TRENDS & Ideas

HEALTHCARE ECONOMICS

Interns Learn about Cost-Effectiveness


Sim Gellman

In addition to diagnosing and treating patients' afflictions, today's physicians must consider the costs of doing so. To help their interns learn about cost-effectiveness, many medical schools around the United States have launched programs in which interns consult price lists of common pharmaceuticals and diagnostic tests before proceeding, reports Michael Winerip in the *New York Times*.

At Long Island Jewish Medical Center, a new academic program is fostering a "revolutionary new breed of doctors" who are aggressive about holding down costs and sensitive to nurses' and patients' needs. According to Steven Walerstein, MD, the program's director, President Bill Clinton's healthcare plan and the increase in managed care "makes these young doctors more receptive [to cost-effectiveness programs] than their predecessors." Each morning senior interns discuss the previous day's admissions with the hospital's Acting President David Dantzker, MD, who questions them about treatment cost-effectiveness.

Long Island Jewish Medical Center is not alone in requiring interns to learn about "healthcare economics." To make interns aware of treatment costs, many programs put the bill on the hospital chart each day, notes William Jacott, vice chairperson of the American Medical Association's Board of Trustees.

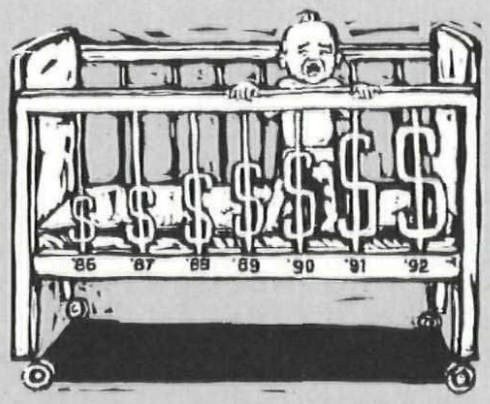
The University of Minnesota requires that its family practice interns spend two weeks with a clinic's business manager. At Georgetown University, interns are expected to compile and prescribe from their own lists of cost-effective medications. And family practice interns at California's Long Beach Memorial Medical Center not only pose as patients for a day but see the hospital bill, a dose of reality for the 95 percent who have never been hospitalized.

Although Jordan Cohen, MD, incoming president of the Association of American Medical Colleges, believes such "healthcare economics" programs "will become much more prevalent," Georgetown University's John Eisenberg, MD, questions whether such programs make a difference. "You can teach them in medical school and then they go out on their own where cost-consciousness is not practiced, and that's the end of it," he explains. Noting that changing payment mechanisms have created strong motivations for reducing costs, those at Long Island Jewish Medical Center counter that cost-consciousness is "not a matter of educational altruism," reports Winerip.

CHILDREN

The Cost of Neglect

Between 1986 and 1991, the percentage of children entering foster care because of neglect increased dramatically, according to a report issued by the U.S. General Accounting Office (GAO).



In a review of randomly selected case files of foster children in Los Angeles County, New York City, and Philadelphia County, the GAO found that in 1991 neglect and caretaker absence accounted for 68 percent of removals from home, compared with 47 percent in 1986. During the same period, foster children at high risk for health problems because of prenatal drug exposure increased from 29 percent to 62 percent.

Total foster care populations in New York, California, and Pennsylvania also grew, increasing 66 percent, and the number of young children in foster care (below age 3 in New York and California; below age 5 in Pennsylvania) leapt 110 percent.

In addition to reflecting extreme social and familial problems, these changes have serious implications for federal foster care and healthcare programs, the report's authors note. Between 1986 and 1992, federal expenditures for children eligible for Aid to Families with Dependent Children funds rose from about $637 million to more than $2.2 billion. And although the study was not able to estimate total healthcare cost increases for these children, the authors noted medical costs for drug-exposed infants are approximately $1,100 to $4,100 higher (in 1989 dollars) than for others. The figures suggest that Medicaid costs for providing healthcare to drug-exposed infants are also increasing rapidly.

EDUCATION

Setting National Goals

To improve Americans' alarmingly inadequate learning skills, educators, parents, policymakers, employers, and other community leaders need to promote higher educational standards and set ambitious goals, according to the 1993 report of the National Education Goals Panel.

The panel—a bipartisan group of governors, federal lawmakers, and administration officials—found that Americans at all stages of life typically fail to achieve adequate levels of education. Nearly half the nation's infants are born at higher risk of school failure because of such factors as having mothers who smoked or consumed alcohol during pregnancy. By the eighth grade, barely one-fourth of students have mathematics and reading skills sufficient to enable them to succeed in today's world. And only about half of U.S. adults have the necessary arithmetic and reading skills to function effectively.

Despite these deficits, Americans seem relatively satisfied with their knowledge and skill levels. Whereas only 13 percent of Japanese workers feel they are adequately prepared for the tasks they must preform in the immediate years ahead, 57 percent of Americans think their skills are sufficient.

To combat such complacency, the panel has suggested the following six national education goals for the year 2000:

- All children will start school ready to learn.
- The high school graduation rate will increase to at least 90 percent.
- Students will leave grades 4, 8, and 12 with competency in challenging subject matter, and every school will ensure that students learn to use their minds well.
- American students will be first in the world in science and mathematics achievement.
- Every adult American will be literate and possess knowledge and skills necessary to compete in a global economy and exercise the rights and responsibilities of citizenship.
- Every school will be free of drugs and violence and offer a disciplined environment conducive to learning.

LONG-TERM CARE

Coping with Dementia

A growing acceptance that dementia cannot be cured is leading many long-term care providers to focus instead on improving residents' quality of life, Marla Fern Gold reports in *Provider*.

According to Mary Lucero—president of Geriatric Resources, Inc., Winter Park, FL—90 percent of catastrophic behavior among dementia patients is the result of care giver actions or the environment. To help patients live with less fear and more dignity, many providers have turned to "validation therapy," adjusting their interventions to residents' level of functioning.

A basic assumption of validation therapy is that patients with dementia eventually lose their sense of "present time." Naomi Feil, who pioneered the technique, uses four "stages of withdrawal" to identify the proper response to various phases of dementia. In the first stage, patients are "maloriented" but still want to be reminded of where they are.

In the next stage, their grasp of present and recent events diminishes while their sense of the past grows more vivid. According to Feil, persons at this stage of dementia benefit most from validation therapy. Proper intervention at this point can slow or even prevent progression to the final two stages of dementia—"repetitive motion" and "vegetation."

Lucero suggests that working appropriate activities of daily living (ADLs) into patients' 24-hour schedule can help slow the advance of cognitive deficits. "ADLs need to be big events," she says. "People do not need to be *entertained* all day; they need to be *involved* all day."

Understanding patients' life histories is essential to identifying the right kinds of ADLs to develop for them. For example, when staff found out that a resident at one facility who regularly rummaged through others' clothing had been a sales clerk, they put out a rack of clothes, with sales tags, for her. The intervention also helped other residents, who were able to "shop" from the rack.

As providers have become more knowledgeable about the stages of decline in dementia, they have been able to further refine their methods of care. For example, researchers have found that persons at a certain stage may get along well with someone whose cognitive deficits are slightly more severe than theirs but not with someone with significantly greater impairment.