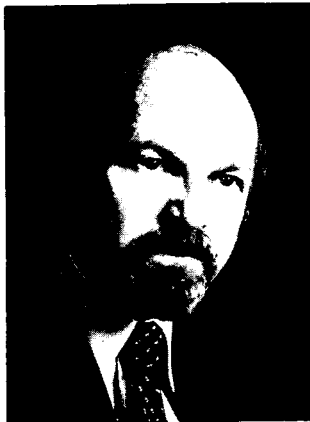


editorial



Who are the culprits in the exploding costs of medicine?

by Reuven Bar-Levav, MD

I happened to attend the 38th Annual Spring Conference of the Council on Employee Benefits. This four-day meeting was attended by the benefit planners and administrators of some of the largest companies in America: TRW, John Hancock, Prudential, Travelers, Aetna and Metropolitan Life Insurance Companies, NCR, Union Carbide, The Chase Manhattan Bank, Motorola, Eli Lilly, Bethlehem Steel, Honeywell, Nabisco, Xerox, Anheuser-Busch and others. The names of some of the companies represented are mentioned to indicate the calibre and economic power of those attending. Most of the formal and informal conversations dealt with one subject: how to limit and lower the cost of health insurance. The exploding cost of medicine was subject #1.

One example given at the meeting was of an ophthalmologist who allegedly charges \$3,500.00 for a corneal transplant, a procedure which lasts half an hour. This surgeon, according to the story, works one and a half hours per day, four days a week, forty weeks per year and grosses over a million and a half dollars. This was used to illustrate why costs were so high. Some participants also recognized that various interest groups such as unions pushed pet projects that made no sense. "My family has eyeglasses coming out of their ears, and more toe-care than I ever imagined possible," said one overweight participant as he was sipping beer by the pool. Nobody mentioned within my earshot the costs of hospitalization.

I would have told the assembly a different tale had I been invited to address them, and would focus on the two reasons that are mainly responsible for the crisis in medical costs:

1. *Patient demands for care:* As every physician knows, medical care is sought as much because of anxiety and fear as is for actual medical problems. The majority of patients have minor physical difficulties that precipitate attacks of pre-existing anxiety and activate dormant depression. Patients seek reassurance for these at least as much as they seek diagnosis and treatment for their physical symptoms. Physicians have come under so much attack in recent years because they often ignored this fact, especially since the advent of modern miracles of scientific medicine. When third-party payers cover all medical and hospital expenses without demanding at least a minimal co-payment, the system is bound to overload, regardless of how many physicians and hospital beds are available. This is essentially true even now and it will continue to be true in the future. Not every physician will always be busy, but if something useful is "free" there is never enough of it.

2. *Hospital inefficiency:* Greedy physicians indeed exist but the ophthalmologist in question probably is mythological. Medicine and surgery are simply never practiced in such a neat and pat way, and the figures deserve re-checking. Although physician greed is not as rare as we like to think and never excusable, it is not the cause of the spiraling costs. Such greed must be weeded out, but the bulk of the health cost dollars go to hospitals which are tremendously

powerful institutions pursuing their own self-interest. The not-for-profit label gives them a holier-than-thou halo and a tax exempt status, but it does not make them virtuous. The financial waste and abuse of hospitals is well documented and well-known, but their political clout is such that nothing succeeded in the past in curbing them. The blind and naive support that private practice staff physicians give to hospitals is the latter's most powerful asset. In fact, hospitals and physicians in private practice have increasingly become natural antagonists, competing for the same health dollar, although they also need each other.

The cost of labor in hospitals has often been pushed beyond that known anywhere else, which was possible until recently because hospital expenses were figured on a cost-plus basis. This was how hospitals managed to get compensation from third-parties, based on the false rationale that nobody profits from them. The new DRG system may also fail if the rumored intentions to sabotage it by multiple diagnosing prove to be valid.

Benefit planners and administrators may find it easiest to blame greedy physicians for their difficulties, but this is a minor part of the problem. Unless they address the real issues, the situation will only get worse once that private practice of medicine falls victim to their "new" insights and ideas.

R. Bar-Levav, MD