EDITORIAL

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OBG MANAGEMENT

Exploding health-care costs threaten other vital needs

Despite troubles inherent in the system, the United States provides the best health care in the world. One reason may be the money we spend—more than any other nation. In 1999, US health-care expenditures accounted for about 13% of our gross domestic product, while in Canada, Italy, Spain, and England, they accounted for 9%, 8.2%, 7%, and 6.9%, respectively.

The problem is that our expenditures are still rising—and rising fast. Although they slowed during the 1990s (after increasing at double-digit rates for 25 years), they have picked up again since 2001. This rapid growth threatens to limit the resources available for other important societal functions such as education, transportation, defense, and elder care. We must balance the need for health-care treatments, which generate expenses, against these other pressing requirements.

Drugs and ambulatory procedures drive double-digit growth

Health-care expenditures fall into 5 broad categories:

- In-hospital expenses (approximately 32%),
- physician costs (22%),
- ambulatory procedures (20%),
- pharmaceuticals (8%), and
- nursing home and other expenses (18%).

However, only 2 areas are responsible for the current double-digit growth: pharmaceuticals and ambulatory procedures such as cardiac catheterization, colonoscopy, day surgeries, and imaging studies.

Interestingly, in-hospital and physician expenses have been growing in the low single-digit range, and nursing home expenses actually decreased over the past few years. In contrast, ambulatory procedures and pharmacy costs are each mounting at a rate of 20% annually. This range of growth may explain why physicians perceive minimal increases in their own revenues—at a time when the costs of running a physician practice are spiking sharply—while the media keeps talking about the skyrocketing growth of health-care expenditures as a whole.

Effective new drugs escalate utilization and expenditures

Reducing pharmacy expenditures is likely to be a top priority for managers assigned to control growth. This category is rising sharply due to the introduction and widespread use of highly effective "blockbuster" drugs such as cholesterol-lowering agents and selective serotonin reuptake inhibitors, as well as the possible overuse of expensive drugs when cheaper alternatives are available.

Cholesterol-lowering agents are a good example of how a highly effective and beneficial class of drugs can boost utilization and total expenditures. A significant number of all Americans over age 55 are taking one of these agents. And once a patient starts using a cholesterol-lowering drug, she likely will continue for many years—possibly decades.

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New procedures may add billions to outpatient costs

Tied with drugs for first place in annual growth—at a rate of 20%—are ambulatory procedures. This category, too, will be difficult to control. For example, while cardiac catheterization clearly has helped reduce in-hospital expenses for treatment of myocardial infarction and coronary artery bypass surgery, its costs are about to explode as drug-eluting stents—each of which costs many thousands of dollars—become the "standard of care." The stents reduce the rate of coronary artery restenosis, but their use could add billions of dollars to the cost of ambulatory procedures.

A gathering storm

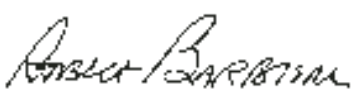
The health-care system faces a gathering storm on 3 fronts:

- rapid increases in health-care expenses,
- slow national economic growth, and
- massive state and federal budget shortfalls.

Currently, the federal government covers 35% of health expenses; private insurance, 35%; and state and local governments, 12%. The remaining 18% comes from patients' pockets.

This year the deficit could top $400 billion. The federal budget is the largest health-care payor, and a looming budget shortfall could require additional steps to slow the growth of health-care spending to help balance the budget. If the federal government cannot find a way to slow the rapid growth of pharmacy and ambulatory procedure costs, it is likely that budget reductions will fall disproportionately on hospitals and physicians.

In 2003, advocacy groups successfully reversed reductions in federal payments to physicians for clinical services. It is likely that in the next few years, advocacy groups will need to work diligently to avoid multiyear reductions in federal payments to physicians. ■



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