Money

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"Money makes the world go around."

—from "Cabaret" by Kander and Ebb

The amount of money in medicine has exploded since the beginning of Medicare and Medicaid in the mid 1960s. With only a few plateaus during the HMO years, the money in health care has risen continuously and now represents over 17% of the US gross domestic product (GDP), putting us in the same league as Tavalu (population 9600) and the Marshall Islands (population 52,000) and greater than 50% higher than most developed countries.[1] Of course the US GDP is over $16 trillion, while Tuvalu is $39 million. The staggering amount of money in health care is the greatest obstacle to substantive reform—some current "winners" will have to lose and that is enough to make those with money and power mobilize their opposition, even to something as obvious as an unsustainable growth in costs. What also should be obvious is that—in the era of health reform—what is seen as revenue will certainly be reframed as costs. Clinicians are already being asked on one hand to increase "production," while on the other hand to cut costs. If that seems like an impossible task, it is.

Physicians historically have had comfortable incomes but as income disparity has grown in the US, unlike many of our patients, the average physician income has risen consistently since the 1960s. Currently, physician salaries average in the top 5% of US incomes, with the procedural disciplines averaging close to the top 1%.[2,3] I spent some time in November at the Center for the History of Family Medicine looking through physician daily log books, and as recently as the 1950s, GPs were charging $2 to $3 for an office visit, and a day's worth of seeing patients would generate about $90 in charges. That was an era when physicians were solidly middle class—when there was a middle class—and expectations were to live comfortably, but not extravagantly.

While physician income is a relatively small part of a very big business, what physicians do and how they do it is the significant driver for everything else in the world of medicine, from hospital charges to Pharma to the technology industry. The education of physicians has very little in it that makes us aware of our responsibility for the costs of health care in the United States. I had an insight into this at a retirement seminar for physicians I attended some years ago, where I thought that I could disguise my ignorance in a roomful of physicians and came to find out that almost none of us knew even how or when to sign up for Medicare, much less what it covered, even though we had been billing Medicare for most of our lives.

Every fall will see discussions in the press about both the complexities of choosing health insurance and the new cost equations imbedded in various plans, which often include copays, deductibles, and varying charges depending on where and from whom patients get their care. But reading the instructions and guidelines in the thick book of health plans I receive every year invokes for me the clarity of the "no parking" sign I remember from my *Mad Magazine* days 60 years ago, which read "No Parking Mondays, Wednesdays, and Fridays, except on other days." While the Affordable Care Act may have expanded the number of covered lives in the United States and helped millions avoid catastrophic costs and destitution from unanticipated illness, nothing is ever easy, particularly where issues of money are at stake. All this is to say that—as Sally Bowles did in *Cabaret*—money does, indeed, make the world go around; and the more money there is, the more the potential for mischief and corruption. The Centers for Medicare and Medicaid Services had to create a Center for Program Integrity to deal with billions of dollars of fraud and abuse in public health care funding.[4] That certainly was not necessary when physicians were charging $3 for an office visit and hospitals were $40 per day.

Hospital Costs and Medical Education

This issue of *WMJ* contains a number of articles about money. Hsu and Brazelton describe the costs of care in pediatric intensive care units and found that medical patients had longer lengths of stay, higher severity, and higher costs compared to surgical patients, but that surgical patients had a higher cost per day.[5] At some level this is intuitive, but finding and presenting these data was challenging for the authors. Hospitals made it hard to describe actual costs broken down by categories, so any effort by clinicians to trim costs would be hard to manage. Imagine trying to manage your monthly budget without any data on how you spend your money. This is often the state of US hospital "budgets" and leaves clinicians confused even if they wanted to control costs.[6]

An encouraging article by Meurer and colleagues describes the opinions and understanding of medical students in Wisconsin about the Affordable Care Act and its role in their future careers.[7] Students expressed optimism that the ACA is benefitting their communities, but the majority also expressed the need to amend the Act over time. They had personal experiences that made them support the need for affordable universal coverage, and 85% of students expressed their belief that physicians are responsible for helping decrease costs. The problem,

of course, is that students are not taught much about costs, perhaps because their teachers don't know much about costs, and the figures they see are global, large scale, and don't translate easily to day-to-day care. The authors give suggestions about bringing the costs of care into medical student curriculum at all levels but, again, lack of specifics will stymy efforts to show where individual action can make a difference. Just as patient health literacy is a crucial component for achieving clinical outcomes, financial literacy on the part of clinicians is essential for managing the cost component of the Triple Aim.

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Prevention and the Cost of Care

Turning to the upstream factors contributing to health care costs, Knox and Remington compress smoking-attributable diseases into a single measure that can be applied to counties and regions to calculate the burden from smoking, the factors that are involved in that burden, and how county-level health policies might have an effect on decreasing costs to individuals and communities.[8] The value of a single measure is that it can be used as an overall measure of improving health outcomes with a focus on the single most important health behavior—smoking—that affects morbidity and mortality. The review article on Hepatitis C by Schrager and colleagues raises a cost issue that has gotten a tremendous amount of attention lately with the approval of new direct antiviral agents that offer high cure rates at very high costs.[9] The costs of prevention, in this case, are very low if one looks at behaviors that create risk for Hepatitis C, while the costs of treatment carries the risk of a financial burden that would break the backs of many insurance programs.

Preventing falls, particularly as we look at an aging and wobbly boomer generation, is a well-described and crucial component to both preserving quality of life and avoiding unnecessary costs. Falls are so often the precipitating factor in what Stein and Mold called the "clinical cascade"[10] that adds cost and suffering to a patient's life that anything that can be done to decrease their incidence is worth the effort. But the study by Deprey and colleagues in this issue shows that the rate of fatal falls, which was high initially in a rapidly aging Wisconsin county, has only fallen slowly and remains a challenge despite community efforts to improve outcomes.[11] Some things are very hard to budge.

Health trends are always interesting in what they say about changes over time—and in the case of Timberlake and colleagues,[12] what they say about the "what" of the Wisconsin state of health. Building on the very successful example of the country report cards, developed by the Population Health Institute at the University of Wisconsin-Madison and now an important contributor to national policy through the Robert Wood Johnson Foundation, the state health trends report synthesizes a number of contributors that focus on behaviors—like smoking—and outcomes, such as cancer and greater-than-expected death rates, to help citizens understand the policy issues about health that they face in the coming years. Unfortunately, as the old saying goes, "Success has many parents, while failure is an orphan," and scorecards don't explain the "why" behind the "what," leaving us to speculate about the reasons behind positive and negative trends in very complex systems. Using state health trends will require counties and municipalities to look at where need is the greatest but often resources are the worst, leaving counties to be creative about addressing negative trends. But trends should be about directionality, as the authors point out, not overall grades.

Finally, we are republishing two pieces that seem especially pertinent as 2015 comes to a close, and many of us take time to reflect. The first is an essay by Darold Treffert, MD, a member of our editorial board and an internationally known scientist, and—as importantly—a wise essayist who, in the spirit of the Oracle of Delphi, suggests all things in moderation as an approach to "rustproofing" our lives.[13] The second is another interesting editorial originally published in *WMJ* 1935 that relates very much to the economics of health care today.[14]

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