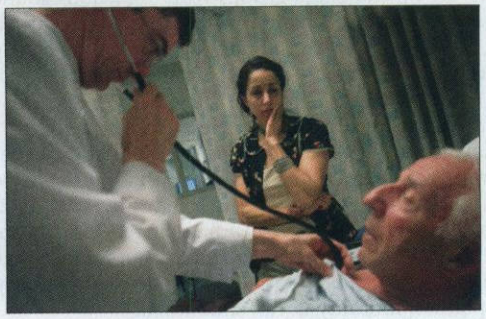
Cutting the cost of health care

The price of medical care keeps rising. Why are costs so high and how will they ever come down?

How much do we spend on health care?

About $2.3 trillion in 2008—or $7,681 per person. That's more than double the per capita spending of European nations, Japan, and other industrialized nations. Between 1965 and 1985, U.S. health-care spending (adjusted for inflation) more than tripled; then it nearly tripled again between 1985 and 2005. In those four decades, America's per capita gross domestic product grew about 2.1 percent annually, while health-care spending rose at more than double that rate—4.9 percent. As a result, health care is now gobbling up a growing share of the country's economic output—more than 17 percent of GDP today. If the trend continues, one out of every four dollars of GDP will be spent on health care by 2025.



Can there ever be too much care?

Why are costs so high?

As medicine becomes increasingly sophisticated, it has become increasingly expensive, and the current health-care system has little incentive to rein in spending. New treatments and technology are big moneymakers, so these advances are quickly embraced by doctors and hospitals, with the rising costs passed on to insurers, which in turn raise premiums. It can cost $1 billion, for example, to develop a successful drug. Drug companies must recoup that investment, plus whatever they've spent on failed drugs—while still seeking hefty profits. Spending on a single class of drugs—statins to fight cholesterol—spiked from $8 billion to nearly $20 billion in the five years from 2000 to 2005. The nation spends $3 billion a year on PSA testing, which screens for early signs of prostate cancer, even though researcher Richard J. Ablin says the test has turned out to be "hardly more effective than a coin toss."

How can we control costs?

Pay less—for less. While prices are rising, so is the *quantity* of care. We not only pay more for treatments, we have many more of them. Between 1996 and 2006, knee replacements for adults over 45 increased 70 percent while kidney transplants increased by nearly one-third. Between 1996 and 2007, use of costly MRI and CT/PET scans tripled. In Japan, patients get more MRI scans and X-rays than Americans do—but an MRI in the U.S. can cost 15 times more than one in Japan. "Under the pressure of cost controls, Japanese researchers found ways to perform the same diagnostic technique for one-fifteenth the American price," says author T.R. Reid.

Can we adopt similar controls?

Not without a political brawl—as the health-reform battle revealed. The Affordable Care Act, signed into law by President Obama in March, seeks to transform the system from the current fee-for-service model, in which doctors and hospitals get paid for each service they provide, to a comprehensive system, in which professionals are paid to produce healthy outcomes in patients, regardless of the number of tests or procedures. In essence, the law's ultimate goal is to stop paying for quantity, whether measured by MRIs or doctor visits, and start paying for quality. But deciding who takes the hit—insurers? hospitals? the poor?—is politically and economically fraught.

So what's the solution?

Ultimately, some form of rationing appears inevitable. Rationing is a loaded term for the simple idea that there is a finite amount of money to spend on medical care, and that someone sometimes has to say no. "The question is who will do it?" says Republican Rep. Paul Ryan, who advocates market-based reforms that would make consumers pay a greater share of the bills, thus giving them more incentive to consume less care. "The government? Or you, your doctor, and your family?" The reform law passed by Democrats calls for more centralized decision-making; various treatments and practices will be compared, and over time, coverage will be curtailed or eliminated for drugs, operations, and other treatments that do not prove effective. Sooner or later, society will also have to grapple with the contentious issue of end-of-life treatment.

Would that require the dreaded 'death panels'?

Not quite. The law contains no provision for a panel of bureaucrats with the power to withhold treatment from Grandma (and politicians who enjoy being re-elected are unlikely to propose one). But most doctors and experts agree that too much of our health-care dollars are spent on aggressive testing, drug regimens, and hospital care for patients who are either dying or rapidly declining in the final year of life. These treatments—which consume 33 percent of all health-care spending—do not significantly prolong life, and often worsen the elderly person's quality of life. "It's not a question of whether we will ration health care," says Donald Berwick, a pediatrician and former HMO executive who was named by President Obama to run the Centers for Medicare and Medicaid Services. "It is whether we will ration with our eyes open." But many Americans remain vehemently opposed to regulating end-of-life care. That way, they say, lies the road to hell. Health-care economists counter that the alternative is the road to ruin.

Cleveland rocks

Reformers cite the Cleveland Clinic as proof that better medical care can be provided for less. The clinic is renowned for quality—ranked among the top medical centers in the country—but also keeps costs unusually low. In some areas, Cleveland costs little more than half of what expensive competitors charge. Doctors there are paid on salary, so they have no incentive to order unnecessary procedures or tests, a practice that PricewaterhouseCoopers says costs the health-care system $210 billion a year. With their incomes untethered from whatever services they render, doctors are free to collaborate with colleagues, seeking the best results for patients without every consultation racking up fees. Cleveland specialists make less than many could earn in their own practices. But they are also freed from the hassles of running their own businesses, so they can focus solely on making patients better. "Day after day for 30 years I did nothing but fix hearts," says Dr. Delos M. Cosgrove, who did cardiac surgery at the clinic before becoming its CEO. "That's how you get good at something."

Ed Kashi / Corbis