

Cost as a Factor in the American Health Care System

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Clearly, this rate is substantially exceeding the growth of the Gross National Product. Our government's attempts to cut costs under the current system have proved incapable of controlling ever-increasing health care costs. The implementation of DRG's attempted to make the medical care industry more accountable for being efficient, but was not effective in controlling the rise in costs. Some argue that if we were to switch to an entirely federally run system, there would be no incentives for entering medical professions, or for drug companies developing new drugs and procedures. They claim that without financial incentives and free-market forces, access and quality would decrease. Others believe the federal government has had a history of making programs worse once it takes them over and operates them inefficiently. Most of our group members think the involvement of the federal government, at a maximum, should be in setting goals and development of a distributive plan. Also, it was our consensus that a sustainable system of universal health care coverage cannot be developed in our current political climate.

There are numerous factors attributing to the increasing costs. These include expanded access, expensive drugs, consumer expectations, fraud, hidden expenses, politics, and increased insurance premiums. Costs reflect the political and social forces that expand access to all without regard for the individual paying for services rendered. If one looks at the history of public health services, the goal was always to provide a limited suite of medical services to a specified group for the greater "good" of society. Over time, these services expanded beyond their original scope. This was the result of a change in the

practice of public health services to the current system of universal health care for everybody for any and all illness. Additionally, legal and political forces have increasingly defined health care as a right. Though promoted as an egalitarian principle, an individual's right to health care in which "others" are obligated to pay is problematic. A prescription drug benefit to senior citizens being promoted by both political parties is an excellent model for why costs continue to rise. The people have learned that they control the purse strings - by electing politicians who are willing to buy power by passing out the boodle.

The cost problem lies on our expectations as health care consumers. Included in these expectations are desires for high tech treatment, but no intention to pay for anything out of pocket. Nobody wants to be excluded regardless of ability to pay. Patients want ever increasing levels of care, technology and convenience without bearing the price tag. There will always be that sector of population that cannot afford services. A federal spending cap needs to be set that would restrict services to what is reasonable and affordable as a society. One example of a cap may be providing only essential health maintenance services to all Americans. Anything additional to routine care would have to come out of pocket or be funded through private insurance allowing the consumer to choose the insurance premium that goes with the desired services. However, society must support this drawing the line. This can prove challenging in a culture placing a higher value on individual versus collective needs.

Other rising costs include administrative services, intensive nursing care for end of life, and heroic medicine for ultimately fatal conditions. The money invested may far exceed the outcomes. Also, some unnecessary expenses occur from simple mistakes that should not occur such as giving too much medication and billing errors. Billing abuse by providers in the in the fee-for-service system has also added to higher costs. Hidden costs include the cost of professional schools, equipment, staff, and utilities needed to provide services. The development of new technology and therapeutics cost money and the government, in one way or the other, foots the bill. The industry keeps on skimming the resource-rich consumer base leaving the public sector to deal with unprofitable business, such as long-term care, mental health, and care for the indigent.

Changes as a result of escalating costs

American healthcare has been subjected to various changes in attempts to streamline the industry and lower costs. Some examples include, shortened hospital stays, increased outpatient services, hospital consolidation, higher numbers of people serviced by managed care networks, and intense competition among hospitals for managed care contracts. Shorter hospital stays are not always determined by physician's choice. Physicians may be forced to discharge patients prematurely due to financial constraints imposed by the patient's insurance. Without adequate recovery, patients may ultimately be readmitted and may take longer to recover thus driving up costs. Physicians should be able to properly care for their patients not based solely on insurance demands at the expense of the patient's health. Medical decision-making has been removed from the hands of the front-line providers who are most knowledgeable of the cases in front of them. This decision-making has been placed with administrators who may not be

medically qualified or fully understand the scope of care needed for the patient's condition. Increasingly, primary care providers feel less autonomous in their clinical decision-making.

Today's American health care is more a business and less a system of caring for the ill. Medicaid and Medicare changes have made the greatest impact when moving to the DRG form of payment. This change developed into capitated payment plans and HMO's, which started focusing on making health care more efficient and cost effective. However, DRG's and capitation have neither prevented drastic cost increases nor the upward spiraling proportion of health care expenses to the rate of increase in national wealth. Changes need to address the individual's "right" to endless medical care in order to reduce cost. Many involved in health care financing know this but are unwilling or unable to limit access.

We need to keep in mind that the type of service is changing from acute to chronic. Chronic care will cost more over time. Cost will be a big factor in providing these long-term services. At current use, costs will continue to increase quickly until they are not economically sustainable no matter what the political or social sentiment desires. Also, providers are often given equipment, drugs types, or material to use without having input and must do the best they can with what is given to them. American Dental Association and American Medical Association have become the strongest leverage for providers to get into the political area for improvements in controlling costs. Providers need to be permitted to have a stronger influence in getting supplies needed to adequately care for their patients.

Changes are not lowering costs of health care

The changes triggered by escalating health care costs have been both positive and negative. The positive changes are essentially limited to operational/tactical issues while the negative represent a failure of not having a central national health strategy to provide vision, focus, and appropriateness of resource utilization.

Changes with the most positive impact consist of: 1) evidence-based medicine and preferred practices; 2) cost-effectiveness research; 3) shift to ambulatory care; 4) emphasis on primary care and gate keeping; 5) the concept of capitation (not the application we have witnessed so far); 6) increase role of management and information systems; 7) group-practice; and 8) integration of systems. Collectively, these provide a sound and rational framework in attaining cost-efficiency.

In contrast a number of changes/policies have had a highly negative impact and or consequences. These include:

- 1) Allowing markets run amuck without a clear vision of the desired end result allowing markets to attempt to maximize gain. Health maintenance is frequently an endeavor that is inherently unprofitable. Markets therefore will only address what is profitable.
- 2) Enacting legislation that triggers costly unintended consequences. For example, initially, DRGs were only applicable to public-financed program payers. This resulted in

cost shifting, a tier of payment schedules, and abandonment by industry for needed but unprofitable services and at risk populations by market players. In the end public money, again, comes to the rescue in the form of more incremental changes to address these negative consequences.

3) Reducing the essence of health care to medical care. The possibilities in health care are endless and so are associated costs. Cost-containment measures have targeted limiting individual care versus augmenting population health efforts. Looking at the big picture, incremental changes to Medicare and Medicaid have overlooked this issue.

Changes in health care have been unsuccessful in controlling the magnitude and rate of healthcare cost hikes. Despite caps and reduced reimbursement, costs continue to soar out of control with the government continually having to pick up the bill. All changes have not been bad. These have made providers, hospitals and patients aware that unjustifiable medical spending is eventually going to have to end. American health care needs to be reviewed in the context of our actual and potential problems. Instead of the government reacting to crisis vs. pre-planning, prevention or looking ahead there is enough history (history repeats itself) for the government, private sector, business, military, and professional organizations to group, review, plan and focus on reshaping our health care system. However, this will not happen until we have society and legislation backing the changes that need to be made in limiting our current free-spending health care system.