



14 Reasons Why Health Care Costs So Much



By Gerald N. Rogan, MD

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THE FEDERAL GOVERNMENT and California may initiate significant health care "system" changes during the next few years. "System" is in quotes because what we have is a crazy quilt of disjointed programs. Anderson¹ and others found that the U.S. spends about 150 percent of what care should cost, compared to the cost per person in countries that offer similar quality.

In 2007, we spent 16 percent of our gross domestic product (GDP) on health care, up from 14.6 percent in 2002, while the French spent 9.7 percent of their GDP. About a sixth of our population has no illness/injury insurance. *Frontline* of PBS recently featured elements of the health care systems of the United Kingdom, Canada, France, Switzerland, Germany, Japan, and Taiwan.² Each has a health care system that delivers health care for everyone - but with remarkable differences.

AARP Magazine in July/August lists several reasons why health care costs so much. I review each item, make comments, and rank with 1 to 5 dollar signs the potential achievable savings were health care reform to lower these costs.

1. Malpractice insurance premiums: 1975 tort reform in California lowered premiums to 37th highest of the 50 states. Tort reform in all states would lower doctor costs by 25-30 percent³ and overall costs by 0.5 percent. **RANK: \$**

2. Defensive medicine costs: "Defensive medicine" is a pre-emptive effort to lower the risk of a law suit and a potential plaintiff judgment for negligence by ordering diagnostic tests not medically necessary based on scientific evidence. Some docs claim it is the community standard to test, to defend against a potential law suit. For others, the "need to defend" is a thinly-veiled excuse to obscure the conflict of interest inherent with test self-referral. An adequate history, exam, and documentation are the best defenses against a malpractice law suit. The cost of defensive medicine includes the cost of unnecessary tests and treatments, plus insurance payout for legal defense and malpractice awards included in #1. **RANK: \$\$**

3. High Collection Costs: The cost to bill insurance is about 8 percent of collections for a primary care physician, because the average bill is small. One specialist reports his cost is 2-14 percent of collections, depending on the insurance plan.

These costs are much too high. In France, a primary care physician bills much like a car rental - with the patient's health insurance card via a hand-held transmitter. Insurers do not require diagnosis codes to determine medical necessity of an evaluation and management (E&M) service. For auditing E&M services, insurers use volume and level of service, not diagnosis. In France, the patient pays the primary care doctor and insurance reimburses the patient. Direct patient payment would constrain insurance payment delays and improper reductions of individual claims. **RANK: \$\$**

4. Unnecessary Services: Patients receive too many unnecessary tests and treatments. Brownlee (AARP)⁴ blames the patient, whereas I blame everyone - advertising, the "glamour" of tests and treatments⁵, patient expectations, doctor willingness to test instead of treat based on history and exam, and excessive reimbursement for imaging and certain treatments.

The best example of too many tests is an ankle x-ray for a suspected sprain. Percussion against the sole of the foot will exclude a significant fracture. Follow-up after three days of splinting will confirm the absence of a fracture. Another example is an MRI for low back pain of short duration without certain "red flags," which will not differentiate disease from health. Cardiac computed tomographic angiography (CTA) is more frequently performed in recent years with many tests self-referred. Yet clinical utility is uncertain, especially for asymptomatic patients. Medicare recently proposed CTA coverage only for selected symptoms and requires additional evidence to prove clinical utility.⁶

A Sacramento hospital system recently advertised virtual colonoscopy via direct mail, yet the California Technology Assessment Foundation (CTAF) did not find evidence the test improves health outcomes in persons of average risk.⁷ Most Medicare Part B restrictive local coverage decisions (LCDs)⁸ were created to control excess test and treatments ordered or provided by those physicians who do not follow medical science. Self-referred tests, particularly imaging studies, have increased twice as fast as all other physician services between 1999 and 2003.⁹

We spend a disproportionate amount on cancer care. Patients have unrealistic expectations, are willing to take large risks, and often want chemotherapy with small benefits. Doctors do not tell hospitalized patients they are dying 39 percent of the time, and some 20 percent to 40 percent of patients receive chemotherapy within 14 days of their death. **RANK: \$\$\$\$** (AARP estimates \$500 billion wasted.)

To the AARP list of costs, I add 10 more:

5. Fragmented acute primary care: About 80 percent of the patients seen in an emergency department could be seen in a physician's office if it were open every day, including evenings until 9 p.m. Emergency departments are too expensive to diagnose and treat problems that are not potentially life-threatening. Primary care physicians are underpaid and, therefore, unavailable during evenings and weekends. Emergency departments are overcrowded largely because primary care is not available when needed for urgent, non-emergent problems.¹⁰ **RANK: \$**

6. Fragmented long-term management of complex cases: Too many patients have no "medical home." Primary care physicians who provide "medical home" services coordinate the care, direct consultations to specialists, monitor inter-specialist referrals, are on-call, and oversee hospital inpatient activities.¹¹ Concierge docs provide this service for a fee. Disease management companies are, in part, a reflection of the need for primary care physicians to increase efforts to manage chronic disease. For example, primary care physicians do not always follow end-stage disease patients after referral to a specialist. Now that family medicine is the least popular specialty with residents, some insurers are paying monthly fees for medical home services that may save unnecessary costs or improve quality. MedPAC is studying monthly supplemental reimbursement for medical home services for Medicare. **RANK: \$\$**

7. For-profit illness/injury insurance companies: Blue Cross and Blue Shield of California began as non-profit. For-profit health insurers must pay dividends and high executive salaries, which reduce physician fees. Non-profit insurance is a less costly product for comparable physician reimbursement. I propose every person should have the opportunity to buy a non-profit insurance product, either an individual plan or a group plan. **RANK: \$\$**

8. Medicaid payment too low: Main-streaming Medicaid patients is an unfulfilled myth. A primary care physician cannot cover practice expenses with Medicaid reimbursement. The solution is to deliver primary care through government-sponsored public clinics, not private offices. **RANK: \$**

9. Medicare has rewarded low quality: Medicare has been "paying for performance" for many

years. The worse the performance, the more Medicare has paid - for complications and additional tests when care is suboptimal. Now the Centers for Medicare & Medicaid Services (CMS) is trying to pay more for better care. Doctors should help find ways to measure and reward quality, by helping and not fighting CMS. **RANK: \$**

10. Preventive care: Immunizations, infant care, and pre-natal care provide long-term high value outcomes and can be provided as a public service through health department sponsorship where needed. For adults, most primary preventive care is through personal lifestyle choices. Preventive care through physician service interventions is mostly secondary and tertiary: early detection of cancer and prevention of disease complications. Insurance coverage for secondary prevention for adults is less important than assuring affordable coverage to finance treatment of illnesses and injuries. Tertiary prevention is disease management which returns us to the "medical home." **RANK: \$\$**

11. Hospital advertising: The need for and propriety of hospital advertising troubles me. Instead of glossy directly mailed magazines, billboard ads and other promotional costs, hospitals should post on the Internet their DRG prices and their discount from retail programs for the uninsured. **RANK: \$**

12. Pharmaceutical costs: We appear to pay double the cost of drugs in Europe, based on my anecdotal purchases in France. The time has come for group purchasing for all insurers, including Medicare. Drug company field representatives do not exist in Europe. **RANK: \$\$**

13. The cost of labor: David Gibson previously published an analysis of the cost drivers in health care.¹² Do physicians charge too much for some services? Compare the average annual income of a radiologist to a primary care physician, and physicians as a group to other professionals for the same stress and hours of work. **RANK: \$**

14. Social cost drivers: Many social issues negatively impact health care costs and health status, including community design (too scattered), cost of gas (too low), public transportation (too little), non-carbon based energy (too little), consumerism (overvalued), news and TV shows about violence (overemphasized), eating too much, exercising too little during day-to-day life, and U.S. culture (too violent, egocentric, and fearful¹³). These are not problems physicians can solve in their role as personal healers. **RANK: \$\$**

In the next several years, we may collectively guarantee, through our government, that an individual who can document no break in insurance can purchase an individual high deductible illness/injury PPO-type insurance product at a reasonable price.

We will not have "Medicare for everyone," *i.e.*, a single payer program. Reforms can focus on a return of not-for-profit "mutual" insurance, guaranteed insurance continuation, and insurance portability.

Government should assure access to reasonably priced, continuous insurance coverage for illnesses and accidents. Reform must re-establish the central role of the primary care physician. Price transparency will support consumer driven health care.

I hope this article prompts you to write our leaders to help guide them as they attempt to improve our health status through changes in system organization, financing, and delivery.

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1. <http://content.healthaffairs.org/cgi/content/abstract/24/4/903>
2. www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/countries/
3. AARP cites the Congressional Budget Office
4. Shannon Brownlee; Why does Health Care Cost So Much?; www.aarpmagazine.org, July, August 2008.
5. www.sacmag.com/media/Sacramento-Magazine/December-2007/Top-Doctors/
6. www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?from2=viewdraftdecisionmemo.asp&id=206&
8. www.ctaf.org/content/general/detail/535
9. [www.cms.hhs.gov/mcd/results_index.asp?from2=results_index.asp&contractor=28&from=Imrpcontractor&retired=&name=National%20Heritage%20Insurance%20Company%20\(31140,%20Carrier\)&letter_range=4&](http://www.cms.hhs.gov/mcd/results_index.asp?from2=results_index.asp&contractor=28&from=Imrpcontractor&retired=&name=National%20Heritage%20Insurance%20Company%20(31140,%20Carrier)&letter_range=4&)

9. www.medpac.gov/publications/congressional_testimony/031705_TestimonyImaging-Hou.pdf
10. www.calphys.org/assets/applets/er_report_web.pdf
11. www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf
12. www.ssvms.org/articles/0501gibson.asp
13. Bowling for Columbine

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