Health care coverage in the U.S. — how we got here, where we're going

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This article is the first in a series on health care reform. Our new health care law, aka Obamacare, has a myriad of features. It is extremely difficult to anticipate what their effects will be in the short run, let alone in years to come.

As with most complex systems, the "devil is in the details." This law has so many details there may be a lot of devils. Let us hope there are a few "angels" hiding in there as well. But before I try to wade through the new law, let's look back to see how we got to where this law became necessary.

In the beginning

My story will start in 1979. As a green intern at North Shore University Hospital in Manhasset, I saw a system grossly out of balance. The following scenario is typical of what led me to that conclusion. This actually happened frequently — it is not an exaggeration.

The chief resident gets a call from Dr. Jones, a community physician attending in the department of internal medicine.

"Hi Chief, I'm going to admit Mrs. Smith to your service through the emergency room. She needs some 'tuning up' for some of her chronic problems." The chief checks his list and finds that I'm next on call for an admission. He tells me to call Dr. Jones and get the details so that I can do a history, perform a physical and make plans for her care.

Dr. Jones gives me the following information: "Mrs. Smith is 87 years old, has Alzheimer's, adult onset diabetes and mild hypertension. Her admitting diagnosis will be congestive heart failure, since she always has a touch of that." Before I can ask what the real reason for admission is, he says, "Her

family is going on vacation for two weeks, and I've promised them that we would watch her in the hospital while they are gone."

Let's examine who benefits from this situation and what harm, if any, is done.

It works great for the family. Their mother has a staff to watch over her every need. They can go on their vacation with no worries, and no expenses. The costs are covered by Medicare and any additional insurance she might have. It works fine for the doctor, who will make daily rounds on this and perhaps a dozen others like her, collecting a nice fee for each note he quickly scribbles in the chart. It works okay for the interns and residents, too. We would prefer an acutely ill patient from whom we might learn more, but we get to address all her issues, adjust her medications, and discuss the latest theories and treatments.

It works fine for the hospital, which was getting paid a fixed daily fee by Medicare and private insurers for each full bed, regardless of the diagnosis. In addition, the hospital could charge for any laboratory or imaging tests we ordered. As for the patient, if the Alzheimer's was severe, the patient may not have even known if she was in the hospital, but if she did, she could be easily convinced the hospital stay was in her best interest. On some level she probably realizes her family needs some time away without having to worry about her.

Amazingly, the insurance company had no problem either. The not-for-profit Blue Cross/Blue Shield-type plans dominated, and whatever they paid out this year they just built into to their premium structure next year.

The down side

Who did this process not work for? It's pretty obvious the health care system could not long afford to be providing the most expensive baby-sitting service in history. The culture in this high-tech, top-of-the-line teaching hospital was, "If you can even think of a test or procedure to do, do it. You will certainly learn something; you'll tend to protect everyone from malpractice; and, who knows, it may even help the patient."

The hospital didn't mind since it meant more revenue for them. The patients might occasionally grumble about all the testing, but again, it was easy to convince them it is "better to be safe than sorry."

The system was wildly out of balance. All elements of the health care system encouraged more — more of everything. Even a novice like me knew that the system couldn't be maintained.

By 1983 Medicare had instituted a new method of paying the hospitals. It was called Diagnostic Related Groups. The idea was that the hospital would be paid by diagnosis, not by number of days. So, if a patient was admitted for uncomplicated pneumonia, the DRG might consider a few lab tests, a couple of chest X-rays and five days in the hospital. For this the hospital would get a fixed amount, say $3,000, regardless of whether the patient stayed for two days or two weeks. Instantly the do-more-and-keep-'em-as-long-as-you-like culture was gone. Word came down from the administration of every hospital in the land: "Get them in and out as fast as you can."

The consequences

There were many consequences, but one of the more obvious was the bureaucracy that developed. The government hired battalions of workers to review charts to make sure the hospitals weren't inflating their DRGs. This, of course, obligated the hospitals to hire equal and opposite battalions to feed data and argue with the Medicare people. Consulting firms popped up to teach hospital staff how to maximize the DRGs and get them approved by Medicare.

In spite of all this added expense, the reversing of incentive worked. The rapid increase in hospital expenses slowed remarkably — so remarkably that the same principle was to be applied to doctor fees in general. The concept of reverse incentive for physicians started spreading like a plague across the country from west to east. This dark force which began in California is better known as — I get chills even typing the horrible letters — HMO.

Part 2 in the series is scheduled for the issue of Nov. 18.

Dr. Alan Cooper, retired, maintained a family practice of medicine for many years in the Three Village area. Consult your physician for personal medical decisions and care.