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ECONOMIC SCENE

In Health Reform, a Cancer Offers an Acid Test

By [DAVID LEONHARDT](#)

WASHINGTON — It’s become popular to pick your own personal litmus test for [health care reform](#).

For some liberals, reform will be a success only if it includes a new government-run insurance plan to compete with private insurers. For many conservatives, a bill must exclude such a public plan. For others, the crucial issue is how much money Congress spends covering the uninsured.

My litmus test is different. It’s the [prostate cancer](#) test.

The prostate cancer test will determine whether [President Obama](#) and Congress put together a bill that begins to fix the fundamental problem with our medical system: the combination of soaring costs and mediocre results. If they don’t, the medical system will remain deeply troubled, no matter what other improvements they make.

The legislative process is still in the early stages, and Washington is likely to squeeze some costs out of the medical system. But the signals coming from Capitol Hill are still worrisome, because Congress has not seemed willing to change the basic economics of health care.

So let’s talk about prostate cancer. Right now, men with the most common form — slow-growing, early-stage prostate cancer — can choose from at least five different courses of treatment. The simplest is known as watchful waiting, which means doing nothing unless later tests show the [cancer](#) is worsening. More aggressive options include removing the prostate gland or receiving one of several forms of radiation. The latest treatment — [proton radiation therapy](#) — involves a proton accelerator that can be as big as a football field.

Some doctors swear by one treatment, others by another. But no one really knows which is best. Rigorous research has been scant. Above all, no serious study has found that the high-technology treatments do better at keeping men healthy and alive. Most die of something else before prostate cancer becomes a problem.

“No therapy has been shown superior to another,” an analysis by the RAND Corporation found. Dr. [Michael Rawlins](#), the chairman of a British medical research institute, told me, “We’re not sure how good any of these treatments are.” When I asked Dr. [Daniella Perlroth](#) of [Stanford University](#), who has studied the data, what she would recommend to a family member, she paused. Then she said, “Watchful waiting.”

But if the treatments have roughly similar benefits, they have very different prices. Watchful waiting costs just a

few thousand dollars, in follow-up doctor visits and tests. Surgery to remove the prostate gland costs about \$23,000. A targeted form of radiation, [known as I.M.R.T.](#), runs \$50,000. Proton radiation therapy often exceeds \$100,000.

And in our current fee-for-service medical system — in which doctors and [hospitals](#) are paid for [how much care](#) they provide, [rather than how well](#) they care for their patients — you can probably guess which treatments are becoming more popular: the ones that cost a lot of money.

Use of I.M.R.T. rose tenfold from 2002 to 2006, according to unpublished RAND data. A new proton treatment center will open Wednesday in Oklahoma City, and others are being planned in Chicago, South Florida and elsewhere. The country is paying at least several billion more dollars for prostate treatment than is medically justified — and the bill is rising rapidly.

You may never see this bill, but you’re paying it. It has raised your [health insurance](#) premiums and left your employer with less money to give you a decent raise. The cost of prostate cancer care is one small reason that some companies have stopped offering health insurance. It is also one reason that medical costs are on a pace to make the federal government insolvent.

These costs are the single most important thing to keep in mind during the health care debate. Making sure that everyone has insurance, important as that is, will not solve the cost problem. Neither will a new public insurance plan. We already have a big public plan, [Medicare](#), and it has not altered the economics of prostate care.

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The first step to passing the prostate cancer test is laying the groundwork to figure out what actually works. Incredibly, the only recent randomized trial comparing treatments is a 2005 study from Sweden. (It suggested that removing the prostate might benefit men under 65, which is consistent with the sensible notion that younger men are better candidates for some aggressive treatments.)

“There is no reason in the world we have to be this uncertain about the relative risks and benefits,” says Dr. [Sean Tunis](#), a former chief medical officer of Medicare.

Drug and device makers have no reason to finance such trials, because insurers now pay for expensive treatments even if they aren’t more effective. So the job has to fall to the government — which, after all, is the country’s largest health insurer.

Obama administration officials understand this, and the stimulus bill included money for such research. But stimulus is temporary. The current House version of the health bill does not provide enough long-term financing.

The next step involves giving more solid information to patients. [A fascinating series of pilot programs](#), including for prostate cancer, has shown that when patients have clinical information about treatments, they often choose a less invasive one. Some come to see that the risks and side effects of more invasive care are not worth the small

— or nonexistent — benefits. “We want the thing that makes us better,” says Dr. [Peter B. Bach](#), a pulmonary specialist at [Memorial Sloan-Kettering Cancer Center](#), “not the thing that is niftier.”

The current Senate bill would encourage doctors to give patients more information. But that won’t be nearly enough to begin solving the cost problem.

To do that, health care reform will have to start to change the incentives in the medical system. We’ll have to start paying for quality, not volume.

On this score, health care economists tell me that they are troubled by Congress’s early work. They are hoping that the Senate Finance Committee will soon release a bill that does better. But as [Ron Wyden](#), an Oregon Democrat on the committee, says, “There has not been adequate attention to changing the incentives that drive behavior.” One big reason is that [the health care industry is lobbying hard](#) for the status quo.

Plenty of good alternatives exist. Hospitals can be financially punished for making costly errors. Consumers can be given more choice of insurers, creating an incentive for them to sign up for a plan that doesn’t cover wasteful care. Doctors can be paid [a set fee](#) for some conditions, adequate to cover the least expensive most effective treatment. (This is similar to what happens in other countries, where doctors are on salary rather than paid piecemeal — and medical care is much less expensive.)

Even if Congress did all this, we would still face tough decisions. Imagine if further prostate research showed that a \$50,000 dose of targeted radiation did not extend life but did bring fewer side effects, like [diarrhea](#), than other forms of radiation. Should Medicare spend billions to pay for targeted radiation? Or should it help prostate patients manage their diarrhea and then spend the billions on other kinds of care?

The answer isn’t obvious. But this much is: The current health care system is hard-wired to be bloated and inefficient. Doesn’t that seem like a problem that a once-in-a-generation effort to reform health care should address?

E-mail: Leonhardt@nytimes.com

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