Rising health-care costs inevitable

Pick up any newspaper, magazine, or journal in any of the industrialized nations of the world and you will almost surely find someone or other lamenting the high cost of health care. From Great Britain and continental Europe to North America to Japan the story is essentially the same. Taking care of people who are not well costs too much money, whether it is in dollars or pounds or yen, whether there is some form of national health insurance or not.

Those countries (such as the United States) whose exports are expensive because companies contribute substantially to their workers' medical insurance premiums are at a disadvantage in the international marketplace. The conventional wisdom in current vogue holds, therefore, that corporate expenditures for medical insurance should go down. National economies will fail if health-care costs are not reduced. But good medicine must remain accessible. Politicians and policy wonks agree that this is so.

A news story in this issue of *Nature Medicine* (p. 895) reminds us that the Japanese are likewise concerned that their economy is in jeopardy because of health-care costs, but for a different reason. Japan has too many elderly souls — men and women over 70, whose care has been calculated to average $71,000 a year. Japanese officials believe that the true cost of health care to the economy is even greater than medical insurance figures indicate.

As the world's population ages, there may be no way to spend less to promote health and treat disease.

Something must be done, but what? Japan is not the only industrialized nation whose population is ageing. Indeed, in one way or another the governments of all industrialized countries are struggling mightily to discover the prescription for high-quality, universal medical care that does not cost very much. But what if it cannot be found? What if truly low-cost access to good medicine is the proverbial free lunch of the health-care world?

What if the truth is that there are really only two things that can happen, once costs at the margin have been reduced and inefficiencies stripped out of the system? One outcome, a decade down the road, is that the health-care system worldwide will be leaner and meaner; that is, people will simply be denied needed care. The second (unmentionable) outcome is that expenditures will continue to rise overall, no matter what cost-saving schemes are put into place, because it is not possible to offer more care for less money. And if the latter is the case, would that really be so terrible?

Those of us who are neither politicians nor policy wonks need to know. Perhaps it would help if the arguments for cost-savings were cast in human rather than macroeconomic terms.

Consider the issue of Japan's apparent dependence on prescription drugs. Comparing Japan's expenditure on pharmaceuticals (30 percent of total medical costs) to France's 20 percent or Germany's 17 percent, officials conclude that Japan is spending too great a proportion of its health-care yen on drugs. Too great by what measure? It would be nice to hear from the physicians on this. Are people being given prescriptions for medicine they do not need? Are pharmaceuticals overpriced? Or, is it possible that, given its elderly population, the Japanese medical profession is doing well by its patients?

Technology is another scapegoat in the health-cost wars. But in many cases, cost increases may be justifiable. The advent of safe, outpatient laser eye surgery is an obvious story of technology meeting a legitimate need. The much decried widespread availability of renal dialysis is another, if somewhat more controversial, example of expensive but medically useful technology. Simply stated, dialysis saves the lives of individuals who would otherwise die of kidney failure. Life is more expensive than death, no doubt about it.

Another issue, this one poorly explored in public discourse, is the size of the health-care workforce. In the United States and elsewhere, hospitals are reducing staff to save money. Doctors, nurses, physical therapists, and aides are all vulnerable. In some cities, hundreds of health-care workers have lost their jobs during the course of a few months. What happens to these people in their local or regional economies? If the resulting economic costs of the unemployed are factored into the cost-savings realized by hospitals or other health-care institutions, is the community really better off?

Health economists and policy analysts have dominated the discussion. The insurance systems of Western Europe, Canada, the United States, and Japan have been endlessly compared. But the physicians and other health-care professionals whose opinions really matter to quality, innovation, and shared experience from country to country have been left out. It is time to change the terms of the debate, putting medicine and patients right up there in the list of priorities, along with money.

Barbara J. Culliton