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"Spending More, Getting Less"

Why does our country spend so much more on health care than other "developed" nations, yet we have worse health across age spectrums and lower life expectancies? Worse health can be economically described in terms of such statistics as years of life lost (YYL) to early mortality and years lived with disability (YLD). In most of the major illness categories, we unbelievably rank less than average; and these rankings include varied enough illnesses that one cannot attribute the "bad" data to racial or socio-economic factors.

It is estimated we spend $8000 per capita per year on health care; and this expenditure consumes a whopping 15-20% of our gross domestic product. Other nations of comparable wealth spend less than half of this amount per capita.

Often cited are demographic and cultural factors. Income disparity in the US undoubtedly leads to those of higher means demanding more health care than is likely needed; and the poor, having less access to doctors, relying on emergency rooms for care when their disease process is more advanced (i.e., demanding less but more expensive health care). Poor dietary habits, obesity, stress, sedentary lifestyle, interpersonal violence, increased incidents of fatal car and other accidents are among the undeniable contributory factors.

Americans also want more expensive diagnostic procedures and therapeutics, even when, on the two extremes, it is apparent without these tests that either there is no threatening illness--or the course of the illness has little chance of being altered by such interventions. Doctors capitulate, sometimes under pressure from patients and their families (including a desire to "please"); under the

dagger of 2nd guessing and potential malpractice litigation; and at least until recently, with the feeling (concurrent with that of the patient) that "someone else is paying for it, so it's nothing on me".

Excess cost is more troubling when one fails to see a significant advantage in outcome. An example dear to me is that of robot-assisted (RARP) versus open radical prostatectomy (ORP) to treat localized prostate cancer. Not even counting the start-up and maintenance costs of a $1.75 million surgical robot (amortized among all patients needing its use), RARP hospital costs are close to $3000 more than ORP—attributable to use of expensive/only partially reusable instruments and longer operating room times, not offset by the [on-average 1 day] shorter hospital stay. Given that currently 85% of all the 90,000 prostate removals yearly in the US are done robotically, the cost differential is a budget stretcher, if not buster. Studies fail to show better cancer cure rates with RARP over ORP. Functional issues such a sexual function and bladder control fare about the same with both procedures. Even claims of lower blood loss and lesser pain with robotics is likely exaggerated; a few investigators, for example, have been able to demonstrate only a slightly lower narcotic pain medication usage in the RARP group over those having ORP—and that only for the 1st postoperative day. Evidence suggests that it is the surgeon and not the technique of radical prostatectomy that most determines the outcome. Should we continue to give patients what they want over what they need, when they are not in a position to make such judgments?

The RARP saga relates to a media fed society highly aware of trends in medicine-and readily accepting claims of superiority for any newer treatment, especially if the engineering seems futuristic. It may also be true that when a technology such as RARP is advertised as minimally invasive and having a lower chance of causing harm, it may

draw a larger audience into considering the operation. This may include older men, sometimes over 80, with localized prostate cancer--who in general will live just as long and have a higher quality of life without ANY treatment for prostate cancer.

Another example in urology is the mass marketing of proton beam therapy, with haughty and inaccurate claims that is it superior to the less than 50% as expensive IMRT (a form of external beam radiation). Medicare and insurers are finally catching on and denying the excess payments for a technology that sounds better than it really is.

When we look at the $8000 per capita health care cost in the US, we have to remember that an inordinate percentage of this veers toward paying for the most critically ill patients, often old and (some studies show) in their last 6-12 months of life. In this arena, advanced directives/health care powers of attorney, as well as frank yet compassionate discussion of "goals" between doctor and next-of-kin, could cut into this exorbitant cost without, some would say, the government or insurance company making decisions to "kill granny". As reality has it, were insurance companies to become non-profit, there would be a lot more capital to pay for health care for all ages and strata of illnesses—but even then, budgetary constraints would still dictate spending our health monies on the front as oppose to the back end of life. The state of Oregon, for 20 years, has attempted to prioritize its health budget for treating Medicaid recipients. Committees of laypersons and health providers, working with actuaries and economic analysts, enumerate health conditions, e.g., from numbers one through 700 or 800 based on the value of the treatment for yielding more years of productive life. A line is drawn beneath a number, let's say 585, in any given year, based on the state's health budget—below this line, there is no compensation to the provider for treatment. Although Oregon should be commended

for having the boldness to “tell the people what they need to know as opposed to what they want to hear”, the program has had a lot of problems, including but not limited to: budgetary shortfalls (too low income tax revenues and need to raise cigarette taxes to offset this); decreasing participation by the uninsured in the program once premiums--albeit small--as well as co-pays were mandated; and frequent “renumbering” of the illnesses, some say under the weight of political correctness or heavy lobbying—for example, over one ten year period, treatment of HIV/AIDS as well as that of drug and alcohol addiction, rapidly ascended to the “top ten”.

Oh, one other comment about high costs and poor results. Could it be that another reason for this disparity is “too much health care” in the US? Is too much medical care in itself detrimental to individual and public health? The Institute of Medicine in a study from the 1990’s came to the conclusion that medical mistakes, if counted as “illnesses”, would be 6th in the top ten causes of death. IOM was focusing a lot on breaches of safety such as wrong drug, wrong dose, wrong surgery, wrong side of surgery, etc. One can add to this serious side effects from procedures/surgeries and drugs--and more so if these were really not necessary. Patients (more so elderly) on too many prescription drugs; unnecessary and repeated/prolonged courses of antibiotics (often without proof of bacterial infection); and those being persuaded to have surgery without a balanced informed consent are at risk. “Have your groin hernia fixed [even though it is causing no symptoms] since failure to do so can result in a sudden deterioration/ surgical emergency”. Left out is the fact that such an emergency acute hernia incarceration or strangulation is a low probability event.

I also see the fragmentation of medicine, with patients changing providers sometimes yearly or more often--and having too many

doctors as problematic and costly. Repetition of tests and poor overall consensus communication among past and present providers and the “team” of current doctors waste money. In the future, electronic health records that are more unified or which can communicate with one another will somewhat dampen this issue.

Either we as a society are too sick; or perceive ourselves as sick; or the very worry about potential illness is making us sick. Suffice it is to say that until our collective behaviors are changed toward positivity, productivity, and personal responsibility for our health and healthcare; and away from fear, malingering, and entitlement, health care costs without [perhaps irrational] rationing will continue to spin out of control and worsen this nations’ economic downturn.

Dr. Alan Freedman
401 Old Newport Blvd., Suite 101
Newport Beach, CA 92663
Phone: (949) 645-3434
FAX: (949) 645-0277