THE BUILDING HEALTH CARE CRISIS IN THE U.S.

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The United States has the most costly health care system in the world. 1.6 trillion dollars a year is spent on health care in this country, which calculates out to almost $5000 per person.

We also have the most inefficient system, 45 million Americans have no health care coverage or insurance at all. We have no national health care policy, our delivery system is disorganized, and we have no incentive for cost savings or economical choices. Our exploding health care costs are 15% of GNP, projected to be 20% in the next few years.

Who are the villains in this depressing, chaotic scenario? There are many, including the pharmatheutical industry, insurance companies, hospital monopolies, overpaid doctors, trial lawyers, private and public bureaucracies, and not to be left out, the patients or consumers, as they are being increasingly called. The combination of their unreasonable demands and expectations, coupled with a high level of non-compliance, results in significantly higher health care costs.

But finding and punishing the villains will not solve the problem and there is no single cure for this national dilemma. It would seems that very few people are thinking about this problem, or understand what is going on. We are headed for a major crisis in

this country, and perhaps until that occurs, we will not see a coherent, workable national health policy.

So, what went wrong? One can say justifiably that we have available in the US the best, most advanced health care in the world. We have wonder drugs that control pain, reduce depression, lower cholesterol, maintain normal BP, prevent hearth attacks and improve sexual function. New technologies abound, reducing tremors, replacing joints and organs and treating cancer. Diagnostic procedures are ever improving.

The public appetite for all of the new pharmacy and technology is insatiable. And it turns out that prescription drugs and new technologies are the most profitable segments in health care. There are no economic brakes applied to the introduction of new drugs and technology. The public wants unlimited access and care, and the government encourages this insatiable appetite. Our lawmakers encourage current cost trends by mandating the expanding scope of health benefits.

<u>Who pays for this dysfunctional health care system?</u>

1) Although we have no national health system, the combined national and State governments pay up to 60% of the total $1.6 Trillion health care costs. This includes Medicare, which covers the population over 65 years old, and Medicaid, and the State Children's Health Insurance program, which covers low income families and individuals.

2) The 2nd largest health care payers are employers who provide insurance coverage for working adults up to age 65. Premiums for employer-sponsored insurance policies now average $2,700 per year for an individual, up from $1,000 per year 4 years ago. A policy

for a family now costs $10,000 per year. Less than 2/3 of the work force is covered by employer sponsored health insurance and fully 18% of the non-elderly population is uninsured – 80% are from working families, while 75% are low income. There are 45 million people uninsured in the United States.

The uninsured individual incurs $1,600 per year in health costs and pays only 35% of that $1,600. The remainder is referred to as "uncompensated health costs" and amounts to $41 Billion per year, mostly paid for by the government. But, uncompensated care is also provided by hospitals and doctors. With their incomes going down, doctors in general are increasingly unwilling to care for the uninsured.

In contrast the insured individual spends over $3,000 per year on health care, as compared to $1600 spent by the uninsured. The insured certainly receives better care than the uninsured. The uninsured, by comparison, waits longer to see a doctor, and is therefore more likely to be hospitalized due to an avoidable problem that could have been treated.

The uninsured population is growing for a number of reasons:

With the welfare reform act of 1995, welfare rolls were decreased and many people lost their Medicaid coverage and have remained uninsured. At the same time, employment-sponsored coverage has declined, going from 66% of the workforce covered in 2000 to 62% three years later in 2003. Small companies and even some larger ones are no longer willing or able to pay the increasing premium costs and many are asking employees to assume a larger portion of the costs of these premiums.

Between 2000 and 2003, 5.6 million Americans dropped below the poverty line, adding to the uninsured population. During these same three years, the US population only grew by 7.6 million.

Employment patterns have shifted, i.e. more people are self-employed or work in small firms where insurance is not offered by the employer. Service sector jobs are increasing and these are more likely to be uninsured. More people are also working part time, again without insurance coverage. Many employees are uninsured because they cannot or elect not to contribute their one-fourth (1/4) share of the employer-sponsored premiums. Low wage workers are less likely to participate in health benefits than higher paid workers.

It is clear, we need major reform in the system and some feel it will get worse before that happens because 1) major reforms will threaten the interests of investors, insurers, vendors and providers and 2) there is no popular grassroots effort to change the system. This is curious and in contrast to the reforms of the civil rights movement, the feminist movement and the AIDs activists movement of the last century, which all succeeded because of grassroots support.

National health reform campaigns have in general been started by elites and academics as exemplified by attempts at establishing a system of compulsory health insurance in 1915 driven by academic reformers, but opposed by labor unions. There was no grassroots support for this movement and it failed. President Truman strongly supported a national health insurance program but it also failed for the same reason. Mounting interest and group pressure finally led in 1965 to the passage of the Medicare

bill, but this was successful partly because it was perceived as a piece of President Johnson's War on Poverty legislation.

President Clinton was elected in 1992 on a wave of popular support for major changes in the health care system. But again the opportunity was squandered because he relied on the same elite-based decision making without grassroots and medical profession support. His reform legislation died in committee and was never voted upon by the House of Representatives and Senate.

Prior to 1965 medical care consisted of personal transactions between doctors and patients and in not-for profit hospitals and clinics. There was very little expensive technology or highly specialized care. Health care accounted for 5% of the GNP and the government paid for 25% of that cost. Most patients were uninsured and paid out of pocket or used private charity or tax supported institutions. No one thought of this system as a "market", and investors, economists and business leaders showed little interest in it.

Suddenly, after 1965 with the passage of the Medicare Act, large amounts of government money entered the health care system and the practice of employer-based health benefits gained popularity and grew. As one would predict, business enterprise blossomed. Investor-owned for-profit hospitals, nursing homes and ambulatory centers sprang up, and many doctors joined the medical "gold rush".

Also, following the 1965 Medicare legislation, amid predictions of eminent doctor shortages, 40 new medical schools were established and the 80 pre-existing schools

increased their enrollment 20-30%. With the resulting increase in numbers of doctors – mostly specialists – economic expansion was further stimulated.

By now the NIH had seemingly unlimited funding, resulting in increased development of expensive treatments, drugs and devices, driving up health care costs and reimbursement. Naturally, coverage costs went up. All this generated new opportunities and economic gain.

In 1975, the U.S. Supreme Court applied anti-trust laws to medical practice. There would be no more suggestion of fair prices and it effectively lifted the ban on advertising. It was thought that competition would moderate costs and improve quality. That did not happen.

All of these changes, economic and legal, diminished the aura of professionalism and social service that had surrounded medicine and previously kept it apart from commerce.

In 1980 Arnold Relman, long time editor of the New England Journal of Medicine, described in an editorial all these changes as the new medical-industrial complex, picking up on President Eisenhower's coinage of the military-industrial complex. Sad, but true, financial incentive was replacing service ethic as a driving force in medicine.

By the mid-to-late 1980's. employers and government began challenging the ever-rising costs of health care and in response a new investor-owned health insurance concept appeared – managed care or HMO's.

The medical profession and hospitals initially embraced this new concept, but soon found themselves taking deep discounts in order to maintain market share of the patient population. Ultimately both patients and doctors perceived HMO's as restricting care for the benefit of the insurance companies. Hospital and doctors' fees went down and for a while in the 1990's health care costs leveled off, as did employers premium costs. As a result, the government and employers in this medical-industrial complex were satisfied.

It didn't take long, however, for those who were unhappy with the new system to fight back. Doctors joined large loosely connected groups often controlling or monopolizing large geographical areas and, consequently, were able to negotiate more successfully with the insurance companies. Brown and Toland is an example of such a medical group. For the same reason Hospitals merged – Sutter in Northern California is a creation of that time period.

But, at the same time there was an acceleration and development of new, expensive drugs and technology, so it was not long before health care costs started rising again. Medicare restraints on hospital costs were ineffective because much of this new technology and drug treatment was used in out patient settings.

With the development of highly specialized care, less emphasis and attention was paid to continuity of care and, perhaps as important, preventive medicine. As primary care doctors were being paid less and less, they were forced to see larger volumes of patients and in shorter time periods, hence the frequently referred to 6 ½ minute doctor's visit. And of course the quality of primary care suffered.

All these changes have brought us to the present where we have a seriously defective health care system based on market incentives. Dr. Relman and others think the health care system has failed because it is a business, no longer a service profession.

How do we spend our health care dollars?

Certainly much differently than in 1965:

1. A phenomena that did not exist then is the permanent or semi-permanent patient. We are much better at keeping patients alive now. Examples are kidney dialysis and kidney transplant patients, also heart transplant, chronic lung and cancer patients. Many of these patients are being kept alive, but not in a productive sense. They are chronic or permanent patients.
2. Heart transplant surgery costs up to $500,000 for each transplant. $500,000. The ongoing post-operative costs –immunosuppressive therapy, rejection RX and infection RX, are largely unrecognized and unappreciated by the public. The follow-up care for heart transplant patient costs $95,000 per year.

Coronary disease intervention, laparoscopic GB surgery, arthroscopic knee surgery are other examples of relatively new costly procedures.

Miracles are provided in chemical versions as well. A newer anti N-V drug for cancer patients costs $56/day, replacing a somewhat less efficient drug which costs

$3/day. Zoloft and Prozac, both antidepressants, cost 10 times as much as Elavil which they have replaced.

Pharmaceutical advertising costs hit $2.5 billion in 2000 and, increasingly, health plans are spending more on drugs than on hospitalization.

And, of course, explosive costs are looming with the onset of the new Genetic Sciences. One thing is certain – every new treatment, every new technique, every new drug costs more then the one it replaces.

3. Payment for unproven, non-scientific based therapy is costly. Patients demand it, the public, the media and often the courts support it. A recent example is autologous bone marrow transplant therapy for breast cancer. Rushed into before adequate studies were done, thousand of women were subjected to unnecessary pain and suffering and debility before dying because it didn't work. Hope and politics trumped science, and millions of dollars were spent before the procedure was discontinued. Fen-Phern, a much heralded weight losing drug was in great demand and frequently used before the discovery that is was associated with heart valve dysfunction.

4. The lack of a best-care standard in our system is also expensive. Every doctor wants to do the right thing, but really none of them can keep current with best-practice therapies and prescriptive drugs. Every year, 23,000 medical journals alone are published. In a recent study, 135 doctors were asked how to treat a particular medical problem. There were 82 separate therapies stated. This is costly, inefficient and

unsafe. Beta blockers are important therapies in 1st time heart attack victims in helping prevent a 2nd attack, yet 40% of 1st time victims don't receive them.

Less than one half of doctors are providing appropriate care for diabetics, yet it is clearly known that with adequate control of blood sugars, complication such as blindness, heart disease, kidney failure and amputation are greatly reduced. 25% of the Medicare dollar is spent on diabetics. Inadequate care and complications cost money.

5. We are a procedure-oriented society. There is no value attached for practicing preventive medicine and doctors are generally underpaid for outcome management. Yet preventive medicine is efficient and cost effective.

6. Patients with insurance are not prudent or wise health care spenders, they tend to overuse the system and they often demand unproven, non-science based therapies. They want discount medicine applied only to the caregiver side of the equation. An American philosophy of entitlement drives up the cost.

7. Patient non-compliance is a growing concern and a growing cost. One example: There has been a 33% increase in the number of people with diabetes in the US since 1990. This has paralleled the increase in obesity. People are less active and tend not

to exercise. They are becoming obese and developing diabetes; soon after they begin developing the many dreaded complications of diabetes.

8. Doctors tend to practice defensive medicine, fearing accusations of neglect and malpractice law suites. This increases costs.

What are the possible solutions to our building health care crisis?

a. There are advocates for a single pay government system, although with little broad-based public support. The insured are more or less satisfied, although they are mostly unaware of the inadequacies of the system, and they don't want to pay higher premiums. The uninsured population tends not to vote, but that will certainly change as they continue to grow in numbers and political strength.

Many often look at England and Canada as systems we might base ours upon. Both systems save by rationing. 50,000 people are waiting over a year for hospitalization in England. Per capita heath care taxes in England are about $1500 a year, and this same amount is spent each year by the UK's National Health System. In other words, care runs out when the budget is spent (although there is a large, parallel privately-insured health system in that country). In contrast, in the United States the annual bill for health care is $5000 per capita, of which approximately half – or $2,500 per person – is paid for by the federal and state governments, which is

more than the NHS spends per patient in Britain. If a single payer government health care system were adopted in the US, the cost would be approximately $2500 per capita or $800 Billion in total. Any US program of this type would emphasize primary care where most people's needs are met.

Although there are differences in the English and Canadian systems, both are based on rationed care. Long waiting lists for various procedures exist in Canada as well. There are more MRI machines in the State of Minnesota than in all of Canada.

The question raised is: Does the U.S. want rationed health care?

b. Contrasted with this method of health care ....is the so-called consumer-driven health care. Patients would have more responsibility in choosing services and would share more of the cost. It would be a competitive system with providers competing for consumers on the basis of quality of care, pricing and convenience. It would make available all the information to the patient needed to make informed choices. Proposals for paying for this system include high-deductible catastrophic health insurance policies that are combined with tax-deductible contributions from individuals and, if they are employed by a company, by their employers. These tax-deductible contributions would create a health savings account --or HSA -- that is owned by the individual. The account can be used to defray premium costs or used to cover any medical costs of the deductible. The HSA concept was actually created by the Medicare Modernization Act of 2003. In theory, Consumer Driven Health Care

would work by making cost-conscious consumers more prudent, and by forcing providers to become more attractive to these consumers, resulting in better quality care at more effective cost.

Previous efforts at creating a more competitive market place have certainly not resulted in lower costs or improved quality of care. One problem: high deductibles place chronically ill patients and low income families in a disadvantageous position.

There are real questions whether a consumer-driven health care market will save money or result in better health care.

c. A third option for a national health strategy is just gathering momentum. The central theme here is that improving health care and increasing efficiency will result in significant savings. Halverson and Isham, in their recent, excellent book identify several key prerequisites of a good national strategy:

1. **Improve quality of care and safety**. Again, this is the critical point everybody can agree upon. Care is now inconsistent and often unsafe. For example, there are up to 100,000 death a year related to hospital accidents.

There must be a measurable standard of best practice care. The internet is a key component and can be used to standardize care nationwide and to rapidly distribute agreed-upon standards. Every physician would have access to these standards of care. Guidelines, not rules, would be established for best care. Payers would reward doctors and hospitals for adhering to these standardized guidelines. Care improves when provider performance is publicly reported. Consumers must have access to this data. The

government could play an important role by funding the internet-based distribution of this public health standards and information system.

2. There will have to be some standardization of the coverage offered so the healthy don't elect the higher deductible, less expensive plans, and the chronically ill are left with the higher priced smaller deductible plan.

3. There should be renewed emphasis on preventive medicine.

4. Any reform plan must provide adequate support to the health care delivery system by funding training, medical research, and a re-supply of the health care workforce. This is a very important point. Demand for nurses is growing, yet enrollment in nursing schools is down 20%. By 2006 we will have a 170,000 nurse shortage nationwide. It has been clearly shown that too few nurses lead to increased hospital deaths.

The special interest groups are entrenched, and reforming the system will be difficult. It is an enormous undertaking, but it must be done.

In Conclusion.

The United States has a costly and inefficient health care system. Reform is badly needed, but will be difficult to achieve. It will take strong political leadership and strong grassroots support to overcome fierce opposition blocking such an effort.

1. Derickson, Alan: *Health for Three-thirds of the Nation*, American Journal of Public Health, Volume 92 (2), Feb 2002, 180-190

2. Halvorson, George and George Isham: *Epidemic of Care*, Josey Bass Publ. 2003

3. Hoffman, Beatrix: *Health Care Reform and Social Movements in the United States* American Journal of Public Health Volume 93 (1), Jan 2003, 75-85

4. *The Uninsured: A primer. Key facts about Americans without Health Insurance*: The Kaiser Commission on Medicaid and the Uninsured. Nov 2004

5. Relman, Arnold: *The Health of Nations*. This is part of an as yet unpublished book by Dr. Relman. March 2005

6. Lowenstein, Roger: *The quality cure?* New York Times Magazine, March 13, 2005

7. Epstein, Arnold m.et al: *Paying Physicians for High Quality Care*, New England Journal of Medicine, Volume 350.4. Jan 22, 2004, 406-410

8. Institute of Medicine. *To Err is Human: Building a Safer Health Care System.* Washington, DC, National Academy of Science, 1999