Medicare: Cost cutting by cutting lives?

The overburdened state cannot afford to sustain its "useless eaters"—that's the way Hitler put it, and that's the thinking of "cost-effective" bureaucrats today. Marjorie Mazel Hecht reports.

The Department of Health and Human Services reported July 29 that the nation spent the highest percentage ever of the Gross National Product on health care in 1985—10.7%—and the headlines blared that the United States spent more on health than any other industrial nation in the world. Health-care spending as a proportion of the GNP has nearly doubled in two decades, and according to department analysts, "little relief appears to be in sight." More than two-fifths of the $425 billion spent in 1985 was on the government's Medicaid and Medicare programs, and despite new Medicare cost-control systems initiated in 1983, total benefit payments for Medicare recipients increased by 12.2% in 1985.

Lost amid the cries for more austerity in medical care, especially for the chronically ill and the elderly, is the simple fact that the nation's increased investment in medical care is directly correlated with the increase in life expectancy, especially among the aged. In other words, the money spent can be measured in the increased lifespan and well-being of the American population.

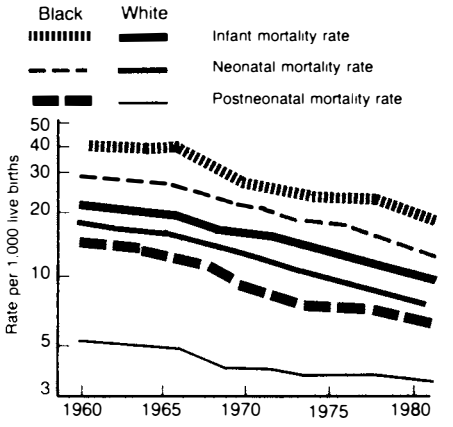
The figures are dramatic. The establishment of Medicaid and Medicare in 1965 made available increased access to medical care and medical technology—from neonatal services to hospitalization and home care—and vastly improved the quality of American life for both young and old, black and white. The advances of the past two decades are well documented, simply by looking at the decrease in mortality and increase in longevity since the introduction of Medicare and Medicaid:

- The infant mortality rate (number of deaths under 1 year of age) fell, on average, about 4% per year between 1965 to 1982, to 11.2 per 1,000 live births in 1982. It was 26.0 per 1,000 live births in 1965. This means that in 1982, per 1,000 U.S. births, 15 more infants survived than would have survived before the introduction of Medicaid (see **Figure 1**).
- Post-neonatal mortality (death that occurs between the 28th and 365th day of life) also declined dramatically, especially for the black population, dropping from 16.5 in 1960 to 6.6 in 1982—a 60% drop. During the same period, the post-neonatal mortality rates for white infants declined from 5.7 to 3.3, a 40% drop.
- Life expectancy, the average number of years a newborn infant could expect to live, jumped from 67 years in 1965 to 72.8 years in 1978, to 74.7 years in 1983. For those who reached the age 65, life expectancy increased even more dramatically. In 1900, the life expectancy of a 65-year-old was 12 years; in 1950, it was 14 years (an improvement of only 2 years over a 50-year period that included the introduction of antibiotics); by 1965, it had increased by .7 years to a total of 14.7 years. In the 10 Medicare years that followed, 1965 to 1975, it increased by 1.4 years to a total of 16.1, and it rose another .7 from 1975 to 1983. To look at this another way, of the 2.9 years gained since 1950, 1.6 years were added between 1970 and 1983, the largest change ever recorded in life expectancy at age 65 in such a short time.
- During these same Medicare years, the mortality rate for the elderly dropped sharply, averaging 1.5% per year for males and 2.1% for females (see **Figure 2**). As one study put it, "The post-1967 mortality declines among the elderly have been greater than for any previous period in American history."

Other factors, in addition to Medicare, such as the general period of growth in the U.S. economy during the years of NASA's Apollo program, no doubt contributed to the decline in mortality. However, to compare the situation to that of

FIGURE 1

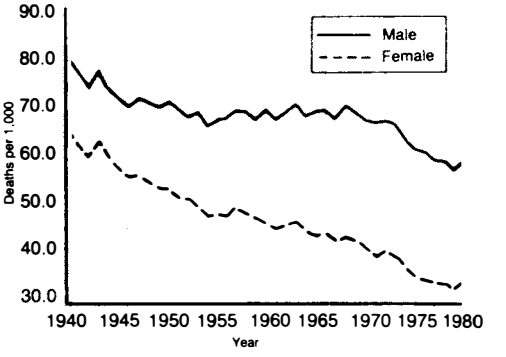
Infant mortality rates, by age and race: United States, 1960–82



Source: Division of Vital Statistics, National Vital Statistics System

FIGURE 2

Age-adjusted death rates for the population aged 65 and over, by sex, United States (1940–1980)



Source: U.S. Senate Special Committee on Aging, *Developments in Aging: 1983, Volume 1,* Washington, D.C., Feb. 29, 1984.

other growing economies during the same period: The decline in U.S. death rates was almost twice the decline of these rates in Canada and in Europe.

• There has also been a sharp decline in the mortality rates for the aged for specific major causes of death associated with old age, although as more people live longer, there is also an increase in the incidence of the chronic diseases associated with old age. In 1980, heart disease was responsible for 46% of all deaths for persons over 65. However, between 1970 and 1979, the death rate from heart disease for persons 65 to 74 declined 22.7%—the most substantial decrease ever recorded in one decade for this disease category and age group (see **Figure 3**). For those 75 to 84, the decrease was 14.5%; and for those over 85, the decrease was 18.7%. Similarly with cerebrovascular disease (stroke), during the 1970s, the rate of decrease in deaths from strokes averaged 3 to 5% per year (see **Figure 4**). Stroke is responsible for 7% of the deaths for persons aged 65 to 74 and 14% of the deaths for those over 85.

• One of the most dramatic results of the Medicare program and advanced technology is the number of people with end-stage renal disease (ESRD) who are still alive. In order to stay alive, people with ESRD require kidney transplants or some form of dialysis. Today, 93% of the U.S. population with ESRD participates in Medicare. This means that 76,117 persons with ESRD were alive and receiving treatment in 1982, compared with only 18,564 ESRD patients in 1974.

• Hemodialysis became available in 1960, after the development of a shunt that connected to an artery and made blood filtering possible without collapsing the blood vessels, but it was not widely used because of the prohibitive cost. In the mid-1960s, there was a national debate over who should pay for ESRD dialysis treatments, which culminated in an amendment to the Social Security Act in 1972 that extended Medicare coverage to more than 90% of the ESRD population. One of the things that influenced the congressional decision was the fact that an estimated 7,000 to 10,000 persons were dying per year because of the unavailability of dialysis.

The number of ESRD patients receiving long-term hemodialysis then jumped from 40 patients per million population in 1972 (most of whom were paid for by non-profit organizations) to 200 per million population in 1982—a fivefold increase.

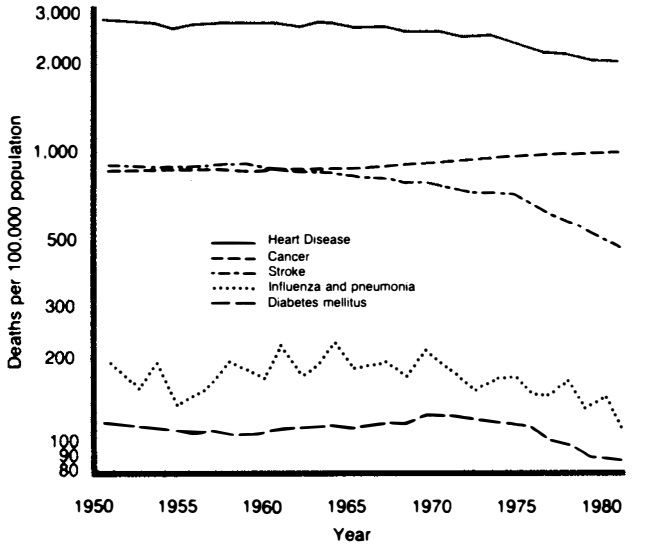
The cost estimates for hemodialysis in 1980 were $25,000 per patient for in-center treatment and $13,000 per patient-year for home treatment after the first year. Although ESRD patients are only 0.26% of the total Medicare population, they receive 5% of the total Medicare expenditures. Medicare's ESRD program grew from $250 million in 1974 to about $1.8 billion in 1982.

Cutting back medical progress

There is no technical reason that prevents the rate and scope of improvements in the health of the U.S. population from moving forward. Even generally pessimistic accounts of U.S. medical technology acknowledge that if the recent advances in medical technology are allowed to continue, it will be possible to make further significant increases in life expectancy, both by control of chronic diseases and by slowing the aging process. In addition, continuing progress in infant mortality could be expected; for despite great improvement, the United States still ranks 13th internationally in this area, below Japan, Canada, the Scandinavian countries, and others. In particular, continuing progress in mortality rates could bring the black and Hispanic population up to the levels

FIGURE 3

Age-adjusted death rates for persons aged 64 an over, United Stats (1950–1979)



Source: U.S. Department of Health and Human Services, 1982

of the white population.

Although the prospects of achieving even further advances are well within grasp, the Reagan administration has moved in the name of cost-cutting not only to limit this progress, but actually to reverse it. The first targets of such cost-cutting are the same ones that Hitler started with—the very old and the very sick. Indeed, the rationale for such cuts is the Nazi rationale: The overburdened state cannot afford to sustain its "useless eaters." Of course, today such murder is called by more polite names, but the effects of the policy are the same. Removing the elderly's access to medical technology means that older Americans will die. That the gains of the two Medicare decades have begun to be reversed is already clear; how rapidly the reversal will proceed remains to be seen.

The Office of Technology Assessment, which has prepared a multitude of reports analyzing medical technologies and cost-cutting, has consistently advised Congress that advanced technology is responsible for the increased costs of medical care and suggested various cost-cutting alternatives. Although the OTA is supposedly presenting value-free analyses, its anti-technology bias is clear. For example, what does the OTA say about life-saving hemodialysis technology provided by Medicare? Its 1985 report on Medicare's Prospective Payment System discusses hemodialysis in the context of rationing health services and reports on the details of the British system, which rations hemodialysis treatment:

> The story is different in Great Britain, though, where the National Health Service, with its limited budget, decides who will receive treatment for kidney failure. Most of the patients in Britain who receive hemodialysis have acute kidney failure, not chronic or end-stage renal disease. The United States has about three times the proportion of patients receiving dialysis as in Britain. . . .
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> What are the criteria for determining who in Great Britain will receive dialysis? There are no official explicit criteria, but physicians in Britain admit that the following factors influence their hemodialysis decisions: age of the patient (usually those 55 and over do not receive it); vascular complications of diabetes; other medical diseases; physical handicaps; mental illness; and lack of adequate facilities in the home. Rejection criteria vary from dialysis center to dialysis center.

As the OTA matter-of-factly notes in its evaluation of the Medicare-Medicaid program:

> The social and political climate today is quite different from that in 1965, and now that Medicare's goal of improving access to health care for the nation's elderly has been largely achieved, the primary focus of policymakers is on containing Medicare costs.

Since 1983, this point of view has prevailed increasingly in the national budget, and as a result of the containment of Medicare costs, written into the law in 1983, has already begun to reverse the progress made in extending the lifespan of America's elderly.

Cost-containment regulations

In 1983, the Health and Human Services Health Care Financing Administration (HCFA) began to phase in a Prospective Payment System (PPS) that pays a flat rate to a hospital for each Medicare patient admitted. The rate is determined according to which Diagnosis Related Group (DRG) the patient is classified in. Previously, hospitals were reimbursed for Medicare patients retroactively, based on the actual services the hospital had performed. The new measures had an immediate and well-publicized effect—hospital costs in 1985 increased only 6.1% over the previous year, the lowest rate of increase in the past 20 years.

Not publicized was the immediate effect on the patient population. From the beginning of the PPS in October 1983 to March 1985, discharges of Medicare patients to skilled nursing homes increased by almost 40%, while discharges to health care at the patient's home increased by 37%. By the end of the first calendar quarter of 1985, more than 50,000 additional patients were being discharged yearly to nursing homes and home health care than at the beginning of PPS.

Those who oppose maintaining the investment in Medicare and Medicaid, would extend the same criteria to the general public. Speaking before a national conference on Diagnosis Related Groups sponsored by HCFA in November

1983, Carolyne K. Davis, the administrator of the HCFA, which supervises the Medicare program, defended the revisions in payment to hospitals:

> [If] one lesson emerges out of our past experience, it is this: We have at last met the enemy of cost-effective care—and it is everyone. To be cost effective and yet deliver quality care, we must all alter our pattern of behavior. We are launched on a reimbursement revolution and prospective payment for Medicare inpatients is but the opening phase. The administration is really pursuing three approaches to reform, all of which stress the underlying theme of competition. They are:
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> - consumer incentives to curtail needless utilization;
> - encouraging less costly alternative delivery systems;
> - and payment incentives for providers to be more efficient.

Davis then outlined a variety of measures, including the Prospective Payment System, to make sure that hospitals are not spending a penny more than the lowest amount recorded for a particular task, are not keeping patients any longer than the shortest time necessary, and that hospital review boards pay close attention to physicians whose practices involve "higher cost."

The associate administrator for policy at HCFA, Patrice Hirsch Feinstein, explained at the same meeting that of the various options available for curbing Medicare costs, the HCFA had chosen "to put emphasis on being a prudent buyer." This course of action is preferable to other options, she said.

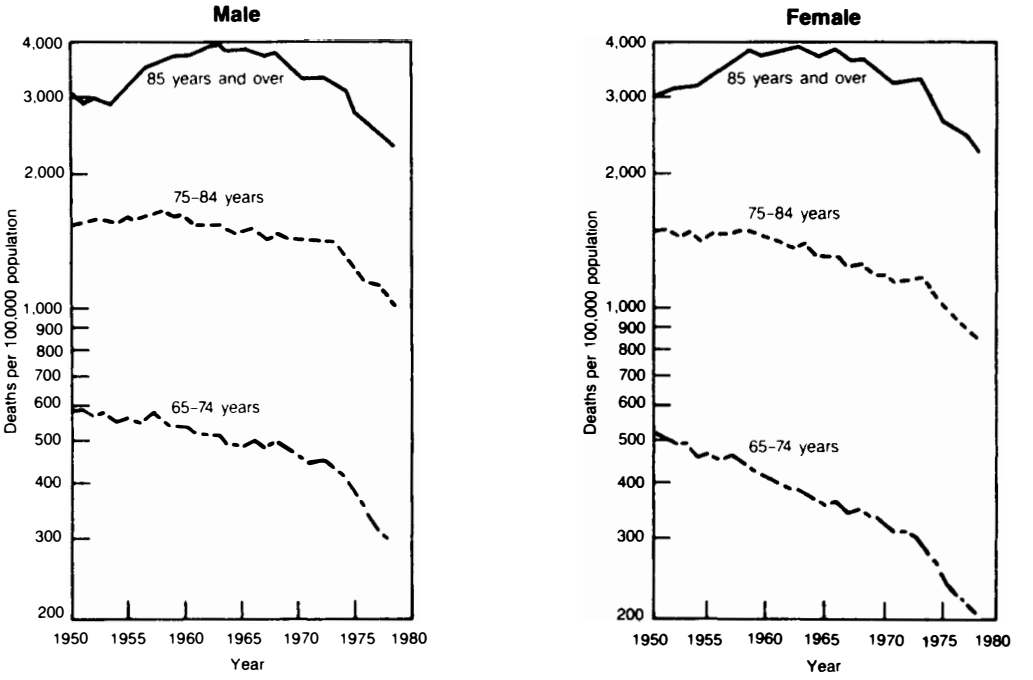
> We could decrease expenditures or the rate of increase in expenditures by some 30%, or we could increase the tax rate by 2½ times what it is today. If we did the latter, we would be imposing that tax on an ever decreasing proportion of workers to retirees, down from 2.3 workers today for every retiree to 1.9. . . . To reduce the number of eligibles, entitlement could be delayed, benefits could be reduced, or new procedures could not be covered.

But such measures could not be justified, Feinstein said, until "we have squeezed out inefficiency in the system. . . ."

At the same meeting, various hospital administrators from the state of New Jersey discussed the impact of the Diagnosis Related Group system that was begun in New Jersey as a demonstration project in 1980. Most of the presentations discussed how hospitals were now "prudent

FIGURE 4

Death rates among persons aged 65 and over for cerebrovascular diseases, by sex and age



Source: U.S. Department of Health and Human Services, 1982

buyers." One hospital administrator discussed how the DRG system had forced the hospital to maximize revenue and thus make decisions on the basis of cost that previously were made using other criteria:

> The greatest change attributable to the DRG payment system is a change in attitude. Because of price, the Hyperalimentation Committee selected the least costly intralipid solution. Consideration of cost was unknown and unnecessary in the pre-DRG era. The element of cost has been incorporated into the patient management decision-making process. . . .

What does "squeezing out inefficiency" look like in terms of patient care?

In March 1986, Medicare deaths in hospitals became front-page news when the Health and Human Services (HHS) agency released a national list of hospitals whose death rates for Medicare patients were above or below the expected norm for the number of persons served. The figures themselves are raw data and do not tell the public anything about the quality of care at the hospitals involved. For example, one city hospital with a high death rate sought out homeless people as patients, a population that has an expected high mortality rate. Another hospital in Nevada is a "hospice," where presumably it is considered to do its job successfully if 100% of the patients die.

The cause for real alarm, however, is the cost-cutting measures for Medicare instituted in 1983 that have cut the Medicare budget by reducing the quality of care for America's 27 million senior citizens. The real question to ask is not which hospitals have exceeded (or undershot) the average death rate expected for Medicare, but how many elderly have died or suffered in the past three years because, as a "cost-effective measure," they were discharged too soon and too sick from a hospital, or because Medicare stopped paying for a needed health service which the patient could then not afford to keep up.

The OTA states over and over again that technology is responsible for the increased cost of health care:

> There is substantial evidence to suggest that inappropriate use of medical technologies is common and raises costs without improving quality of care. Such excessive use exists within the norms of medical practice and across the spectrum of technologies available to physicians. Physicians' habitual behavior can cause excessive use of medical services. Until recently, medical education trained physicians to do all they could for their patients' well-being without concern for the cost.

In other words, as Sen. John Heinz (R-Pa.), chairman of the Senate Committee on Aging, put it, patients are being discharged "quicker and sicker." The further problem is that there are not adequate facilities to treat such patients. A report prepared by the Senate Committee on Aging noted that "very few facilities [nursing homes] have the resources necessary to 'gear up' to meet the heavy care needs of these patients." The Committee heard testimony in hearings in 1985 citing case studies of patients who had died unnecessarily as a result of premature discharge from the hospital—discharges that would not have been made two years ago.

The huge increase in Medicare discharges to nursing homes and home health care after the institution of the Prospective Payment System has begun to exacerbate an already abysmal situation. Nursing home care in the United States varies widely from state to state and home to home, but as a 1986 study by the Institute for Medicine at the National Academy of Sciences concluded:

> There is a broad consensus that government regulation of nursing homes, as it now functions, is not satisfactory because it allows too many marginal or substandard nursing homes to continue in operation. . . . Poor quality homes outnumber the very good homes.

As reported at hearings of the Special Committee on Aging, discharging seriously ill Medicare patients to nursing

Medicare: A Profile

Medicare now covers more than 30 million people, 90% of whom are 65 years old or older. About 11% of Medicare recipients are disabled and not elderly, and the disabled recipients use more of the Medicare funds per capita. In 1984, for example, the estimated payment for an elderly person was $1,773, while the estimated payment for a disabled person was $2,136.

When Medicare was initiated, 9.4% of the population was 65 or over; by 1984, 11.6% of the population was in this category—an increase of 24%. This increase in the percentage of the population eligible for Medicare has, according to the Health Care Financing Agency, "put the solvency of the Medicare hospital insurance trust in jeopardy."

Unlike other federal health programs, Medicare is not paid for solely out of general revenues. In 1984, 92% of the income for the hospital insurance part (also called Part A) of Medicare came from a 1.3% payroll tax on employers and employees for the first $37,800 of wages, while self-employed persons contributed 2.6%. Payroll contributions to the program increased 13.7% that year, while the payments to Medicare beneficiaries increased 8.9%.

Clearly in order to support a growing population of elderly at a higher standard of medical care, it is necessary to provide for a growing workforce at a higher level of productivity. Under these circumstances, the increase in quantity and quality of care offered should not prove an excessive burden to the economy. Because 66.3% of Med-

icare's payments are for in-patient hospital services, examining hospital costs provides much of the answer to why Medicare costs have increased. The answer is straightforward: An increasing number of Medicare participants entered hospitals; hospitals provided an increased intensity of services, including many new, advanced technologies; and labor costs increased.

In addition to more hospital admittances, Medicare participants have longer hospital stays and require more services. For example, according to the Office of Technology Assessment (OTA), the rate of surgery for the elderly in 1980 was 61% higher than the rate for the population as a whole, and from 1973 to 1980, it increased by 37%, while the rate for the total population increased only 22%.

The other part of the Medicare program, supplementary medical insurance (also called Part B), was paid for by monthly premium payments of $14.60 per Medicare participant in 1984, as well as by general tax revenues. In 1985, the individual premium rose to $15.50 per month.

Medicare's benefits do not cover many preventive services, including eye examinations and physical checkups, hearing aids, custodial care, dental care, and orthopedic care. Therefore, Medicare participants, who have a greater need for medical care in general than the younger population, pay more out-of-pocket expenses for their health care than the rest of the population. About one-third of all health care expenditures are for the Medicare population, up to 30% of which are made for care of persons in the last year of life.

homes that are not equipped to provide the kind of intensive care necessary puts the recovery of these patients at risk; more of them are likely to die sooner.

Just one year after the cost-cutting system began, the inspector-general of HHS, Richard Kusserow, wrote, "The impact of this type of abuse on quality is so significant that its potential visibility could jeopardize the integrity of the medical review process and the payment system."

Since the PPS program began, representatives of hospitals, physicians, nursing homes, and patients have complained that the PPS and DRG systems are not being monitored for quality, just for cost. In fact, HHS has still not carried through the quality of care study mandated by Congress in 1983. HHS has a system of independent overseers, called Peer Review Organizations, but the department has not required of them the kind of reporting necessary to determine if patients are being discharged too soon and too sick. In fact, the PRO system was mandated by Congress to check precisely on the potential threat to the quality of care of the Prospective Payment System.

Testimony by the Government Accounting Office to the Senate's Special Committee on Aging Nov. 12, 1985 reported:

> HHS does not have the necessary data to evaluate whether PPS has either increased or decreased the quality, access, demand, use, or cost of post-hospital care for Medicare beneficiaries. Furthermore, HHS is not planning to do the types of evaluations that are necessary to determine whether PPS is the cause of changes in these five areas.

In many cases, the paperwork HHS requires for the Peer Review Organizations (PROs) has upped hospital costs significantly, according to testimony to the Committee on Aging. Data available from one teaching hospital in North Carolina showed that the PRO last year requested copies of portions of 568 patient charts averaging 30 pages per chart, as well as documents relating to 31 cases that exceeded usual costs (called outliers), 20 complete charts for appeal, and 11 charts for special review. To provide this paperwork, the hospital paid $3,300 for paper and hired three clerks and one nurse at $93,865 per year, just to deal with what the PRO required; a fourth clerk is employed full time xeroxing. In work time, including half-time for one administrator, the hospital calculated 9,360 manhours were spent. Another hospital spent $26,000 to meet the PRO requirements, which it paid for by cuts in nursing staff and services.

The OTA report on Medicare's Prospective Payment System purports to throw up its hands. "It is simply not possible to assess, for example, whether the observed changes in length of stay have had any impact—for good or bad—on the quality of care given to Medicare beneficiaries." The OTA goes so far as to say that perhaps discharging patients sooner is beneficial, for it exposes them less to the kinds of serious infections one might get in a hospital!

". . . Although the ultimate impacts of PPS on technological change may never be known, evaluation on a less ambitious level might produce some useful information. . . ." said OTA. One study, for example, noted that the computer assisted tomography (CAT) scanning shifted from hospitals to physicians' offices. Another found that New York state's rate-setting program "appeared to depress the availability of all types of services."

Other problems noted by the Special Committee on Aging, but not documented in detail, are that hospitals now have an incentive to deny admission to Medicare patients who require heavy resources or who have an illness that is classified as an "unprofitable DRG." A staff report prepared by the Special Committee on Aging Sept. 26, 1985 stated that the financial incentives provided by DRGs encourage hospitals to pressure doctors to treat patients in ways that violate good medical judgment—quicker discharges, admittances based on "inflexible sets of DRG 'cookbook' admission criteria," and a poor accounting of the severity of a patient's illness, which is "a major determinant of the actual cost of hospital care." In some hospitals, administrators kept lists of doctors who had higher rates of admittances of "unprofitable DRGs."