Robert H. Goldberg

False Economy On Drugs

WASH. POST

The debate in Congress over prescription drugs has focused largely on cost-saving issues: coverage, copays and competition. But more important questions have been overlooked: Will the new drug coverage pay for the best medicines available to seniors, and what will happen to the overall Medicare budget if it does?

The perceived wisdom underlying congressional debate has been that giving physicians freedom to choose the best medicines for their patients (including the newest medicines) is in conflict with the imperative to rein in Medicare spending. Everyone seems to assume that any coverage plan that pays for the newest medicines will break the bank. This assumption is badly flawed. Years of research indicate that using newer drugs and allowing doctors to choose and mix the medicines that are right for their patients is generally better for patients and costs less in the long run than the kind of bureaucratic cost containment strategies Congress is contemplating. Both seniors and Medicare's ultimate financial solvency would be better served if Congress stopped trying to reduce the Medicare drug budget through the use of restrictive formularies and generic substitution and instead adopted a policy of reimbursing for the drugs a physician believes are medically necessary.

Standard cost containment practice these days is to substitute old medicines for new, or to allow patients to "fail" on cheap drugs before trying a higher-priced one. Private insurers and state governments are rushing to adopt formularies—a list of preferred drugs that forces patients to pay more out of pocket for the newer, more expensive drugs. Notably, both the House and Senate prescription drug bills would strongly encourage the use of generic medications.

with that of patient health often have the unintended consequence of making people feel worse, not better. And sick patients who can't get the drugs they need are forced to use other parts of the health care system, driving up total costs in the end.

Take, for example, the approach used by the Department of Veterans Affairs to contain drug costs. The VA implemented a policy that requires schizophrenics to "fail first" on the cheaper drug before being allowed to use the one that works. This policy was developed not in response to published guidelines or best practices or to the needs of individual veterans but in an effort to cut drug costs. But "fail-first" was found to drive up the total treatment costs of people who needed not the cheapest medicine but the one that was right for them.

Similarly, a small study of the VA's efforts to switch patients to the cheapest ulcer drugs found that patients who "failed" were sicker and cost more to treat than those who were able to stay on their more expensive medicine.

These findings have been replicated in studies focusing on seniors. A 1996 study of 13,000 patients from six HMOs conducted by Dr. Susan Horn found that the more restrictive the limits on drugs, the more patients used other, more expensive services such as emergency rooms, hospitals and doctor visits. Horn's research also shows that limiting access to new drugs simply because they are new drives up total costs and increases sickness, while increasing access to new drugs does exactly the opposite. When she looked at the relationship between use of new drugs and total spending on specific illnesses, she found that a 10 percent increase in use of the newest asthma medications was associated with a $72.31 decrease in overall annual drug costs per patient and a 1 percent decrease in doctor visits per patient. Meanwhile, greater use of older asthma technology was associated with a $41.59 *increase* in total drug costs and about a 1 percent increase in office visits.

prescription drugs than we do. But at the same time they are substituting cheaper medicines and restricting access to newer ones at an accelerating pace. The impact has been twofold: increasing rates of suboptimal care for chronic illnesses, which translate into more hospitalization and doctor visits for these diseases, and a decline in discovery of new drugs as the "market" for new medicines evaporates. Americans can avoid this fate by giving seniors and doctors in Medicare more freedom and more dollars to spend on the best medicines for them now and the next generation of medicines in the future.

The writer is director of the Manhattan Institute's Center for Medical Progress.

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