling ever harder
to keep pace or barely limp along. The
forces creating that chasm, leaving
their imprint on the form of health
care, may ultimately prove themselves
terribly costly to the nation in ways
that may make one shudder to imag-
ine. Scientific advance, we all know,
will not split asunder the knot binding
psychic and physical health.

Avoiding social costs, Dr. Rothman
reminds us, will mean asking physicians
to take a different kind of step than they
have taken traditionally. He concluded:
“In order to get the health-care system
under control, allowing cost to enter into
the examining room in this case, and in
the case of other very high-cost ther-
apiies, is eminently defendable.”