

[IMAGE]

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Health Care "Bass-Ackwards"

By Anthony Rosner, PhD

"This is a simple game," snorts Skip, the exasperated baseball manager of the Durham Bulls, during the middle of a horrendous losing streak, in a popular Kevin Costner movie. "Ya throw the ball; ya hit the ball; ya catch the ball."¹ One would hope our advances in medicine could lead the way to a better health care system in much the same manner. Accordingly, in the early 1990s, new U.S. health care plans were conceived to address the problem of 37 million citizens without health insurance, while steering a precarious course between the perceived twin specters of excessive health care costs and the arbitrariness of socialized medicine. So, what did we wind up with 10 years later? Arbitrary medical decisions passed down by CEOs of HMOs, and similar insurance organizations, that often lacked medical expertise and operated from the perspective of earning profit. Unlike those in socialized medicine, these decisions not only seemed despotic, but were driven by a profit motive, which one would suspect tends to make the pool of funds available for actual health care diminish. In other words, it was a case of King Kong meeting Godzilla. Oh yes, and we also wound up with at least 4 million additional uninsured Americans by the year 2001, with the figure expected to have increased in 2002.²

In world health standards, the picture doesn't get any prettier. In a comparison of quality of health care by the World Health Organization, the United States ranked **37th** on a list of 191, coming in well behind nations such as San Marino, Andorra, Malta, Oman and Singapore. The comparison found that the United States spends an estimated \$3,724 per person on health care each year, compared to \$2,125 in France and \$1,759 in Japan. (The latter two countries are among the list's top 10). Said Princeton University health economist Uwe Reinhardt, "While good at expensive, heroic care, Americans are very poor at the low-cost preventive care that keeps Europeans healthy."³

According to medical anthropologist Barbara Starfield, in a separate study in which 13 countries (Japan; Sweden; Canada; France; Australia; Spain; Finland; the Netherlands; the United Kingdom; Denmark; Belgium; the United States; and Germany) were ranked for 16 available health indicators, the U.S. ranked **dead last** in infant mortality and low birth-weight, **11th** for life expectancy at one year for males (12th for

females), 10th at life expectancy at 15 years for females (12th for males), and 10th for life expectancy at 40 years for females (9th for males).⁴ Curiously, it was found that these poor figures were not so much a function of "bad behavior," such as smoking, drinking and perpetrating violence, but rather, limitations on access to good health care through strong primary-care infrastructures.^{5,6}

Thus, despite the unquestionable advances in treatments for such major illnesses as heart disease, cancer or infectious disease, American health care is still beset with such statistics as:

- 106,000 deaths per year from nonerror and adverse effects of medications;
- 12,000 deaths per year from unnecessary surgery;
- 80,000 deaths per year from nosocomial infections in hospitals;
- 7,000 deaths per year from medication errors in hospitals; and
- 20,000 deaths per year from other hospital errors.

That's about 225,000 deaths per year from iatrogenic causes,⁷⁻⁹ or even higher (230,000-280,000 deaths per year, according to the Institute of Medicine).^{10,11}) When you factor in outpatient settings, the manifestations of iatrogenesis become more numerous, to the point of overflowing - much like clowns spilling out of a VW microbus at a three-ring circus. Now figure in, on an annual basis, 116 million extra physician visits; 77 million extra prescriptions; 8 million hospitalizations; 3 million long-term admissions; and, incredibly, **\$77 million in extra costs and 199,000 additional deaths.**¹²

The CEO of the Beth Israel Deaconess Medical Center in Boston captured the full essence of this problem, and made it so unmistakably clear that it could not be dismissed: "When all sources of error are added up, the likelihood that a mishap will injure a patient in a hospital is at least 3 percent and probably much higher. This is a serious health problem. When one considers that a typical airline handles customer baggage at a far lower error rate than we handle the administration of drugs to patients, it is also an embarrassment."¹³

Wait - it gets uglier. From the time that the Institute of Medicine (IOM) painted such a discouraging picture of errors in American hospitals in November 1999,¹¹ little change was noted by December 2002 by Lucian Leape, the Harvard physician who helped to write the original report. Among the reasons cited:

- fierce resistance by doctors and hospitals to the mandatory reporting of errors;
- lack of governmental oversight; and
- lack of an effective consumer lobby.¹⁴

According to the *Chicago Tribune* some months ago,¹⁵ 75 percent of the nation's hospitals have never filed a report with a databank created by the Joint Commission on Accreditation of Healthcare Organizations, a government-sanctioned watchdog agency charged with oversight of the nation's hospitals.¹⁵ As many as "tens of thousands" of preventable patient deaths may never have been reported. The JCAHO turned to its seven-year database and - lo and behold - found only 10 such reports involving 53 patients. The reason? It's real knee-slapper, if you have a twisted sense of humor. According to JCAHO President Dennis O'Leary, this egregious underreporting was deemed possible because "many health care organizations do not consider the incidents as errors."¹⁶

Hold on - let me get this straight! If these aren't errors, in which universe are we performing? Standard procedures? Systems normal? Default position? A-OK? This sounds like something straight out of *Catch-22*.¹⁷

Our saga continues with the JCAHO issuing a bulletin to try to remedy the situation. The agency urged compliance with a new set of hand-washing guidelines issued by the CDC to reduce the spread of infections. Hello? Kids, can you spell S-E-M-M-E-L-W-E-I-S-S? Are we still trying to learn aseptic lessons over 150 years old? OK, it's back to "Infectious Diseases 101" for everyone. And if we issue bathroom passes, **wash those hands**. Actually, this all sounds a lot more like hand-wringing than hand-washing.

Where is this train wreck taking us? Not surprisingly, the IOM, in a groundbreaking and comprehensive report on the state of our health care issued almost two years ago, concluded, "The American health care system is in need of a fundamental change," especially because "what is perhaps most disturbing is the absence of real progress toward restructuring health care systems to address both quality and cost concerns."¹⁸ Pointing out a 1999 Harris poll that showed just 39 percent of respondents have much confidence in "people in charge of running medicine,"¹⁹ the IOM report added that the 1998 American Customer Satisfaction Index placed hospitals somewhere between the U.S. Postal Service and the Internal Revenue Service.²⁰

That is why a recent report on workers' compensation claimants from Florida is particularly galling. It demonstrated that for industrial musculoskeletal injuries, chiropractic care demonstrates marked trends toward lower medical and claim costs (some differing by over 200 percent) and shorter durations in both reaching maximal medical improvement and returning to work. Incredibly, over the same seven-year period, **the frequency of specific musculoskeletal-related cases treated by chiropractors in 1999 was only 25.7**

percent of the level seen in 1994 (coinciding with the date managed care was introduced into the Florida workers' compensation system).²¹ In other words, just when workers' access to chiropractic care should be **increased** to result in significant direct and indirect cost savings (as previously demonstrated by Manga),²² we are witnessing precisely the opposite. Chiropractic care seems to be getting squeezed out of the system.

How are we to deal with this? Among the IOM's many thoughtful proposals in its health care quality report, it bemoans the current system of medical licensure and scope of practice that lacks assurances of continuing competency, suggesting instead from recent research^{23,24} that licensure be granted on a professional's demonstrated ability to perform specific functions or on a certain level of practice. An excellent precedent for this procedure already exists with the granting of licenses to pilots by the Federal Aviation Administration, which first offers a basic private, single-engine license, and progressively adds more sophisticated requirements, based on the number of engines and instruments, until a commercial license is attained. In addition, pilots are routinely recertified at regular intervals throughout their active flying careers.¹⁸ If such a model were applied to chiropractors who are demonstrating increased primary care responsibility, or at least first-contact capability,²⁵ a major flaw in our health care system would begin to be addressed.

Superficial makeovers will not suffice. The IOM indicated that entirely new patterns of thinking will be necessary to escape this dilemma. "Our present efforts," suggested Mark Chassin,²⁶ "resemble a team of engineers trying to break the sound barrier by tinkering with a Model-T Ford. We need a new vehicle, or perhaps many new vehicles. The only unacceptable alternative is not to change." Medical gatekeepers: Are you listening?

References

1. Shelton R. *Bull Durham*. Screenplay, 1988.
2. Census Bureau 2001 Data on Health Insurance Coverage, Center on Budget and Policy Priorities, press release Oct. 8, 2002. www.cbpp.org/9-30-02health.htm.
3. *The Week in Chiropractic* June 26, 2000; 6(36):1.
4. Starfield B. Is U.S. health really the best in the world? *Journal of the American Medical Association* 2000;284(4):483-485.
5. Starfield B. *Primary Care: Balancing Health Needs, Services, and Technology*. New York, NY. Oxford University Press, 1998.

6. Starfield B. Evaluating the State Children's Health Insurance Program: critical considerations. *Annual Review of Public Health* 2000;21:569-585.
7. Leape L. Unnecessary surgery. *Annual Review of Public Health* 1992;13:363-383.
8. Phillips D, Christenfeld N, Glynn L. Increase in US medication-error deaths between 1983 and 1993. *The Lancet*;351:643-644.
9. Lazarou J, Pomeranz B, Corey P. Incidence of adverse drug reactions in hospitalized patients. *Journal of the American Medical Association* 1998;279:1200-1205.
10. Schuster M, McGlynn E, Brook R. How good is the quality of health care in the United States? *Milbank Quarterly* 1998;76:517-563.
11. Kohn LT, Corrigan JM, Donaldson M, eds. *To Err is Human: Building a Safer Health System*. Washington, DC. Institute of Medicine, 1999.
12. Weingart SN, Wilson RM, Gibberd RW, Harrison B. Epidemiology and medical error. *British Medical Journal* 2000;320:774-777.
13. Reinertsen JL. Let's talk about error. Leaders should take responsibility for mistakes. *British Medical Journal* 2000;320:730.
14. *The Washington Post*, Dec. 3, 2002.
15. Berens MJ. Oversight panels don't see all facts of medical mistakes cases series: Dangerous care: Nurses' hidden role in medical error. *Chicago Tribune*, Sept. 12, 2000.
16. Associated Press release, Jan. 23, 2003.
17. "Rottentomatoes.com" describes this "wacky romp" as "a military snafu that results when a bombardier in the war attempts to get out of the military by feigning insanity - however, completing the paperwork for this proves him sane."
18. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press, 2001.
19. Taylor H. Harris Poll #9: For the second year running, there has been a dramatic increase in confidence in leadership of nation's major institutions. Online. Available at www.harrisblackintl.com/harrispoll/index.asp?PID=32 [accessed July 13, 2000].
20. Lieber RB. **Now are you satisfied? The 1998 Customer Satisfaction Index**. *Fortune* 1998;137(3):161+Smart Managing.
21. Folsom BL, Holloway RW. Chiropractic care of Florida workers' compensation claimants: Access, costs and administrative outcome trends from 1994 to 1999. **Topics in Clinical Chiropractic**

2002;9(4):33-53.

22. Manga P. Enhanced chiropractic coverage under OHIP as a means for reducing health care costs, attaining better health outcomes and achieving equitable access to health services. *Report to the Ontario Ministry of Health*, 1998.
23. Cooper RA, Henderson T, Dietrich CL. Roles of nonphysician clinicians as autonomous providers of patient care. *Journal of the American Medical Association* 1998;280(9):795-802.
24. Weed LL, Weed L. Opening the black box of clinical judgment. Part II: Consumer protection and the patient's role. *Electronic British Medical Journal* Nov. 13, 1999. Online. Available at www.bmj.com/cgi/content/full/319/7220/1279/DC2 (Accessed Jan. 24, 2001).
25. Gaumer GL, Walker A, Su S. Chiropractic and a new taxonomy of primary care activities. *Journal of Manipulative and Physiological Therapeutics* 2001;24(4):239-259.
26. Chassin MR, Galvin RW, National Roundtable on Healthcare Quality. The urgent need to improve health care quality. *Journal of the American Medical Association* 1998;280(11):1000-1005.

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