

Lowering Health Care Costs in Wichita: A Summary of Physician Perspectives

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Visioneering Wichita's Health Care Alliance has established for the Wichita MSA a benchmark that calls for improving the quality of and accessibility to health care, while also lowering the annual percentage increase of health care costs below the U.S. or regional percentage increase. This benchmark is based on the perception that overall health care costs in Wichita are high when compared to national statistics, and that these higher costs negatively affect economic development activities in Sedgwick County and surrounding communities.

In an editorial published in the *Annals of Internal Medicine*, Victor Fuchs, nationally recognized health economist and faculty member at Stanford University's Center for Health Policy, raises the question—are we getting higher value for the increased costs of health care, i.e. longevity, improved quality of life, etc.?

According to Fuchs, it may not be necessarily bad that health care costs garner a larger part of the nation's GDP. If America's health care system is delivering more value for every dollar increase spent, then the increased amount expended on health care costs is not a negative. If, however, a significant value is not received from these increased expenditures, then a problem does exist.

While higher health care costs in the Wichita area are suspected, there is no real documentation of this assumption. The Medical Society of Sedgwick County (MSSC) calls on Visioneering Wichita to compile data to verify that health care costs in the Wichita MSA are higher when compared to other surrounding peer metro areas and to provide information to document the reasons for regional price variations. This information will be useful for measuring progress toward additional health care benchmarks that call for improving the quality and accessibility of area health care services. Whatever actions are undertaken to lower costs,

they should not negatively affect either patients' access to basic care or the quality of care they receive.

The MSSC Board has engaged in a discussion examining health care costs — an issue rife with complexities and competing agendas. The following comments voiced during the discussion identify some of the reasons causing the continuous increase of the nation's health care costs and offer potential solutions for reducing these costs:

- During the last two decades, new technologies, diagnoses, treatments, medications, even the development of new specialties have increased health care costs because they generate new services or products and create additional patient demands.

- Contributing to increasing health care costs are:

- * Rising expenditures for nursing home care, hospice services and other end of life treatments.

- * Higher inpatient hospital costs resulting from hospitals raising rates to recoup lowered profit margins incurred during the 1990s when hospitals sought to gain a larger market share of the HMO business by offering significant discounts.

- * Impact of subsidizing health care services provided to an increasing number of uninsured patients by hospitals and physicians. These costs are added to the premium costs of insured patients.

- Health care costs in Sedgwick County could be reduced significantly over time by addressing several essential public health issues, such as adopting anti-tobacco measures, fluoridating the city's water system, promoting exercise and better nutrition and advocating treatment programs for drug and alcohol use.

- Under the existing insurance system's payment process, patients have been insulated from any meaningful

awareness of health care expenses, resulting in a sense of entitlement. Currently, the receiver of health care benefits or services pays very little of the actual costs for services, thus eliminating any real incentive to be cost conscious. Increasing the patient's role in paying for their health care, through higher deductibles, co-insurance and the use of consumer-driven mechanisms, will help control the demand and utilization of medical services.

- Consideration should be given to changing employer-provided health coverage from a process that pays a monthly premium to an insurance company to one that uses a voucher-type system to pay employees a pre-established amount for the purchase of their own health care coverage. This contribution would remain a deductible business expense to the employer, but would become a taxable benefit to the employee. Also, self-employed individuals paying for health care coverage should be treated equally under the U.S. tax codes.

- A national coalition should establish a core set of health care benefits and accepted best practice principals. All Americans should have access to these basic benefits based on reasonable eligibility guidelines. Employers, government, and employees would pay for the cost of these basic services. Additional benefits could be added and paid for through appropriate cost-sharing arrangements. Offering a basic set of benefits would address the issue of access, enable patients to compare health care plans and premium costs, and develop more patient involvement in the payment process for their health care services.

- Improving the process for patients to establish a "medical home" for their primary health care needs and to receive referrals to appropriate specialty and hospital care is another way to lower costs.

- Five percent of patients account for approximately half of all health care expenditures in a given year, according to a 2005 report produced by the AMA's Council on Medical Services. Focusing on potential care-giving changes to this segment of the population could possibly lead to a reduction in health care expenditures.

- Training patients to take better care of their chronic diseases, particularly in their own homes, could help lower the cost of health care. Insurance companies could encourage self-care by paying a greater percentage of the health care bill for patients who better manage their own medical conditions.

- The cost benefit ratio of using care and disease management to coordinate the care of patients with chronic conditions and other high utilizers of the community's health care services should be explored. Case management could assist these patients in navigating the health care system and accessing appropriate care. It would help eliminate duplications of services, limit the number of catastrophic episodes, and change behavior that negatively affects patient health.

- Project Access is an example of how the community can better coordinate care for the uninsured among the community's health care providers, clinics, hospitals, etc. Since 1999, based on charges, hospitals have donated \$28,700,000 and physicians over \$12,000,000 worth of care. However, even if access to a basic core of health care services were established, programs like Project Access would continue to be needed to serve as a safety net for those patients who fall through the cracks.

- Improving health education in the schools and raising the general population's overall level of education would lead to better informed users of health care services. In addition, improving educational achievements will lead to higher levels of economic well being, thus enabling more people to pay for their health care costs.

- Administrative costs associated with health care services are rising faster

than the annual overall cost of health care. The average physician's office staff works with up to 20 different insurance plans, all with different requirements and benefit coverages, in addition to a wide array of state and federal regulations. Simplifying the administrative aspect of the modern health care system would reduce expenditures that could then be redirected to the purchase of direct medical services.

- Developing electronic records for patients that could be communicated across geographic and provider boundaries would simplify record keeping, improve communication between caregivers, allow for better coordination of patient care, and reduce costly duplication of services.

- Revenues received from taxes on alcohol and tobacco products should be utilized to develop and implement prevention programs that address the consequences of using addictive substances, instead of spending these funds on other state expenditures.

- The rising costs associated with new medical technology could be better controlled if a mechanism was established, such as a national screening panel, to review the value of new technology, determine its efficacy, and measure its impact on treatment outcomes before insurance companies begin paying for the technology and legislatures begin mandating its coverage. Better controls should be implemented to ensure new prescription drugs meet accepted evidence-based research standards and deliver beneficial results before they are available to physicians and patients.

- During their medical training, physicians need to be exposed to more information about the costs of the health care treatments they order and prescribe.

- More competition in the delivery system can be found in some cities due to the high number of large employers. However, the pressure on doctors to lower their costs due to competition could encourage physicians to leave the affected area

and hospitals to close high cost-high risk medical programs.

- Increasing the number of companies writing health care coverage in the State of Kansas could lead to a more competitive insurance environment. Actions by the Kansas Insurance Commissioner that encourage innovative benefit packages offering adequate coverage at reasonable rates and new procedures streamlining the administrative component of health care delivery could reduce health care costs in the Wichita MSA.

- The current reimbursement system should recognize the effectiveness and efficiency of physician services provided to patients — known as pay for performance — rather than paying for the number of services rendered.

- Changing the current medical-legal culture from one of blame to a non-punitive reporting system would allow for the development of strategies to improve patient care and safety by identifying and eliminating the cause of medical errors. This also should help reduce the practice of defensive medicine that often results in over-utilization of health care services.

- The rising number of mergers in the insurance market and other similar trends in the health care industry have created a profit-driven system that seems to be more interested in raising the stock price, gaining market share, and eliminating competition, than containing costs, reducing utilization, and improving patient health.

- The free enterprise system has been the basis for much of America's successes. However, the evolution of the nation's medical delivery system over the past several decades demonstrates that the traditional economic market-based model can not be successfully applied to the U.S. health care industry. Should all health care insurance companies and hospitals be organized as not-for-profit entities versus for-profit businesses?