

CRITICAL ISSUES IN HEALTH ECONOMICS

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ABSTRACT

The healthcare industry faces critical issues including co-payments that exceed the cost of ethical drugs, general cost inflation in ethical drugs, establishing potential cost efficiencies in operations that might help stabilize costs, rising rates for physicians' malpractice insurance, and fear by seniors that they will be dropped by their HMO. Costs for both medical procedures and hospital stays have also escalated over the decade and are forecast to rise in 2003 and thereafter. It is imperative for individuals, organizations, healthcare providers, and pharmaceutical firms to examine their cost structures. There are no easy solutions that will solve all of the above problems.

INTRODUCTION

In a recent issue of the Wall Street Journal, in the Health and Family section,ⁱ the results of a poll of "Health-Care Headaches" were presented. They were very interesting and pointed out differences between perceptions of the general public and primary healthcare providers. The two groups tended to be concerned about substantially different issues. Some of their concerns do overlap. According to the general public, the most important concerns were ranked as follows:

1. Health-care costs – 38%
2. Prescription-drug costs – 31%
3. Corporate bureaucracy – 11%
4. Availability of care – 11%
5. Medical errors – 6%

The poll included the most important concerns of physiciansⁱⁱ as follows:

1. Malpractice insurance costs and lawsuits – 28%
2. Health-care costs – 27%
3. Problems with health plans – 22%
4. Availability of care – 19%
5. Uninsured/Underinsured – 16%
6. Declining reimbursement – 14%
7. Prescription-drug costs – 13%
8. Managed care/HMOs – 11%
9. Medical errors – 5%

The task for the politicians is made more costly and difficult, as each of the state legislatures and the congress, try to offer legislation that pleases both of the above very important constituent groups. Thus, 2003 and beyond may be the era of politics, medicine and war – all very expensive entities and complex in their own areas. Solving one issue may create other concerns and spread even more dissension among either the general public and/or the primary healthcare providers. Thus, the voters will see multiple-plans launched by various political parties and, just as quickly, dismissed by the very party that launched the plan.ⁱⁱⁱ The playing field has many political land mines that as yet have not been conceptualized – but they will be politically explosive for politicians and the general public.

DISCUSSION

A growing problem, for all interested parties, is the dissent among primary physician groups. Physicians, facing rapidly increasing malpractice insurance costs, have begun to launch short strikes in order to draw attention to their economic plight. Some, faced with \$290,000 annual premiums, have chosen to drop their practice or move to states where caps have been imposed on maximum awards that juries may give plaintiffs in such cases.^{iv} Some states have suggested that healthcare may be “rationed.” Rationing may be the only solution that will stabilize costs to both providers and patients. Economists point out that the role of prices is, among others, to “ration” assets along lines of affordability and real income levels. Louisiana has imposed a cap of \$500,000 on medical malpractice suits.^v Other states, faced with mounting budget deficits, have passed laws with caps as low as \$250,000. The healthcare industry will seek political solutions to what are essentially economic issues because they do not want to face the reality of their own economic condition. Political decisions are rarely in the best interest of either group – unfortunately for them and the nation at large.

Critical issues also include the purchase of drugs by cost-constrained patients – usually senior citizens - from other countries such as Canada and Mexico. Claims have been made that these drugs may not be produced using the high production standards of the United States but these claims are usually efforts by large drug companies to maintain their high cost structure in the face of global competition. An online source of ethical drugs from Mexico may be found at www.medsdex.com.^{vi} Data on drugs there are shown along with prices for various counts of each ethical drug. In a check with an area pharmacist it was said that there are some cost savings on the Mexican drugs but he urged those interested to exercise due caution in buying online.^{vii} Caveat emptor prevails here as it does in all markets – domestic or international. Credit card fraud is also a major concern of online consumers.

In the area of co-payments, some patients have begun to substitute over-the-counter drugs for those ethical drugs with a typical \$30 co-payment.^{viii} While the efficacy of the drugs may be less than prescription drugs their cost is frequently less than co-payments for the prescription drugs. One example of the cost of a brand name prescription drug before and after it became an over-the-counter drug is Claritin D. As an ethical drug it cost approximately \$4.50 per capsule. After it became an over-the-counter drug in late 2002 the price dropped to approximately \$1.29 per capsule. Assuming a \$30 co-payment as an ethical drug it may quickly be determined that the co-payment far exceeded the cost of the drug. More data of this type will become available as patents expire and some drugs are shifted to over-the-counter items. Claritin D^{ix} was never a prescription drug in Canada and was from the

start much lower there than in the U.S.^x Price elasticity does exist in this domain given that consumers are seeking optimal solutions based on incomes that tend to be quite rigid and fixed for most Medicaid and Medicare patients. They are making decisions that are very rational for them – given their income levels.

The escalating healthcare cost issue has made projections of anticipated healthcare costs for all parties, including HMOs, a most vexing economic problem. Thus, HMOs are beginning to leave certain markets where they feel that they may never be able to earn a reasonable return on investment. These decisions are troublesome to public providers, such as Medicaid and Medicare, and obviously to those who signed on to use the HMOs rather than the more common PPOs.^{xi}

Some seniors have great difficulty in locating alternate sources of healthcare when a large HMO vacates a market – particularly in the Florida market where HMOs for this type coverage are used more frequently than is the case in other geographic markets. Florida, with the highest concentration of persons over age 65, was an early adopter of HMOs in vain efforts to control exploding healthcare costs.^{xii} The loss of HMO coverage has severely complicated the healthcare issue for seniors who tend to vote at the 90% level in all elections. Elected officials fear their wrath at the ballot box over healthcare costs.

Finally, some measure of relief may be on the way given that the CEOs of healthcare organizations have been slightly more aggressive in recent years in use of proven management practices used by for-profit non-medical business firms.^{xiii} For too long they have been led by physicians who have insisted on the purchase of very expensive but rarely used equipment because “other hospitals have it.” Economic justification was rarely used in making the purchase decisions.

In a study published in the *Journal of the American Medical Association*, there is evidence that patients do exercise economic due diligence in making selections between and among generic, prescription, and over-the-counter medications.^{xiv} American workers spend less money on prescription drugs when their employer-sponsored insurance plans raise co-payments for these medications. Shifting payments to workers is gaining momentum because many firms provide employee health insurance plans where unlimited use of prescription brand-name drugs by workers has been badly abused. Workers are more prudent when they must pay some of the cost. Switches start first with a shift from brand-name prescription to generic drugs in efforts to reduce their overall cost. The recent increase from \$5 to \$10 on generic co-payments and \$15 to \$30 on brand-name drugs also has motivated patients to make another switch. The second action by patients has been decisions to seek remedies provided by medications available over the counter. The cost of these medicines is typically lower than the co-payment of generic or brand-name medicine and it is frequently about as effective in treating the ailment as the more

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Expensive drugs. This change saves money for both the patient and their employer. The practice will grow in utilization by employers.

In a study of 421,000 workers, from 25 large private employers, employer imposed increased co-payments - from \$5 to \$10 - reduced prescription costs by 22%. Costs per worker dropped from \$725 to \$563 annually. Another as yet unpublished study alleges they found no evidence the higher co-payments are forcing patients with chronic illnesses to go without medications. It should be noted that while 50% of

prescriptions filled in 2002 were generic – up 20% from the mid-1980s – they account for only 8% of the \$132 billion Americans spent on prescriptions.^{xv}

The largest pharmacy chain – CVS – reported in their annual report for 2002 that profits were negatively impacted by the switches noted in the paragraphs above. It may be expected that later financial reports may reflect the same type of financial data and results reported by CVS. Thus, patients are indeed having an impact on total expenditures as a direct result of decisions that are shown to be directly related to co-payment price inflation and tighter financial control of health benefit costs by large, private employer-sponsored plans. Economic decisions are coming into their own even as healthcare costs rise rather rapidly.

Research data reported in the Property and Casualty/Risk and Benefits Management edition of National Underwriter publication show that prescription drug costs continue to soar – about 15 to 22% annually – and that 68% of employers expect to share these increases with their workers over the next few years - either voluntarily or by managerial decisions.^{xvi}

Inflation in the U.S. in early 2003 is projected to be over 1.8% - and, given current increases in energy costs, will undoubtedly be higher than this. The rate of inflation for 2002 was about 1.2%.^{xvii} Assuming healthcare constitutes about 15.9% of the Gross Domestic Product projected to be \$1,082 billion in 2003, it is easy to show that \$172 billion will be consumed in healthcare expenditures across all types of health-related products and services.^{xviii} The projected inflation in drugs and hospital care is in the range of 18-22% - grossly more than the highest projected inflation rate for 2003 of 2.3%. The urgency and critical nature of the efforts to contain these costs is much more apparent – especially at the time that a federal deficit for 2003 is predicted to be over \$331 billion.^{xix}

States are wrestling with budgetary shortfalls and trying a variety of methods in efforts to reduce expenses in all state programs. Medical and educational programs have received the largest cuts because they are the largest components of state budgets.

A review of managerial practices points to the need for managers, in all areas of healthcare, to utilize accounting cost controls and slightly-less-efficient medical drugs and procedures - in these times of declining budgets. There aren't enough funds to provide the healthcare that various segments of the population seem to think is their legal right no matter that funds are simply not available. The problem is compounded when it is realized that 11.7%^{xx} of the population live below the poverty line and this percentage is growing as the current recession continues into 2003. The recession may get much worse.

An example of measures being used to reduce expenses may be illustrated by this short vignette. A hospital administrator for a medium size hospital recently called all staff and medical personnel to a meeting and explained the new process for requisitioning equipment.^{xxi} The administrator explained that all future requests would have to be accompanied by a thorough report of benefits and costs – a standard Benefit: Cost Analysis – no exceptions. A reason for selecting the expensive equipment based on information that other hospitals had the same equipment was not going to become a part of the decision matrix – it simply was not relevant to the expenditure of major funds for the item requested. Often administrators have caved in when confronted with the so-called “vanity factor” and committed funds that were never recovered and were not justified given the Mission Statement of the hospital. These types of management tools may help stymie the rapid growth of grossly

underutilized but very expensive equipment that many hospitals have acquired in their vanity races with area hospitals. There is much

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More that may be done in reaching for levels of optimal efficiency congruent with the economic environment that surrounds nearly all medical facilities.

Finally, HMOs have had to drop many Medicaid and Medicare patients because of reduced funding from federal and state sources. The last reduction was 4.4% in funds for Medicare patients. These organizations simply cannot offer the legally mandated healthcare for the per capita allocation given to them for their service. All of this has meant that millions of poor and senior patients have been “dumped” into the market served by medical practitioners who have made decisions that it is not profitable for them to serve these market niches. The dropped patients must scramble to locate any physician willing to accept them at the price the federal or state governments are willing to pay. Daily, the quantity of physicians who accept these patients is diminishing - at an increasing rate.

CONCLUSION

The above noted health economic issues point out that if nothing is done, rising healthcare premiums will force individuals and families to be unable to purchase health insurance and prescription drugs. Physicians and HMOs will leave the rural markets and concentrate on the more profitable large metropolitan areas. The medical industry may have reached a dilemma that only economists and professional managers may help resolve if the general public is to continue to have access to reasonably affordable healthcare.

ENDNOTES

- ⁱ Wall Street Journal, January 2, 2003, page D4.
- ⁱⁱ While there were overlaps in concerns between the general public and physicians it is easy to see that the two entities see the issues from their own unique perspectives and thus solutions are made more complex as a result of this dichotomy.
- ⁱⁱⁱ Bush, in his State of the Nation address in January 2003, outlined briefly plans to offer relief to Medicare recipients, only to see the plan attacked the next day by both Democrats and members of his own party. To date he has not stated the specifics of his plan and most say that the plan is dead.
- ^{iv} The cap in Louisiana is \$500,000 and, in other states with caps, they may be lower. Some states have had to ration the number of different prescriptions that Medicaid recipients may have at one time, according to *The Advocate*, Baton Rouge, LA Sunday, February 2, 2003. Louisiana is one state that has imposed this restriction on Medicaid patients.
- ^v The state legislature passed legislation in 2001 that limits compensatory and punitive awards by juries.
- ^{vi} A printout of available drugs and prices from this source is available for your review at the site.
- ^{vii} Not only are drug standards a potential problem but it may be possible for some companies to steal an identity using a credit card number submitted by a patient seeking drugs. Fraud is always possible.
- ^{viii} Co-payments for generics average \$15, and for prescription drugs, \$30 with 2003 increases expected.
- ^{ix} Claritin D is a registered trademark of Schering-Plough Inc., Memphis, TN.
- ^x Personal conversation with one panelist's pharmacist - February 6, 2003.
- ^{xi} PPOs are Preferred Provider Organizations in medical lingo.
- ^{xii} A member of the panel has a relative in a Florida HMO for Medicare clients.
- ^{xiii} JetBlue and Southwest Airlines have been profitable while other airlines have gone into bankruptcy. Their basic operational plan is one of keeping their operations simple and paying reasonable wages and salaries to personnel. It is too bad that boards and the CEO(s) of United, American, and Delta can't figure out how to cut expenses and earn a reasonable profit on their flight operations.
- ^{xiv} JAMA, October 9, 2002 article.
- ^{xv} Washington Post, October 9, 2002, as posted online at <http://web.lexis-nexis.com/universi...>
- ^{xvi} National Underwrite, February 5, 2001.
- ^{xvii} Data from www.commerce.gov.
- ^{xviii} Data from www.census.gov.
- ^{xix} www.whitehouse.gov source.
- ^{xx} Data - www.census.gov.
- ^{xxi} Location anonymous - to protect proprietary information.