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High Cost of Healthcare in the United States-A Manifestation of Corporate Greed

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Abstract

Rising costs of health care has been a cause of concern in recent years. According to the latest estimates we spend $2.9 trillion dollars every year, around 18% of the GDP, and about $9,255 per person each year in health care costs. But it is highly debatable if this high expenditure translates into improved patient care and healthcare outcomes. The healthcare is presently considered an industry or a business venture. The corporatization of medicine leading to the rising administrative costs and growing cost of prescription drugs and devices is also a cause of concern and are major contributing factors to the rising health care costs. The practice of defensive medicine is, in part, contributing to the present situation. We believe that the present-fee-for-service reimbursement model needs to be changed to value-based-care which can help in improvement of patient care outcomes without increase in the health care costs. Major health care reforms are long overdue, but who will ring the cat?

Keywords: Health care costs; Administrative costs; Fee for reimbursement; Value based care

Introduction

"The world has enough for everyone's need, but not enough for everyone's greed." -Mahatma Gandhi

'Corporate greed'; these are the two words that can best describe what ails US healthcare today. That is the reason US healthcare is least efficient among eleven developed, industrialized nations [1]. This is despite the fact that we spend close to $ 2.9 trillion dollars every year, around 18% of the GDP, and about $9,255 per person each year, significantly more than any other country. Increasing cost of healthcare and corporate greed are best reflected in a recent report of Turing Pharmaceuticals increasing the price of its recently acquired drug Daraprim, brand name of pyrimethamine, which is an important drug to treat rare opportunistic Toxoplasmosis infection in HIV patients, from $13.50 to $750.00 per tablet [2]. This news created a furor among the public and lawmakers.

The news reached a fever pitch and, actually, prompted Turing's founder, Martin Shkreli, to agree to reduce the price, though it has not been done so far. While the media attention given to Daraprim was strong and unusual, the 'price gouging' associated with prescription drugs is not new. In April, 2014, the price of doxycycline, a common antibiotic, went from $20 a bottle of 500 tablets in October 2013 to $1,849 [3]. There are numerous commonly and less commonly used drugs that the small new upstart pharmaceutical companies buy the marketing rights to, and then increase the price several-fold for big profit. These small companies do not have any significant research and development of their own as they often claim to invest money in. To make profits and recover the horrendous cost of acquiring rights to one or more drugs, they just increase the cost of the drugs acquired. Sometimes the price rise is gradual over a period of time, but at other times the price is increased abruptly several-fold as in the case of Daraprim.

In fact these stories can be used as case studies in business schools on how to make huge profit where none truly exists. There is a striking case of EpiPen®. EpiPen® is epinephrine, a lifesaving medication used to treat anaphylactic shock. Mylan Pharmaceuticals, Inc. purchased the product's marketing rights from Merck in 2007. At that time EpiPen® used to cost around $57 and its annual sales were $ 200 million; today the same drug costs $415 for a pack of 2 EpiPen®, which expire within a year. With help from savvy marketing and increase in drug price, its annual sale today is more than $1 billion [4,5]. There are multiple examples of huge increases in prices of life saving drugs [6]. In reality it raises questions about fair practices in corporate governance, moral ethics, and price regulation by federal government and its effect on US public health and associated healthcare costs.

In a free market economy like the United States, it is understood that when demand for a particular product increases, resources multiply. It often leads to increase in supply, and the price of the product stabilizes and at times comes down. But the reverse is true in the drug industry today; as the demand increases or remains stable, the industry keeps increasing the price regardless of the supply or demand. Ultimately, all these increases in price of drugs are passed on to the consumer and/or the payer (the government or the private insurers). Actually, Medicare plans to increase the premium of its drug plan by almost 8% early in 2016 to meet the rise in the prices of drugs [7]. This raises the question whether the federal government should play a more active role in regulating drug prices?

To be sure, the federal government has – at times – played a role in the regulation of drug prices. For example, in 2010, the Department of Justice announced a $421 million settlement with three drug companies over their role in setting the Average Wholesale Price (AWP) of various medicines [8]. Prosecutors alleged that these manufacturers - Abbott Laboratories, Inc., Roxane Laboratories, Inc., and Braun Medical, Inc. - falsely published inflated AWPs of numerous pharmaceuticals in an effort to market, promote, and sell the drugs to existing and potential customers. According to the Department of

Justice, the scheme involved an agreement between healthcare providers and the manufacturers to falsely adjust the "spread" on the price of pharmaceuticals in order to create larger profits for the healthcare providers. The "spread" is the difference between the inflated published price, which the government reimburses at, and the actual price paid by the healthcare provider for drugs.

Yet, government regulation of drug pricing is the exception, rather than the norm. In fact, the Medicare legislative structure envisions that the federal government will not play a role in drug pricing. In fact, unlike the state Medicaid programs, the federal government is actively prohibited from negotiating drug prices [9]. The New York Times has described this prohibition as financial "windmill" for the pharmaceutical industry and as "a sop to the drug industry" [9] back to our story, pyrimethamine (Daraprim) is not a new drug; it has been available since 1953. It was only a few years back when it was available for about $1 per tablet. In fact, GlaxoSmithKline (GSK) which was producing this drug since 1953 sold the marketing rights of albendazole (albenza) and pyrimethamine (Daraprim) in the United States to CorePharma in 2010 [10]. Later, Impax Laboratories agreed to buy CorePharma and affiliated companies for $700 million. Then Impax sold Daraprim to Turing Pharmaceuticals for $55 million [2]. Shortly after acquisition of Daraprim, Turing Pharmaceuticals, a smallish brand new company [11], raised the price of drug from $13.50 to $750 per tablet. Everybody made profit with each transaction.

Albendazole also has the same story. It is an old drug discovered in 1971, included in the WHO list of essential medicines. In many areas of the world the wholesale cost of albendazole is between $0.01- 0.06 per dose [12]. In late 2010, the listed average wholesale price (AWP) for albendazole was $5.92 per typical daily dose in the United States. After acquisition of the marketing rights by CorePharma, the price of albendazole rose steadily to $119.58 per daily dose by 2013. This price rise is reflected in overall increase in healthcare costs [13]. The Medicaid data shows that spending on albendazole increased from less than $100,000 per year in 2008, when the average cost of a prescription was $36.10, to more than $7.5 million in 2013, when the average cost was $241.30 per prescription [10]. Currently, in 2015, one 400 mg tablet (an adult dose) of albendazole costs around $50 [14].

Moses et al [15] have recently reported in an article in JAMA (Journal of American Medical Association) that the increase in the cost of the drugs and devices is single-handedly responsible for about 4% increase in healthcare cost year over year. The spending on prescription drugs and devices increased from around $61 billion dollars in 1980 to $349 billion dollars in 2011. If the costs associated with healthcare continue to increase at the present rate, our total health care costs in the US will be close to $5.1 trillion or close to 20% of the GDP by the year 2022 [16]. Increase in the cost of pharmaceutical agents is only one of the major drivers of the rise in healthcare costs. Greed and profit motive are all pervasive in other areas of healthcare as well.

Moses et al [15] described the anatomy of the US healthcare system and noted that the biggest increase in healthcare spending, approximately 5.6% annually, is due to the rise in administrative costs since 2000. In 1980 the administrative costs accounted for $ 29 billion but these costs rose to $189 billion in 2011. This is intriguing. It is common knowledge that the number of physicians in private practice and the number of private practices both are declining since 2000. In 2005, more than two thirds of the medicine practices were owned by physicians; a recent survey shows that now only 35% of the physicians are practicing independently [17,18]. This is in large part due to large hospital-based healthcare systems taking over physicians' practices. In this healthcare scenario (which we will call "medical-industrial complex"), physicians are mere employees, just like nurses, health care technicians and other employees who do not have much say in the functioning of these mega corporations.

The healthcare in United States is now considered a business venture, and rapidly becoming so in many developing countries where medicine has been privatized. Like all business ventures, these business ventures acquire professional managers, legal advisors, information and technology experts, billers and coders, insurance and marketing folks, and office workers like any other business- say Exxon or Colgate-Palmolive. Now in this medical-industrial complex, we have more 'non- healthcare' people than healthcare providers. This medical-industrial complex, while good for administrators, adds up phenomenal non-medical expenses to the medical care costs, and increases total healthcare costs astronomically. It is not surprising that the highest paid individuals in healthcare today are not physicians, but administrators, corporate CEOs and CFOs [19].

In a recent New York Times article, it was stated that the average salary of a healthcare company CEO in 2014 was close to $400,000 per year, and often in seven or eight figures [19]. The compensation package of the CEOs of some of the healthcare firms would put to shame business power houses of corporate America. For example, General Electric is a fortune 500 US company with assets close to $680 billion with operating revenue of $142 billion in 2014, and about 300,000 employees; it paid its CEO $18 million in compensation in 2014 [20,21]. On the other hand, Barnabas Health System, a New Jersey based integrated healthcare delivery system, which operates seven hospitals, employs around 25,000 people, including 5,200 physicians, paid its CEO a $21 million compensation package in 2012 [19]. It is notable that the average salary of a general physician, who actually works day in and day out for the healthcare corporation seeing patients and taking night and weekend calls, ranges from $150,000-$180,000. In the health insurance industry, the discrepancy is even more marked, the CEO of Aetna earned a total compensation package of over $36 million in 2012 [19]. Obviously, it adds to the overall costs, and most of the times it is passed on to the common man and US healthcare system in general [15]. This scenario raises very important question as to the need for more managers and administrators in the healthcare industry.

To be sure, the consolidation of healthcare systems has not reduced prices or corporate expenses. On the contrary, these big consolidated or integrated healthcare systems are not always efficient or result in improved health outcome. In a recent JAMA article, these concerns were raised [22]. Tim Xu et al [22] found out that healthcare costs increased from 20-45% after the hospital consolidations and mergers. These costs were passed on to the consumers resulting in higher deductibles, co- pays and insurance premiums [22]. The concerns were also raised about monopoly of few health systems which could lower the competition, a key factor in driving down costs in any market-driven economy.

Another major cause of increased healthcare costs in United States is the presence of flawed reimbursement model for health care services. The fee-for-service reimbursement model which is universal in the United States, while well-intended, has become a victim of its own intent. It favours and rewards physicians and healthcare institutions that generate more revenue which means more tests and more procedures. There is constant pressure on the physicians to increase billing for the services provided to the patients from the hospital

administration. An increase in the amount of services provided at each visit and scheduling multiple visits for the same or related problem/s enhances the hospital revenue and makes 'corporate medicine' more productive. This system is not only inefficient, but also immoral and unethical. Unnecessary care is not only expensive, but has the potential to harm the patient. Healthcare costs are major reason for personal bankruptcy in the US [23,24] and injury caused by unnecessary care is now a subject of multiple lawsuits.

A large number of physicians who took an oath in medical school not to hurt their patients are sometimes involuntarily becoming profit-making tools in this medical-industrial complex, and at times they become willing partners in this unethical practice for their own profit motive. The payment reform in Medicare and Medicaid patients is long overdue. Besides the fee-for-service model, there are other models like value based services, bundled payment model, pay-for-performance and comprehensive-care service model that can be and should be explored [25]. There is urgent need to focus more on outcome, value and quality of the service provided rather than just the volumes of patient seen and number of tests/procedures performed. The reforms are hard to come by because medical care is complex and there are guidelines to follow, but each patient is different and implementation of guidelines is difficult and standardization is variable.

For example, Center for Medicaid and Medicare Services (CMS) introduced in 2012 hospital readmissions reduction program, which requires CMS to reduce payments to hospitals with excessive readmissions [26]. This penalty to hospitals did not take into consideration that all hospitals are not created equal. There are some private hospitals that take care of patients with private insurance and those from higher socioeconomic strata. But most hospitals in the US, especially the University teaching hospitals, are still not business ventures, and they cater to lower socioeconomic status population and also play important role in medical education, especially in teaching medical students and other healthcare providers. In most of these hospitals, patients often use the emergency room for primary care as they do not have any insurance or have only basic insurance with high co-pays for even common drugs and procedures. These patients often do not have the education and resources, both social and economic, to afford modern drugs and other healthcare tools. Therefore, following discharge from the hospital with diagnosis of chronic illnesses, like chronic obstructive pulmonary diseases (COPD)/ congestive heart failure (CHF), they frequently return to the emergency room sometimes within days to weeks.

This problem was highlighted in an important study conducted by Henry Ford Hospitals in Detroit [27]. The authors found that patients from lower socioeconomic status have 24% higher chances of readmission. This phenomenon was recently recognized by our lawmakers, and in 2014 they introduced legislation - the Hospital Readmissions Program Accuracy and Accountability Act that would require the CMS to account for patient's socioeconomic status when calculating risk-adjusted readmissions penalties [28]. This was a timely move but we need more to fix the healthcare than merely write a few laws. Federal price regulation of the drugs, especially drugs which are not new and not a result of new research, less pressure on physicians leading to change in payment models reforms from current volume/ numbers based to value based system, rewards focusing on disease prevention and judicious use of resources is required. This will not only ease the pressure on physicians but also improve the patient satisfaction and will bring back care back in healthcare.

More importantly, the high cost of healthcare is particularly painful for the socio-economical disadvantaged individuals. They have not only more disease, but also inability to pay high costs; this often leads to adverse outcome in this unfortunate population. In summary, we believe nothing short of revolution is needed to address the cost of healthcare in the US today, but the big question is: are we as a nation ready for it?

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