Sustainable Medicine

There is hardly a developed country where health care reform has not become a kind of chronic disease of modern medicine: as soon as some reforms are implemented, a call comes for yet another round. Costs continue to climb, but nothing seems to contain their growth for very long.

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Why? Politics surely plays a role. But a more fundamental reason is the nature of modern medicine itself. Most developed countries have a growing number and proportion of elderly. Since health care costs for those over 65 are approximately four times higher than for those under 65, aging societies place massive claims on medical resources.

This is compounded by the constant introduction of new (and usually more expensive) technologies, together with increased demand for high-quality health care. We want more, expect more, and complain more loudly if we don't get it. When we do get it, we quickly raise the bar, wanting still more.

The net result has been an average general system-wide cost increase of 10%-15% annually in the United States for the past several years--and with no end in sight. European countries are under severe cost pressures as well, undermining their cherished ideal of equitable access.

Unfortunately, greater use of co-payments and deductibles, privatization of health-care infrastructure, and waiting lists for elective surgery and other non-emergency care are unlikely to work much better in the future than they have in the past. What is needed is a radical change in how we think about medicine and health care, not simply better ways to reorganize existing systems. We need a "sustainable medicine" that is affordable to national health care systems and provides equitable access in the long term.

The notion of "sustainability" comes from environmentalism, which seeks to protect the earth and its atmosphere in order to sustain indefinitely human life of a good quality. As with environmentalism, sustainable medicine requires reformulating the idea of progress that drives technology costs and fuels public demand. The Western idea of progress, translated to medicine, sets no limits on the improvement of health, defined as the reduction of mortality and the relief of all medical miseries. However much health improves, it will never be sufficient--so further progress is always required.

But unlimited progress cannot be paid for with finite funds. Long-term affordability and equitable access requires a finite vision of medicine and health care, one that does not try to overcome aging, death, and disease, but tries to help everyone avoid a premature death and to live decent, even if not perfect, lives.

This implies shifting medical resources sharply towards health promotion and disease prevention. Billions of dollars have been spent on mapping the human genome. Comparable sums must be spent on understanding and changing health behaviors that are most likely to bring about disease. Why is obesity increasing almost everywhere? Why do so many people continue smoking? Why is it so difficult to persuade contemporary people to exercise?

Sustainable medicine also requires comparing health care expenditure with spending on other socially important goods. In a balanced society, health care may not always be the top priority. At the same time, we often overlook the health benefits of spending money in ways that have nothing to do with the direct delivery of medical care: education and health, for example, are strongly correlated: the higher the former the better the latter.

In any case, sustainable medicine acknowledges that rationing is and always will be a part of any health care system. No system can give everyone everything they need. Our aspirations will always exceed our resources, particularly since medical progress itself raises public expectations. But, to be fair, rationing requires the knowledge and general consent of all who are subject to it.

One place to start is to evaluate the economic impact of new technologies, preferably before they are released to the public. Evidence-based medicine--a popular technique for controlling costs--is ordinarily aimed only at the efficacy of diagnostic or therapeutic procedures. But if drug companies must test new products for their safety and efficacy, why not also for their economic impact on health care? New technologies should not be dropped into health care systems uninvited. Only if a technology does not significantly raise costs, or does so only exceptionally, should governments be willing to pay for it.

Most fundamentally, a finite model of medicine must accept human aging and death as part of the human life cycle, not some kind of preventable condition. Medicine must shift its focus from length of life to quality of life. A medicine that keeps people alive too long is not a decent and humane medicine. We can live to be 85, but we are likely to do so with chronic conditions that leave us sick and in pain.

This is not an argument against progress: I, for one, am glad that people don't die of small pox at 40 anymore. But aging and death will still win out in the end. Medical progress is like exploring outer space: no matter how far we go, we can go further. With space travel, the economic limitations of unlimited exploration soon became obvious: no more moon walks. Medicine needs an analogous insight.

Slower technological progress may seem a high price to pay for sustainable health care. But our current systems carry an even higher price, threatening justice and social stability. At the same time, only about 40% of the rise in health status over the past century is attributable to medical progress, with the rest reflecting improved social and economic conditions. This trend is likely to continue, so that even if technological progress slows, people are almost certain to live longer lives in the future--and in better health--than they do now. That outcome should be acceptable to everyone.

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