The sickness of the USA model of healthcare—is it a contagious disease?

I write this letter after attending the Preventing Overdiagnosis Conference in Dartmouth, New Hampshire, USA. The conference focused on a relatively new field of research, which investigates the harms and costs associated with overdiagnosis and overtreatment, and the extent to which this is adding considerably to the cost and resource burden in healthcare.

I presented my research findings into patterns of off-label prescribing of atypical antipsychotics (AAPs) in Christchurch, New Zealand.\(^1,2\) That study found that 96% of psychiatrists in Canterbury prescribe AAPs off-label, 58% do so at least weekly and that overwhelmingly the drug of choice is quetiapine, which is prescribed for (non-psychotic) conditions for which there is very little evidence of efficacy and safety. The direct cost burden for this type of use in 2010 was $9.5million. Other presenters found similar patterns of off-label AAP and other medication use in the USA and Europe, and strongly criticised this practice expressing concern about public harm and cost.\(^3\) Part of my motivation in writing is to alert colleagues to the research into overdiagnosis and overtreatment and to encourage clinicians to consider what role this plays in their area of practice.

I also write to sound a cautionary note, based on my personal experience of healthcare in the USA and to point out the potential pitfalls of following their model, with its emphasis on private health insurance. This at a time when the New Zealand Government is keen to promote privatisation (ACC), arguing that it will improve performance, access, quality, and greater efficiency in healthcare.

Within days of arriving in the US I developed moderately severe symptoms of Bell’s palsy (unilateral facial paralysis). As I was scheduled to deliver a number of presentations this was a particularly inconvenient context in which to develop this condition. Bell’s palsy is a diagnosis of exclusion and as I was not keen to be subjected to exhaustive investigations in the US I largely ignored the symptoms for several days. However as these progressed I finally accepted the inevitable wisdom of seeking treatment. I was told to contact the local hospital (Dartmouth-Hitchcock), who directed me to the “ER”.\(^4\) There I went through the customary triage process.

I then waited for 2 hours to be ushered into the medical examination room where I met the billing clerk who was armed with a series of questionnaires and questions, which I had to complete before I could proceed to the medical examination. The completion of this task required a high degree of cognitive functioning as I not only needed to provide a comprehensive medical history, proof of identity and detailed financial information, but also had to decide whether I wanted to be “resuscitated” and what my advanced directives were in case of a medical emergency. As I appear fit and healthy, take no regular medications and have no medical history of serious illness it all seemed a little over the top.
Finally after signing a number of medicolegal documents (which were largely unintelligible to me, despite my training in forensic psychiatry) I met the duty doctor, who quickly diagnosed Bell’s palsy and prescribed the standard prednisone, acyclovir combination treatment, without any physical examination or investigations.

Armed with my script I was anxious and ready to leave, but was told that I had to again see the billing clerk before “discharge”. She asked whether I could pay for the bill and presented me with a hospital invoice amounting to $USA1000 ($857 plus taxes)!! I then realised why she had gone to so much trouble to ask whether I wanted to be resuscitated—the invoice was sufficient to provoke a heart attack or stroke in the most robust individual, even in the absence of other risk factors.

I made discrete enquiries but no one could clarify how a simple 10-minute medical consultation could lead to such an exorbitant bill. Had I been more anxiety prone or uninformed about Bell’s palsy I may have asked or been advised to have a number of investigations, such as brain CT and blood tests to rule out a stroke, Lyme’s disease or middle ear tumours—the bill then would surely have caused a coronary, leading to further interventions and wildly escalating costs (I should have opted out of “resus”).

Without a hint of irony the clerk confirmed that I wasn’t charged excessively because I was a tourist and that the charge is the same for any of the 46 million residents (15%) in the US who are uninsured and do not qualify for Medicaid or Medicare. A recent investigation into the costs of healthcare in the US by Time Magazine shows this is the norm. Given that the minimum wage in the US is $8/hour this equates to 120 hours work to pay for a 10-minute medical consultation!

Reviews have repeatedly found that despite having the most costly healthcare system in the World (US$7960 per person cf. US$2983 in NZ), the United States consistently underperforms on most dimensions of performance, relative to other countries. Compared with five other nations—Australia, Canada, Germany, New Zealand, the United Kingdom—the US healthcare system ranks last or next-to-last on five dimensions of a high performance health system: quality, access, efficiency, equity, and healthy lives.

Because of its long-term experience with private health insurance, in my opinion the US presents a compelling real-world case study of the likely long-term disadvantages of introducing competing private health insurance to improve performance and efficiency in the health sector in New Zealand.

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