Disease, Diagnoses, and Dollars

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Facing the Ever-Expanding Market for Medical Care

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Preface

Good health is our most precious asset. Without health, life becomes much more challenging. Because health is so central in our lives, we invest trillions of dollars to achieve more wellness or to remedy diseases. A vast healthcare establishment is ready and willing to receive these investments. Some investments in healthcare result in healthier and happier citizens. Other investments have little effect on health, are wasteful, and even harmful.

It is widely acknowledged that there is a serious crisis in American healthcare. There is no real healthcare system in the USA. Instead, we have a patchwork of competing systems. Medicare covers the elderly and people with some defined problems, such as kidney failure. Medicaid covers the blind, the disabled, and families with dependent children. Most people have private insurance that is paid for by their employers. The public systems are in financial trouble, and an increasing number of employers claim that they are no longer able to pay for insurance. The number of uninsured or underinsured people in the USA has soared to well over 45 million.

Proposals for national health insurance abound. However, virtually all of the proposals focus on providing coverage for all people. Although universal healthcare is an attractive goal, there is another problem. We have been persuaded to want more healthcare than we need. A *New York Times* article by columnist by Gena Kolata [1] described patients lining up for all of the care that Medicare will cover. The article describes patients in a Florida clinic seeking every service that the Medicare program will pay for. They ask for the latest diagnostic tests, and they want the latest medicines that they have learned about by watching advertisements on television. The Medicare system, in some ways, encourages this. If a service is covered, the provider only needs to send in the bill and he will be paid. Is all of this medical care necessary?

This book is about some disquieting conflicts between consumers and their healthcare providers. Our healthcare system is big and complicated: it is the largest sector in the biggest economy in the history of the world. But, unlike other industries, healthcare has not been held accountable for what it produces. We know, for example, that the USA spends significantly more per capita on healthcare than any other country. Yet, we rank last among comparison countries in the Organization for Economic Cooperation and Development

on the major health indicators. We also know that there are substantial regional differences in healthcare expenditures within the USA. Even when we adjust for a variety of variables, such as age distribution, poverty, education, or minority status, regions that spend more do not have better outcomes, and some evidence suggests that quality of care is lower in the regions that spend more, not less, on healthcare.

Our problem is not that providers charge too much, it is that they do too much. We assume that the high costs of healthcare reflect the expense of services and medications. *Disease, Diagnosis, and Dollars* calls this assumption into question. Drug prices in the USA are not significantly higher in comparison with that in other developed countries, because few patients actually pay the listed retail price. Total costs are a function of two factors: unit price and volume. Volume, not unit cost, may be driving our healthcare crisis. The following chapters suggest that mass markets have been created for services that may offer little or no benefit to patients. Many of these markets are for preventive medicine. These include cancer-screening tests, and medications to control blood pressure, cholesterol, and glucose. The attractiveness of preventive medicine is that it can make well people a market for expensive pharmaceutical products and tests.

These mass markets have been nurtured with the support of respected panels of experts who have created guidelines for new tests to diagnose illness and new drugs to treat disease. New revisions of these guidelines are unlikely to benefit most consumers of healthcare. Still, these guidelines are used to set standards for the practice of medicine, and quality of care is often defined as adherence to the standards. Once the guidelines are set, doctors follow them. We have been intentionally led to believe tests and medicines will offer greater benefits than evidence supports. The result: uncontrollable costs and minimal benefits.

There are consequences to the overuse of medications and tests. Although most screening tests and modern medicines used in prevention are safe for individuals, their use runs up the costs of healthcare. High costs result in higher insurance premiums for all of us. As more employers drop health insurance for their employees when costs accelerate, the expanded use of ineffective preventive medicine may have the unintended consequence of increasing the number of uninsured patients, potentially damaging the health of others in the community.

The concluding chapters offer suggestions for policy makers and for patients. Methods for systematically evaluating the cost-effectiveness of new guidelines are discussed. The final chapter provides practical suggestions to enable patients to share in decisions about treatments or tests that can have uncertain benefits.

Many colleagues have contributed to the development of this manuscript. I started thinking about these problems 10 years ago during a sabbatical year at the Dartmouth Medical School. That year I got to know Elliott Fisher, Gil Welch, Lisa Schwartz, and Jack Wennberg. The Dartmouth experience shaped my thinking about overuse in medical care. The ideas for the book have been

shaped by a dozen years of experience as a faculty member for the American Health Association US Seminar on the Epidemiology and Prevention of Cardiovascular Disease. The core of the book has been adapted from the lectures I offered at the Lake Tahoe seminar. While a professor at the University of California, San Diego School of Medicine, close colleagues including Rick Kronick, Robert Langer, and Ted Ganiats discussed these ideas with me on many occasions. I am particularly indebted to Mike Criqui, a noted physician epidemiologist who, over the course of 25 years, systematically taught me the basics of epidemiology and helped sharpen my thinking. Mike may not agree with all of the ideas in this book, but I hope he will see that he inspired some of the critical reflection. At UCLA, I benefited from feedback from Gerald Kominski, Tom Rice, Bill Cononar, Dominick Frosch, and several others. Readings of early chapters by Andrea Grefe and Margaret Gaston guided the direction and the prose. I am most sincerely appreciative for the detailed feedback I received from Paul Farrell from Springer and Copernicus Press. Paul critiqued every page, challenged the thinking and the writing, and made the manuscript better in countless ways. My senior editor Bill Tucker has also been exceptionally helpful. Finally, I am most indebted to the Rockefeller Foundation who provided a quiet study in Bellagio overlooking Lake Como Italy, where the manuscript was finally completed. The fellow resident scholars at Bellagio also provided very valuable feedback.

I expect that many intelligent and well-informed readers will disagree with some of the basic premises in these chapters: the book was intended to be provocative. However, the text is built upon data from contemporary, peer-reviewed literatures in medicine and health services research. I hope the book stimulates debate, fosters new research, and makes us wiser consumers of healthcare.

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Reference

1. Kolata G. Patients in Florida lining up for all that Medicare covers. *New York Times*, 2003.

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