A. FYI E.

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american society of internal medicine

Evans:

I thought you'd like to know that we've gotten a few letters concerning Dr. Nelson's recent C-SPAN appearance. (see enclosed example)

Let me know if we can be of assistance in the future.

Best—

[redacted]

LOG JUL 26 [illegible]

22 July 1993

Alan Nelson, MD
Executive Director
American Association for Internal Medicine
2011 Pennsylvania Avenue, NW #800
Washington, DC 20006

Dear Dr. Nelson

I was able to watch a little of your interview on C-Span on July 9th. Your views and comments were most appropriate. I am concerned that so few details about our health care problems are presented in the lay or general professional literature, such as the NEJM, AMA Journal, Annals etc. There is instead an abundance of ideas about how to fix the system but no real analysis of the problems. Nor do the fixers reference studies which document their view of an indicator that there is problem (infant mortality). Nor is there a direct comparison with the systems of other countries which are proposed as models.

How do the Brits provide care for a patient with Disease X or Y? Or the Canadians or Germans or Swedes. And what is the cost annually, not as a factor of GNP but per person?

I would guess that more than 98% of us do not have the foggiest what goes to make up the $800 + Billion alleged to be spent on health care annually. Perhaps those who write about the problem are among the 98%.

In any event, Primary Care MDs are, if a part of the problem are not benefiting much. For a service provided in 1965, most of us have received a 300% raise, from $12-$15 for an office visit to the prevalent $36-$45. A complete new patient examination for even the most complex problem has increased far less. Medicaid has raised its reimbursement a little more actually, from $3 to $12 for an office visit and from $7.50 for a home call to $22.50 or $25.00. Which is not to say they do not make an adequate living but the percentage of income an office based primary care physician takes home has steadily decreased. You work much harder for less satisfaction and for less income.

If you calculate the increase in reimbursement for basic services provided in 1965, factor in increases for inflation in human costs for hospital operations with a catchup factor for most of those persons who were severely underpaid, and the increase in costs for the expansion of the population as well as for providing more care for more people due to the availability of insurance coverage and Medicare you end up with a large gap.

It is my observation that this is composed of a lot of money spent for attached items which are only vaguely related to the direct provision of care such as research, and social services

and services related to care for our drug dependent society and the unfortunate AIDs epidemic. And then we have the largest of all factors, TECHNOLOGY.

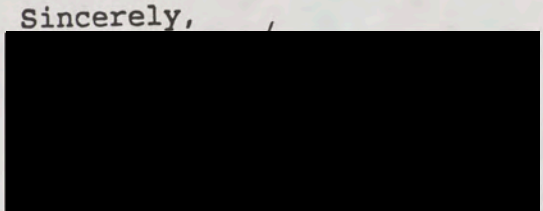
TECHNOLOGY, in my view, is the main factor which has directly and permissively accounted for the enormous increase in health care costs over the last 3 decades. Directly on its own in the form of equipment, necessary building, associated administration and supervision etc. Permissive in the enormous expansion of the cadre of professionals required to operate the new TECHNOLOGY and the enormous increase in what can be done. If a heart attack victim cost $12 per day for the doctor and $35 - $50 per day for the hospital and perhaps $200 for diagnostic studies for an uncomplicated case in 1960-5, it would have cost perhaps no more than $1000 for 10 days in hospital. Today that would cost as much as $10,000 or more when one includes scans, cardiac cath, perhaps PTCA; and a good bit more if you need surgery. And your attack need not be a complicated one for this scenario to unfold.

I would hope that you consider and perhaps stress more strongly this aspect of the cost of care. If the problem is not addressed, physicians will receive an even smaller reimbursement for their services in order that the program may afford TECHNOLOGY.

Medicare reimbursement and most HMO and group linked insurance company services such as Blue Shield and Blue Cross have a fixed fee schedule. Blue Cross has recently reduced its reimbursement schedule. So there is a form of price control in effect at the present time.

Finally, I find it curious that the Health Care Task Force is resorting to releasing little bits of information as in the form of trial balloons, rather than getting it out and allowing us to get our teeth into it. What is needed is a full debate of the ideas to be presented.

Sincerely,



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