The Unkindest Cut: Where Are All the Transplant Programs Going?

Roger Evans

Graft 2001; 4; 574

The Unkindest Cut: Where Are All the Transplant Programs Going?

Roger W. Evans

The "cost" of transplantation has been, and remains to some extent, a matter of considerable controversy. Although debate concerning insurance coverage of specific organ transplant procedures has all but vanished, there is still the odd skirmish over the level of reimbursement that providers receive, and the financial obligations patients are forced to endure. Although the picture may not be as attractive as Marilyn Monroe, it is more handsome than Cary Grant.

But times remain both troubled and uncertain. Increasingly, amid a sea of red ink, transplant programs are running afoul of institutional efforts to either maintain or achieve financial solvency. Once considered to be the cornerstone of high technology, the foundation for research and innovation, a harbinger of success, and a marketer's poster child, transplant programs are hitting the chopping block with about the same enthusiasm as a Perdue chicken headed to Popeye's.

In anticipation of this inevitable state of affairs, I have, on many occasions, climbed atop a soapbox and pontificated at length about the economics of transplantation. Sobering thoughts have often been sandwiched between humorous sentences. However, most people preferred to chuckle than to knuckle, and a few got downright mad. As a result, despite my efforts to impart knowledge, I entertained, and absorbed the odd comment disparaging my ancestry. In the end, I must confess, people prefer to ignore what they don't want to hear.

The level of institutional self-promotion associated with transplantation has often amused me. Unfortunately, like "New Coke" in 1985, great marketing concepts sometimes lack business sense. In health care, this is usually apparent when hospital boards call in management consultants and other dubious characters to "turn around" failing medical centers. Popeye's "little helper" typically exercises a "one-size-fits-all" mentality—chop, chop, chop—and, as their critics point out, when it comes to economics, these folks are savages.

Over the past decade, hospitals and health care systems have periodically grappled with the problem of controlling "costs." In an effort to do so, most hospitals and health systems have managed to cobble together accounting systems with the versatility of a four-function calculator.

In my opinion, terminology is the root of the problem. Words typically get in the way of understanding. This is certainly true in any attempt to appreciate the nuances associated with the economics of transplantation. Although most people now realize there is a difference between a cost and a charge, when more detailed discussion ensues, my level of amusement is soon on par with a *Sanford and Son* or *Monty Python* rerun.

Over the past decade, hospitals and health care systems have periodically grappled with the problem of controlling "costs." In an effort to do so, most hospitals and health systems have managed to cobble together accounting systems with the versatility of a four-function calculator. This is not surprising. In more lucrative times, it wasn't even necessary to understand "production" or actual costs since reimbursement typically equaled or, at the very least, approximated billed charges. Frankly, there was more gravy in the system than the entire chain of Cracker Barrel restaurants has served over the course of its corporate life. In this era, cost containment meant increasing charges to enhance margins, without the faintest understanding of true costs.

"Expense management" is a concept that has now achieved buzzword status. It has captured the imagination of the proverbial bean counters. A new fetish has even emerged—a clinically morbid fascination with the bottom line. To relieve anxiety, there has been a proliferation of "decision support systems." These mindless contrivances enable accountants and "financial analysts," with varying degrees of expertise, to allocate costs, set charges, project reimbursement, and speculate about margins. In short, for clinical "product lines," decision support systems abstractly identify the "winners" and the "losers"—those services that make and lose money. Transplantation is often considered suspect because it has a tendency to generate a lot of revenue, but little, if any, margin.

In reality, decision support systems consist of nothing more than computer software—if you will, metaphorically like a cowboy with a big hat and no cattle. The software manipulates

extant data according to various accounting principles—principles that are often modified to meet the needs of a particular external "client," or internal "customer." This feature is necessary since few hospitals and healthcare systems follow precisely the same rules in deriving their costs, allocating their expenses, setting their fees, and determining their charges. Ultimately, a diversity of accounting principles has its benefits when accountants fail to adequately explain results.

Unlike science, accounting seems to place little value on replication. Therefore, different accountants and financial analysts essentially use the same system to provide widely discrepant results and divergent conclusions, all of which depend on the desired answer. (This isn't hypothesis testing, it is belief confirming.) Thus, when a transplant program is about to face the chopping block, there are usually endless analyses by different persons who offer inconsistent interpretations of the same data, all in a predictable direction.

Now that decision support systems have seemingly metastasized throughout the entire healthcare system, a whole host of folks have become expert financial analysts. Many now bear the in vogue credential—a master's in business administration (M.B.A.). These weekend warriors, unlike the U.S. National Guard, have spent a bit of their rest and relaxation time earning some administrative "stripes," thus enabling them to function as "physician managers" or, worse yet, managers of physicians. When approached by one of these painful characters, I reach for the old standby—Preparation H—to relieve my hemorrhoidal symptoms.

I believe we have finally reached a point where hospital officials are beginning to reconsider the market value of what they now confess are "loss leaders"—services that have marketing appeal, but for which there is little expectation of a favorable margin. And, as my foregoing remarks imply, while many arguments have been used to justify transplant centers, there remain some very outspoken critics of the alleged "proliferation" of centers. In addition, analogies with the space program have, thus far, proven to be wide of the mark. As a result, perhaps the chicken has come home to roost as transplant volumes have moderated in response to donor organ constraints, and transplant iatrogenesis has become increasingly expensive, in both medical and human terms.

As currently practiced, transplantation is anything but a growth industry. Based on existing technology, it is a service that has reached its market potential. And, as financing has become a more pressing and widespread concern for most segments of the healthcare industry, transplantation programs are falling victim to both the success and the inherent limitations of their own technological underpinnings.

Ignoring evidence to the contrary, physicians and surgeons continue to erroneously believe that life has no price.

Admittedly, it is no fun being fiscally responsible when the goal is to save lives. Ignoring evidence to the contrary, physicians and surgeons continue to erroneously believe that life has no price. Thus, national policy dictates that we first transplant those patients who will have the poorest outcome at the greatest expense. This practice ultimately shortens the life of patients, compromises any benefits they may enjoy while living, and will almost certainly undermine the survival of transplant centers as well. Ethical arguments to the contrary are as bogus as the proponents of cost-ineffective health care.

There are many ways to assess the economic toll of transplantation. It can be examined from the perspective of the individual procedure, evaluated in terms of aggregate expenditures, or, in the case of a health plan, the impact can be computed on a per-member-per-month basis. Each perspective yields a different picture. Individually, transplant procedures are very expensive. In the aggregate, expenditures associated with transplantation are unremarkable. And, from the perspective of a large health plan, the expense of transplantation is almost trivial.

I have always maintained that a paucity of donor organs has favorably limited the economic implications of transplantation. If every person who might benefit from a transplant received one, the economic burden would be much greater, and the impact would be felt at every level, regardless of perspective or participant. In short, considering the possibilities, the debate concerning resource allocation could easily be far more vigorous than it has been.

I have also insisted that, in the United States, managed care has done more to moderate the economic costs of transplantation, both individually and in the aggregate, than any drug, medical, or surgical innovation of the past 20 years. It is foolhardy to think otherwise. When insurers moved from generous payments based on discounted billed charges to case rates, transplantation actually became a far less expensive intervention. No immunosuppressive drug has even come close to producing a similar effect.

However, depending on one's perspective, the situation I describe here has been both good and bad. In reality, in addition to capping prices, managed care has had another effect. There has been a reallocation of increasingly scarce resources, much to the detriment of transplant centers. In effect, margins and profits within the system have simply been reallocated among the participating parties. Providers are making less money than they were and writing off more; insurers are less generous in their reimbursement and limiting the size of their annual premium increases; patients enjoy fewer benefits and are paying more out of pocket; pharmaceutical companies are experiencing record profits and are enduring serious criticism for doing so. In the end, transplant centers have been the big losers.

Clearly, if it is not obvious by now, what we have here is the proverbial shell game where no one seems intelligent enough to grasp and convey the big picture. I have tried to do so, but I am convinced that clinical judgment often stands in the way of prudent healthcare policy. The problem of seeing the forest for the trees is unavoidable.

The picture I have painted is dismal, but I firmly believe that institutional pressures on transplant programs to cover their costs and to turn a profit will persist. Programs can no longer be sustained at or below cost. Intra-institutional "charity programs" or "loss leaders," where there is little or no expectation of a payoff relative to investment, are less appealing when the technology has become established and the service routine.

"Cutting edge" technology has a short shelf life, and in the case of transplantation, there has been a relentless pursuit of new "gimmicks" that will enable transplant centers to distinguish themselves among their competitors. Recent examples include living-related lung transplantation, living donor liver transplantation, and laparoscopic nephrectomy. In reality, these are not new technologies at all. They are merely variations on old themes, and not particularly persuasive ones at that.

Thus, when the roosters start crowing, the decision support systems begin churning, and the hospital officials call in the management consultants, transplant programs will experience firsthand the lesson I have preached—life does have a price, and some clinical programs intended to ensure human longevity are more valuable than others. Consequently, most transplant centers would do well to build their case now to minimize the discomfort associated with a stretched neck and to avoid the disquieting sound of yet another devastating hatchet job—chop, chop, chop.

Roger W. Evans, Ph.D.
2251 Baihly Hills Drive Southwest
Rochester, Minnesota, USA 55902-1311
Tel: 507.281.0886
email: Evans.Roger@Home.com