The Economics of the US Health Care System: A Personal Perspective

In almost 20 years as an independent practicing physician (10 years as a hospitalist, after 8 years as a primary care pediatrician [PCP] in private practice), I have cared for a wide variety of patients. I have also had firsthand knowledge, from 2 sides of pediatric practice, of how the strange economics of the US Health Care System strongly influence my day-to-day practice. As I look back on my years as a PCP, I now realize that there were 2 main reasons why I chose to become a hospitalist. First, I missed caring for more acute, sicker patients. Second, I was extremely frustrated with the waste, inefficiencies and bizarre incentives of the system. The fact that taking a few minutes to reduce a nursemaid’s elbow was more valuable to the bottom line than spending 45 minutes with a family to break the news that their newborn has Down syndrome caused me a lot of stress and anxiety. The fact that as a partner in a private practice I had a responsibility to make sure we could pay our bills and keep the office open just made things worse.

Much has been written about our broken health care system over the past several years. Experts enumerate many factors that led to our current state, including a high percentage of uninsured/underinsured, high prices, overutilization of some things, underutilization of others, waste, inefficiency, fraud, and fee-for-service.1–3 The question remains: which factors are truly responsible for the problems with our system? I do not know the definitive answer to this question, and I’m sure if you asked 10 experts you would receive 10 different answers. However, I have identified 2 factors that I believe were mostly responsible for the issues I struggled with in private practice. As a hospitalist, I find that remembering them is extremely helpful when I encounter patients who have had treatments or therapies ordered by PCPs that seem questionable or when I encounter difficulty identifying a PCP to follow-up a patient who is inadequately insured. I also try to incorporate my experience to educate our residents that the care a patient previously received as an outpatient is not necessarily all directly attributable to the PCP, so we need to make sure that we do not judge people unfairly.

The first factor is that families with “good” insurance (read “low co-pays, and generous coverage”) generally have poor price sensitivity to the care they receive.3 Simply said, they don’t know what the cost is of the test or treatment ordered by their PCP or other physicians.1–3 Why should they? Because most of the payment for services is directly from the insurance company to the provider, cost is removed as a reason for families to decide if something is really needed. Furthermore, patients rarely have access to enough information to do
any price comparisons even if they are inclined to do so. One example I still think about was a child with chronic abdominal pain not associated with fever, vomiting, weight loss, or any other symptoms. She had a normal physical examination, despite a long history of constipation, diagnosed by one of my partners, which the family was resistant to treat. The family self-referred to a pediatric gastroenterologist, who also diagnosed constipation. The family disagreed, and subsequently went to the emergency department to demand a computed tomography scan, which was normal. They self-referred again and were evaluated by 2 other gastroenterologists, with the ultimate diagnosis of constipation. When I asked the mother if she was happy with the outcome, she said, “Sure, it’s not like I paid for all the tests and doctors … the insurance paid for it.” As a physician who was trying to provide high-quality, cost-effective care, this experience was not rewarding.

The second factor I try to remember is poor reimbursement from many insurers for primary care, particularly for patients covered by Medicaid. My former practice was more inclined to accept patients with Medicaid than our competitors. Our payor mix was somewhere between 20% and 25% Medicaid compared with <5% for the other practices. Although reimbursement barely covered our expenses for this, we truly enjoyed caring for these patients. Unfortunately, the combination of stagnant reimbursement and the increasing administrative complexity of Medicaid, along with increasing practice expenses in general, made it more and more difficult to continue accepting new Medicaid patients. We had to hire additional office staff to process specialty referrals and billing for our Medicaid patients, pushing expenses over revenues for these patients. This made it difficult to offer competitive salaries and benefits for staff and new physician recruits. Although we continued to accept new patients with Medicaid, we had to start restricting the number to meet our other obligations. Although Medicaid reimbursement should improve in many states in the coming years, I believe it will remain challenging for private practitioners to accommodate all patients who need a medical home. As a hospitalist I try to keep this in mind when a patient with no PCP is admitted.

I am optimistic that the national push toward accountable care organization (ACO)-type payment reforms has great potential to improve PCP reimbursement (such as incentivizing efficient, high-quality care across the continuum compared with our more traditional episodic fee-for-service model). However, I am concerned that without a parallel strategy to improve the price sensitivity among both patients and providers that US health care expenditures will not decrease significantly. Furthermore, I do not believe that we can reasonably expect effective price sensitivity by patients, regardless of the amount of data and education that can be provided for them, without providers leading the way. I really think that a PCP or hospitalist telling a patient that “we can do the computed tomography if you want, but I do not think it will change the diagnosis or the treatment plan and will cost $1200” will be much more effective than expecting a patient to take the initiative in researching current prices. Of course, as providers we are not knowledgeable enough about prices either, but there is growing evidence that we can learn and effectively use price data in clinical settings. My hope is that one day when using my electronic medical record/computerized physician order entry system to place some orders, along with a “Best Practice” alert with a link to the latest evidence-based guideline, I will see the price of the tests and treatments I intend to order, along with a list of alternative choices, which I can then use during rounds when discussing treatment options with a family. This might be an uncomfortable idea for some, but haven’t we all made major positive changes in our practice that we didn’t always believe in initially? When I started practice, family-centered rounds, evidence-based pathways, and quality improvement were not things I knew about, and when I first learned about them, I certainly did not think they would be good for patient care. Now these things make up the core of my practice. I believe that we can and should work toward including the financial impact of our day-to-day decisions as part of our practice, and it is our responsibility to provide usable information for our patients and families.

The history of the US health care system is long, complex, and often frustrating, with many changes and innovations often working at cross-purposes. As the Affordable Care Act is slowly integrated into practice, there is some hope that the waste, inefficiency, and hidden costs of the system will lessen, but this remains unproven (personally I am skeptical). I have no doubt the future will bring new challenges and problems. I hope, however,
that 20 years from now, I’ll be grateful that the problems of health care in 2014 were thoroughly and effectively resolved.

REFERENCES


