# Medical costs—our common dilemma

George R. Dunlop, MD, FACS, *Worcester, Mass.*
President of the American College of Surgeons

Honored guests, members of the Board of Regents, Officers of the College, members of the 1976 Class of Initiates . . . on such an occasion it has been a tradition of the College for the incoming President to review the past, comment on the present, or speculate about the future. In selecting a subject for this address, it was apparent that the most important problem facing surgery today is the escalation of medical costs and the effect that this problem will have on the professional lives of this audience.

The men and women of this 1976 Class of Initiates are probably better prepared to practice in this technological age than was any other generation. You have undoubtedly survived greater competition in the selection and training process than in any other decade, but are you prepared to answer some of the social questions that will necessarily be before you during the immediate years ahead?

Today medicine stands at the highest peak of its many achievements. Infant mortality has declined 12.7 percent since 1950. The death rate from heart disease has declined 15 percent in the last six years. The average life expectancy has increased by four years. There are more physicians per capita than ever before. With medicine's support this country has developed the largest, most rapidly growing, comprehensive, private health financing system in the world.

A recent Roper opinion survey on health care delivery and financing showed that the public is more satisfied with the quality of care, its accessibility, and the arrangements for paying for medical care than it was two years ago. Further, physicians continue to stand at the top of the 'most respected profession' list.

According to the SOSSUS report, there has been no other period in surgical history in which the yield in scientific investigation was so bountiful and the resultant change in practice so great.

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The public, increasingly impressed with medicine's accomplishments, is demonstrating an insatiable demand for health services. Why then, you may ask, with such a record, is the medical profession being attacked almost daily in the media and by labor officials and certain segments of government? Why is the public demanding more intense scrutiny of the practice of medicine and greater public accountability? Why, when during the past decades the public has traditionally allowed the medical profession almost complete autonomy in the handling of its own affairs, should it want to impose increasing restrictions on our surgical practice? Why . . . when no other profession has so many self-imposed controls, checks, and audits as medicine?

From a modest beginning, the financing of medical care has drawn the profession into its entangling net. Nourished in a free environment, our profession grew and prospered until physicians from every shore came to the United States to train and often to stay on and practice. Hospitals expanded and others were built. Research was generously funded and as our technology grew so did the demand for medical services.

While this expansion of knowledge in the biomedical field was occurring, other developments were taking place that were having an increasing impact on the financing and delivery of health services.

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## In brief . . .

*In this presidential address, delivered October 14, 1976, in Chicago during Convocation Ceremonies of the 62nd annual Clinical Congress, Dr. Dunlop asks why, when no other profession has so many self-imposed controls, checks, and audits as medicine, does the public want to impose increased restrictions on its practice?*

*The answer, he believes, has to do with economics. And unless medicine can recapture some of the community leadership that is a part of its heritage and unless physicians become as concerned about the costs of medical care as they have traditionally been concerned with its quality, the public's wants will too soon become an externally-imposed reality.*

Our government was embarked on a course of deficit financing which was to fuel the fires of inflation. As federal deficits grew, the interest on our national debt became a major item in the budget. These inflationary national policies forced wages up, as well as the cost of medical care. From 1960 to 1973 medical costs went up 80 percent while at the same time the consumer price index went up 60 percent.

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Translated, this means that 73 percent of the increase in the cost of medical care had nothing to do with the medical market but was due to the government's spending policies. In addition, government's entry into the health system with Medicare and Medicaid improved access to health care services. This stimulated demand and cost, and what started as a problem in medical economics soon became a problem in national economics.

The rapid increase in medical costs has placed the health care system on a disaster course. Last year the nation's Blue Shield and Blue Cross plans collectively lost over $600 million, reducing their reserves to an all-time low and threatening some plans with bankruptcy. The increase in the health care costs from 1974 to 1975 at the federal level was $14.5 billion, the largest yearly increase in the nation's history. In the last decade expenditures under private carriers rose from $8.3 to $27.3 billion, an increase of 229 percent. However, government programs, Medicare and Medicaid, rose from $7 billion to $40 billion, an increase of 484 percent. Only national defense, interest on the national debt, and the social security program consumed a larger share of the federal budget.

General Motors spent more money last year on health insurance premiums for its employees than it paid to U.S. Steel, its major supplier of metal. Recently *Business Week* reported, "Confused by a staggering rise in employee health costs over the past five years, employers have tried to check the flow of cash, but mostly they have simply wrung their hands in frustration".

In my home town, the Norton Company, a worldwide producer of abrasives, had a 91 percent increase in health insurance costs in the last five years. In desperation they hired a consultant to devise claim controls in addition to analyzing costs and benefits.

Some of our smaller towns have had to decide whether to cut fire department budgets or health care budgets.

Labor finds that it is leaving the negotiating table with increased health provisions but with less increase in take-home pay. It is little wonder that its leaders are pressing for an all-inclusive national health insurance program, which would allow them to place increased emphasis on take-home pay.

Business finds that its contributions to the health insurance premium of its employees are a significant component of production costs and one that is threatening to price them out of the market. The current burden of the cost of health care coverage to government and industry might prove to be bearable in a rising economy were it not for the fact that there appears to be no limit to the annual increases that far exceed the consumer price index.

If the current trend representing the cost of financing health care for the elderly is projected to the year 2000, assuming the same utilization rate, the same inflation rate, and the same life span, but allowing for a five percent increase in the number of those over 65 years of age, the cost of the program could be well in excess of $2 trillion.

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Obviously this projection reduces our present situation to an absurdity. Something must be done to turn these alarming increases around... but when and by whom?

Up until now I have emphasized that the profession has become entangled in the tightening threads of this complex economic web which is no longer simply a national problem but one that has become worldwide. Industry and government are now paying our bills and like it or not we must be able to answer their questions, project our future, defend the positions we take, and have the data to support our contentions. As we face this challenge and assess our resources, it is alarming to see how unprepared we find ourselves for this expanded role.

Can a profession linked only by its concern for the sick and injured, which traditionally has concerned itself with the quality and not

with the cost of medical care, be expected to provide the necessary answers to a concerned public? As a well educated and highly respected profession, do we not have the capacity to respond to this challenge?

We must start with the assumption that given increased access to higher quality health care, the American public has the capacity to utilize an unlimited number of medical services. If the premiums are buried in production costs and tax assessments, the public is less aware of the burden of its health care costs. In such an environment not only does utilization go up but our social and economic goals are in conflict as we begin to reach the end of our health funding resources.

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If the demand for services is unlimited and our resources limited, the solution is no longer simply a social issue but an economic one as well. Society, including the medical profession, must face some agonizing decisions as to how the health care dollar can best be spent. Medicine alone cannot make these decisions, but who, I ask, should be better prepared to advise the public on these issues?

It is recognized that the physician receives only 20 percent of the health care dollar for his services, the greater proportion going to the hospital. Whereas the profession has only a limited control over hospital wages and administrative costs, the utilization rate of our X-ray and laboratory studies and the expense of our expanding technology are major items over which we have almost complete control.

New technology in medicine, unlike that in other industries, tends to be cost raising rather than cost saving. Furthermore, we must assume that new and revolutionary discoveries will be made with increasing frequency. For example, Rushmer has pointed out that the interval between the discovery of the principles of photography and their utilization was 112 years, while the telephone required 56 years to implement and the electric motor 65 years. The atomic bomb appeared six years after nuclear fission was demonstrated, but transistors were commercially produced three years after their first experimental demonstration.

The cost of expanding medical technology is receiving increased attention. Howard Hiatt of the Harvard School of Public Health has raised the question as to how much of our resources should be devoted to the development of such technologies as the artificial heart and kidney dialysis. "Proof of effectiveness by itself cannot justify the unlimited spread of new technology. Some technologies will be so costly in relation to benefits that society will be forced to renounce them", he has said.

A time approaches when the boundaries of our research and its evolving technology will be the concern of legislators, economists, labor union officials, and interested citizens. Whole regions of research will be denied funding as being economically unworthy of pursuit. New and expensive technology in the health field should be pilot-tested and shown to be cost effective before it is generally adopted.

Dr. Hiatt goes on to remind us that freezing of the stomach for ulcer disease was first tried in 1962. In spite of the fact that a panel of the American Gastroenterological Association recommended that adoption of this procedure be delayed for future testing, 2,500 machines were in use by 1969. After the publication of the results of a carefully controlled clinical trial showing the ineffectiveness of freezing, it was abandoned. Can society afford to follow the same road with all new technology?

*As physicians we must recognize that medical care has a limited impact on health*

In a special article in the April 29, 1976, issue of *The New England Journal of Medicine*, Cullen and his group from the Department of Anesthesia at Massachusetts General Hospital reported on a study of 226 consecutive critically ill patients requiring intensive medical and nursing care. At the end of 12 months, 27, or 12 percent, had fully recovered, for a total charge of $3,232,647, an average cost of $119,727. The charge for blood and blood fractions alone was $617,000. Over half a million dollars was spent on blood for 164 nonsurvivors.

What percentage of our national resources should be spent on health? Will increasing this budget item result in a corresponding improvement in the health outcome of the American people? This is the assumption of many of our politicians, but is it the studied opinion of this audience?

As physicians we must recognize that medical care has a limited impact on health. Most of our patients seek a caring or a reassuring

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service from us. Others have conditions we cannot cure. Fuchs has said, "Health has never and will never be the exclusive product of medical care. The public must be made to realize that medical care has less impact on health than has generally been assumed and that the best system in the world will never entirely relieve them of the responsibility for their own personal health. It can be stated categorically that the differences in the state of health in developed countries are not primarily due to the quality and quantity of health care available but to genetic, environmental, and personal behavior."

The availability of a service in no way guarantees its use. In 1974 one-third of the children between the ages of one and four were not inoculated against polio. There is a wide variation in the use of surgery, drugs, and hospitalization without an apparent effect on the outcome. Rene Dubos stated some time ago that to ward off disease or to recover health, men as a rule find it easier to depend on healers than to attempt the more difficult task of living wisely.

The health care profession is the second largest social service system in the world, education ranking first. The escalating cost of this system has frightened business, labor, and government until they are willing to try any experiment that holds some promise of relief; HMOs, PSROs, peer and utilization review, national health planning, and second opinion programs are but a few examples.

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Even with the most effective peer review the need to make choices between laudable goals will be increasingly before us and I am afraid we are poorly prepared at the present time to develop the priorities that society must soon have if we are to spend our health care dollars wisely.

Bloom and Osler Peterson of Harvard studied the distribution of coronary care units in Massachusetts and concluded that the state's 5.9 million people could be better served with 110 fewer beds in the coronary units.

The Commission on Professional and Hospital Activities in 1969 compared the effectiveness of sample hospitals with and without coronary care units. The survival rate was seven percent better in those hospitals that had such units, but if each of the 7,000 hospitals in the United States had ten such beds it would cost $2.5 billion or about $70,000 per patient.

Another of the issues that needs our attention is the routine annual medical physical examination. Industry spends millions of dollars on annual checkups. Could these dollars be better spent on other health programs?

Dr. Richard Spark of Harvard is quoted in *The New York Times* as asking this question after reviewing the data of the Kaiser Permanente program: "Why do people who submit to these periodic examinations have the same disease disability and mortality rates as those who seek medical advice only when they feel sick?" Dr. Catherine Boucot and her group at the Medical College of Pennsylvania screened 6,136 males over 45 with chest X-rays every six months for ten years. Initially none of the men had symptoms of lung cancer. Over the course of the program, however, lung cancer was discovered in 121 of them. These men were given immediate and sustained treatment but only eight percent survived over five years.

*It is imperative that we become familiar with the costs of all the services we order*

But such problems as the cost effectiveness of our medical screens and the order of our national medical priorities cannot be made by the profession unilaterally. We have a tremendous research capacity and a tradition of problem solving supported by clinical trials, pilot studies, and data gathering. We have a communication system strengthened by our journals and our meetings such as this great Congress, but this is not enough. We can determine the medical effectiveness of a procedure and pass judgement on the medical necessity of its use. The allocation of our medical resources is another matter. Here we are dealing with serious social problems and we must inform ourselves and be willing to join with representatives of business, labor, government, and the consumer in answering these difficult questions.

My objective is not to discredit medicine's effectiveness in restoring health to the critically ill and injured, but to point out that if society, including the medical profession, establishes reasonable health priorities and if we are wise in the allocation of our medical resources, the system may not need to default to the stringent

and often unrealistic controls of a federal bureaucracy.

Short-sighted politicians believe that a federally financed and administered health program is the nation's only answer to our increasing costs and diminishing financial resources. In every instance where such a program has been introduced it has not only increased demand but has been inflationary as well.

It is imperative that we become familiar with the costs of all the services we order. Hospital administrators are reluctant to post these figures or institute any measures that might affect their revenues through a reduction in utilization.

We must know more about the practice patterns of our colleagues. Unfortunately, it is the large purchasers of medical care who know more about our practice profiles than does the profession itself. Every year we are producing thousands of studies reporting on biomedical research and reviewing clinical results; however, there are very few studies concerned with the medical necessity and cost effectiveness of our laboratory tests and X-ray studies and even some of the drugs we are ordering for our patients. Such information as does exist has primarily come from the system's critics who, in pointing out the waste in our methods of practice, call for a reduction in professional fees.

With an increasing percentage of physicians' income drawn from a premium pool, the public sees our fees as its most visible target. Yet because so small a percentage of the health care dollar goes to the profession, a 20 percent reduction in fees would result only in a 2.5 percent reduction in the cost to the system.

*As you return to your respective hospitals and offices, I hope that you will take a new look at the surgical environment in which you work*

If we deplete this premium pool by the extravagant use of supporting services, we threaten the very foundation of the health financing system, and patients as well as physicians will suffer.

In my own state of Massachusetts, the utilization rate for supportive services went up 27.5 percent last year. Reserves in the Massachusetts Blue Shield plan dropped from $27 million to $200,000 and physicians' fee profiles were frozen and not updated. At one large Boston teaching hospital these supportive services cost the patient $112 per day.

It is important that the profession direct some of its impressive research and investigative capacity to the field of medical economics, thereby placing us in a better position to advise the public as this nation searches for answers to our health care problems.

The cost effectiveness of various types of peer and utilization review needs to be documented. As our daily medical decisions place an added burden on the country's economy, the wisdom of our judgement is being questioned. If we are to continue to have an effective voice in our own affairs, a new dimension must be added. Physicians must be as concerned about the cost of medical care as they have traditionally been concerned with its quality.

*In addition to monitoring the extreme ends of the practice spectrum, we should concern ourselves more with its center where most of us practice*

The challenge is before us. As you return to your respective hospitals and offices, I hope that you will take a new look at the surgical environment in which you work. Select your support services prudently, direct your investigative capacity toward finding the answers to some of these questions I have raised, become better informed, and let your voices be heard in advocating the provident use of our health services. Recapture in these matters some of the community leadership that is a part of our heritage.

In addition to monitoring the extreme ends of the practice spectrum, we should concern ourselves with the center, where most of us practice. If the charges for rare conditions are raised by ten or even 15 percent, the overall effect would be modest. If, however, the charges for common conditions are raised by just two or three percent, the total effect on the financing system will be enormous.

Furthermore, we should look twice at our day-to-day practice habits. The extra chest plate or blood gas sample, or the extra half day of hospitalization may be popular "defensive medicine", but are they always necessary? Multiplied, they can be a greater burden to the financing system than, perhaps, any other single factor.

Costs will most certainly continue to go up but we must be prepared to join forces with all segments of society in facing this, our common dilemma.