

0 percent.³ Modeling with the use of quantitative infection data would be a useful next step.

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Controlling Health Care Costs

TO THE EDITOR: In their recent articles on rising health care costs, economists Paul Ginsburg (Oct. 14 issue)¹ and Joseph Newhouse (Oct. 21 issue)² and presidential candidates John Kerry and George Bush (Oct. 28 issue)³ do not directly address the well-known fact that approximately 10 percent of patients account for 70 percent of costs.⁴ To control costs we must acknowledge this skewed distribution and honestly address the major factor driving costs: the growth of technology.⁵ Managed care's lack of candor undermined its efforts to control costs and led to patient backlash.⁶ Since rationing is politically untenable, government has retreated from these issues. And current efforts at patient cost-sharing with caps will not curb spending for those with high utilization.

However, in order to obtain basic health care, some patients are willing to accept limits on care. We need efficient insurance systems in which patients willing to accept such limits are linked with caring physicians who use innovative practice styles and consider both costs and benefits as they care for their patients. Although this approach may make some uncomfortable, it is both ethical and necessary.

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TO THE EDITOR: Dramatic advances in medicine and technology have resulted in widespread benefits from lifesaving but expensive devices and drugs such as implantable cardiac defibrillators, drug-eluting coronary stents, and new chemotherapeutic agents. Interestingly, three of the four options for reducing rising health care costs proposed by Dr. Ginsburg would require people to obtain less medical care. If our society continues to reject limitations on health care acquisition, one reality must be faced by all: whenever technological advances occur, there are increased costs to individuals (for example, automobiles cost more than horses and buggies, televisions cost more than radios, and air travel costs more than rail travel). Our hope is that, over time, cost containment can occur as a result of three mechanisms: reductions in the price of technologies through free-market competition, medical-liability reform (which will reduce the practice of defensive medicine),¹ and the growth of information technology, leading to a more efficient system.^{2,3} Until then, the American people must assume some personal responsibility for financing the most advanced health care system in order to continue to reap its benefits.

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DR. GINSBURG REPLIES: Dr. Abbo correctly points out that the large proportion of spending for the relatively small group of patients with high medical expenses limits the role that patient cost-sharing can play in containing costs, and his point about some patients' willingness to accept limits in return for access to important care is well taken. However, I must disagree with the prediction of Dr. Coca and colleagues that we can contain costs without some sacrifice — that easy gains in efficiency are possible if only we pursue them. Inevitably, the gains do not pan out. Today's promises are that expanded information technology and malpractice reform will yield large enough savings that trade-offs will not have to be faced. These steps are worthy ones, but we should not oversell the likely cost savings.¹

The challenge of effective cost containment is to encourage access to new medical technologies that provide important improvements in outcomes while

discouraging the use of high-cost treatments with small or unknown benefits. Too often, our health care system allows the rapid diffusion of new technologies without rigorous examination of their effectiveness in comparison with that of existing treatments. Sometimes, much-heralded new technologies turn out to have small benefits or even to cause harm — Vioxx comes to mind. The reality is that we as a society do not have the resources to provide all the care that patients might want and physicians might want to provide. Without effective cost containment, the result will be increased rationing on the basis of ability to pay, rather than rationing based on clinical effectiveness. In the end, we have to answer this question: Is it better for many to do without low-value services or for the few who cannot pay to go without important care?

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Bell's Palsy

TO THE EDITOR: In his Clinical Practice article on Bell's palsy, Gilden (Sept. 23 issue)¹ recommends treatment of the patient in the vignette with oral prednisone. The Cochrane Collaboration² has pointed out that the statement of the American Academy of Neurology — that early treatment with corticosteroids is “probably effective”³ — is most likely invalid because their evidence synthesis (i.e., their summary of the best available evidence) included a trial with a high rate of loss to follow-up⁴ and a nonrandomized trial⁵ — trials that both had serious threats to validity.

Without these studies, the pooled results are no longer in favor of corticosteroids.² We concur with the Cochrane Collaboration and believe corticosteroids have not been shown to be effective in Bell's palsy. Cause-and-effect conclusions cannot be drawn from observational studies.

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