



Controlling Doctors' Decisions

The legislation that could force you to undergo “cost-effective” treatment.

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By Betsy McCaughey



President Obama pledges to provide health insurance for 46 million uninsured people and, at the same time, restrain the nation’s total health spending. Covering the uninsured is a worthy goal, but it will not save money: Once they are covered, they will use 70 percent more health services overall than before, according to the Congressional Budget Office.

So where will the promised savings come from? The truth is that Americans who already have insurance will get less care.

Health spending is higher in the U.S. than in Europe not because the American medical profession is less efficient, but because Americans have higher incomes: “The more people have, the more of it they tend to spend on health care,” wrote David Blumenthal, a Harvard Medical School professor. Blumenthal was recently chosen by Pres. Barack Obama to be national coordinator of health information technology, a key position. In his academic writings, Blumenthal has long advocated government limits on how much health care you can get.

Patients will be dissatisfied, he admits. “Government controls on health care spending are associated with longer waits for elective procedures and reduced availability of new and expensive treatments and devices,” he conceded in the *New England Journal of Medicine (NEJM)* in 2001.

Legislators slipped the framework for top-down government controls into the stimulus package passed in February. One provision called for computer technology that will “guide” doctors’ decisions about what care is “cost-effective.” Beginning in 2014, Medicare and other federal programs will impose financial penalties on doctors and hospitals who are not “meaningful users” of this system. Private insurers historically have followed Medicare’s lead.

How much leeway will your doctor have to order tests and treatments? It’s hard to say,

because the government can make the standard of compliance “more stringent” over time. Blumenthal says his job is not about “just putting machinery in offices.” In fact, it’s about control. In a *New England Journal of Medicine* article published April 9, just after his appointment to the Obama administration was announced, Blumenthal explained that if electronic technology is to save money, doctors will have to take advantage of “clinical decision support,” a term of art for computers telling doctors what to do. He predicted that “many physicians and hospitals may rebel, petitioning Congress to change the law or just resigning themselves to . . . penalties.”

Government controls on health expenditures will reduce the availability of medical technology, such as MRIs, and cause waits for treatment. Blumenthal says it’s “debatable” whether the timely care Americans currently receive is worth the added price. Ask a cancer patient about waiting, and you’ll get a different answer. Delays lower your chance of survival. For example, women in the U.S are more likely to have regular mammograms than are women elsewhere, according to data from the Commonwealth Fund. Their breast cancer is detected sooner. They are also treated faster and have higher survival rates than women in any other developed country, according to the CONCORD study published in 2008 in *Lancet Oncology*. These statistics include all American women, not just those with insurance.

Treating cancer is costly. Nancy-Ann De Parle, newly appointed director of the White House Office of Health Reform, said on March 23, “we have to get to a system of keeping people well, rather than treating the sickness.” That would make sense if all disease were preventable. But many cancers and other diseases are linked to genetics or unknown causes. De Parle’s pronouncement echoes the chilling explanation offered by Sir Michael Rawlins, head of Britain’s National Institute of Clinical Effectiveness (NICE), for his nation’s low cancer survival rates. The British National Health Service, he is quoted as saying in the *NEJM* last November, has to be fair to all patients, “not just the patients with macular degeneration or breast cancer or renal cancer. If we spend a lot of money on a few patients, we have less money to spend on everyone else.”

This approach is deadly for those with serious illness. In the U.S., the CBO notes, about 5 percent of the populace uses 50 percent of treatment dollars.

Also, built into the U.S. health-care tab is research for cures. Five hospitals in the U.S. do more clinical trials than any entire country in Europe, including the U.K., the McKinsey Global Institute reported in December. If someone in your family has an incurable disease, you start each day hoping for a breakthrough. Yet in his writings, Blumenthal identifies innovation as a culprit driving up health spending.

The health provisions in the stimulus legislation were rushed through without discussion. “Speed is essential,” Blumenthal wrote in the *NEJM* last November. “Bill Clinton waited for nine months to introduce his Health Security Act in 1993, which allowed his opposition to mobilize and defeat him.” This time, he added, a “savvy health advisor” will warn the president, “Hurry up, we’re almost out of time for health reform.”

That may be smart politics, but it is bad medicine.

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