At What Cost?

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The Bush administration informs us that we are making “good progress” with respect to the economy. Chairman Alan Greenspan tells us that there is no significant inflation detectable today, and other economists agree. The big picture is rosy they say. Perhaps that is so. The little picture, however, of the healthcare sector, is quite another story. Double-digit percent increases loom this year in all areas of healthcare except in physician and hospital reimbursement for professional and institutional services.

Let us consider the causes and effects of these astounding increases.

It appears that over-utilization and wastefulness are among the leading causes of the cost increases. With the elimination of Certificate-of-Need laws in many states, many physicians purchased and operated, in their own practices or in other non-hospital settings, equipment such as CT scanners, gamma cameras, catherization units, MRIs and similar high-cost diagnostic devices in order to take away market share from the traditional hospital monopoly. Utilization of these devices rose sharply for a variety of reasons. Not least among those reasons was the fact that these devices had to be paid for and their owners expected a good return on their investment. The fact that patients enlightened by the popular press about the superior diagnostic capabilities of these “new” devices demanded their use of their litigation-weary physicians further contributed to utilization not often justifiable as “medial necessity” as the government defines that term.

The current health insurance payment schemes for professional services have not kept pace with the practice cost increases physicians experience due to ever-increasing labor, supply and insurance costs. The nation-wide shortage of nurses and technologists has driven up labor costs significantly and has pitted physicians against hospitals in a competition for experienced staff. The cumbersome and onerous procedures of verifications, authorizations, and billing in general has necessitated the addition of clerical staff with special skills, again at premium costs. The recently mandated HIPAA rules have added yet another set of tasks that have to be carried out and require staff time. The recent significant increases in the cost of professional liability insurance, especially in some parts of the US, have placed a serious burden on physicians. As reimbursement languishes and costs rise, physicians’ incomes are reduced. Some of our colleagues have tried to maintain or increase their remuneration by providing more services while others have suffered the losses.

A recent study by the hospital cooperative VHA of the usage of three common antibiotics, ceftriaxone, levofloxacin and vancomycin at eleven different hospitals indicated that between 25% and 68% of the patients receiving these drugs were either over-treated or received the drugs unnecessarily. The researchers concluded that the average 250-bed hospital could save $100,000 per year by improving antibiotic usage. The authors estimate that US hospitals could save over 1 billion dollars annually by eliminating unnecessary use of antibiotics. On an out-patient basis, unnecessary antibiotics prescribed in physicians’ offices are estimated to cost in the hundreds of millions of dollars annually.

In a study of 994 hospitals in 28 states conducted by researchers from the Center for Quality Improvement and Patient Safety of the US Department of Health and Human Services it was determined that preventable medical injuries cause more than 32,000 deaths each year in the United States. The costs attributable to such preventable medical injuries are staggering. These errors generate 2.4 million additional charges each year. The study results were reported in JAMA.

Escalating drug costs and an increasing rate of drug use have had a significant effect on healthcare costs. Patient-direct advertisement of patent-protected drugs by pharmaceutical firms causes patients to pressure their physicians to prescribe such drugs. The effect on HMOs that generally provide a drug benefit has been significant enough to cause them to establish limited formularies and to charge much higher co-payments for brand drugs than for generics. A survey of Pharmacy benefit Managers (PBMs) indicates that the average wholesale price for brand drugs in 2003. Was $68.46, while the AWP for generic drugs was only $15.55. One has to bear in mind, however, that there is not a one-on-one relationship, as many of the brand drugs do not yet have a generic equivalent.

According to an economic forecast released by the National Center for Policy Analysis, if Congress passed the Medicare drug benefit bill that is currently in conference committee, the bill would add approximately 12 trillion dollars to the governments future unfunded liabilities, that in addition to the currently estimated 30.5 trillion Medicare shortfall.

On a much smaller scale, but mathematically far more comprehensible, is the financial impact of the healthcare fraud. In 2002, the federal government collected 1.6 billion dollars as a result of having won judgements, settlements, and administrative penalties. The joint annual report by the Departments of Justice and Health and Human Services indicates that in the year 2002 the Justice Department filed 361 criminal indictments and the IG office of HHS filed 221 civil actions. The Inspector General's office also excluded 3,448 individuals and organizations from participation in federal healthcare programs. Congress' failure to enact a comprehensive tort reform continues to allow juries to set irrational penalties for non-economic damages. Fought vigorously by trial lawyers' associations throughout the US, serious tort reform is unlikely to be passed this Congress. With an election year on the near horizon, it is improbable that the Bush administration will waste political capital on such measure. The impact of rapidly rising professional liability insurance premiums on physicians' practice expenses is profound. Raising professional fees is of little value as most third party payers pay on the basis of contractual fee schedules that are based on discounts from Medicare schedules, and have little semblance to a physician's personal fee schedule. As is the case with hospitals, only the uninsured are charged the full fee schedule prices, most of which are significantly above any fees Medicare or other plans will pay. Any relationship to actual cost of production of a service is purely accidental. Some astute physicians have recognized the fact that most of the uninsured patients they see fall in a group that earns too much money to be on Medicaid/AHCCCS, and not enough to be able to afford insurance. As a result of that realization they were able to determine that by charging "full schedule" fees they were doing little more than increasing their bad debt experience. The occasional, rare wealthy self-pay patient certainly doesn't make up for bad debt losses. A number of practices now offer deep cash discounts to self-ay patients and are willing to make time-pay accommodations.

According to the Kaiser Family Foundation, the average health insurance premium costs have risen drastically. For families, the average annual premium cost rose from $6,438 in 200 to $9,068 in 2003, the employee's contribution from $1,619 in 2000 to $2,412 in 2003. Generally, co-payments have also risen significantly, especially in relationship to drug purchases. The result is disturbing: as premiums rise, more individuals drop their insurance coverage. As the number of uninsured increases, physicians' bad debt experience increases when these individuals require care. Larger hospitals, have caused patients to declare bankruptcy. The multiple of health plans in existence today has contributed to the increase of health insurance premiums as each of these plans has its very own, usually heavy administrative layer and thus generates heavy administrative costs. There are, of course, notable exceptions that manage frugally and provide reasonably good benefits. Unconscionable salaries paid to some of the executives of health plans drain the pool of funds available for patient care.

These problems are not unique to the United States. The universal coverage healthcare systems of Canada and the United Kingdom are overwhelmed. Patients wait months and even years before receiving necessary care. Other nations such as Germany, Austria, France, and the Scandinavian countries are seeking to reduce the ever-increasing costs of healthcare through various mechanisms. So far all measures have been unsuccessful in that respect. In Germany, the debate over rationing of healthcare has once again been opened. The youth organization of the Christian Democratic Party is proposing that patients aged 85 and over should not receive joint replacements or new dentures. Others have advocated that no elective surgical procedures be available to persons 75 years of age and older. Governments have recognized for some time now that healthcare costs for the elderly increase rapidly as longevity increases.

Are there any solutions? There are some, but they are all difficult to achieve. There must be a change in the societal mindset that requires that life must be prolonged not matter what the cost is, and no matter what the quality of life remaining. We must return to accepting death as a natural consequence of life, and we must allow death to occur with dignity and in peace.

We must place ever so much more emphasis on prevention of illness. The current epidemic of obesity among all Americans, but especially among our children, will have disastrous consequences in the near future in the form of long-term, debilitating diseases such as diabetes. The consequences of smoking and substance abuse place a horrendous social and financial burden on our society, and we must take serious steps to intervene.

Congress must act swiftly and decisively to reform the judicial system will special emphasis on rational tort reform.

Whether or not the necessary changes will occur depends to a large degree on our wiliness to change our ways when that is necessary and to make sacrifices along the way.

As always, I welcome your comments and contributions

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