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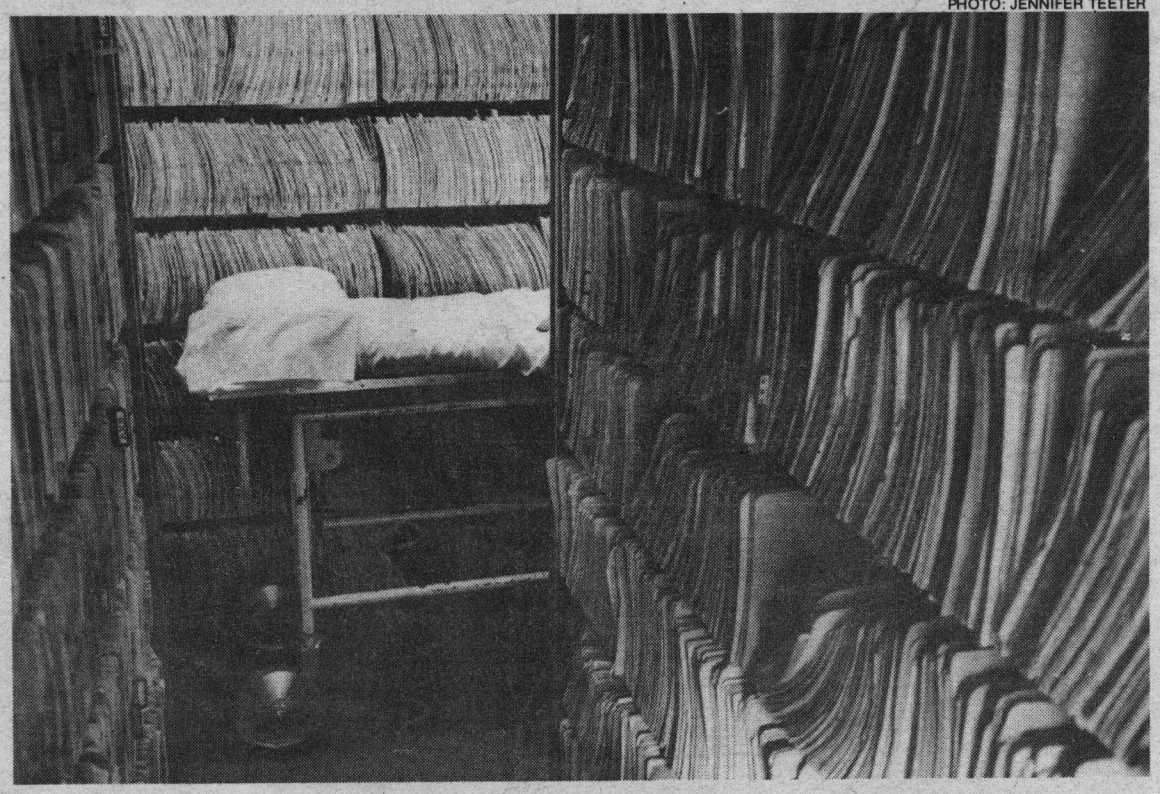


Why Health Care Costs Are Killing Us

Mary Barnett

A heart patient spent 45 days in Community Hospital of Santa Cruz and left with a bill for $60,000. "I don't think he was insured," says Richard Swanson, hospital public relations director. "But he came from a wealthy family."

Others are not so lucky. Medical care costs are the leading cause of bankruptcies in the United States.

"More than once we've had people leaving the hospital with $80,000 to $90,000 charges," Swanson adds. "A guy could be in a motorcycle accident, go into an intensive care unit, have surgery several times, spend 45 days in rehabilitation — it mounts up."

When Chris was born at Dominican Hospital last May, it cost his parents $2098 — $1000 for the doctor and $1098 for the hospital. That's just about 11 times what Chris' father's birth cost HIS parents — $100 for the doctor, $100 for the hospital and $10 for the usual circumcision. True, Chris's father makes more than Chris's grandfather did — but not 11 times as much.

At the other end of life, the picture is far bleaker. Medical bills for the aged can exceed $100,000, reports Bonnie Burns. The Scotts Valley woman has a contract with Senior Information and Referral to help seniors through the financial labyrinths of Medicare and private insurance.

And if you think Medicare picks up the tab, Burns has news for you. For covered services — everything Medicare will pay for — seniors get back only 56 cents of every dollar they spend on health care. For all medical services, the reimbursement drops to 36 cents.

Ironically, the younger, employed population is more fortunate. Burns says health insurance usually pays 80% of costs. About 90% of the population is either covered by private insurance or is eligible for public health insurance programs. But health insurance is no panacea for the epidemic of increasing medical costs. Premiums keep mounting, as do taxes for paying Medicare and Medi-Cal bills.

All told, health care costs Americans over a quarter of a trillion dollars a year — more than the entire federal budget in 1973. General Motors spends more for the medical expenses of its employees than it does for the steel in its cars.

Now almost 10% of the gross national product, health care costs have been rising much faster than the general inflation rate. Between 1959 and 1979, the consumer price index rose 202%, but doctor's fees climbed 341% and the charge for a semi-private hospital room rose 1122%. And the cost trend is definitely up.

Health care costs nationally rose 15.1% in 1981, to $281 billion, reports the Department of Health and Human Services (DHHS). Per capita health spending reached $1225. HHS Secretary Richard Schwieker calls it "disturbing."

Let's narrow our focus to California. Total health care expenditures in this state in 1978 were estimated by the Office of Statewide Health Planning and Development at $20.5 billion. Per capita health costs were well above the national average — $1025 as compared to a nationwide $863 in 1978.

Costs are till going up. The California Health Facilities Commission (CFHC), established by the State Legislature to keep track of such things, has just come out with a report on health care costs for the second quarter of 1982. It says Californians can now expect to pay an average of $649 per day for an average stay of 6.9 days in a California hospital, or a total average bill of $4459. This represents a 23.2% increase in the average patient bill over the second quarter of 1981.

But CHFC executive director Joseph Hafkenschiel sees light at the end of the tunnel. Probably as a result of the current recession, prices hospitals pay to providers of goods and services have begun to stabilize after peaking in the first quarter of 1982. The rate of increase in hospital input prices dropped from 10.8% in the first quarter of 1982 to 9.9% in the second quarter.

"Other things being equal," says Hafkenschiel, "this should tend to reduce hospital charges."

Alas, other things are not equal. Medicare and Medicaid (the program for low-income persons under 65 known as Medi-Cal in California) pay about half of hospital costs. They have begun a drastic tightening of payment policies, refusing to pay for "unreasonable costs." So hospitals are raising charges to private patients to get back the charges Medicare and Medi-Cal don't pay. The charge shift is about $100-per-day in a typical California hospital on each patient bill. It amounts to more than $500 million a year.

This so-called "cost shift" is a myth, charges David Wright, director of the Mid-Coast Health Services Agency (MCHSA), a health planning body serving Santa Cruz, Monterey, San Benito and San Luis Obispo Counties.

"The 'cost shift' that other patients are soaked for the poor patients doesn't represent cost at all—it's profit," Wright declares. "Some hospitals are lumping in costs like entertainment and luxuries."

One reason the CHFC keeps track of all this is to find out if a voluntary effort by the California Hospital Association, the United Hospital Association and the California Medical Association is working. Conclusion: it isn't.

In Santa Cruz County's three acute care hospitals, average costs and average patient bills varied widely—especially the latter.

Here's the picture at the three hospitals.

- Average charge to the patient per day: Community, $831, up 40.8% from the first quarter of 1981; Dominican, $441, up 11.9%; Watsonville, $482, up 17.8%.
- Average costs to the hospital per patient day: Community, $606, up 46.7% from the first quarter of Dominican, $568, up 20.3%; Watsonville, $608, up 22.6%.
- Average length of stay: Community, 4.1 days; Dominican, 5.3; Watsonville, 5.02.
- Average costs to the hospital per patient stay: Community, $2,473; Dominican, $2,353; Watsonville, $2,419.64.
- Average charge to the patient per stay: Community, $3,387; Dominican, $3,031; Watsonville, $3,052.16.
- Total discharges from the hospital per second quarter: Community, 1,151, down 22.1% from the second quarter of 1981; Dominican, 2,093, up 2.5%; Watsonville, 705, down 50.2%.
- Average bill to the patient at Community Hospital exceeds average costs by $225. At Dominican, the excess of charges over costs is $127 per day, and at Watsonville, $126.

The explanation is not difficult. Community Hospital of Santa Cruz is a proprietary, for-profit hospital operated by American Medical International, Inc., with headquarters in Beverly Hills. The other two are non-profit hospitals governed by local boards of directors.

Community's Swanson explains that unlike the competition—which in Santa Cruz is Dominican Hospital—Community has to pay taxes.

"This hospital contributes over $2 million a year in taxes—$100,000 in property taxes alone," Swanson says. "We pay sales tax. We're a productive part of the community. Dominican is a tax-supported institution. It pays no taxes and receives public services—fire protection, roads, sewers. Yet we operate at pretty much the same costs as they do."

The patient charges, however, are considerably different per day. But Swanson noted that the average length of stay at Community is shorter than at Dominican, which helps bring down the bill.

Hospital Director John Adams pointed out that Community Hospital's outpatient volume is going up. "It's a trend we're seeing everywhere," he says. "It's cheaper, there's no room and board, and not as much overhead. We stress heavily the whole aspect of outpatient care."

More outpatient care is recommended by most health care costs experts as a way of holding costs down.

Swanson says statistics showing hospital stays cost less at Dominican are misleading.

"A lot of our patients require more acute care," he says. "We have a primary nursing care system, which means almost all care is delivered by registered nurses. Dominican has a team system, including RNs, licensed vocational nurses and others. When you come to Community Hospital you will have one nurse taking care of you throughout your hospital stay. It's better care, but it tends to increase costs."

This explanation, of course, fails to explain why the difference between patient bills and patient costs is higher at Community than at the other two hospitals.

Dominican's Frank McGovern, not surprisingly, sees the whole thing in a different light. The mere idea that Community might offer better care outrages him.

"Why do the doctors prefer us?" he demands. "Why do the patients prefer us? Look at our occupancy rates and theirs."

He also came up with quite different figures on the Community tax issue.

"Community Hospital had a net profit for 1979 of a little over $1 million," he asserts. "They paid $500,000 in taxes and got a $600,000 reimbursement from Medi-Cal for depreciation of equity, an allowable expense. They came out ahead on the deal."

McGovern says Dominican's income over operating expenses all goes back into the hospital. "We don't give any money to the Dominican Order or the Catholic Church, or vice versa," he says. "We're run by a board of local people. Community is run by a board in Beverly Hills."

Hospital care, although the largest single item in the national health care budget, represents only 40% of the total. Physicians' services account

for 18%. However, although doctor's fees have gone up faster than the cost of living, they've been declining as a share of the total health budget. The hospital share went up from 18% to 40% from 1929 to 1978. The physicians' share of the national total dropped from 28% to 18%.

The law doesn't require hospitals to report the amount of the total budget spent for physicians' services, but CHFC tries to get them to provide this information. In Santa Cruz County, for the first quarter of 1982, Dominican reported $371,069 as the "physician professional component expenses," Watsonville reported $209,684 and Community did not report its figure.

Explanations for the big rise in health care costs vary with the source.

Frank McGovern admits the average cost per patient day at Dominican Hospital has doubled in five years. But he has a little comparison he likes to make to put these figures into perspective.

"The cost of a gallon of gas and of a patient day at Dominican Hospital have both doubled since 1977," he points out. "A gallon of gas that cost 70 cents in 1977 now costs $1.40. But a gallon of gas is the same as it was five years ago, whereas the services you buy for your hospital charge are entirely different.

"We can save lives we couldn't save five years ago. We save more cancer patients. We have a laser coagulator and can control serious internal bleeding we couldn't control five years ago. We can cauterize a bleeding artery without surgery. So the overall bill is lower.

"We have a greater intensity of service. It requires expensive technology and more highly-educated people. The average annual salary here now is $18,000-$20,000."

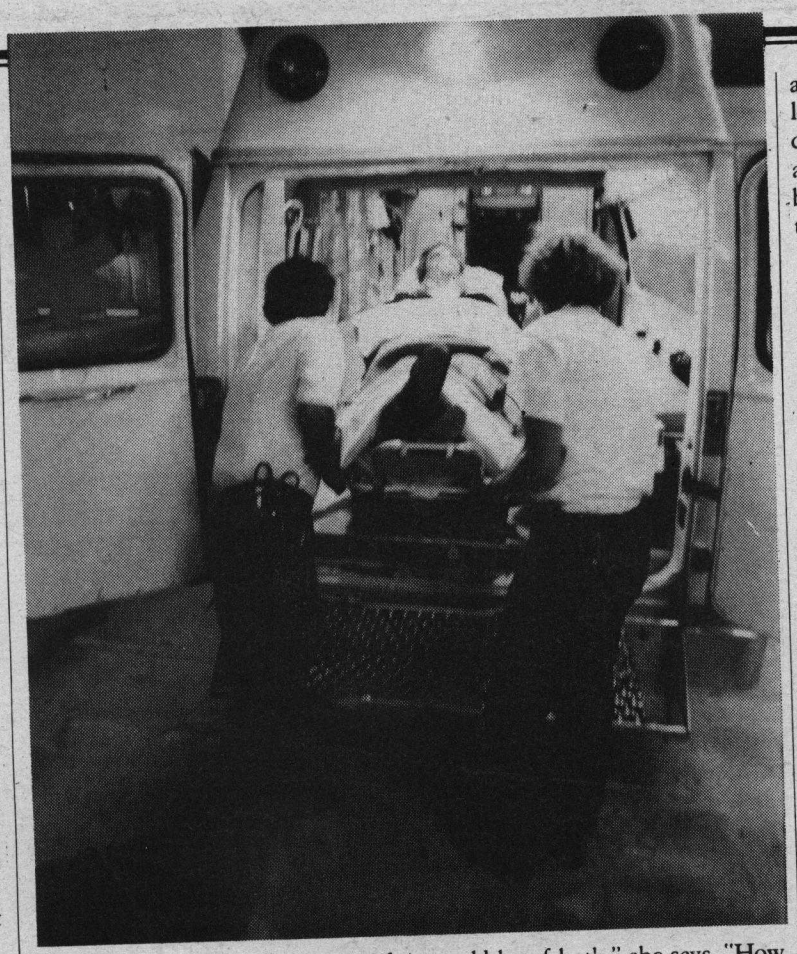
McGovern says the average length of stay at Dominican in the past four years has dropped from 10 to six days. Lowering the length of say, he notes, usually increases costs per day but can cut total costs.

Doctors are sometimes accused of ordering unnecessary tests and performing unnecessary operations. Echoing a familiar argument, McGovern attributes such tendencies to fear of malpractice suits.

"The doctor is covering his tail," he says. "No doubt some doctors run every test they can to make money reading them. But I see doctors do free operations."

McGovern blames government regulations for much of the medical care cost. As an example, he cites the Certificate of Need (CON) procedure a hospital has to go through to get permission to expand. He says Dominican had to work for two years to get permission for its current 115-bed expansion.

"It cost us $325,000 in out-of-pocket expenses to put together an application," he says. "It's 500



pages long—a whole ream of paper. We had to do a $20,000 survey of consumers and doctors. We had to do forecasts and a demography of the hospital. Just to send it to the state cost thousands. It cost us $70,000 for a state architect to look over plans for our psychiatric unit alone. The whole CON process cost close to half a million."

New federal legislation eases up on the CON process. "It hasn't been eliminated, but the trend is there," David Wright of MCHSA says. "The industry is probably winning on this one."

The purpose of CON is to save money. The idea behind the state and federal legislation establishing certificate of need procedures is that hospitals, and health care facilities generally, are different from grocery stores. Too many grocery stores in an area will lead to increased competition, and maybe some of the stores will close.

It doesn't work that way with hospitals. The usual competitive forces of supply and demand do not apply. Hospitals get paid on a cost basis, providing incentives to expand. But the consumer must pay for all hospital beds and services—even if they are used only part of the time. Hence the effort to limit expansion to that really needed. On the whole, however, the CON review procedure has failed to hold medical care costs down.

A different view of health cost increases is offered by Linda Bergthold, a Santa Cruz woman who is a consumer board member of the American Health Planning Association (HPA). Looking for something to do that would be "fun and challenging," Bergthold applied for an opening as a consumer member on the mid-coast HSA board, and was appointed.

"I didn't realize how much it would be of both," she says. "How much fun—and how challenging."

She rose to a leadership role. Recently retired as Mid-Coast HSA board member, she still sits on the statewide HSA board. She is so fascinated by the field she is currently studying for her Ph.D. in health policy at UCSC.

"I see every component of the health care system blaming every other part of the system," Bergthold says. "Hospitals blame doctors for ordering too much care, and consumers for demanding too much. Doctors blame hospitals and patients. Patients blame government, doctors and hospitals. Each is responsible for part of the problem."

Bergthold notes, as most observers of health care costs do, that consumers have little incentive to keep down their health care costs because most hospital costs are paid by private insurance or by the government.

"But if consumers suddenly became cost conscious and shopped around for medical care, it wouldn't cut costs more than 5%," she adds. "As long as doctors can order any tests they want, choose their hospitals and get fully reimbursed for costs—no matter how high—what's to keep costs from going up? Hospitals can get 'reasonable costs' back. So they can build huge new buildings, order any equipment they want, and get reimbursed."

But Bergthold says even if every element of the heath care system suddenly became cost-conscious, there would still not be enough money to pay health care costs, and there would be a problem in rationing health care.

However, she sees a lot of unnecessary expenses. "We don't need as much in-patient surgery," she says. "Much of it could be done on an out-patient basis. Often it's not necessary to keep people in the hospital overnight. I think people are kept in an average of a day too long. We could cut a lot of costs by cutting stays. But when hospitals are not full—and most are over-bedded—there is almost no incentive to cut stays.

"We have a crazy system that rewards people for seeking the highest level of care. There's no reimbursement for going to chiropractors or herbal doctors. And why should people seek out-patient care when they can go to a hospital emergency room and get reimbursed by insurance?"

Insurance plans commonly pay for hospital costs but not out-patient visits.

Bergthold sees "perverse incentives" built into the whole system, particularly in the mental health field. Insurance usually covers hospitalization in psychiatric wards, but not visits to psychologists. More and more plans are cutting out-patient visits.

"In general, the system rewards patients for getting into the hospital," Bergthold sums up.

A health activist who comes down even harder on the current health care system—or non-system—is Kayla Starr. Holder of a master's degree in public health from UCLA (1975), Starr has worked with the Medical Committee for Human Rights, chaired the Santa Cruz County Mental Health Advisory Committee, served in the Santa Cruz Health Action Alliance, helped form the Mariposa House shelter for battered women, and worked with Westside Neighbors, a health activist group that has managed to get a clinic project underway in west Santa Cruz.

"The United States is the only developed country in the world that rations medical care by ability to pay rather than by need," Starr declares. "Australia, New Zealand, Japan, the European countries and Canada all have national health plans—some through the private sector and some, like England, with salaried providers."

Medicare and Medicaid reforms of 1965, Starr points out, were designed to equalize access to medical care. They were supposed to end the two-tier system of care and mainstream the poor into a single system. Federal and state governments through Medicare and Medicaid (Medi-Cal in California) agreed to pay health care costs for the aged and poor. But these reforms, Starr notes, caused a huge inflationary spiral in health care costs.

"We opened Pandora's box," she says. "The state and federal governments can't keep up with spiraling costs. Doctors charge 'usual and customary' fees, and hospitals bill for all costs they incur. There were no limits. For the past five to eight years, we've been trying to put the lid on."

What do Americans get for their costly health care system? Its spokespersons and many laypersons assume health care in the United States is the best in the world. Critics like Starr do not agree.

"We are paying a higher percentage of our resources for health care than any nation in the world," she says. "Yet we are getting less for our money than many other nations.

"We are 14th in the world in infant mortality—behind many advanced nations. We are only 17th in male life expectancy.

"Doctors can pick where they practice, and many shun rural areas and the poor. So there are huge gaps in our service."

Spokespersons for the health care industry like to talk about the bright new technology that hospitals and doctors offer today. Newspaper features and magazine articles tell of the miracles of laser surgery, fiber optics, body scanners, organ transplants. Most people think of medical progress in such terms.

Yet such advances benefit only a relatively few persons. Despite the advances in surgery and treatment of cancer, for example, the death rate from cancer is increasing, while that from heart disease is declining. Why? Experts believe the causes lie in the areas of lifestyle and environment. They say the role of the entire costly health care industry in the nation's health status is exaggerated.

Health status of a person, or a population, is determined by four influences: heredity, environment, behavior and health services. Of the four, the health services factor is by far the least important. A report by the U.S. Surgeon General says lifestyle or behavior accounts for 50% of the influences on health, environ- for 25%, heredity for 20% and health services for only 5%.

Recognizing these facts, the 1980 California State Health Plan puts a high priority on health education as the best and cheapest investment in better health. Unfortunately, funds for health education are in short supply and the supply is getting shorter.

There are even those who question whether medical care is good for people. Perhaps the most outspoken critic of modern medicine is Ivan Illitch, author of *Medical Nemesis*, who sets the tone for a bitter attack in the first sentence in the book: "The medical establishment has become a major threat to health."

Even less extreme critics doubt modern medical technology is an unmixed blessing. The federal Office of Technology Assessment says "only 10 to 20% of all procedures used in present medical practice have been proven by clinical trial."

The question of whether medical care is good for you was posed dramatically by the curious side effect of a doctors' strike in Los Angeles a few years ago. Fewer people died during the strike. When the doctors went back to

work, the death rate went back up to normal.

But most of us would agree that there are times when doctors and hospitals are necessary. They just cost too much. How can we hold costs down?

Kayla Starr thinks we need more prepaid health care plans to introduce an element of accountability into the health care system. Under such plans, consumers pay in advance for their medical care, rather than paying on a "fee-for-service" basis.

"Under fee-for-service, the incentive is to do more treatments," Starr points out. "With prepaid plans, the fewer treatments the better. More money is left for prevention and bonuses. The incentive is for doctors to prevent illness. In traditional fee-for-service practice, the incentives are the other way."

Starr emphasizes that her comments about doctors don't apply to all of them. "Some are socially conscious, care about the poor and minorities, and want to keep costs down."

One type of pre-paid health plan is the Health Maintenance Organization (HMO). Patients pay for their care in advance. Doctors are on salary and thus have no incentive to provide unnecessary services.

Changing Times (June, 1980) reported health care bills for HMO members are 10 to 40% smaller than those of other medical care consumers, and HMO members tend to go to the hospital one-third as often as patients under traditional care and lose less time from work.

The largest HMO of this type is California's Kaiser-Permanente Plan, with eight million members. By 1988, the federal Department of Health and Human Services foresees that there will be 442 HMOs serving over 19 million Americans at a saving of $20 billion a year in hospital costs alone.

A second type of prepaid plan is the Individual Practice Association (IPA). Doctors receive fee-for-service, usually 80% of the standard fee. However, says *Scientific American*, there is no evidence that costs are lower with this type of prepaid plan.

Published evidence indicates HMOs offer care as good as, and possibly better than, that of traditional medical practice.

However, some patients don't like HMOs. Bonnie Burns says the elderly patients with whom she deals perceive Kaiser care as inferior. It takes them longer to get in to see a doctor. Fewer prescriptions are written. There's less surgery and less treatment. All this may be good, but patients usually don't see it that way.

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Starr thinks a better model for prepaid plans is the membership group run by the patients. One such is the Mid-Peninsula Health Center in Palo Alto. There's another like it in the Puget Sound area.

"It's too bad there are no prepaid health plans here in Santa Cruz County," Starr says. "Medical care is the only cottage industry we've got left."

But the scene may changing. The California legislature at its last session adopted a Medi-Cal reform package. It may revolutionize medical care not only in California but throughout the nation.

Faced with mounting health care costs and shrinking revenues, the state legislature adopted sharp cutbacks in Medi-Cal costs and tightened up on eligibility. But what may be far more significant is that it put an end to the fee-for-service system. The state will enter into contracts with hospitals to make services available to the poor at pre-established rates.

William Guy, a former Blue Cross administrator, has been named the state's first contract negotiator or "Medi-Cal Czar." He's started negotiating with hospitals in the large population areas of Southern California. Next July, negotiating powers will pass to a seven-member commission, of which Guy will be executive secretary.

"Don't expect to see negotiated contracts in the Monterey Bay area in the next year," says Ellie Hall, Santa Cruz County Health Services director.

How will the program work?

"There are a lot of scenarios," Hall says. "There could be one Medi-Cal hospital in Santa Cruz County. Or the state could negotiate one contract, and say that all other hospitals would have to meet its terms to enroll Medi-Cal patients."

Guy says he doesn't want to create "Medi-Cal hospitals," so he'll probably try to sign up as many hospitals as possible. Whether all hospitals will want to be signed up is another question.

Dominican will probably sign. McGovern says, "Dominican's philosophy won't let us drop Medi-Cal patients. We're a Catholic hospital, and philosophically we should serve them. Our purpose is to take care of people."

Swanson is less sure that Community will want to negotiate with the state to serve Medi-Cal patients. "We're better off with an empty bed than with a Medi-Cal patient," he says. "Medi-Cal pays 85% of the costs. We lose 15% on the deal. No profit hospital can make it that way. After all, we pay $100,000 a year in city taxes alone."

In addition to putting cost lids on Medi-Cal, the legislature did something still more sweeping. It adopted a plan proposed by health insurance firms extending health provider contract services to the private sector. Blue Cross, for example, can now negotiate contract rates with hospitals and doctors. Patients will be allowed to get services only from providers under contract. It could mean that most Californians will be served in time by health maintenance organizations.

Many observers think the changes will be carried to the national level. It could mean the end of most fee-for-service medicine and with it, the madly-spiraling increases in costs of medical help. □