THE GREEN SHEET

News About the U.S. Department of Health, Education and Welfare

Massachusetts Physician; 8/78

What To Do About Rising Health Care Costs

By George LeMaitre, MD

President, Massachusetts Council of Medical Staffs

Well, it's not 1990. But the circumstances which would lead to such a crisis are clear. Notwithstanding the insurmountable difficulties of a *"No Insurance Law,"* it is worth speculating on its consequences, since radical hypotheses often reveal hidden truths.

Those who view a *socially insured existence* as a prime function of government and a basic necessity for the individual would forecast a blood bath with such a law, claiming that, "People who could not afford treatment would simply forego it. The critically ill would not be hospitalized. Life expectancy would decrease. The health care system would collapse."

Not necessarily. If insurance is the cause of the rise in health costs, not the solution, then the phasing out of health insurance would arrest inflation and rationalize expenditures on health, each citizen acting as a stop gap.

How would the "No Insurance Law" affect physicians? The floor would be knocked out of the physicians' incomes and, for the first time in decades, doctors would be forced to compete in an open market as demand for their services took a dramatic downturn. As fewer patients sought physicians' services (using their educated common sense for minor ailments), fees would begin to fall as a medical "gas war" erupted. Physicians would make themselves more available, holding evening hours and communicating better with their patients in their efforts to grab a piece of the collapsing market.

Over-specialized physicians would begin to realize that some primary-care medicine is well within their competence, and they could ill-afford to hide behind their specialties.

And the patient? He would not be rejected, but would be intensively courted by the physician, seeing greater physician loyalty, an enhanced bedside manner, and more convenient services rendered by personable and available physicians.

But is this good for our profession? It is the best thing that could happen to us.

We are on a collision course with government, labor and big business who cannot sustain health costs much longer. Our incomes are being sharply curtailed and our professional freedoms shackled. Consumer dissatisfaction, fueled by price, unavailability and over-specialization, has reached a dangerous pitch and will result in controls beyond our gravest fears.

Furthermore, health insurance tables of fees emphasize technological accomplishments. This creates a grievous injustice against our primary care physicians who cannot compete in the health insurance marketplace with surgical specialists and medical sub-specialists who sell definable techniques. This fee imbalance will be rectified only when patients must pay their own bills and judge the relative worth of the physician's intervention. With this imbalance removed, primary care will have a much needed renaissance.

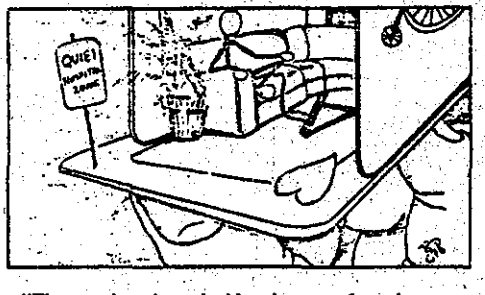
But what would the "No Insurance Law" do the hospitals? Skeptics would say: "Surely the uninsured patient could not possibly afford them!"

The modern hospital is a house of cards supported by the insurance system. We don't have hospitals. We have luxurious healing hotels and health resorts. The *"No Insurance Law"* would change all that. Thirty per cent of hospital beds, and probably more, would empty. Payrolls would shrink as whole wards closed, reducing overall expenditures dramatically.

Hospitals would turn, as in the remote past, to local charities for support. Local charities are now effectively shut off because citizens no longer view their hospitals as integral parts of their communities. They see hospitals basking in luxury created by cost-plus insurance.

Harry Schwartz, author of *The Case for American Medicine*, and a science editor for *The New York Times* wrote recently:

> "Just abolish Medicaid and Medicare. The 38 billion dollars saved that way would come to about half the projected Carter budget deficit in fiscal 1978. And imagine how doctors' fees and hospital room rates would crumble in consequence. Your friendly G.P. might even call you up and ask if you wouldn't like a house call at a special rate — just for sociability, even if there is nothing detectibly wrong with you. And that local general hospital which is collecting $200.00 a day from Blue Cross every time you go in to have your heartburn investigated, might run a sale day — you know, $25.00 a week in a private room for a honeymoon couple and nobody will ask you for your marriage license. There is nothing like a sharp decline in business, after all, to make people much more reasonable about price and delivery conditions"



"The modern hospital is a house of cards supported by the insurance system. We don't have hospitals. We have luxurious healing hotels and health resorts."

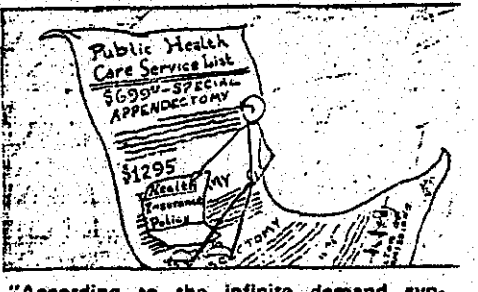
A radical but not very practical hypothesis? Not compared with the one was are using now. On the one hand, government and organized medicine are firmly set on their present course of expanding, not decreasing social health insurance, while efforts to control health costs through such measures as PSROs, HSAs and HMOs are token gestures at best, because they do not eliminate the cause of the problem.

Defining the Problems

According to the *infinite demand syndrome*, patients purchase medical care up to the level of their insurance coverage, and given the *medical uncertainty principle*, in any doctor/patient encounter, the physician is never certain that he has done enough and will always order more tests when pushed.

But the problem is caused by the basic nature of health insurance itself, *Life's Little Orphan Annie*. The fundamental defect: it breeds overutilization. "Life" insurance is simplistic. The covered contingency *death*, only happens once, is statistically predictable for each age, and not likely to be used for secondary gain by the insured. Health insurance attempts to cover *illness* which, for a variety of poorly understood reasons, expands with financial coverage, creating a vicious circle: the more the coverage, the sicker the "sick role," the higher the cost of coverage.

When health insurance was initiated, this phenomenon was not appreciated by the insurors for whom the insuring of life was a gold mine. They assumed illness to be just as definable and its costs just as predictable. The expanding sick role will blossom under any national health system because it will become politically impossible to restrict the rights of the people to be sick when they so desire.



"According to the infinite demand syndrome, patients purchase medical care up to the level of their insurance coverage..."

—cont. on next page

THE GREEN SHEET

News About the U.S. Department of Health, Education and Welfare

Boston Herald American 8 - 23

Colleges allegedly duped in collections

By FRANK THOMPSON
Staff Writer

A collection agency, which allegedly deposited in its own account funds collected for state and private educational institutions, is under investigation by federal and state agencies.

Alleged victims of the operation included Wheaton College in Norton, Worcester State College, Northern Essex Community College and Massachusetts Bay Community College. Efforts to determine the total number of schools duped or total losses were unsuccessful.

The company, Accounts Analysis, Inc., lost its license to operate in Massachusetts on July 8, 1977, after a June 30, 1977, hearing before the State Division of Loan Agencies.

Robert S. Leadbetter, supervisor of loan agencies, said yesterday, "We pulled their license. Supposedly they moved their operation to New Hampshire."

He said the matter was turned over to the attorney general's office. The attorney general's office said the company now is operating in Pennsylvania.

The federal investigation is being conducted by HEW.

A report of State Auditor Thaddeus Buczko of an examination of the accounts of Worcester State College for the period July 1, 1976, to June 30, 1977, said its study showed a letter from a student had been received stating part of the balance on a National Direct Student Loan had been paid to the collection agency.

In January and March, 1976, the audit showed payments were received by the agency in behalf of the college. Correspondence with the student produced canceled checks for $500. The agency had not remitted the last $200 to the college, the auditor's report said.

Instead, the report said, "The collection agency endorsed the checks 'Worcester State College' and then deposited them in its personal account."

Everett Hicks, fiscal affairs director for the 15-institution Community College System, said Accounts Analysis, Inc., had contracts with six of its colleges but four concluded their arragements with AAI before any problems arose.

He said Northern Essex Community College lost about $2,500 that they could not account for, while Massachusetts Bay Community College had placed about $48,979 with the company. He said that amount has been whittled down, but that he does not presently know where it stands.

Hicks explained the contracts with AAI were made by the individual institutions. Since getting rid of AAI, he said, collection business for the entire chain was put out to bid and the contract awarded to another company.

Mrs. Janet Nason, supervisor of student accounts at Wheaton College, said she was not so much concerned about the money involved, as she was for alumnae relationships. "We alienated some kids who had paid and were still being billed," she said.

She said the total figure involved at Wheaton might have been $2,000, but that it has been reduced to $600. She said AAI deposited the money in its account "and for two years collected interest on our money." She said she had sent copies of all her records to HEW.

Kennebec Journal (Me.) 8 - 17

Figures healthier than in federal effort

Default rates low in Maine student loan program

State House Bureau

In its 10-year existence, the Maine Guaranteed Student Loan Program has given state residents 66,246 loans totaling more than $87 million.

And, unlike the troubled federal program, Maine has had a low default rate, according to a state official.

Robert Brown, director of federal programs for the Department of Educational and Cultural Services, says the low interest student loan program has been a success here.

"It makes it possible for deserving Maine students to go on to institutions of higher learning, some of whom couldn't have gone before," said Brown.

"It has been a tremendous help to lower-middle income and middle income parents."

The default rate on the federally run student loan program, which is used in 24 states, has been running 15 percent to 18 percent.

Maine, which like 26 other states runs its own program, has had a default rate of from 4 to 5 percent.

"Maine traditionally has been very low," Brown said.

Because of the high rate of defaults with the federal loans, Congress has ordered the states using it to start developing their own programs.

Recently completed statistics for the fiscal year ending June 30 show that of the $87,224,000 loaned in Maine since 1968, $20 million has been repaid; $45 million is being paid; $180,000 has been cancelled because of death or disability and another $225,000 because of bankruptcy; and $2.8 million has been defaulted.

Although Maine has a state-operated program, the federal government is heavily involved. It pays the interest on the loans while the student is in school, and pays for the defaulted loans. Until 1976, the federal government paid only 80 percent of the loans that were defaulted, and the state paid 20 percent.

The state guarantees the loans, but the money is put up by Maine banks and credit unions and must be repaid within 10 years of leaving school. The loan carries a 7 percent interest rate.

Brown believes the loan program would not be as successful as it is if the state had opted to allow the federal government to run it.

"If it were in the federal program we wouldn't have the guarantee program where it is today," he said. "The reason is because the banks, I'm sure, never would have joined the program. I personally feel the state program is far superior. We are closer to the borrower and in our service to the banking institution..."

Brown, who has been handling the program since 1970, said it is still growing.

THE GREEN SHEET

R3

News About the U.S. Department of Health, Education and Welfare

cont. from previous page

The second problem we face is that health care is a labor intensive industry:

> "Labor costs account for about 60% of hospital expenditures, and labor costs dominate the other principle sectors as well, with the exceptions of drugs and appliances. But the role of labor in health transcends the question of its share of total cost. In addition, its approximately 4.5 million employees make health the largest industry in the country in terms of workers and the third largest, next to construction and agriculture, in terms of income produced ... With regard to continuing large scale growth of the health services industry in the future, we have to postulate that it can be achieved, if at all, only at the price of substantially improving wage structures, and this will mean substantially increasing total costs."

Because of trade unions, and the fact that only recently have hospitals and nursing homes been brought under the fair labor standards act, we can expect rising costs in health care regardless of what type of insurance covers the citizen.

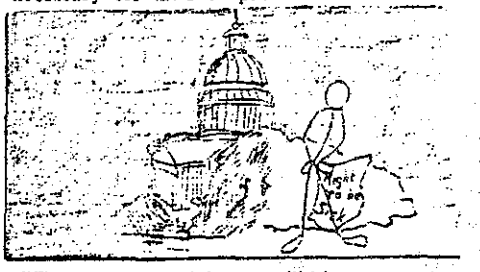
Third is the problem of the aged, unproductive citizen. As our technological expertise expands, we will extend still further the spread between retirement age and death. As chronic diseases develop in aging citizens, and third-order technological devices continue to be imposed upon them, health costs will continue to expand. With longevity extended, we face a total siphoning off of our insurance resources, caring for the elderly.

A fourth problem is the reduction of productivity as bureaucracy and centralization expand. The individual, by nature, tailors his initiative and productivity in proportion to how little self-interest he sees in working within any designated system. As health systems develop centralized management tools and aim for "efficiency," they do so only by reducing freedom, flattening out incentives and decreasing the gains which accrue to the individual who makes the effort. A national health scheme, a sure corollary of any national health insurance law, will soon lead to a substantial decrease in physician productivity, raising costs again.

Sickness is now a big industry because we have programmed people to be overly dependent on medical professionals. We have made our aging citizens non-productive and dependent on the society at an arbitrary and fixed age unrelated to their competency. We have regulated the health industry so tightly as to eliminate competition and drive hospitals and physician groups, through the Certificate-of-Need stimulus, to seek out the best when much less would suffice. We have under-written the entire system with a health insurance program which offers a free lunch in a luxurious hospital where the sick role is encouraged and rewarded. Small wonder health costs are rising so fast! No industry in the world could sustain itself within a fixed cost, given these factors.

Toward a Solution

The first requirement of the health industry should be a critical analysis of the dynamics of health insurance. We need to know what effect health insurance has on over-utilization, in order to refine our deductible and co-payment mechanisms to prohibit over-utilization. It may be necessary for laws to prevent insurance companies from selling first-dollar coverage!



"The expanding sick role will blossom under any national health system, because it will become politically impossible to restrict the rights of the people to be sick when they so desire."

We must define those illnesses where all would agree that social insurance should pick up the tab; chronic renal dialysis being an example. The federal government could pass specific laws financing the care of specific diseases.

We need to scrutinize the expanding sick role. To what extent, and under what circumstances, do people "play sick" to escape life's responsibilities? Can society protect itself against this tendency if all health care is to be socially insured? Can health programs be established in our school systems so that basic care and health maintenance become a function of the citizen, not the professional?

Government has over-regulated the health industry and stifled competition. How can this be reversed? We must ask ourselves some important questions. Do health planning councils which emphasize regionalization, lower cost through efficiency or raise cost by eliminating competitive models? Is the voluntary, non-profit hospital the only viable model or couldn't the development of highly specialized, *for-profit* hospitals and free-standing, *for-profit* ambulatory systems inject competition and lower over-all costs?

What about the senior citizen? So long as we arbitrarily limit the productive years, thus forcing dependency at a fixed age, we are fostering an insurmountable drain on our finances. Perhaps *age* should become a totally confidential piece of information, not available to government or private industry, and each worker treated in accordance with his or her individual competency. This would sustain each citizen's independence by extending the productive years and reducing the drain.

How do we solve the maldistribution of physician? *Force* is not a workable solution. It seems that a rewards system, such as reduced income taxes for physicians working in defined ghetto areas, would be a more appropriate solution. We have many precedences in our national history for this approach, such as the Homestead Act of 1862 which granted land to farmers willing to settle and cultivate it.

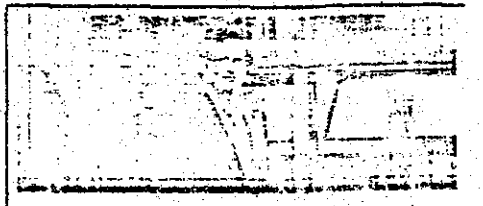
What about the intractably poor, those of our brothers and sisters who can never afford proper medical care? They must be cared for long before we concern ourselves with the rich and the middle class. Government should purchase private health insurance for them, but always, to preserve their dignity, require a token payment from them for medical services. Nothing could be worse than to make these citizens feel totally dependent on their society.

The affluent should not be eligible for free care, and government should not pay for services that a patient can well afford — and can purchase more cheaply without the administrative over kill.

The unemployed can be covered by voluntary riders to add health care coverage during unemployment.

For the high risk patient or the uninsurable sick: Each state legislature should require insurance companies to pool their resources and provide coverage at reasonable cost.

But most important, in the long run, is an unemotional, unbiased and non-ideologically based study of the factors outlined above that lead to escalating health costs. Until liberals and conservatives, collectivists and capitalists are willing to eliminate their rhetoric and jointly strive for a workable program based on facts not fancies, escalating costs and rising disillusionment are headed up a dangerous incline. We are presently courting a totalitarian response by government.



George D. LeMaitre, MD is Senior Surgeon of Lawrence General Hospital and Bon Secours Hospital in Massachusetts; Chief of Surgery of Lawrence General Hospital; President of the Massachusetts Council of Medical Staffs and Fellow of the American College of Surgeons. His articles have appeared in *Medical Opinion, Medical Economics, American Operating Room Nurses Journal* and *Private Practice*. He is author of the textbook, *"The Patient in Surgery,"* and recently completed his latest book, *"How to Choose a Good Doctor."*

Selected Items from the Regional Offices

News About the U.S. Department of Health, Education, and Welfare

R1

Wednesday, August 30, 1978 **I Boston**

18 PAGES

Burlington Free Press (VT); 8/18/78

Salt: Menacing Additive in Food

Sales have been slow in the case of a "midget encyclopedia on nutrition," designed to help people eat healthier meals at lower prices.

Why shouldn't literature with such noble objectives be more popular?

Resistance might stem in part because people don't want to hear the message. The American diet in the past 65 years has deteriorated badly in terms of over-all nutrition, despite an ever-growing abundance of food. A lot of Americans are aware that they consume too much fat and sugar, but they have not changed their eating habits and would rather not be reminded of the health hazards of such a poor diet.

Another possible reason why this little encyclopedia (comprising five brochures) is not selling like hot cakes is that it has received relatively little nationwide publicity.

That at least may change in the coming months as the encyclopedia's author, the Washington-based Center for Science in the Public Interest (CSPI), resorts to the national political arena in an attempt to get one of the publication's major nutritional messages adopted — namely, limitations on salt content in processed foods.

Salt long has been regarded as a cherished seasoning, but in the midget encyclopedia, it is identified as one of the most menacing of the 2,800 additives that can end up in our food.

CSPI said that a high salt diet can bring on high blood pressure (hypertension), and as a result, has filed a petition with the Food and Drug Administration (FDA) to require warning labels and certain restrictions on salt content in foods.

The link between excessive salt intake and high blood pressure has been documented in numerous cases. A recent study by the University of Massachusetts, for example, found salt used for snow removal that seeped into a community's drinking water supply caused higher-than-average blood pressure levels among high school students.



Edward Flattau

CSPI's petition appears especially timely in light of a review of additives by a group of scientists under contract with the Food and Drug Administration. Among the scientists' preliminary recommendations is that salt be removed from the "safe list" and the guidelines be developed for limiting salt content in processed foods.

Industry spokesmen have not lodged a formal response to CSPI's petition as yet. But they have said in the past that the existing salt levels are what the public wants, the evidence implicating the seasoning as a source of hypertension is ambiguous, and even if true, the majority should not be deprived because only a relatively small number of people would be likely to be vulnerable.

FDA, for its part, said it will be reviewing at least the labeling aspect of the CSPI's petition this fall.

Of course, salt is not the only villain identified by the midget encyclopedia. Excessive intake of sugar is linked to obesity and the $3 billion-a-year health problem of tooth decay. Animal fat with its low nutritional value (and disease-producing potential when taken regularly in large amounts) provides 40 percent of the calories in the average American diet.

The CSPI nutrition brochures do contain some surprises. Starches are classified as non-fattening, with the result that nutritious foods such as bread and potatoes are recommended, provided one goes easy on the butter. Additives are not all risky. CSPI even cites nine that it considers safe.

The midget encyclopedia counseis the reader to build a diet around fresh fruit and vegetables, lean meat, fish, poultry, potatoes, brown rice, skim milk and cottage cheese.

The CSPI encyclopedia can be obtained by sending $1 to:

CSPI
Department H
P.O. Box 3099
Washington, D.C. 20010