Health Care Reform and the Clinical Laboratory

There appears to be a remarkable consensus among government groups, the private sector, and even professional organizations, including the American Medical Association, that reform of our health care system is an unavoidable necessity. What is unremarkable is that there is no consensus on many important aspects of this reform, for example, on global budgetary caps for medical expenses. The three leitmotifs orchestrated in proposed reforms (some 30 were drafted by members of the 102nd Congress) are access, quality, and cost. It doesn't require a Harvard degree in economics to conclude that cost will be the overriding consideration. We are spending more than $800 billion annually for health care, which represents 14% of the Gross National Product, up from 9.1% in 1981. This is three times the amount spent on defense and twice that spent on education (1). Total costs of medical care are projected to surpass $1 trillion in 1995.

In this issue of Clinical Chemistry, Benge et al. (2) summarize information collected on workload, staffing, costs, and charges in the clinical chemistry laboratory at the Vanderbilt University Medical Center during the period 1980–1990. This laboratory might be considered a microcosm of the health care system; the trends described mirror those that have taken place in the total system over this decade. Test volumes increased progressively, even when they were based upon numbers of admissions and outpatient visits, and personnel costs became a larger portion of the total direct costs. Gross billings (called “revenues” in the article) increased at the dramatic rate of 25.8% per year. This was due in part to higher test volumes, which increased by 12.1% per year; however, a substantial part of the increase can be traced to simple inflation of test charges. Extrapolating the information from their Figure 1, direct costs per billable test increased from $4.70 to $5.00 per test, a modest increase. However, the ratio of charges to direct costs per billable test increased from 3.66 to 5.85. These charge/cost ratios made any attempt at restraining utilization an unattractive process in a fee-for-service environment. Indirect costs are fixed costs, and savings through decreased utilization would affect only the direct costs. However, for every $1 of direct costs saved in the Vanderbilt laboratory, the gross billings would be reduced by almost $6.

Most industries pass lower costs along to the consumer, to be price competitive and to expand market share. Consider the dramatic reduction in the price of personal computers over the past decade with concurrent evolution of more powerful machines. Without the intense competition in the personal computer market, a top-of-the-line PC might sell for $40 000 to $50 000 today. Of course, if someone else were paying for the PC, the price would be immaterial to most computer hackers. The economic history of the clinical laboratory, and of medicine in general, demonstrates policies completely contrary to the competitive free market that exists in other industries.

After World War II, clinical laboratories began their rapid technological development, which continues even today. Automation greatly reduced the costs of many tests, but the beneficiaries of these technological breakthroughs were hospitals because charges for laboratory services continued their inexorable levitation despite lower costs of production. This fiscal anomaly was possible because hospital laboratories have an effective monopoly on laboratory services; put the patient in a hospital bed and the hospital laboratory becomes the only player.

Hospitalization and other health care insurance was a rarity before World War II. The first group health plan was initiated in 1929 for school teachers in Dallas, TX, but it was not until 1960 that a nationwide plan, Blue Cross, approached a membership of 60 million members, a fraction of the total population (3). At that time, a “member of a typical Blue Cross group” might pay from $5 to $10 a month for coverage of hospital bills that averaged more than $200 a day (3). For those not having insurance, the patient or a welfare agency paid the costs of hospitalization, or the hospital simply wrote off the bad debt.

The 1960s witnessed a rapid growth in health insurance: Medicare was introduced in 1965; Medicaid, the federal/state program for the indigent, was soon started; and the cost of medical care began to balloon out of control. The first full year of Medicare involved what now appear to be modest expenditures, but they reached $88 billion in 1988, and estimated expenditures for 1992 are $130 billion (1). To limit expenditures, the Health Care Financing Administration (HCFA), the agency that administers Medicare, replaced retrospective itemized payment for inpatient hospital services with a prospective system in which a comprehensive payment is made to the hospital according to the patient’s diagnosis—the Diagnosis-Related Group (DRG). It is important to note that introduction of the flat payment, which does not identify charges for laboratory services, immediately converted the clinical laboratory from a revenue center to a cost center for these patients. We should anticipate similar comprehensive payments for most or all patients, both inpatients and outpatients, and from all insurance carriers. As can be seen from the data in
the article by Benge et al., introduction of DRGs had no effect on test utilization. It also had no effect on utilization of other hospital services. Hospitals coped with these unwelcome financial constraints by raising their charges for all services, to collect as much as possible from the charge-based insurance carriers, private insurance companies that will pay what is charged and that can recoup the expenditures by raising premiums paid by the policy holders. As indicated in the article, this practice is called "cost shifting."

A number of interrelated problems must be addressed in any health care reform program. Recent experience has demonstrated that simply increasing the amount of money being poured into the system is not a viable solution. The major players, government and industry, pay 80% of health care costs, and their immutable objective will be to ensure more prudent, even parsimonious, utilization of medical resources. Monetary constraints will be utilized extensively for this purpose; however, the most effective approach will be to place responsibility for paying a meaningful portion of the total cost of care on the patient, to stimulate cost-conscious consumerism.

By reducing or eliminating the tax deductions related to employee health insurance, the government will force industry to examine competing sources of health insurance. The documented but inexplicable differences in utilization of health care resources between physicians in different geographic localities will be addressed by promulgation of practice guidelines that define optimum patient management in specific clinical situations; the Agency for Health Care Policy and Research (AHCPR) has a budget of $200 million for developing such guidelines. Fee schedules will be standardized among all insurance carriers to prevent cost shifting, and the >1500 claims forms now in use will be reduced to one standard format—which will be electronic. Perceived fraud and abuse will be prosecuted vigorously with severe, even draconian, penalties. Tort reform to reduce the exorbitant costs of malpractice insurance will be an important part of any efforts aimed at cost containment. And some way will be found to provide basic health insurance for the 37 million Americans who now lack this safety net. There is a macabre surgical aphorism, "Bleeding always stops"; its counterpart in economics must be, "Financial distortions are always corrected" (4).

What should we in the clinical laboratory do to meet the impending fiscal challenges? We must make wise decisions, and this will require development of management systems that provide the information necessary to select the most cost-effective methods and schedules for providing essential laboratory services. The other side of the coin is that we must identify and eliminate nonessential services. The changes now taking place in the clinical laboratory will require more sophisticated approaches to laboratory management; however, it is essential that we maintain and continue to develop the science and technology that provide the foundation for our contributions to patient care. Failure to do so would result in an optimally managed but obsolete dinosaur.

References


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