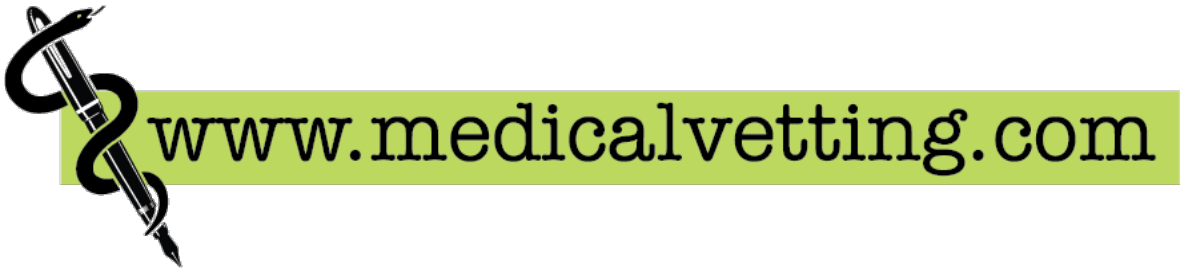

Healing in a Hurry

Hospitals in the Managed-Care Age

by Suzanne Gordon and Timothy McCall, M.D.

Just as he was trying to get acclimated to the new world of managed care, George LeMaitre, a Massachusetts surgeon, received a call from an HMO he works with. The administrator wanted to know if LeMaitre would be willing to discharge patients having carotid endarterectomies (a major operation in which fatty deposits lining one of the main arteries to the brain are literally reamed out in an effort to prevent strokes) the day after the procedure. A decade ago endarterectomy patients typically stayed in the hospital ten days. By 1996 it was down to two days. LeMaitre told the reviewer that he would only keep such patients in the hospital for a single day when he saw scientific studies documenting the safety of the practice. Resorting to peer pressure rather than peer review, the HMO administrator countered that another area surgeon who he named was keeping his endarterectomy patients for only a day.

"That," says LeMaitre "is when I hung up."

What this New England surgeon experienced is typical. In everything from bypass surgery to hip replacements to mastectomies for breast cancer, the length of stay in the hospital has shortened dramatically. Under market-driven managed care, dramatic reductions in hospital stays has become one of the central strategies of insurance companies and of the employers who are the major purchasers of health insurance. As a result, managed care plans and hospital administrators all over the country are now pressuring doctors and nurses--or bribing them with financial incentives--to discharge patients more quickly.

Although few experts dispute that hospital stays were unnecessarily long under the fee for service system, that some patients do better when cared for at home, and that advances in medical technology allow some conditions to now be safely treated outside the hospital, the driving force behind recent dramatic reductions in hospital stays --a la the infamous "drive through delivery" — has been financial. While the result has been lower health care premiums to employers, the effect of shortened hospital stays on overall health care costs is far less certain. What is clear, however, is that some patients are being harmed, even dying, as a result.

His is because despite assurances from the industry that shorter stays improve quality while saving money, the industry is applying a slash and burn approach to

hospitalization. Patients are unceremoniously ejected from the hospital with fevers, urinary catheters, draining wounds, on ventilators, not able to walk and with conditions that could destabilize within minutes. They have been promised that carewon't be compromised and that instead of recovering in the hospital, professionalnurses and home health aides will care for them at home.

I nstead, these promises are being systematically broken. HMOs have initiated draconian cuts in home care, Congress has followed suit, and home care agencies are responding to their financial crunch by either closing their doors, limiting services or simply refusing to care for those patients who are predictably more expensive—those who are sicker, frailer or who have more complex problems. The system now demands that friends or family members provide care in the home. This
expectation persists even in some cases when there is no one is available to serve that function or when the technology loved ones are supposed to master is beyond their capabilities.

Grace Dean, an oncology nurse at the City of Hope Medical Center in Los Angeles, recounted her youngest sister's recent experience. During her sister's twelfth week of pregnancy, the previously health 23 year old woman began to have severe nausea
and vomiting. She became dangerously dehydrated but her HMO physician refused to admit her to the hospital for intravenous fluids. Instead, he insisted that IV fluids
be administered at home.

The exhausted, dehydrated young woman who could barely stand up, was to be cared by her father who had emphysema and was himself still recovering from a life-threatening illness, a mother who had just had a hip replacement operation and a
husband whose own mother was having a bone marrow transplant in another city. Despite their best efforts, the family was unable to ensure that she received sufficient fluids. Her worsening dehydration resulted in a kidney stone which finally
forced a hospital admission for intravenous fluids.

Hospitalization is one of the most expensive components of healthcare and it has been assumed that by cutting it, major savings could be realized. An influential early
study by H. S. Luft, published in 1978 in the New England Journal of Medicine, concluded that virtually all of the savings achieved in HMOs was due to lower rates of hospitalization.

To cut hospitalization rates, HMOs use a three-pronged strategy. First, many routinely deny coverage for some elective procedures-such as cataract surgery and bone marrow transplants for advanced breast cancer--which traditional insurance would have paid for. In a *Journal of the American Medical Association (JAMA)* study of California, in hospitals in markets with the lowest penetration of HMOs, the total number of operations increased by 7.9 percent between 1983 and 1993. In markets with the highest penetration of HMOs, the number of operations dropped 14.8 percent. Second, HMOs shift many other procedures to outpatient settings. In the JAMA study in markets with high penetration of HMOs, the number of inpatient procedures was almost halved while outpatient surgeries almost doubled. Third, they discharge patients sooner. In California, the total number of hospital days in high HMO markets was cut in the ten year period from 4.9 million to 2.8 million.

Because childbirth is the number one cause of hospitalization, managed care plans saw that if they could cut time mothers' time in the hospital they could save billions of dollars. In 1970, women having normal vaginal deliveries stayed an average of 4 days; those undergoing Cesarean sections stayed 8 days. By 1992, those numbers were cut in half. By 1994, most HMOs were limiting stays for C-sections to two or three days and for vaginal deliveries to 1 day. Some California plans, like Kaiser Permanente, were encouraging new mothers to leave the hospital after only eight hours.

For traditional heart bypass surgery, hospital stays of two or more weeks were common as recently as a few years ago. Now four days is considered the goal. Women having mastectomies for breast cancer have gone from more than a week in
the hospital to recent attempts to perform the procedure on an outpatient basis. According to oncologist Glenn Bubley of Boston's Beth Israel-Deaconess Medical Center, patients undergoing radical prostate surgery used to stay in the hospital between seven and nine days. Now they are out in two or three days--and must go home before their urinary catheters have been removed. The logic seems to be if cutting a little was good, then cutting more is better. "There is a 'can we get away with it' attitude among insurers," Bubley says.

One reason that insurers have been able to get away with cutting so much is that for
most conditions it's never been proven that shorter stays harm patients. For the handful of conditions that have been investigated, the researchers have often

concluded that cuts in length of stay are safe. Typically, however, these studies have
excluded more seriously ill patients--even though the results of the studies have been used as justification to apply the protocols to these sicker patients.

Rather than randomly assigning one group of patients to a shorter hospital stay and
comparing the results with another group allowed more traditional hospitalization, most of the studies didn't include a control group. Most studied so few patients that
they lacked sufficient statistical power to detect important differences in quality even if control groups had been used.
Many of the studies that insurers rely on to justify their policies are also outdated and the effects of the more recent cuts in hospital stays haven't been studied at all. Since cuts in hospital stays have been progressive, recently published studies often report on the results of hospitalization lengths that managed care executives would now consider too long. A 1991 JAMA study compared the effect of varying length of stay for six common medical and surgical conditions. No significant differences were found in deaths, likelihood of readmission or patient satisfaction but get this: In the case of bypass surgery, in the hospital with the shortest length of stay, patients stayed 8.9 days on average. In 1999, that would be considered the height of
luxury.

Another problem with most of these studies is that they fail to mirror real world conditions. Our review of dozens of studies revealed that the doctors involved experienced less interference in clinical decisions from insurers while their patients received more education prior to discharge and more nursing and other services in the home than are commonly provided by managed care plans.

For many researchers, the things that matter most to patients and their families don't show up on their radar screens. Take pain control. Dr. Kathleen Foley, chief of
Memorial Sloan Kettering's Pain Services explains, "Today's shortened average length of stay has altered the kind of pain management that doctors can use because
they are trying to get patients out of the hospital so quickly." Colleen J. Dunwoody, Clinical Coordinator for Pain Management at the University of Pittsburgh Medical Center states, "Unfortunately patients are leaving the hospital with more pain because they are leaving earlier."
I
ronically, failing to adequately control pain could ultimately increase costs.

According the government's Agency for Health Care Policy and Research uncontrolled pain may lead to shallow breathing and cough suppression resulting in
pneumonia. Pain also causes the release of stress hormones, the agency's report explains, which suppress the immune system, promote the breakdown of body tissue, delay the recovery of bowel function and increase the formation of blood clots.

When insurers and health policy makers calculate the cost-benefit ratio of early discharge practices, what is also never included is the costs -- emotional, physical and financial -- borne by patients and family members. When acutely ill patients are
sent home too early, someone has to provide the 24 hour a day nursing care that registered nurses deliver in hospitals. If the patient lives alone -- the patients have to be their own nurses or recruit friends to do the job. If patients are lucky enough to have family members, the family member steps in.
Caring for an acutely ill family member goes way beyond tea, toast, and tenderloving-care.

With no respite, family members must now provide round-the-clock nursing surveillance, juggle complex medications, and manipulate I.V. s, ventilators and other high tech medical equipment to patients who are highly unstable.
To make matters worse, managed care under both private HMOs and under Medicare is significantly limiting the availability and reimbursement of home care services, just when earlier hospital discharges means the patients will need even more care. According to a 1994 study, HMOs give about half as many home visits per hospital discharge as traditional Medicare. Under the Clinton administration, Medicare is doing its best to close the gap. In an effort to cut the home health care program by $16 billion over five years, the Clinton administration has severely cut reimbursement rates in the Balanced Budget Act of 1997. To meet these budget cutting goals, the Health Care Financing Administration (HCFA) initiated a so-called
interim payment system which caps home care at 1994 levels in both the number of visits provided and the total amount spent on patients. The result has been that the average home care agency will lose 30 percent of its Medicare revenue,
with Medicare financing the overwhelming majority of home care visits.

The administration has justified these cuts by citing examples of fraud and abuse in home care. Instances of fraud, however, have been largely limited to the for-profit sector of home care but it is the not-for-profit agencies and their patients who are

suffering the most under these changes. That's because agencies not involved in fraudulent practices, have little room to cut costs without cutting services.
"If an agency is not going to be reimbursed for all the care they provide, they are forced to limit the amount of services they deliver," says Karen Dick, a nurse who heads Boston's Beth Israel Deaconess Medical Center's home care program. "In Massachusetts there was a net loss of 2.7 million visits from 1997 to 1998. We are seeing a lot of agencies that aren't accepting really sick patients or discharging them
really early. It's a terrible disincentive to care for anyone who is frail, complex or really sick."

The National Association for Home Care reports that 1200 agencies have closed since the initiation of the interim payment system, 77 percent of agencies have reduced staff, some by more than one fifth. And home care experts say that the full impact has yet to be felt since the transformation to the new reimbursement system
happened later in some agencies than in others.

Cutting hospital stays and home care services certainly reduces governmental and corporate costs for health care—at least in the short term--but the question remains
whether overall costs to society are reduced. In order to calculate the social costs of these policies we need to look at the impact on individual patients and their families.

"When insurers and the government consider the safety of shortening length of stay,
patients' and families' comfort and convenience do not figure into calculations at all," Dr. Glenn Bubley explains. "The patient can be at home in pain and suffering, the family can be terrified, but if the patient does not come into the Emergency Room, it's going to be tracked as a positive experience in the literature. It's simply not in insurers' interests to know about the myriad problems patients have at home."

It's also not in insurers' and employers' interest to calculate the financial costs to family members who must take time off work to care for a loved one. As David M. Witter Jr., of the Association of American Medical Colleges observes, data assessing
the cost effectiveness of shortened length of stay do not reflect the cost to families in
such areas as volunteer labor and lost work time and to the larger society. "If it were

possible to measure these costs," he says, "the true nature of the excessive cost being
borne by the economy would seem staggering."

Not only do scientific studies fail to calculate these costs, they often dismiss the patient's and family's experience as trivial. One study of outpatient mastectomies, for example, concluded that: "The physical and psychological benefits of such an approach outweigh any minor inconveniences on patients and families." Facilely included in the catalogue of minor inconveniences are anxiety over performing complicated medical and nursing procedures without adequate training, lost income, lost promotions and even lost jobs, and guilt if the loved one's condition deteriorates.

Thousands of American patients apparently judge these problems to be serious indeed. In 1997, a study sponsored by the American Hospital Association found that
one third of the 37,000 patients questioned said that they had been discharged from
the hospital too quickly. Thirty percent were not told what danger signals to watch for after discharge and 28.7 percent said they had problems with continuity and transition.>
What is perhaps most frightening is that patients may actually forfeit their lives when they are asked to nurse themselves, or when family members are asked to play
the role of professional nurse in the home. In February of this year, the prestigious medical journal The Lancet published an article that found an eight-fold increase in
deaths in the U.S. due to medication errors. The investigators wrote that the "shift to out-patient treatment implies that more medications are taken with the patient, not medical personnel, exercising quality control." In other words, when patients are asked to be their own nurse or doctor, they often fail and may die as a result.
The sacrifices imposed on patients, families and their caregivers are all justified by the supposed social benefits, primarily reduced health care expenditures, which lead
to better competitiveness in the global marketplace and more money to spend on other worthy causes. The ultimate irony is that there is evidence that cutting length of hospital stay hasn't saved the country much money. According to Princeton economist Uwe Reinhardt, from l980 to 1993, real per capita spending on hospital in-patient care rose by nearly 53 percent even though in-patient days plummeted by
36 percent. Reinhardt tersely concludes, "As track records go, this one is truly

remarkable."

This apparently paradoxical rise in costs accompanied by declining number of inpatient days occurs because the hospital days that have been cut really cost very little. Yet the way hospitals price their services disguises this fact. Hospitals have traditionally negotiated their services at a flat daily rate--say a $1000 a day. In the hospital, however, the earliest days of care tend to be much more costly. That's because a patient who has just undergone a surgical procedure or who has an acute illness will need more tests, more medication and more intensive nursing care. As the patients recuperates, his or her needs decrease. The actual cost of a day later in the hospitalization might be only $150. Professor Alan Sager of the Boston University School of Public Health concludes that it may cost as little as $30 to $60 to care for a mother and newborn in the hospital after the first day. This figure may seem startlingly low but if little nursing and physician time is needed, few tests are done, and the bed would otherwise lie empty, the costs are negligible.

The only costs may be meals and laundry services. Whether care costs $30 or $300 that day will still be billed at $1000. Reinhardt calls this system “perverse pricing.” It encourages insurers to try to kick patients out of the hospital as quickly as possible-- or not admit them at all--nomatter what their doctors think. "We're all under pressure," Holly Roberts, a New Jersey obstetrician says of the kinds of practices utilized by more and more HMOs, especially the aggressive, cost-cutting for-profit plans. "We know that if we don't perform like insurance companies want us to we'll be out the next year. One of the very large HMOs in the area came to my office with two graphs with little dots. Each dot was a physician. There were 130 dots and I was dot number 37."

According to the HMO, Roberts patients were staying in the hospital for too long. "They told me that the only thing keeping me in the system was my low C-section rate. If I didn't get patients out sooner they would have to eliminate me from being able to participate in the system and care for patients in this HMO, which is a major provider."

"They don't care whether patients are exhausted or fainting in the bathroom," she continues. "Unless they're hemorrhaging or have a high fever they want them out. After that meeting, I realized it was either my profession or my patients getting out."
George LeMaitre, the Massachusetts surgeon mentioned earlier, tells of effectively being fired by one of the largest HMOs in his area after refusing to discharge a patient of his recovering from a major operation for colon cancer surgery in what in his judgment was too soon. "The feedback I've been receiving," the letter from the

plan's administrator read, "is that you are most unhappy with the requirements/ constraints of Managed Care and would be much happier not having to deal with them. There is no point in us causing needless grief to you, ourselves, and the patients."

LeMaitre has decided to go public with the situation but says, "Were I a younger surgeon, just getting started, I might choose to wimp out, beg the forgiveness of the HMO and promise to make amends in the future."

When one looks at health care costs in other nations, it's clear that hospitalization is
not the most important factor. The U.S. which has the most expensive health care system in the world--by far--has the shortest hospitals stays. In Germany, hospitalization averages over seven days longer than in the U.S. while that country spends only 8.5 percent of its GDP on healthcare compared to our 14 percent. England and Canada similarly have much lower overall healthcare costs than the U.S. but more generous lengths of stay.

Nevertheless, cutting hospital stays has become almost a religious principle among managed care administrators and their allies in business and academia. In fact, the trend is worsening every day -- with insurers trimming more and more "fat" from already anorectic hospital stays. And because of the financial pressure on individual
doctors and nurses, we can't count on them to act as heroes and sacrifice themselves
to protect their patients. That's why government intervention is critical.

And indeed, some of the most highly publicized victories of the growing consumer movement against managed care have been over the issue of the length of hospital stays--focused on high-visibility, emotionally compelling cases like maternity stays and outpatient mastectomies.

But piecemeal efforts--such as the federal legislation which banned drive-through deliveries--while helping some individuals, obscure the breath of the problem. Many
people may feel the overall problem has been solved because it's been remedied for one category of patient.

The most vulnerable patients, however--the poor, the chronically ill and the elderly--make the least attractive "poster children" for legislators hoping the ride

the wave of anti-managed care sentiment. Their problems with hospitalization have
been largely forgotten: witness that none of the current regulatory bills in Washington even mention the issue--which is admittedly almost impossible to solve
through piecemeal legislation.

Given the thousands of medical diagnoses and surgical procedures, it will simply be impossible to enact a law mandating appropriate lengths of stay for each one. Would
lawmakers mandate hospitalization for intractable nausea and vomiting during pregnancy? Would there be a minimum length of stay for kidney stones? Would there be special Congressional dispensations for people who have hip replacements and whose spouse is over 85 (or should we make it 90)?

The obvious solution to our health care ills of which dehospitalization is simply one symptom is some type of comprehensive universal health program, which in addition to solving the problem of the 43 million uninsured Americans, would save money. Our highly-fragmented non-system allows hundreds of insurance companies to take anywhere from 16 to 40 percent of premium dollars off the top for profit, administration and multi-million dollar CEO salaries. Each insurer has its
own rules, its own forms to be filled out and its own bevy of "utilization reviewers" saying who can have which test, see which specialist and stay in the hospital how many days. And as we've seen, legislators both nationally and in the States have been infected with the "market medicine" bug and have been only too anxious to follow the cost-cutting example of managed care companies.

Given Congress' ideological attachment to market-based solutions—in spite of the evidence that they are failing to meet the needs of the American public—it may be tough indeed to institute fundamental reform of the system. This difficulty is made worse by the fact that insurance companies and others with a vested interest in continuing the corporate takeover of health care are large campaign donors. The reality is that Congress is unlikely to enact anything more than piecemeal reforms unless they feel forced to by overwhelming public opinion.

Only a mass movement to change our health care system is likely to force the politicians' hands. That can only happen if the public is energized the way they were
in the anti-Vietnam war and nuclear freeze movements.

If health care is to be wrested away from those who would sacrifice quality and

access for profit, the movement must hit the streets. The hundreds of small and medium sized groups working more or less independently to reform health care must come together. Perhaps it's time for a "Million Patient March" on Washington.

Doctors, nurses and other health professionals would be asked to participate, or course, since they are all at one time or another patients, too. But the focus must be on the needs of patients—all of us.

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