

Health care cost containment

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Medicine is art and science. Taking care of patient's health status, claims for ethics. The ethical aspect is often subordinated to impulse of achievement in medical practice. In this issue of the Acta Chirurgica Belgica, an Invited Paper, written by Oscar Grosjean, aims to draw attention of the readers to health care cost inflation. In this introduction, the Editor wants to outline the topic with data illustrating the evolution of health care provision in recent decades.

Health care cost inflation is a major concern and it is growing faster than general inflation. Overall, medical costs outstrip the national budget. During the past decades, the budget for health care provision increased annually with a mean of 3%. It is uncertain if the national health insurance is able to continue coverage of these tremendous costs of growing health care consumption. For 2008, the global budget for public health is estimated at roughly six billion € (6×10^9). An essential ethical question is : "How to control wasting of health care resources ?". A sound health care policy aims to deliver optimal care within the limits of available resources. Ideally, the strategy should aim at delivering accessible, affordable and quality health care to those in need of it.

One of the reasons of the rising health care costs is the relentless innovation in technology, in implants and in pharmaceuticals. The claim for reimbursement of such new, high-cost procedures or drugs is not always well-founded, nor evidence based, because of its unproven efficacy. Surgeons encounter continuously all kinds of external pressure, not the least coming from industry, undermining their professional integrity and sound judgment of "good medical practice". For instance, the rate of pacemaker implantation in Belgium ($600/10^6$ inhabitants) outnumbers German and Swedish rates and is even double of UK, the Netherlands and Denmark's rates. Is it justified ?

Progress in medical science is galloping last decades. Should these findings be widely applied in public health care ? Sound and fair judgement should always remain of prime importance. What is the benefit of a less invasive procedure, and does it justify the supplementary cost ? Should we further lower the threshold for recommending interventions on the sole argument that procedures has become less invasive, are better tolerated, with shorter in-hospital stay ? An increase in procedure

utilisation, where conservative treatment is at least as effective (but less profitable to the interventionalist) is recently observed in the management of claudication (managed by infrainguinal percutaneous angioplasty) and asymptomatic carotid artery stenosis (managed by carotid artery stenting). *A perfectly performed unnecessary (and often expensive and potentially morbid) procedure remains unnecessary.*

The pharmaceutical industry provides many futile drugs, inciting prescription, often on unfounded demand by the patient himself. Should we not resist to the impelling promotion of new drugs or devices by industry, which primarily is concerned by its own profit ? Over-treatment often slips in beneath watered-down indications, whispered and suggested by medical companies. The mediatisation of health care creates unfounded expectations among patients (sick or healthy). Medical doctors should not always follow the demand of their patients, who got incomplete (or even forged) information via modern media. There is a growing tendency towards inappropriate prescriptions and excessive tests (biology, screening). This is typically illustrated in the fact that half of all antibiotic prescriptions are written for viral infections, on which they have no effect. The physician decides how much of health care services are consumed and has a crucial educational task towards his patient. The gratuitous delivery of health care (cost principally covered by health insurance), is not inciting the patients to moderate their seek for health services. It rather drives into over-consumption, since the patient is unaware of the real cost of the therapeutic choices, he and his physician have made. The educational role of the physician mainly concerns encouragement of life style changes. It is well known that "one ounce of prevention is worth a pound of cure".

Ideally, physician's self-interest should always remain subordinated to patient's health-related interest. Each physician will pretend to only strive for improvement of patient's health (the ultimate idealised goal or mission of the medical profession), denying any financial interest in providing procedures. However, it is asking more than human perfection to assume that a surgeon's judgement may not be influenced unconsciously by a pressing financial need (1).

Cost containment in health care becomes problematic and raises conflict of interests between free decision making in medical art and financial restrictions for reimbursement of health care fee charged to the patient. Is an ultraliberal free-market health system care in which providers claim unrestricted rights of free choice of any treatment and unlimited professional autonomy, still workable today? There is a need for implementation of evidence based medicine. Government regulation and managed care contracts are necessary means of cost containment, even if physicians are unhappy with it. Excellence in the practice of evidence based medicine requires a continuous readjustment of decision making, as data input changes. A more judicious and rational use of the budget for public health is an urgent necessity. Could co-payment, co-insurance and cost-sharing favourably influence the behaviour of the health care consumer? There is, however, a reverse side of the medal: only the rich patients would be able to get access to the newest modern medical innovations and cutting-edge technologies. This violates the solidarity principle of our post World War II European social system.

Hospital managers encourage their medical staff to increase the productivity level, mainly driven by concerns of competitiveness with neighbour hospitals and exclusively preoccupied by the financial health of their institute. This demand for larger workload is conflicting with basic ethical principles. Hospitals share a critical social contract to provide valuable health care services to the sick and injured with the allocated budget they receive (2). In 2004, the American College of Surgeons stated in a Task Force on professionalism: “*We, as surgeons, frequently perform expensive therapy. The interest of our individual patient may conflict with the resources available in our hospitals and our communities*” (3). The physician’s professional responsibility for appropriate allocation of resources, requires scrupulous avoidance of futile tests and procedures, for which any long-term proofs of effectiveness are lacking. The provision of unnecessary services not only exposes the patient to avoidable harm and expenses, but also diminishes the resources available for others (4). Cost should enter into the treatment decision. However, cost consideration should be placed in a subordinate position, compared to effectiveness of treatment, but this does not mean that it can be disregarded (5). Surgeon’s responsibility to practice economically is almost secondary to his responsibility to practice effectively: *economical efficiency is second to clinical effectiveness* (6).

Many other examples of inefficient use of medical care exist. There is the burning challenge of palliative care versus unnecessary suffering from life prolongation. Patients, as well as physicians are afraid to face the fatality of some diseases, and do not accept the incapacity to reverse the course of some pathologies. For advanced lung cancers, aggressive oncologists administer chemo or radiotherapy costing 100% more

than palliative care, and despite the increased cost and morbidity, survival is the same for both treatment regimens (neoadjuvant versus palliation) (7). End of life situations provide a seduction towards over-treatment (8). Up to 16% of patients, 65 years old, with terminal cancer, receive chemotherapy within the last two weeks of their life (9).

This short introduction illustrates the uncomfortable truth that medicine is at risk of getting out of its rails and that health care costs are spinning out of control.

In the following paper, Oscar Grosjean approaches the problem in a rather provocative style that could shatter and deeply distress the reader. The editorial board reminds the readers that the author (and he alone) is entirely responsible for the statements and suggestions in his paper. The Journal nor the editor are implied to subscribe author’s opinion. The merit of Oscar Grosjean’s text is that it claims for critical reflection and shake awake health care providers. The paper does not pretend to offer a solution to the problem of derailing health care costs. The personal ideas worked out in Grosjean’s paper will undoubtedly evoke comments and remarks by the readers. The reader is invited to address a “*Letter to the Editor*”, summarizing and underscoring his objections and grievance, or mentioning his alternate views on the topic of health care cost containment.

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