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"39 AND HOLDING"

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The middle letter of the word "SPHEX" is "H" which stands for history and over the past 75 years the club has been blessed with a membership of some eminent historians. However, I suspect that there is a little history buff in most all of us, particularly as it relates to our own lives. It recently occurred to me that within the next few months I will have practiced medicine in Lynchburg for 39 years and since I had kept some of my earlier patient and financial records, I thought it might be interesting to compare medicine nearly 40 years ago in this city with what it is today. There is a motive in this comparison and that is an attempt to look at one of the major issues in health care today and that is the cost of medical care - why it is so high and what there is that we can do about it.

Now I am going to discuss such things as the changing pattern of health care, the increased costs of practicing medicine today and the explosion in medical technology and I want to say in the beginning that I recognize that medicine ~~xxxxxx~~ has not been ~~affected~~ alone in being effected by these changing patterns. After all, in 1951 one could buy porter house steak for 49¢ a pound and you could buy a Buick Roadmaster, the top of the line of General Motors at that time, for less than \$2,000. Also in 1951, the average citizen of Lynchburg could not foresee the vast explosion in technology, particularly as it relates to electronics. There was no TV station in Lynchburg and only a few people had TV sets who were trying to pick up a weak signal from Richmond, which was the nearest station we had. Who could have foreseen VCR's, camrecorders, microwaves, and of particular importance, the computer age. All of this has contributed to a better way of life but also a more expensive way of

life but I would submit that in the area of health care the explosion has been even more fantastic and the costs even higher.

In 1951, when I came to Lynchburg, there were 65 doctors in the city. Almost all of them were located on Church Street in the Allied Arts Building, the Young Building, the Medical Building, and several others. There was one who practiced on Rivermont Avenue and there were two family practitioners in Fort Hill but other than that they were all right here downtown. There were no physicians in Forest, on Timberlake Road, there was none in Rustburg, there was one in Madison Heights, two in Amherst, one in Appomattox, two in Altavista. The ~~WERE~~ 65 physicians were mostly primary care physicians, that is family practice, internal medicine, and pediatrics. There were a few specialities represented: general surgery, obstetrics, orthopedics, urology; there were no psychiatrists or dermatologists or cardiologists or rheumatologists or gastroenterologists or cardiac surgeons all of which and many more are represented today. As a matter of fact, we now have 250 members of the Lynchburg Academy of Medicine of which about 220 practice in Lynchburg and all specialities, including cardiac surgery, are now represented here.

When I came to Lynchburg I rented my first office in the Medical Building on Church Street for \$65 a month. In 1989 I have been paying \$1200 a month for almost the same space. My first employee worked for \$25 a week which is about \$1300 a year. At the present time salary ranges for medical office personnel range from \$12,000 to \$25,000 a year depending on the level of their educational background.

As I have said, overall prices and the cost of operation have increased but I would submit that the expense of delivering health care has risen faster than the overall cost of living and there are a number of reasons. First of all, there is the overhead of operating an office or hospital; second, there is malpractice insurance; third, there is the cost of medication; and fourth, there is the explosion of medical

technology. All of these are interwoven as I hope we will be able to see.

First let me discuss overhead. I have already talked about the increase in cost of operating a medical office. Let us look for a moment at the hospitals. In 1951, there were three hospitals in Lynchburg: Marshall Lodge -Memorial Hospital located on Grace Street; Lynchburg General Hospital located at the end of Federal Street at the intersection of Hollins Mill Road; and third, Virginia Baptist Hospital which is still at the same location on Rivermont Avenue. Each hospital had/one room laboratory with one laboratory technician. Each hospital had one x-ray machine with one x-ray technician. We now have two hospitals and each of them have entire wings devoted to laboratory and x-ray each with hundreds of employees in the two hospital x-ray and laboratory units. Things that we take for granted today were unheard of in 1951: intensive care units, coronary care units, respiratory therapy, neurological intensive care units, surgical intensive care units, physical therapy, occupational therapy, and many many more which are costly and which increase the number of employees tremendously.

These things cost money and remuneration must come from someplace - that is patient charges. In 1951 a hospital room averaged \$8 a day with Memorial Hospital having beds as low as \$4 a day in semi-private rooms. Recently a member of my family spent a short time at Lynchburg General and her hospital bed and meals was alone \$270 a day. In 1951, it was rare for anyone to have a hospital bill of over \$100. Now a hospital stay can run as high as \$700 to \$800 a day, or more depending upon what unit one is in and the amount of laboratory work, x-ray and other ancillary services that they require. The cost of medication, as we will see a little bit later, is also a very important item.

Now these figures that I have mentioned for Lynchburg, which according to the Wall Street Journal in a recent article, <sup>are</sup> ~~is~~ in the lowest 20% of health care costs

of all metropolitan areas in the country. As close as Roanoke, the average daily ~~xxx~~ cost in a hospital is about \$200 a day more than in Lynchburg.

Secondly is the cost of ~~medical~~ malpractice. In 1951, my malpractice premium was \$65 a year for \$100,000 of liability insurance. In 1989 I paid \$7,000 for a million dollars in coverage and my specialty, internal medicine, is in the lowest group. In Lynchburg some specialists, particularly neurosurgeons and obstetricians, pay as high as \$45,000 annually and in other areas of the country the same specialists may be paying \$135,000 and up. And I would point out that the hospitals also must carry liability insurance at astronomically high prices.

Malpractice has implications other than the cost to physicians. For instance, of great concern to the Medical Society of Virginia in recent years has been the availability of certain services throughout the state caused by either the high cost or the inability of certain physicians to get malpractice insurance which has caused a crisis in some specialities, particularly obstetrics, but that's another story. Also, the malpractice crisis has increased the cost of medical care because of what has come to be known as "defensive medicine." Physicians feel obliged to cover themselves by ordering procedures or referring to specialists which may not be needed in the management of a patient but is needed to protect the doctor against malpractice. For instance in 1951 we had no board certified cardiologists in Lynchburg. We now have four. I think that the general internist who is capable of managing most heart problems would leave himself open to liability of claims if he had a heart patient in the hospital and did not seek consultation from a cardiologist and this type of defensive medicine, of course, increases the cost of medical care.

The third item that I would mention is drugs. In 1959 we had morphine for pain, phenobarbital to treat nervousness and high blood pressure, and very little else.

Penicillin had just come on the market but was in short supply and really didn't become readily available until a couple years later when the armed forces released their stock piles that they had had during the Korean war. It was rare in 1951 for a prescription to cost more than 50¢ to a dollar. As a matter of fact, when I came to Lynchburg all drug stores operated a soda fountain and there was more financial remuneration from such facilities than there was from filling prescriptions. Now there are monstrous drug bills. As an extreme example, there is one drug named Activase which is abbreviated by the letters TPA which is used to dissolve blood clots in people who have had heart attacks. This drug costs \$2500 for one dose. Now that's extreme but we now have a variety of drugs which are used for the treatment of hypertension, heart trouble, cholesterol lowering, psychogenic, and many many more many of which at the drug store will cost you from \$1.50 to \$2.00 per capsule or tablet and it is not unusual for drug bills to run as high as \$400 or \$500 a month for an individual.

I have already mentioned the explosion in medical technology. We have talked about the special units but we need to add the fact that we have some remarkable machines: cobalt, the CAT scan, the magnetic resonance imaging machine (MRI), linear accelerators, lithotripsy machines for breaking up kidney stones and gall stones and many many more. These are multimillion dollar machines and we also have remarkable surgery: coronary bypass, angioplasty, and organ transplants and all of these are expensive.

I think it is important to recognize that the cost of medical care does not follow the same economic laws that apply in the general market place. It can be reasonably argued that technology in the electronics field for instance is very expensive and it is, but the marketing area for microwaves, computers, VCR's, etc. is worldwide. The ~~marketing area~~ marketing area for the Lynchburg hospitals and

Lynchburg physicians is relatively limited to the Central Virginia area of some 200 to 250 thousand people and to provide state-of-the-art medical care for that small number of people is costly.

We need to also mention the cost of medical education today which is really quite high. Almost all physicians who come ~~xxxxxx~~ out of medical school are heavily in debt having borrowed to pay for their medical education and it is very hard for a solo practitioner to get started. Most physicians ~~xx~~ are either looking for a medical association or going on into one of the highly technical specialty areas.

What all this means is that we have a highly technical system of health care which provides a high quality of care at high cost but not for everyone. We do have a system of rationed care in this country based on economics. Now the truly indigent or welfare patient has access to medical care through Medicaid, Medicare and, in Virginia at least, through the local health departments. But it is estimated ~~xxx~~ that ~~the~~ there are about 37 million Americans who are working but who are working at wages which will only allow them to subsist and does not allow them to pay for medical care or to pay for the cost of health insurance. These have been sometimes called the "medically indigent" or in Lynchburg have been referred to as "working poor." Here in Lynchburg as well as in Roanoke and several other communities in Virginia, this problem has been partly solved by providing free clinics for people who fall into that category but throughout the country this is a big concern and is a big concern of Congress today. Congress has toyed with the idea of requiring every employer to provide insurance for every employee but with the high cost of medical insurance, this would put a lot of small businesses out of business.

Now I am not sure that anyone has a satisfactory answer to the high cost of medical care. I think that if the American people were surveyed they would say that they would like to continue the quality of care that they are now getting but they

would like to have it for everyone. The question is, "How can that be done? How can we lower the cost of medical care without lowering the quality?"

The big question is the percentage of gross national product spent on medical care and is that too much or is that enough? At the present, it is estimated that we spend about 11% of gross national product on health care. Now since the gross national product is now measured in trillions of dollars, this means that we are spending in the billions for health care in this country. Well where can we save? There are several areas that we might be able to reduce costs. One, of course, is in the area of malpractice. Perhaps the lawyer members of the club will not agree but there are many who feel that the question of professional liability should be removed from the tort system. In Virginia two years ago we were successful in getting the neurologically damaged infant problem out of the tort system and putting it into a workmen's compensation type of setting and we believe that this has ~~xxxx~~ ~~xxxx~~ been a big influence in lowering malpractice premiums in Virginia by about 25% in the past two years. It is not likely that state legislators will go so far as to remove professional liability from the tort system but there is are some rumblings in Congress that this might be a part of a package that some federal legislators are contemplating.

Another area is in the efforts of institutions to consolidate certain activities. This has been done in Lynchburg. You are all familiar with the fact that ~~xxx~~ the two Lynchburg hospitals merged several years ago but for about 15 years prior to that merge many of you may not be aware <sup>that</sup> ~~of the fact that~~ ~~xxxx~~ the two hospitals had a liaison committee which met on a regular basis to discuss the introduction of new services in Lynchburg and efforts were made by that committee to make certain that expenses for services such as cobalt, neonatal intensive care unit, emergency rooms, CAT scanners, MRI's were not duplicated at each hospital. If that had been allowed to

happen and we had to have the hospitals competing with each other for the limited two hundred population market that we have here, the costs of medical care would be considerably higher in Lynchburg and we would not be in that low 20% that the Wall Street Journal has reported that we occupy. However, cooperative action and merger between hospitals is very difficult because the Federal Trade Commission and antitrust units of the Treasury Department look askance at mergers and ~~xxx~~ put forth the idea that merger of hospitals is restraint of trade by establishing a monopoly and therefore would drive costs up. This is another example of what I previously mentioned - that the economic factors which work in the general marketplace do not work in a provision in providing health care because of the high cost of such provision and a limited market in which they find themselves.

I think the bottom line here is that the cost of medical care is not going to decrease. Technology will continue to expand and the costs will continue to go up.

Congress has made a number of attempts to reduce care by various means. They have tried to establish what they call expenditure targets which means that they would target so much for medical care each year and that was it. This failed because no one could decide how to ration medical care on the basis of limiting money. Recently there has been a lot of discussion about so-called resource base relative value scales. This is called RVS and came out of a Harvard study which indicated that some doctors, particularly those who are procedural doctors such as surgeons, were overpaid and that cognitive physicians, such as family physicians, internists, and pediatricians, were underpaid under the present system. ~~and~~ The resource base relative value scale would revise the fee system as it applies to federally funded programs by reducing fees paid to procedural doctors and increasing the fees paid to cognitive physicians. This would in fact be redistributing the wealth and it is hard for us to see how this could really save money.

There has recently been a lot of interest in Congress in the Canadian system of medical care. Congressmen who are promoting the Canadian system have been supported by ~~xxxxxxx~~ a very strong voice in the person of Lee Iocca who is touting the Canadian system as the best solution to our health care cost problem in this country. However, there are voices in Canada which are now being raised which question whether or not the Canadian system is all that it is touted to be. The Canadian system, for instance, is now about 20 years old and it is actually a program of rationed health care. A recent study by the Heritage Foundation has raised very serious questions about whether or not the ~~xxx~~ Canadian system would work in this country. Actually the Canadian system really shifts the cost of health care from the purchaser to the taxpayer. In Canada the entire cost of the system is on the government which in turn means the taxpayer. One important thing to note that the Heritage Foundation has pointed out is that taxes are higher in Canada than in the United States and that the per capita national debt in Canada is double what it is in the United States. The link between who pays the bills and who receives the services is broken because the service is free and the demand is high. Consequently, the cost of care, not quality, is the primary consideration of the government so to control costs, prices must be fixed which reduces the number of physicians and hospitals willing to provide services at a fixed price. The best way to reduce cost is to place barriers in the way of those who seek care and this is what the Canadian system does. For instance, in all of Canada there are only 11 units capable of doing open heart surgery while in the United States there are approximately 800. I recognize that Canada has a smaller population than we but on a per capita basis that means that in Canada there is one open heart unit for every 2.3 million people and in the United States there is one for every three hundred thousand people. There are only four lithotripsies in all of Canada. We have five lithotripsies within 60 miles of Lynchburg. There are approximately 250 lithotripsies in the United States. In terms of availability of

care, cataract surgery in Canada is available only a wait of approximately nine months; corneal transplant will require a wait of approximately four years; cardiac catheterization is not done on an urgent basis - the wait is usually about six months and coronary artery bypass has a waiting period of six to nine months. I think someone has pointed out in an article recently that if you wait long enough to provide some of these services then you don't have any problem - that death is the ultimate economy. ~~XXXXXXXXXX~~

In the end it seems to me that the American people must decide what level of care they want and are they willing to pay for it. I think that all of us - physicians, politicians, bureaucrats - need to be honest with the American people and tell them what they are getting for what they pay for and what it will cost in terms of money to provide that quality of care for everyone in this country. And also tell them what it would cost in terms of quality to reduce the cost as is done in the Canadian system and certain ~~XXXXX~~ others. In my opinion costs can be reduced in some ways: court reform, reduction of paper work, reform in methods of reimbursement. But in the long run "read my lips, increase taxes" is the only method that we can provide the quality of care that the majority of Americans have become used to. What I am saying is we need to let the American people have the full story and find out what quality of medical care they are willing to pay for and that is going to be a very difficult question.