CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. NEWSLETTER

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EDITORIAL

Target for Medical Cost Control

FRANK P. SMITH, M.D., EDITOR

As the various bureaucratic procedures for containing costs of medical care become apparent on the horizon, one realizes that surgeons will be the prime target for not only surveillance, but also for control. It does not require very much orientation to learn that hospital costs relate to the various diagnostic studies that are required by surgeons and the operations to be performed. To the average bureaucrat, this is an area of study with particular reference as to what can be done about professional fees. It is well recognized that the cost for hospitalization is the greatest problem, but very little can be done to challenge the basis. However, it is relatively easy to challenge how much any one surgeon should be paid for a given procedure.

Those members of state legislatures who are doing their best to cut down the necessary appropriations for medical care do not seem to understand that the greatest part of the expense for hospitalization relates to the "labor cost" in terms of salaries paid to nurses, technicians, medical attendants, (formerly called orderlies), as well as the high-powered administration and advisory staff needed to keep the hospital out of trouble. In fact, these so-called "labor costs" are in the range of 70% of the total cost of hospitalization. Thus, when various legislators are talking about cutting down on hospitalization costs, they are in the process of telling any of their friends who might work in a hospital that the salary is going to be reduced.

Some of the major costs facing hospitals relate to very expensive care provided to critically ill patients who have very little, if any, financial support for paying their bills. These are the cases that can later have malpractice issues brought by surviving relatives because some sophisticated form of treatment might not have been provided. In fact, the medical-legal issues have kept all members of the medical staff, as well as members of hospital administration, on the alert to avoid some major malpractice claim that might be made in the case of a most seriously injured patient. There seems to be a number of rather poorly-oriented members of the medical community who will make reports just sufficient to give an alert attorney enough encouragement to move in the direction for recovery. The question of "withholding therapy" or "turning off the respirator" has become so complicated that even the President's Commission to study the various issues has not been able to evolve any firm protocol. The reaction is one that the attending doctor will have to be responsive to certain guidelines, and that no specific details can be listed for all cases. In the meantime, in many circumstances, the long-term artificial respiration continues, and hospital costs mount to extreme levels, so that hospitals in general have no choice but to extend the actual cost to the so-called "private sector." This means that treatment in an intensive care unit can be levelled at $600 to $1,000 per day, depending upon the location of the hospital in a small or large community.

Currently, there is a great deal of controversy about extended treatment for an infant born with an apparently hopeless outcome. It is a problem quite similar to the question of extended care for a senior individual in the last year of his life, or the continued support of an individual who, through trauma, or anoxia, has sustained cerebral death. Neurosurgeons, for many years, have been handling these problems in a manner that has seemed to be appropriate for the conditions specific for each case. However, elements of bureaucracy and political expediency have entered the general arena, and the budgetary factors move out of control.

Good medical care is expensive, even to the point of being a luxury, but not really as expensive as the elective costs on a person-to-person basis. The average person does not mind spending a great deal of money for the automobile of his choice, or for the personal cosmetic, or even gambling entertainment. However, the average person does expect that his employment will provide him with free medical care, without even requiring the so-called "first dollar up front." Somewhere along the line, the various labor unions got onto the concept of having the employer pay one half of the cost for medical care, and then the appetite grew to the extent of requiring full coverage. All of this has led to a coalition between big business, labor, and insurance companies, to push the medical profession into a status of lower rates in order to give

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the coverage at a rate that would leave plenty of paycheck money to purchase recreational vehicles, outboard motorboats, and a special excursion to Hawaii. The average worker wants free medical care as a fringe benefit, but when this is truly evaluated, one finds that the average worker might be getting less than average medical care. Labor unions may go to the bargaining table intent upon returning with a guarantee for free medical care, but physicians know that the ultimate service would be at least second or third rate, and not very much different from that provided in a socialist or communist state.

Our present society must not try to balance its budget by denying the value of health care costs. Hospital care has become expensive because formerly the low-paid nursing staff and minority group employees were unwittingly subsidizing medical care for many years. Formerly, a dedicated nurse was paid $5,000 or $6,000 per year. Now, she makes five or six times that much. Nursing assistants, technicians, dietary staff, maintenance workers, and others, are all paid wages that are competitive with others in the labor market. There is no way to go back to the time when hospitals subsisted with a very low-paid staff. The legislative bureaucrats can squirm, squeal and desist, but they will have no solution other than to go back to the county hospital system for those who cannot afford medical care, and adjust to the private insurance type of coverage for those who are employed, or otherwise able to take care of their own insurance premiums. There must be a reversal of the concept that medical care should be a part of the working wage. Otherwise, there will be a total involvement in what has already been developed on a limited scale for groups of employees, in which less medical care, ordinarily of a lower standard, is provided to those who are enrolled in the system. The health care programs of the United States of America have developed the highest level of medical care in the entire world, and it would be most unfortunate if a coalition of big business, labor, and bureaucrats could develop a "turnabout" which would involve less care for less dollars. It was the "do-good" politicians who gained votes by offering the free medical care as the carrot on the stick. There was a very satisfactory county hospital care system for which physicians contributed a significant part of their services, without income. When the politicans started paying all doctors for all services, they embarked on a program that they could not continue. This elected a great many people a generation ago, and even more recently. However, we cannot afford that type of political bonanza any longer. Medical care plans should be formulated along the same lines as have been designed for every other type of services required in the daily program of the average individual. There is no point in focusing attention on providing free medical care, any more than there is in guaranteeing free housing, free food, and even free legal services for all of those who are employed or unemployed. A state and county health care system can develop a hospital facility for those who are unable to meet the expense of private health insurance. There are plenty of doctors at all levels who could be appropriately employed, since we now have an excess of professional providers at all levels. It is unjustifiable for legislators to reduce all hospitals and physicians to a level that will be subservient to bureaucracy.

Contracting Alert

California neurosurgeons are going to be interested in a publication provided by the California Medical Association entitled *"Contracing ALERT."* This publication is designed to provide essential information regarding the new age of contractual arrangements for medical and surgical care. Volume 1, No. 3 issue provides an analysis of Blue Cross' revised Participating Physician Agreement. The contents of this publication are so important that it is quite impossible to provide an abstract. However, we can quote to impress physicians how important it is, with particular reference to Section 6.0 which states that "physicians shall not charge members for medical services denied as not being medically necessary under Section 7.2, unless the member has agreed in writing to be responsible for payment of these charges." With all of the Blue Cross utilization procedures, certain elements of treatment might be considered as unnecessary, and therefore the physician may not be paid, unless the member patient has agreed specifically by contract to make payment on his own. The publication warns that "physicians may be placed in situations where their professional judgement requires the rendering of services which Blue Cross deems "medically unnecessary." Under this provision, the physician may well render services "free of charge" unless the patient has executed a clear and unmistakable waiver." You may obtain a copy of the complete, informative issue of *Contracting ALERT* by writing directly to the California Medical Association, Department of Contract Evaluation/Negotiation Services, 731 Market Street, San Francisco, California 94103, or you may call (415) 777-2000.

COMPLIMENTARY NEWSLETTER

Complimentary Newsletters are being mailed to non-members of the California Association of Neurological Surgeons, Inc. Those interested in becoming a member of the Association may send a request for an application form to: Executive Office, California Association of Neurological Surgeons, Inc., P.O. Box 41761, Sacramento, California 95841, or telephone (916) 966-9760.

Review of JSEC-CSNS Meetings In Washington, D.C.

April 22-24, 1983

FRANK P. SMITH, M.D.

It has been routine for a number of years for the Joint Socio-Economic Committee of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons to hold meetings for various deliberations prior to the Annual Meeting of the AANS, ordinarily held in April, and before the Annual Meeting of the CNS, ordinarily held in October of each year. Since the Council of State Neurosurgical Societies was spawned from the same general group of delegates, there have been specific meetings of the CSNS, somewhat apart from the JSEC, but both sessions attended by much the same group of delegates. To understand the interlocking relationship, the average neurosurgeon would have to attend the various sessions.

The Joint Committee of Socio-Economic matters was designed to cover the multiple, mundane issues of both of the major neurosurgical societies at a time when there would be annual sessions for considering the research papers and scientific matters. The frustrations of the JSEC in getting fruition through either parent organization led to the formation of the Council of State Neurosurgical Societies, with the general concept that this in itself might break away at some appropriate interval and become the spokesman for neurosurgery in relation to socio-economic matters. The associated pressures in this regard even proposed a so-called House of Delegates that would be representative of each State and would function much along the lines of the AMA in furthering the interest of practicing neurosurgeons.

As the various delegates of the state neurosurgical societies convened on Friday evening, April 22, 1983, at the Sheraton Washing Hotel in Washington, D.C., they met in separate quadrant sessions, according to their geographical distribution. This provided a consensus type of report to be submitted on the following morning for general reaction.

During the afternoon of Saturday, April 23, 1983, the major subcommittee reports of JSEC were provided. This session included the report on the national survey on neurosurgical manpower that had been conducted by the Subcommittee on Manpower through a questionnaire to all practicing neurosurgeons in the United States. This session also included reports on cost control of health systems, as well as problems of medical-legal nature.

On Sunday, April 24, 1983, the morning sessions included additional subcommittee reports relative to medical practices, technology and terminology, as well as inter-specialty liaison. During Sunday afternoon, the delegates were treated to a series of presentations relative to national authorities on the origin of special health control bills in Congress by Mancur Olson, Ph.D., and a report from Mr. Morris B. Abram, relative to his activities with the President's Commission for the Study of Ethical Problems in Medicine, primarily related to the "origin of life" regarding abortion and the factors related to cerebral death in decisions about turning off the respirator. All of those attending seemed to gain a great deal of orientation relative to these problems as surveyed at the national level.

During these lengthy sessions of the CSNS and the JSEC, all of which were closely entwined, multiple major issues came up for discussion and orientation, such as chymopapain guidelines, the AANS fascicle on neurosurgical treatment of head injuries, medical malpractice issues looming in the future, and much about the "extensive California experience with contractual arrangements and collective bargaining" in reference to neurosurgical care of the future. Anyone interested in the details relative to the subject matter may obtain a full transcript of all of the proceedings by writing to John M. Thompson, M.D., Liaison Secretary, 2000 Blossom Way South, St. Petersburg, Florida, 33712.

Business Meeting of AANS in Washington, D.C.

APRIL 1983

At the business meeting during the annual sessions of the AANS in Washington, D.C. in April 1983, the various proceedings included adoption of the Bylaw relative to reinstating quadrantic Board of Directors members; election of Byron C. Pevehouse as President, and Philip M. Lippe as a member of the Board of Directors of the American Association of Neurological Surgeons.

JSEC-CSNS Sessions at the Congress Meeting

OCTOBER, 1983

In line with routine arrangements, delegates to the Joint Socio-Economic Committee and to the Council of State Neurosurgical Societies will be converging in Chicago, beginning October 27, 1983, for multiple sessions prior to the Annual Meeting of the Congress of Neurological Surgery. We shall be sending the usual delegation from CANS, and members of the Association are encouraged to write to the Secretary regarding any problems or proposals that should be ventilated during the various sessions in October. Our delegates represent you best when they know how you feel about various issues, and whether or not you have any prime targets for consideration in regard to the practice of neurological surgery. The subject matter may range from fee schedules to various health plans, medical malpractice, and even international involvement. Please do not hesitate to let us hear if you have any particular project or complaint at the present time.

CHANGE OF ADDRESS

Please notify the Executive Office of any change of address, including county, or telephone number, so that we might keep our membership records current.

Items printed in this Newsletter are for the purpose of disseminating information and stimulating discussion. The opinions and comments expressed herein do not necessarily reflect the official position of the California Association of Neurological Surgeons, Inc.

Reserve March 10th & 11th, 1984 Date of next Annual Meeting of CANS. Site & other details to be announced.

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