CAN WE AFFORD PRECISION MEDICINE?
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Note: This essay was adapted from remarks delivered at a panel on the “Future of Medicine” at my 25th college reunion on May 26, 2018. Most of the panelists discussed technological advances that they envisioned, with a focus on precision medicine (an emerging approach to medicine that proposes to customize the selection of treatment for patients in part based on genetic variability).

I’d like to contribute to this discussion by talking about healthcare costs. I’d like to start with the intentionally provocative assertion that we can’t afford precision medicine. We as a country can’t afford it, so we shouldn’t pursue it. I say this not because I really mean it, but because it so striking that we never say things like that. Can we afford it? How do we figure out what we can “afford?”

When I was in college, I majored in psychology, fascinated by the concepts of motivation and behavior. Why do people do what they do? What are the incentives that influence them?

I graduated from college in 1993 and went straight to medical school, which meant that I was a first-year medical student at the time that the Clinton health plan was being debated. I took an elective in health insurance my first semester of medical school, which was taught by Dr. Rashi Fein, a professor who was in Washington, DC in the 1960s when Medicare and Medicaid were created. I was absolutely captivated by this course. I thought, here was a social system, health insurance, that was profoundly influencing the way patients behave and the way providers behave. And we weren’t being taught in medical school how those forces would affect our practice of medicine or what to do about them. I tried to engage my classmates in discussions about health insurance. I would say something like, “Hey, guys, let’s talk about health insurance.” My classmates would say, “Lisa, we’re studying H2 receptors.” And I would say, “Health insurance.” “H2 receptors.” I didn’t get far.

I have since done a residency in internal medicine and a fellowship in research methods and healthcare policy called the Robert Wood Johnson Clinical Scholars Program. I am now an associate professor at Weill Cornell Medicine, where I do research on how to improve healthcare delivery and how to measure those improvements. I also teach medical students, residents, fellows and faculty. My favorite class to teach right now is for second-year medical students. I teach a series of lectures on healthcare policy, and I basically try to answer the questions: “How did we get here? Why is healthcare such a mess?”

As I have taught this class, I have tried to emphasize just how much our healthcare system today is a function of choices that we as a society have made in the past. So, allow me to take you on a whirlwind tour through the history of healthcare financing to see if that helps us answer the question of whether we can afford precision medicine or not.

Prior to 1870, doctors made house calls with their little black bags. Patients paid their doctors directly, or gave them something for their effort—perhaps a chicken or a loaf of bread. There were no intermediaries. Health insurance didn’t develop until the 1940s, in the context of World War II. During that war, many men of working age were overseas fighting, and the U.S. govern-
 customized medicine. And you can be sure that anything custom is more expensive than anything standard. I don’t know if we can afford precision medicine. But I’m thinking that the music teachers will be the next to go.

References